**DMH Talking Points**
**FY 19 BAA**

## Reduce Sheriff Supervision

Gross: $145,508 GF: $67,239

This is a reduction for ¼ year to Sheriff Supervision cost. A large portion of the money we pay under the sheriff's contracts is for supervision in emergency departments (ED) vs transportation. We are legally required to provide transport, we are not for supervision – it was something DMH started doing after Irene to help the hospitals. However, it has been an ongoing and increasing cost for DMH's budget. Supervision simply provides an additional body other than hospital staff to keep eyes on a person. A hospital's ability to manage the dysregulated behavior of a patient who is waiting for an inpatient psychiatric bed varies from hospital to hospital. This may be due to the need to maintain a safe surrounding, availability of support resources, or security services at the hospital

Per Centers for Medicare and Medicaid Services (CMS) standards non-hospital personnel may not put hands on, restrain, contain in any way, or otherwise stop a person from leaving the ED. CMS is very clear that patients in the hospital are the sole responsibility of the hospital. Should a sheriff intervene, which unfortunately happens, Licensing and Protection (L&P) can and does investigate. At least two hospitals have had findings against them and one is working on a corrective action plan to avoid losing their CMS certification. Using Sheriffs in EDs continues to expose the hospitals to increased risk of further CMS violations. Should they find the hospital violated CMS standards, the hospital's certification may be at risk. Hospital's will insist this is a necessary service as they are people under DMH custody, but it is not legally required and does nothing more than cost DMH hundreds of thousands of dollars each year to pay sheriffs to simply watch a person in an ED, without being able to actually help in an intervention. Further, some hospitals have built psychiatric-specific supports in their emergency departments allowing reduced reliance on sheriff supervision, which may have contributed in an overall decrease of sheriff supervision use in 2018.

## Physician Contract with University of Vermont Medical Center (UVMMC)

Gross: $214,558 GF: $99,147

DMH re-negotiated the UVMMC contract this year and with that, UVMMC required salary increases for their Psychiatrists. With the recent retirement of some of the Psychiatrists providing services to VPCH and MTCR, UVMMC has had difficulty hiring into these positions due to the statewide shortage of Psychiatrists. Therefore, it was necessary to increase salaries for recruitment and retention purposes by bringing their salaries more in line with those of hospital psychiatrists in the region. This is to cover the cost of those increases.

**Recognition of additional Medicare Revenue for VPCH**

Gross: $0 GF: ($346,575)

VPCH has several funding sources. One of those sources is Medicare and other insurance billings. These funds are accounted for in a special fund that is not specifically Medicaid, Federal or General Fund. When VPCH opened DMH did not have history of Medicare and other billings, therefore we estimated the revenue to be $423,068. Over the last couple of years, the revenue has averaged ~ 1.2M. This is to recognize the additional revenue being received, thus reducing the need for GC Investment funds.

**Increase to VPCH Operating Costs**

Gross: $750,000 GF: $346,575

$750,000 is needed to cover additional operating expenses at VPCH, mostly due to traveling nurses in FY 19. VPCH continues to struggle recruiting classified nurses. Although we are experiencing some success, there is still a significant need for travelers due to vacancies as well as nurses being out on workers comp through FY 19.

**Child/Youth Residential**

Gross: $1,548,085 GF: $751,478

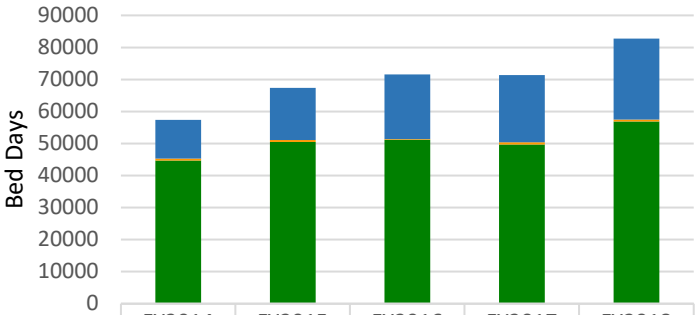
DMH has an ongoing pressure in PNMI (private non-medical institutions – residential treatment for children). Due to many factors, but primarily increased family challenges (including adverse family experiences such as opioid use, parental MH, and difficulty managing a child/youth's challenging behaviors), decreased access to community-based services due to staffing challenges, and decreased risk tolerance in communities due to threats of violence, the demand for residential has increased. DMH has seen an increase in the acuity of clinical need in the children and their families. When the community-based array of clinical and support services has not been able to adequately address the clinical needs, children are referred for residential treatment.

Our children's clinical care management team uses clear procedures and guidelines with clinical criteria to determine medical necessity for residential treatment and provides technical assistance with expecting schools, communities, families and Designated Agencies (DAs) to work together to explore options to meet the needs of the child in the community. When children or youth are determined to meet the medical necessity criteria for residential treatment, the DMH is required to provide that level of care under the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Determinations adverse to the request of the family are sometimes met with appeals. In order to fulfill the EPSDT mandate to provide medically necessary services to address or ameliorate a child/youth's identified mental health needs, we fund the necessary residential treatment for children in programs in-state and out-of-state. While DCF has seen a reduction in their residential utilization rates, DMH's experience is that children and their families still have very high needs that are addressed through the DMH system (see charts below).

Lastly, while our request is in response to the increased need for residential assessment and treatment, PNMI also funds the local short-term crisis beds at Howard Center; however, these are accessed by local

crisis teams following specific protocol. DMH does not approve the initial placement; crisis teams are authorized to approve up to 10 days in this setting. This represents around $1M of the DMH PNMI spending and is often impacted by Howard Center's requests for extraordinary financial relief which DMH is unable to budget for in advance.

**Total Residential Bed Days by Department per Fiscal Year Through FY18**

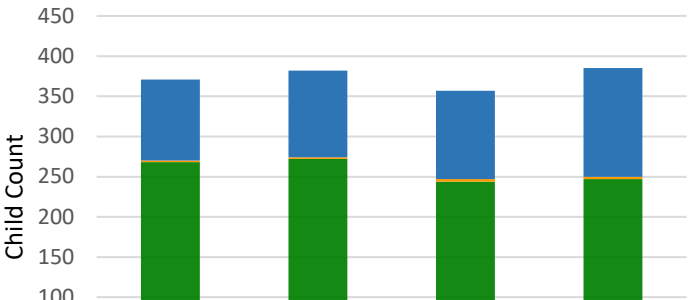



| | FY2014 | FY2015 | FY2016 | FY2017 | FY2018 |
|---|---|---|---|---|---|
| DMH | 12105 | 16341 | 20145 | 21047 | 25318 |
| DAIL | 557 | 511 | 289 | 623 | 598 |
| DCF | 44711 | 50539 | 51144 | 49725 | 56869 |

State Fiscal Year

unduplicated count

**Total Child Count in Residential by Department per Fiscal Year Through FY18**




| | FY2015 | FY2016 | FY2017 | FY2018 |
|---|---|---|---|---|
| DMH | 101 | 108 | 110 | 135 |
| DAIL | 2 | 2 | 3 | 3 |
| DCF | 268 | 272 | 244 | 247 |

State Fiscal Year

unduplicated count

**Additional Mental Health Block Grant (MHBG) Funds**

Gross: $339,204 GF: $0

DMH received notification that our block grant funds increased in FY 19.

The mental health block grant federal funding allocation varies each year, generally hovering around $1,100,000 and provides ongoing assistance towards efforts to support children and adolescents who are experiencing a severe emotional disturbance or adults with long-term mental illness to successfully remain in the community and avoid out-of-home and community placements.

The additional funds received this year are allocated as one-time funding based on current needs of the system informed by recommendations from the mental health block grant advisory council with members from AHS, the community and individuals with lived experience.

Specifically, the additional funds in FY19 were allocated to support the following:

- Respite services for families with a child or adolescent experiencing a severe emotional disturbance
- Efforts to maintain stable housing in the community for adults with severe mental illness
- The VT Support Line at Pathways
- The implementation of best practices for Suicide Prevention by The Center for Health and Learning
- The Pathways VT Community Center
- Agency/Provider Trainings
- Homeless youth. Grants given to each of the 5 Youth Services programs that offer transitional living programs to pay for housing related costs like rent, security deposit, furniture or moving expenses.
- Special Services funding supporting concrete needs for children and families (Weighted blankets for children/youth on the spectrum, access to a specialized summer camp, etc.)
- Dialectical Behavior Therapy training for providers
- Recruitment for individuals with lived experience and other community representatives for Advisory Councils

**Transformation Transfer Initiative (TTI) Grant**

Gross: $116,667 GF: $0

DMH has applied for grant funds through the Substance Abuse and Mental Health Services Administration (NASMHPD) to establish and expand comprehensive, crisis psychiatric bed registry programs. We were supposed to be notified in December, however, notice has been delayed. We expect to hear something this week. Because of the short timeline, it was necessary to obtain permission from the Joint Fiscal Office so we could start grant activities upon receipt.

The Vermont Department of Mental Health's current contract for an electronic bed board expires in the next year. See the end of this section for a description of what the electronic bed board is.

The Department's proposal is to leverage funds offered through the Transformation Transfer Initiative to perform an evaluation of Vermont's E-bed board functionality against current and future business needs and to provide a gap analysis based on currently available resources to meet the business needs. The evaluation results will be the basis for an E-bed board RFP and a determination to perform maintenance, update or replace the current electronic bed board system.

- One of Vermont's goals for the E-bed board is to expand current functionality so that it can better support individual's transitions in care and enhance and manage flow in our mental health system and improve discharge data and analytics.
- In addition, the evaluation of the current E-bed board will assist with near and long-term planning regarding the collection of additional encounter data about services provided for individuals in residential or crisis bed setting.
- Finally, the Department is seeking to align the E-bed board functionality to the extent practicable with planning underway by the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs. The Vermont Department of Health will use STR and SOR funds to develop a centralized intake/call center that will support consumers and providers accessing timely care for addiction treatment. The core elements of the system are expected to include a resource website, a call center for information, referral and appointments; education supports, outreach and case management, and marketing. Additional capacity through the TTI grant will assist the Department of Mental Health and others in the State of Vermont to align resources for ease of access to individuals, families, providers and payers.

The total grant proposal is $150,000. DMH estimates that we will expend $116K of that in FY 19 if this grant is awarded.

**What is an electronic bed board?**

The Vermont statewide electronic bed board (E-bed board) is designed to assist health and mental health providers to locate potential openings in mental health services so that patients can be referred for care. This system currently locates Adult Inpatient, Crisis, Addiction Recovery, Intensive Residential, and Residential beds as well as Children's Inpatient and Crisis beds within the State of Vermont[1].

The Vermont statewide E-bed board includes hospitals with inpatient psychiatric care units including the state-operated psychiatric care hospital, residences operated by community mental health agencies including crisis stabilization beds, and one state-operated secure therapeutic residential facility. A Facility Administrative User (FAU) is identified for each program included on the E-Bed Board. The FAU is responsible to update the bed census for their program at established minimum times. Both the FAU and state Administrator receive notices if an update has not been entered within the minimum standard. The program FAU also maintains a comprehensive profile of their programs, admission criteria, referral process, and point of contact that is included on the E- Bed Board. Each program has the option of attaching additional forms/pamphlets to their site. A general "search user" account allows any community clinician to execute a bed search. The search screen will display the name of the facility, number of beds, number of vacant beds, as well as a link to the program description. The screen also displays the time between the last update and when the search was executed. All options are listed geographically starting with the program that is closest to the zip code entered by the user.

The E-bed board web site is fast and easy for providers to locate openings for services such as inpatient mental health hospital beds, saving hours that would otherwise be spent calling facilities to locate openings. Once services are located, essential information including contact names and numbers and directions to the facility are easy to obtain on this site.

[1] https://bedboard.vermont.gov/

**Allocation of AHS-wide Grants reduction plan (AHS net-neutral)**

**Gross: ($1,032,921)** **GF: ($477,313)**

This is an AHS-wide grant reduction initiative to implement best practices around grant management. While DMH has an unachieved target, we are continuing to search for opportunities for savings, and will address at closeout if necessary. DMH is committed to continuous quality improvement of grant oversight and monitoring critical metrics of progress towards outcomes.

**AHS/AOA changes:**

**Vermont Department of Health (VDH) Memorandum of Understanding (MOU) for Maternal Health grant**

Gross: $26,624 GF: $0

This funding is to support .5 position for ½ year beginning January 1, 2019. This position will work with the Department of Health on a project to expand early identification of maternal depression and provide access to mental health and substance use disorder screening, treatment and referral. This project is funded by the Health Resources and Services Administration (HRSA) through a grant program approved by the Joint Fiscal Committee via JFO # 2708.

The Health Department will collaborate with the Department of Mental Health on this five year project. The Health Department is the federal grantee, and Department of Mental Health costs will be funded through a transfer of grant funding.

**Agency of Digital Services (ADS) true-up from AHS Central Office**

Gross: $394,134 GF: $197,067

This is a true-up of ADS cost associated with the Department of Mental Health.

**VDH MOU for Opioid Overdose Prevention**

Gross: $270,000 GF: $0

This is a technical assistance grant received by VDH and will be handled through interdepartmental transfer. The purpose of the grant with the Vermont Department of Health is statewide implementation of evidence-based practices for co-occurring disorders (substance use disorders and mental illness) with a special focus on identifying and responding to individuals with mental illness who are at risk of or are currently engaged in opioid misuse. The Department of Mental Health will work with an independent contractor that will work closely with the state, Designated Agencies, Preferred Providers, and community partners to improve upon the current system of care's treatment and prevention services for

individuals diagnosed with severe and persistent mental illness who are receiving services in Community Rehabilitation and Treatment programs in Vermont.

The overall goal of the proposal is to address ways that direct service staff of a DA can reduce the number of deaths related to opioid overdose among adults supported by the Designated Agencies' Community Rehabilitation and Treatment programs. The quality of services provided in the community to individuals served will be greatly improved through expert training and consultation to increase staffs' knowledge, clinical skills, and sustained competence with Integrated Dual Diagnosis Treatment and/or similarly effective Motivational Interviewing and Cognitive Behavioral Therapy combined approaches (e.g. Integrated Cognitive Therapy). The opportunity to receive ongoing supervision/coaching will also provide an evidence-based or best practice approach to ensure skill transfer and sustainability which directly contributes to better outcomes for people served. This work with designated agencies and preferred providers will also focus on developing ongoing methods to improve communication around individualized, person-centered treatment planning for individuals receiving both mental health and substance use services.

**Success Beyond Six (SBS) - Locally matched**

Gross: $16,200,000 GF: $7,486,020 (locally matched)

Overall program growth for the SBS program, which includes behavioral interventionists, school-based clinicians, and funding for specialized schools, is anticipated to be approximately $16.2M more than the fy19 base appropriation, bringing the program total to just over $70M. Match is paid for by the local schools.

The children's system is experiencing pressures in community-based, inpatient, crisis stabilization, and residential treatment programs, so the needs for children and families appear to be increasing across our system, including within schools. Youth Risk Behavior Survey (YRBS) data indicates that 19% of middle school students show signs of depression and 18% have had serious thoughts of suicide; 25% of high school students show signs of depression, 16% have hurt themselves on purpose, 11% have made a plan and 5% attempted suicide. Although overall student enrollment has decreased, VT has the highest rate of identified SED in the nation and schools are requesting mental health supports so that students can remain in the classroom and school setting, while also bringing MH expertise and consultation to their school-wide efforts to address all students' needs.

**Move Children's Individual Service Budget (ISB) Funds back to DCF (BAA Item)**

Gross: ($750,000) GF: ($346,575)

With the DMH payment reform effort, the Medicaid services being provided by the DA system for the children and youth in DCF custody will be included in the Medicaid bundles. This includes the Micro-residentials as well as individual fee for service. The remaining funding is being returned to DCF for a direct contract to Laraway for services similar to those previously provided through ISBs.

**Brattleboro Retreat (SFY 18 Carryforward funds)**

Gross: 1,045,496 GF: $483,124

In FY 18, DMH had a surplus that was in part due to Brattleboro Retreat Billing issues at both Children's and Adult programs. Because of these billing issues in FY 18, the funds will be expended in FY 19. Therefore, DMH was allowed to carry forward the funds.

**Applied Behavior Analysis (ABA) funding back to DVHA for NCSS**

Gross: ($697,100) GF: ($322,130)

This funding was added to the NCSS (Integrating Family Services) IFS bundle over a three-year period beginning in FY 16. DVHA has created a bundled payment structure to pay for all ABA services beginning July 1, 2019. This is a net neutral transfer to DVHA.

**DVHA to DMH for Payment Reform**

Gross: $2,796,026 GF: $1,271,432

This is the cost associated with Mental Health services currently being paid to the Designated Agencies through DVHA. DMH has gone through an extensive payment reform effort, which began on January 1, 2019 to bundle adult and children's mental health services. Included in these bundles is the dollars associated with the DVHA spend for mental health services through the designated agencies.