AHS Testimony: Programming for Youth with Complex Needs

Department of Mental Health (DMH)
Department of Disabilities, Aging and Independent Living (DAIL)
Department for Children and Families, Family Services Division (DCF-FSD)

VERMONT
AGENCY OF HUMAN SERVICES

Monica Ogelby, Medicaid Director, AHS
Emily Hawes, Commissioner, DMH
Cheryle Wilcox, Mental Health Collaborations Director, DMH
Jennifer Garabedian, Developmental Disabilities Director, DAIL
Melanie Feddersen, Developmental Disabilities Services Specialist Supervisor, DAIL
Aryka Radke, Deputy Commissioner, DCF-FSD
Tyler Allen, Adolescent Services Director, DCF-FSD

What is the problem we need to address?

- We have insufficient programming in Vermont to support youth with complex, high needs.
- This results in youth being placed out of state (Florida, Tennessee, Massachusetts, Pennsylvania, Virginia) far from their families, school, and community.
- It also results in youth getting "stuck" at levels of care that are too high, or do not meet their needs.

How we have focused on this problem across AHS

- In 2017, AHS and AOE submitted a joint legislative report on the use of out of state and in-state residential placements, including Woodside.
- In 2020, an interagency team comprised of staff from the Department for Children and Families, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, and the Agency of Education worked with a consultant to do an analysis of residential programming in Vermont to identify gaps and hear from families about their needs.
- In 2021, an AHS group including program and fiscal staff across AHS depts began meeting monthly (with subgroups meeting in between) to discuss and take action for the children's system of care focused in alignment with each other.
- Beginning in 2023, DCF began facilitating a taskforce for the purpose of strategizing ways to restore the High-End System of Care (HESOC)—in both the short and long term. The group is comprised of staff from DCF, DAIL, DMH, law enforcement, residential program leadership, hospitals and individuals with lived experience. Currently, the taskforce is discussing staging a foster care summit focused on retention and recruitment of foster parents.
- DCF also facilitates a Shared Response to Emergency Placements meeting, involving DAIL, DMH and DCF that meets bi-weekly to discuss, and brainstorm solutions for children and youth that may have cross departmental involvement and experiencing being stuck in an incorrect level of care or other placement challenges.
- In 2023 DCF also began hosting the Facility Planning for Justice-Involved Youth Stakeholder Workgroup. This group will be deeply involved in the planning process for the permanent secure facility to be built over the next few years, including providing input into the size, scope, protocols, and policies of the programs. This stakeholder's group includes attorneys, advocates, court personnel, those with lived experience and staff from DAIL, DMH and DCF.
- Our State Interagency Team which meets monthly and includes DMH, DAIL, DVHA, DCF-FSD, CDD, Health Department, Vermont Family Network, and the Vermont Federation of Families. This group discusses the system of care and what is working well and where gaps exist.

An addition needed to the high-end system of care--A Psychiatric Residential Treatment Facility (PRTF)

PRTF = A treatment program that is under the direction of a physician, each youth must have a treatment plan within 14 days of entering the program, employs social workers, nurses, psychiatry.

- This is a place for youth who need 24/7 support and specialized interventions to keep them safe and address their mental health.
- Placement at a PRTF is based on medically needed treatment for youth with significant mental health challenges.
- Security features: Bedroom doors are NOT locked. Outer doors may be locked or alarmed.
- Educational and clinical services are provided.

Who will be served at the PRTF?

- **Youth ages 12 up to 21** (if they were placed there by their 18th birthday). This age group is set by the Centers for Medicare and Medicaid Services.
- The PRTF will have **15 beds**; this is based on the number of youth across departments who are placed at out of state PRTFs or are needing that level of care.
- This level of care will help move youth out of Emergency Departments and ensure youth have more options to be in the right level of care.

Where does a PRTF fit into the high-end system of care?

Dev. Disability

- Psychiatric Residential Treatment Facility (PRTF)
- Private Non-Medical Institutions (PNMI)
- State and Regional Crisis Beds (i.e., VCIN)
- Home-and Community-Based Services

Mental Health

- Inpatient Psychiatric beds
- Hospital Diversion/ Crisis Stabilization
- Psychiatric Residential Treatment Program (PRTF)
- Residential Treatment Programs (Private Non-Medical Institutions; PNMI)
- Group Homes (including micro-residential)
- Intensive home & community wraps

DCF

- Short-term Secure Stabilization Facility (temp. Middlesex)
- Short-term Secure Stabilization & Treatment Facility
- Staff-secure Crisis Stabilization
- PRTF

VERMONT

Why do we need to invest in the high-end system of care?

- Intensive placements have diminished over the past decade in Vermont– we still pay for high level care but send children to PRTF and other residential programs out of state.
- Children and youth deserve intensive treatment in Vermont where they reside so they can be transitioned back to their families and community.
- This level of care will always be needed – even with community investment and supports.

How will a PRTF in Vermont help Youth and Families?

- By having a PRTF in Vermont, children and youth who need this level of care will be able to do more family work and do home visits which we believe will mean shorter lengths of stay in the program than for youth out of state.
- This PRTF can be accessed by families who work with DMH, DCF-Family Services, or DAIL. This program will serve youth with co-occurring challenges.
- Providing this level of care next to the inpatient psychiatric hospital will improve system flow and child/youth/family experience. Remaining at an inpatient level of care beyond clinical need can have unintended consequences and impact a youth's positive progress.
- Youth and children still wait in Emergency Departments to access inpatient psychiatric care, an issue the departments have been working hard to address – a PRTF provides appropriate step down for youth in inpatient or other stabilization programming, as many youth currently in those settings are ready to discharge.
- Likewise, as part of the DCF higher end system of care, a PRTF will serve a critical role by providing step down programming for youth exiting more acute levels of care, such as stabilization treatment or even a hospital setting. This is vitally important so that our youth can receive the level of treatment designed to fit their current level of need.

Using Data to Determine how to right size the high-end system of care

	Total Vermont youth who are out of state	Youth in an out of state program that isn't a PRTF	Youth in an out of state PRTF	% Out of State in a PRTF	Referral pending for Out of State placement in a residential or PRTF
DMH	29	27	2	7%	6
DCF	49	39	10	20%	12
DAIL	7	3	4	57%	4
Total AHS	88	69	16	18%	22

Source: Case Review Committee (AHS), Point in time data, 3-4-2024

- Quarterly trend data released by DMH about youth in residential across DMH, DCF, and DAIL
- Annual System of Care report published by State Interagency Team

Fiscal Impacts

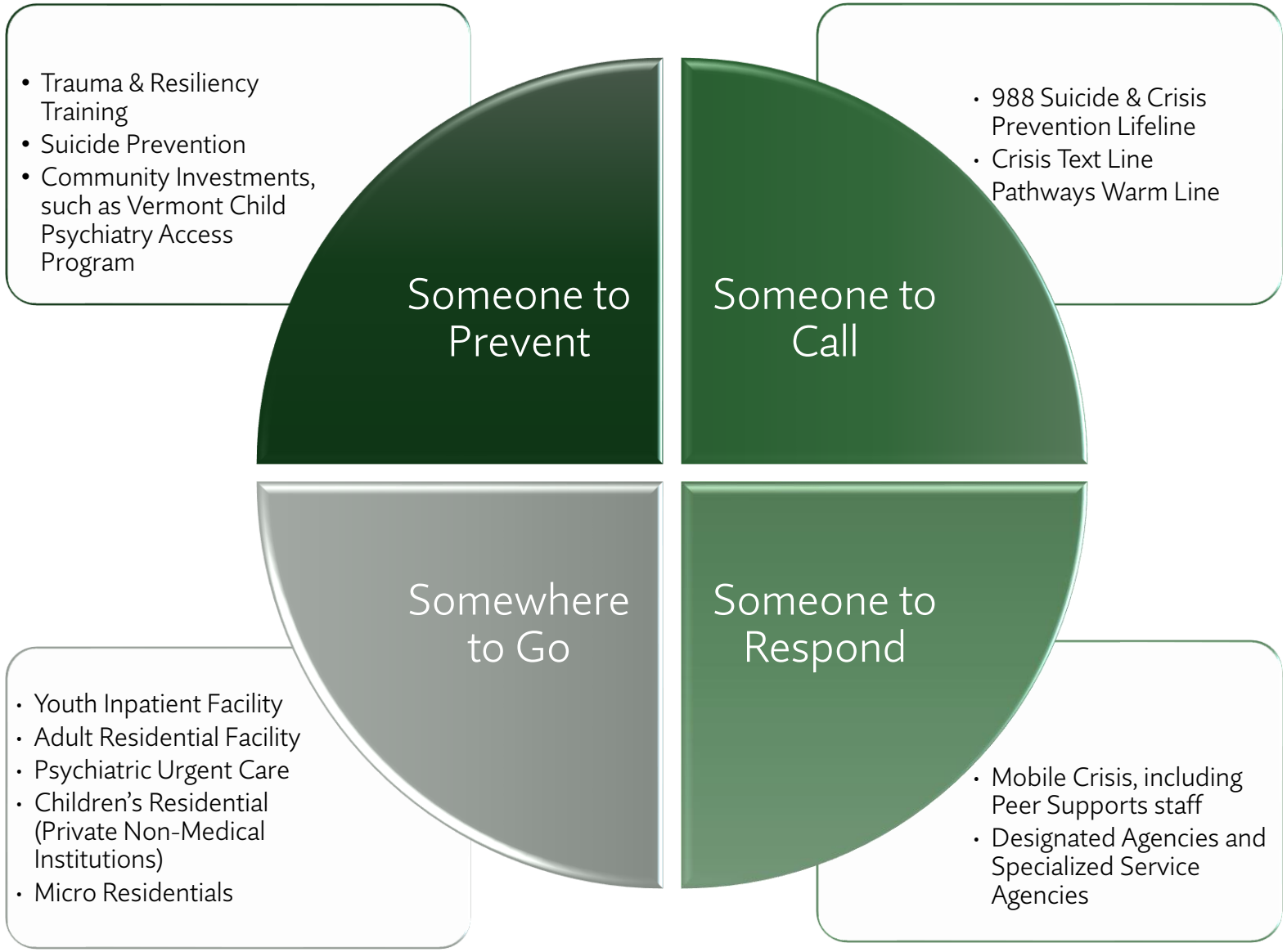
- Medicaid pays for these services delivered out of state
- PRTF Medicaid rate includes room & board costs, unlike other residential programs
- Base funding line item to establish in-state service with a new contract – began with 6 months of funding as that is what is foreseen given startup
- Ongoing funding decisions will be made based on caseload data similarly to other Medicaid services – expect some savings from out of state changes and other service shifts

Operational Requirements and Next Steps for the PRTF

- Contract work with vendor
- Applying for a State Plan Amendment so the service can be billed to Medicaid.
- The PRTF vendor reached out to the Green Mountain Care Board to share their intention of providing this service and were notified it did not require a new Certificate of Need.
- Secure funding so the PRTF can hire and be prepared to start accepting youth this calendar year into the program.
- We need an exception to the moratorium on independent schools that was passed last session H. 483 so the PRTF can apply to operate a school on site.

Department of Mental Health

VERMONT


Someone to Prevent
Someone to Call
Somewhere to Go
Someone to Respond
• Trauma & Resiliency Training
• Suicide Prevention
• Community Investments, such as Vermont Child Psychiatry Access Program
• 988 Suicide & Crisis Prevention Lifeline
• Crisis Text Line
Pathways Warm Line
• Youth Inpatient Facility
• Adult Residential Facility
• Psychiatric Urgent Care
• Children's Residential (Private Non-Medical Institutions)
• Micro Residentials
• Mobile Crisis, including Peer Supports staff
• Designated Agencies and Specialized Service Agencies

Why do we need different levels of care in Vermont?

- We need inpatient beds, mobile crisis, a PRTF, AND community supports and services.
- This isn't an either/or for needs. We need to help children earlier to prevent crisis *and* we need to care for our children and youth currently struggling with severe mental health challenges.
- Challenges in meeting medical needs of youth who are placed out of state. While the OOS residential program is enrolled in VT Medicaid, other health providers in that state are often not willing to enroll in VT Medicaid.

Disabilities, Aging and Independent Living

VERMONT

PRTF in Developmental Disabilities Services Philosophy

- Developmental Disabilities Services Act ("DD Act") provides set of Guiding Principles.
- First principle: ***Children's Services. ...Children with disabilities benefit by growing up in their own families; families benefit by staying together; and communities benefit from the diversity that is provided when people with varying abilities are included.***
- Creating a PRTF in Vermont increases opportunities for families and community providers to visit and meaningfully participate in transition and discharge planning.

Developmental Disabilities Services Need for PRTF

- Current state has resulted in:
  - Repeated presentations to Emergency Departments,
  - Admissions to Brattleboro Retreat without appropriate disposition, and
  - Inadequate community-based supports.
- Acuity of need surpasses community-based capacity
  - Designated Agencies and Specialized Service Agencies, as well as other community partners are not able to adequately meet the complexity of care in the community
  - Children require treatment and stabilization prior to returning to community-based supports.

Children and Families

VERMONT

PRTF: An Important Feature in DCF's Continuum of Care

- DCF's longstanding value is ensuring the right program, at the right time, for the right length of time for all youth in residential level care.

- DCF's HESOC plan, which is described in our Act 23 report, identifies four distinct types of programs needed to bolster the most critical elements of the statewide system of care, including a PRTF. *(See here for the Act 23 Report and related update report.)*

PRTF: An Important Feature in DCF's Continuum of Care

- PRTF level care operates not only as a step down from higher acuity placements, but also as an intermediate step to lower acuity placements, such as community based residential or foster care with support and stabilization services.

- Providing another avenue to step down from a residential placement, such as from a PRTF to foster care with services, can support the downward trend we see in the number of DCF youth currently placed in residential care.

    - As of 2/1/24, 84 out of 944 children/youth in DCF custody are in residential level care, which is 8.9%. This number has been trending down for many years, and this is the lowest it has been in a decade. In comparison, 10 years ago we had over 15% of our youth placed in residential level care.