Department of Mental Health
FY 22 Budget Submission
Narrative Talking Points

Salary and Fringe Increases

Gross: $109,821 GF Equivalent: $224,561

Annualization of the FY21 salary and related fringe changes (salary, FICA, life, retirement, health, dental, EAP, LTD).

Annualization of 12-hour Shifts

Gross: $163,533 GF Equivalent: $71,955

VPCH is proposing to continue the 12-hour shift model that has been implemented during the COVID-19 pandemic for direct care staff to stabilize staffing. The current 12-hour shift model as implemented utilizes CRF funding. This funding is to annualize the amount requested in BAA for that model.

VPCH Leadership has conducted extension strategic planning over the last three years and has completed a thorough functional review that assessed the clinical, operational, and financial impact of the previous 8-hour staffing model. Based on this assessment it was concluded that the current VPCH Staffing model contributed significantly to:

- **Employee Dissatisfaction** –low morale, poor work-life balance
- **Clinical and Operational Shortcomings** –recruitment challenges, high rates of absenteeism and turnover
- **Significant and Unnecessary Financial Burdens** –high rates of overtime, temporary employment, and travel nurse contracts.

According to the most recent State of Vermont Workforce Report the five-year average turnover rate at DMH is 16% with DMH ranked the highest at 22% above average turnover rate for FY ’20. Job titles within state government who experienced the highest rates of turnover in FY 20 included Registered Nurse 60% and Mental Health Specialist 30.9%. Compared to previous fiscal years three departments (DMH, Vermont Vets Home, and DOC) had higher than average turnover with DMH listed as the highest. VPCH also experiences an above-average length of time (62.7 days) between a position becoming vacant and filling it. These challenges are exacerbated at VPCH by high rates of absenteeism including callouts, workers compensations, and Family Medical Leave absences.

The 12-Hour Shift model has already resulted in significant improvements and will allow VPCH to continue to advance these significant gains and improvement noted below:

- Improve retention and recruitment of MH Specialists and Nursing Staff
- Increase employee satisfaction and productivity
- Reduce absenteeism
- Reduce error rates
- Reduce Emergency Involuntary Procedures
- Decrease in HR/Personnel type concerns
- More effectively meet VPCH operational and financial needs

- Propel the State toward their important goal of achieving a sustainable and healthy workforce statewide

CRF Backfill (FY 21 One Time)

Gross: GF Equivalent: $19,283

This is replacing the one-time CRF funds from FY 21 for COVID contract expenses.

CRF Reduction (FY 21 One-Time)

Gross: ($106,199) GF Equivalent:

This is to eliminate CRF authority from FY 21 that is no longer needed.

Internal Service Fund – Workers Compensation

Gross: $106,471 GF Equivalent: $10,703

This is the increase cost of Workers Compensation for the Department of Mental Health.

Reduction of HHS CARES Revenue

Gross: $ GF Equivalent: $909,169

VPCH received funds from the HHS CARES Act program to cover lost revenue and to ensure that VPCH could continue its operations during the pandemic. This replaces the GC funding that will be needed for to fully operate the 25-bed hospital in FY 22.

VPCH Electronic Health Record Updates

Gross: $18,829 GF Equivalent: $8,285

This is to update the current EHR for VPCH with a training and test environment as well as new billing software. VPCH requires an EHR training and test environment which mirrors the production environment. The current EHR test and training system is stand alone and cannot be updated to match the production environment. Staff learn utilizing the EHR production environment which contains active patient data, leading to errors which are potentially fatal. VPCH is unable to test upgrades, updates, and train staff without jeopardizing active (live) patient data. Two primary components for documentation, the MedAct and Physician notes are set to expire 12/31/2020. No supports will be available from the vendor for these documentation platforms. The training and test environment will allow VPCH to appropriately update and train staff on the replacement platforms.

The Joint Commission requires an accredited hospital to have a functioning EHR which addresses JC patient safety goals. This includes: Patient identification, Staff communication, safe use of medication, infection prevention, med reconciliation, and suicide risk. VPCH is unable to test, train, and update following these requirements outside of the live system potentially leading to fatal errors

In addition, the EHR billing software module currently utilized will be discontinued as of 03/31/2021. RCM software will replace the existing software per the vendor.

VPCH and MTCR annualization of Copier and Van Reductions

Gross: ($1,543) GF Equivalent: ($679)

In the FY 21 amended budget, DMH reduced operating expenses at VPCH and MTCR by reducing the number of photo copiers by one at VPCH and reducing the total of vans at MTCR for the three quarters in FY 21. This represents the annualization of these reductions.

Eliminate CRF Authority for COVID Related Operating costs

Gross: ($10,613) GF Equivalent: $

This eliminates the CRF authority for COVID operating costs such as laptops for telework.

Internal Service Fund (ISF) changes TBD

Gross: $118,833 GF Equivalent: $56,890

Internal Service Fund changes, such as liability insurance, fee for space, Workers Comp, VISION, HR and Agency of Digital Service (ADS) charges.

Child and Youth Residential

Gross: $259,100 GF Equivalent: $164,609

This increases PNMI (private non-medical institutions – residential treatment for children and youth) funding by 3% to account for the increased cost to facilities providing residential treatment to children and youth.

This budget pressure is due increases in rates between FY 20 and FY 21 set through the Rate Setting process. Annually, the Division of Rate Setting reviews rates for these facilities based on their expenditures from two years prior. There are methods, standards and principles for establishing payment rates for these institutions which must be adhered to.

Room & Board Phase Down

Gross: $ GF Equivalent: $315,427

CMS is requiring the State of Vermont to phase down our payments toward room and board beginning on January 1, 2019 by 1/3 of the total each calendar year through 2021. This represents the remaining amount that needs to be moved to General Fund for the phase down of GC.

Annualization of New Level 1 Beds at Brattleboro Retreat

Gross: $2,513,157 GF Equivalent: $1,105,789

The FY 21 budget assumes the 12 new Level 1 beds at Brattleboro Retreat will be on-line beginning January 1, 2021. The amount in the FY 22 budget build is the annualization of those beds.

The 12 new Level 1 beds will provide essential inpatient capacity to serve the most clinically acute individuals seeking mental health care and treatment. This additional inpatient capacity will contribute to substantially decreasing Emergency Department wait times and ensure timely access to quality mental health care and treatment thus improving outcomes.

Remove IDT Funding for Windham Center Capacity Payment

Gross: ($1,792,197) GF Equivalent: $

This removes the funding for the Windham Center capacity payments for COVID positive mental health patients, as this authority is no longer needed.

Increase Federal Authority

Gross: $251,438 GF Equivalent: $

This request is a technical adjustment to increase Federal spending authority due to increases in Federal funding for Mental Health Block Grant, as well as new funding under TTI and Suicide Prevention.

Implement Mobile Response (MRSS)

Implementation in 1 Region of Vermont:

Gross: $600,000 GF Equivalent: $600,000

Implement a Mobile Response team demonstration site in Rutland, Vermont. This would include the core components of Mobile Response including face-to face mobile response to the children's home, school or other location; on-site/in home de-escalation, assessment, planning and resource referral; follow-up stabilization services and case management; and data tracking and performance measurement reporting. Managing the social and fiscal impacts of the utilization of higher levels of care is important. Current data that looks at the utilization and total cost of care for Vermont children and youth with mental health needs indicates that Rutland has the highest average ED's visits for children and youth with mental health needs across the state (see chart below).

Mobile Response and Stabilization Services (MRSS) differ from traditional crisis services in that MRSS provides more upstream services. A mobile face-to-face response is provided to a *family-defined crisis* to provide support and intervention for a child/youth and their family, *before* emotional and behavioral difficulties escalate. MRSS has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as

emergency departments, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018).

In Vermont we have the following challenges:

- ✓ Increases in children/youth (0-17) who go to Emergency Departments with a mental health crisis and then wait, sometimes for days, for a plan to be put into place (inpatient, crisis alternative program, or community-based).
- ✓ Designated Agencies' emergency services are expected to provide "Mobile outreach capability and crisis stabilization services *as feasible within existing resources* to help prevent need for higher level of care" (emphasis added). There is a gap between the current resourced capacity of the DA emergency services teams and the current demand for these services.
- ✓ The DA emergency services teams manage this gap between resource and demand by determining what constitutes a crisis and prioritizing crisis screening for inpatient admissions.
- ✓ Families and providers see a need for responsive, in-home community supports beyond screening.
- ✓ For additional information on mobile response see Making the Case for Mobile Response in Vermont.

States which have effectively implemented MRS have shown the following savings and outcomes:

- Connecticut: A study showed a 25% reduction in ED visits among children/youth who used MRSS compared to youth who didn't access MRSS *(Child Health & Development Institute, 2018).*
- Washington State: The Seattle, WA MRSS reported diverting 91-94% of hospital admissions and "estimated that it saved $3.8 to 7.5 million in hospital costs and $2.8M in out-of-home placement costs" (*NASMHPD 2018).*
- Arizona: Arizona's MRSS reportedly "saved 8,800 hours of law enforcement time, the equivalent of four full-time officers".
- New Jersey: Data showed that 46/46 children who entered foster care and who had a mobile response were able to remain in their first placement.

Vermont strives to get upstream as a system, but due to many factors including funding levels, much of our system supports are available only in reaction to an identified problem. We want to shift from being reactive to responsive. When supports and stabilization are offered earlier for families in their chosen setting (home or community), we can shift the trajectory for children and their families, heading off the need for more intensive, expensive and/or longer-term services down the road. Without new investment in MRSS, these trends will continue. MRSS is recognized as an effective component of a comprehensive crisis continuum.

Emergency Department Use by "High Utilizer" Children/Youth by Health Service Area

Member HSA	# Members	# ED MH Visits	Avg ED Visits/Member
Burlington	1056	631	0.60
Barre	644	481	0.75
St Albans	577	230	0.40
Rutland	505	626	1.24
Bennington	470	411	0.87
White River Jct	447	252	0.56
Brattleboro	290	292	1.01
St Johnsbury	277	152	0.55
Springfield	269	243	0.90
Newport	268	126	0.47
Morrisville	264	80	0.30
Randolph	200	80	0.40
Middlebury	124	77	0.62
Grand Total	**5391**	**3681**	**0.68**

Project of Depts of Vermont Health Access (DVHA), Mental Health (DMH), and Onpoint Health Data consultant

Justice Reinvestment

Gross: $400,000 GF Equivalent: $400,000

This funding will be split between DMH and VDH to target gaps in community mental health services for people on supervision. The intent is to expand community-based services for the non-Serious Mental Illness (SMI) population and people with substance use or co-occurring disorders.

AHS/AOA changes:

Transfer from DCF for PCC Investments

Gross: $34,012
GF Equivalent: $14,965

For over eight years now the Addison Parent Child Center IFS grant has included funding from DCF that is invoiced each quarter by ACPCC. The invoices come to the IFS grant manager at DMH, are then sent for approval to CDD and the DCF business office, then the payments are processed.

These funds cannot be included in the bundled case rate which is why they are invoiced separately. The funding is for parent education and ECFMH services that ACPCC provides. The administrative burden entailed in receiving the invoices, getting approval from DCF and then processing has delayed payments on numerous occasions. To resolve this issue, DMH, DCF business office and CDD leadership have all agreed to transfer these funds in the next ups and downs from DCF to DMH so the ACPCC would submit their invoices to DMH for processing and payment.

DMH already monitors the ACPCC for their services through quality reviews and MSR data reporting. As well, the services paid through this invoice system have been and would remain in the IFS grant overseen by DMH.