Designated and Specialized Service Agencies

Providing an indispensable community-based system supporting mental health, substance use, and intellectual and developmental disability needs across Vermont

VERMONT CARE PARTNERS

Testimony for House Health Care on S.36
April 5, 2025

Community Based Co-Occurring Crisis Supports

SAMHSA Best Practice:

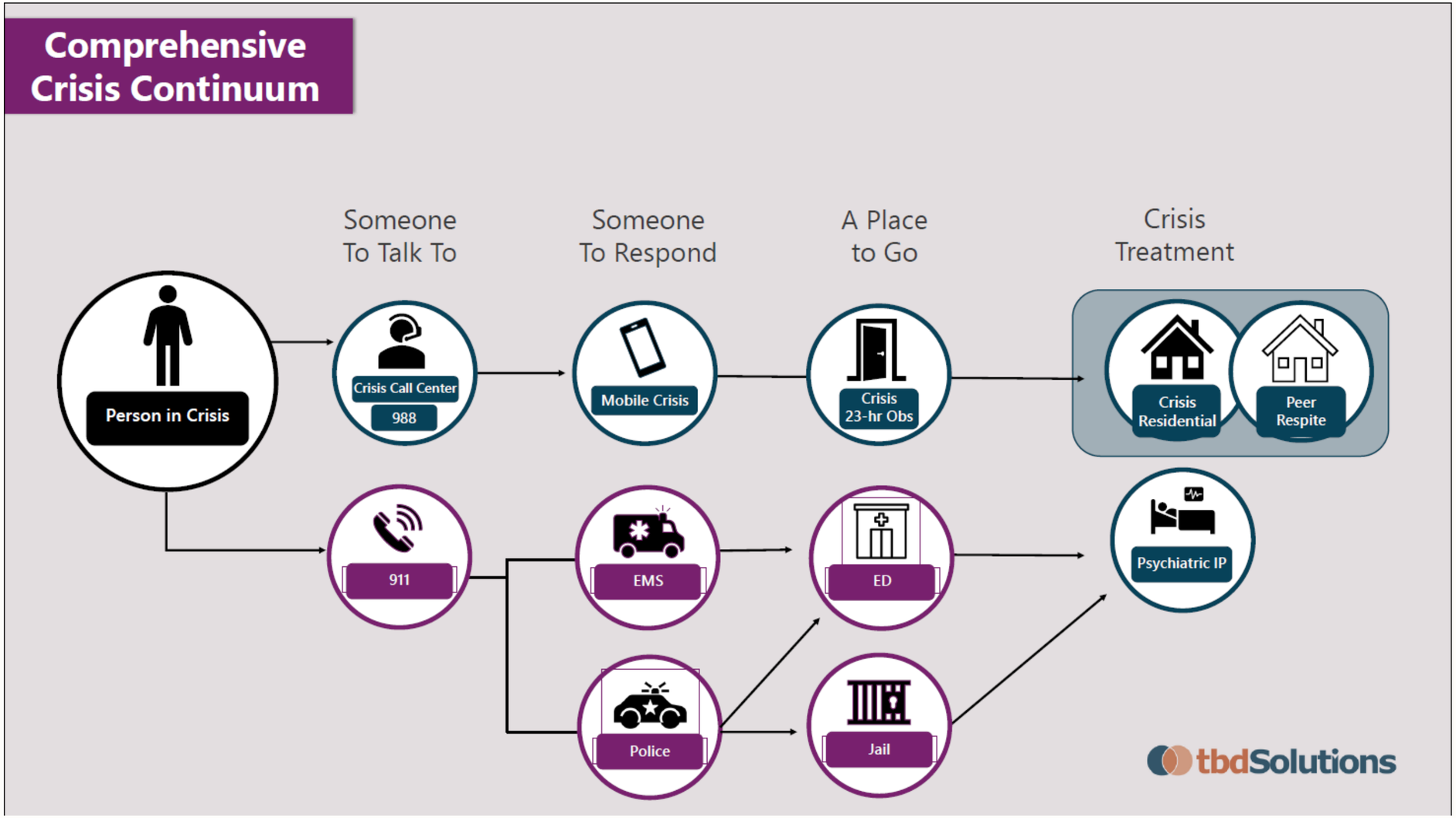
1. Crisis Services Should Be Comprehensive, Integrated, Coordinated, and Developed Utilizing a Systems Based Approach
2. Crisis Services Should Be Person-Centered, Family Focused, and Provide the Right Level of Care at the Right Time
3. Crisis Services Should Prioritize Safety
4. Crisis Services Should Be Equitably Accessible and Responsive to the Diverse Needs of Populations
5. Crisis Services Should Prioritize Quality and Effectiveness
6. Crisis Services Should Be Developmentally Appropriate
7. Crisis Services Should Be Resiliency- and Recovery-Oriented
8. Crisis Services Should Be Trauma-Informed
9. Crisis Services Should Provide Continuity of Care from Onset of Crisis Until Stability and Include Follow-Up Care and Linkage
10. Crisis Services Should Be Evidence-Based, Evidence Informed, and/or Reflect Best, Promising, and Emerging Practices
11. Crisis Services Should Be Responsive to Individuals' Wholistic Needs

"Throughout the crisis system, services should be co-occurring capable and designed to meet the needs of individuals who present with SUDs as well as mental health conditions."

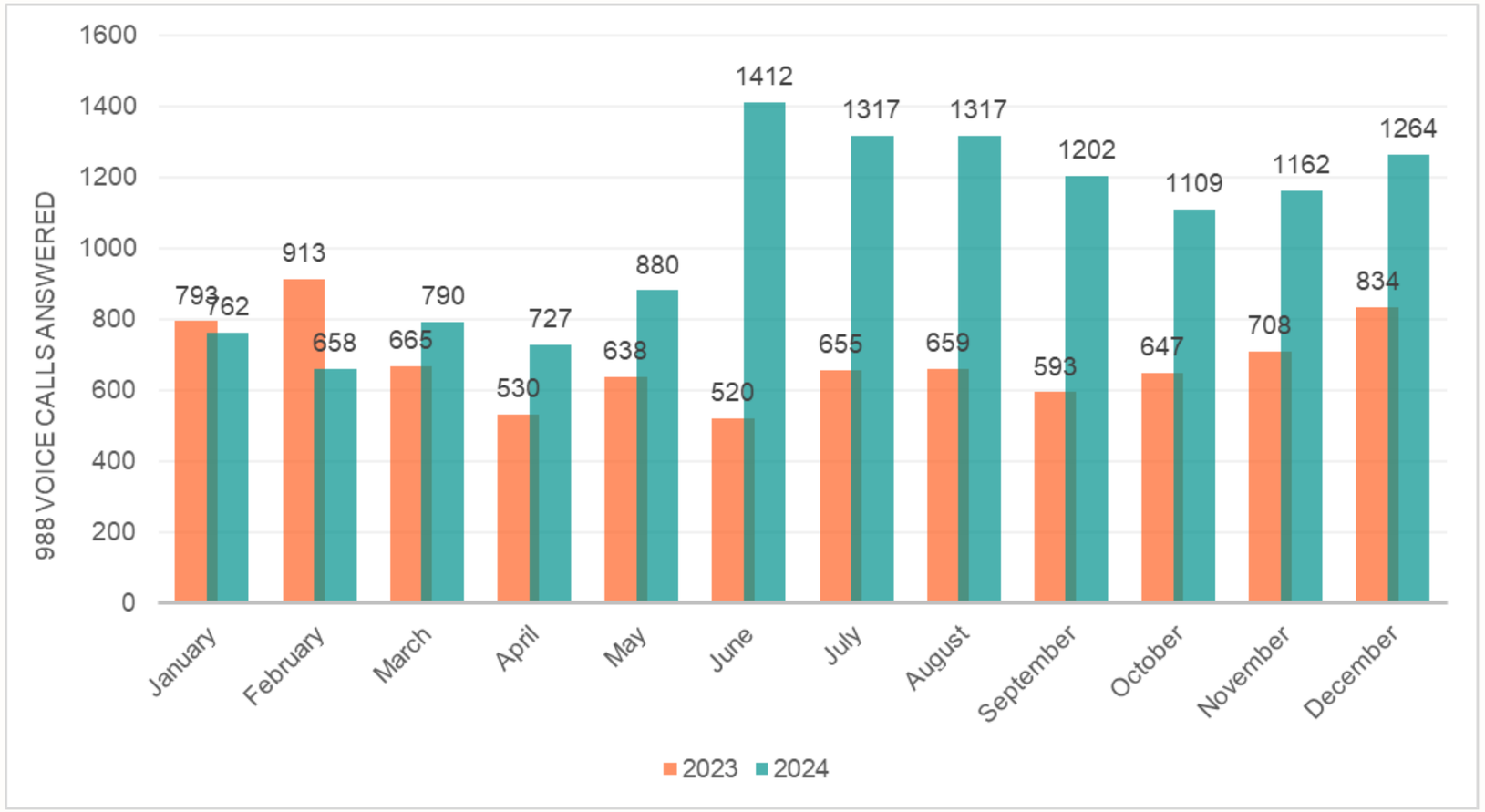
Note:

- Research Demonstrates it takes 2 years to bring a new program to fidelity.

Co-Occurring Supports – Comprehensive Crisis Continuum



988 Lifeline – Call/Chat/Text



Comparison of Total Vermont 988 Lifeline Voice Interactions

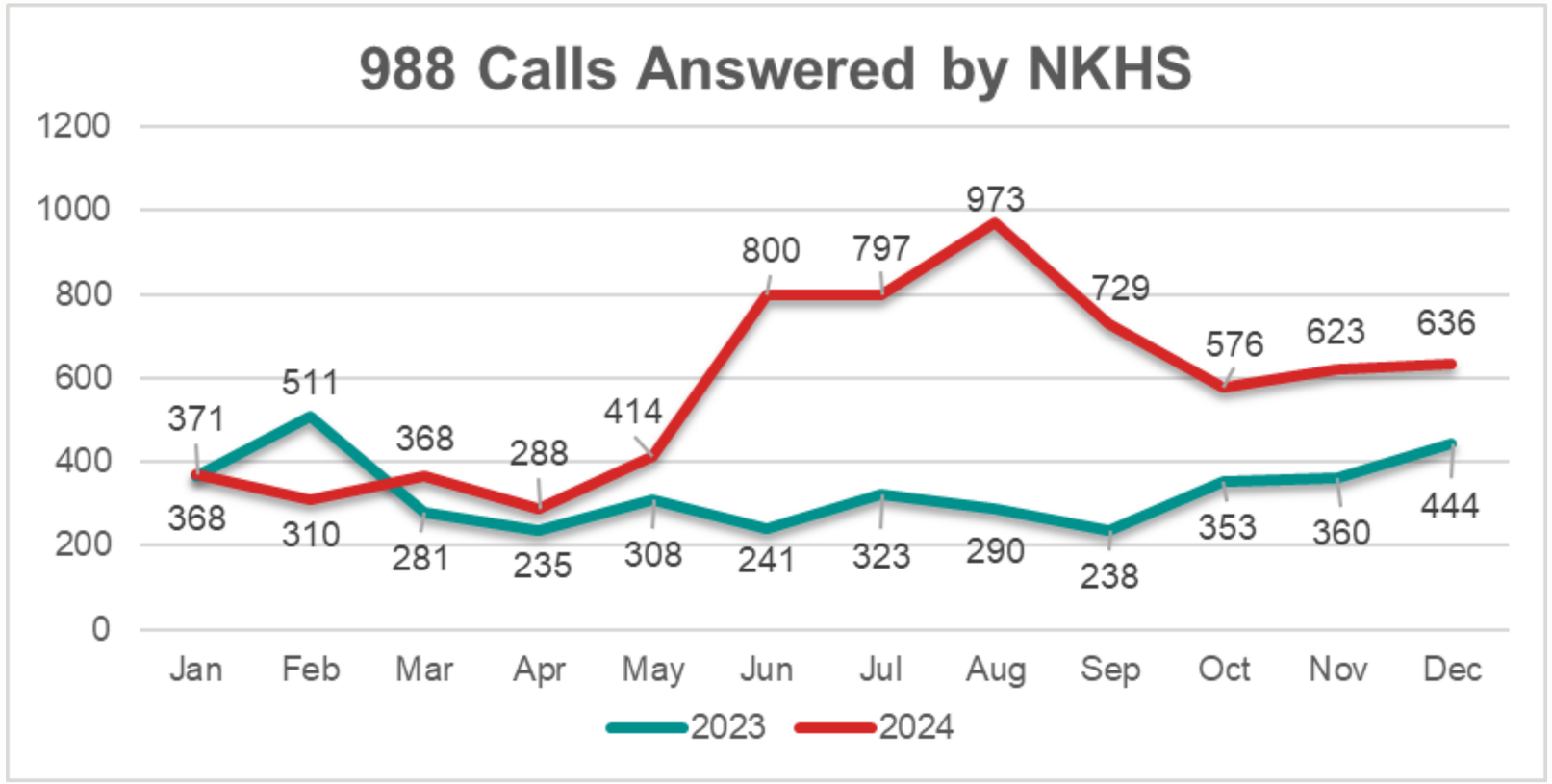
2023 vs 2024

2023 Total: 8155 calls

2024 Total: 12487 calls

Increase: 4332 calls (53.1%)

988 Lifeline – Call/Chat/Text



January 2025

863 calls answered

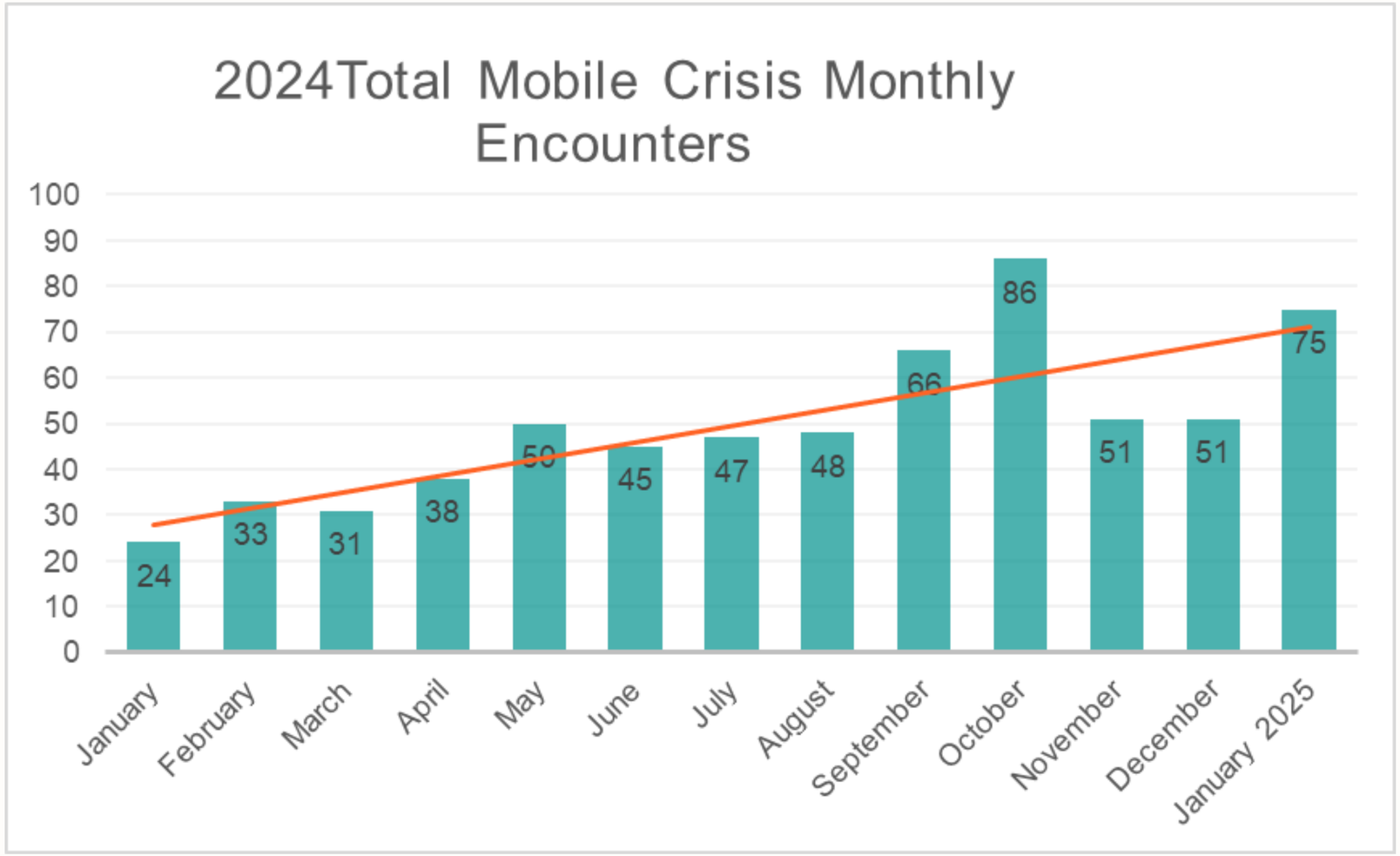
19.3 minutes – average talk time

163 chat and text contacts

35.01 – average text/chat duration

Each intervention directly supported a Vermonter in need and was delivered by
NKHS responders.

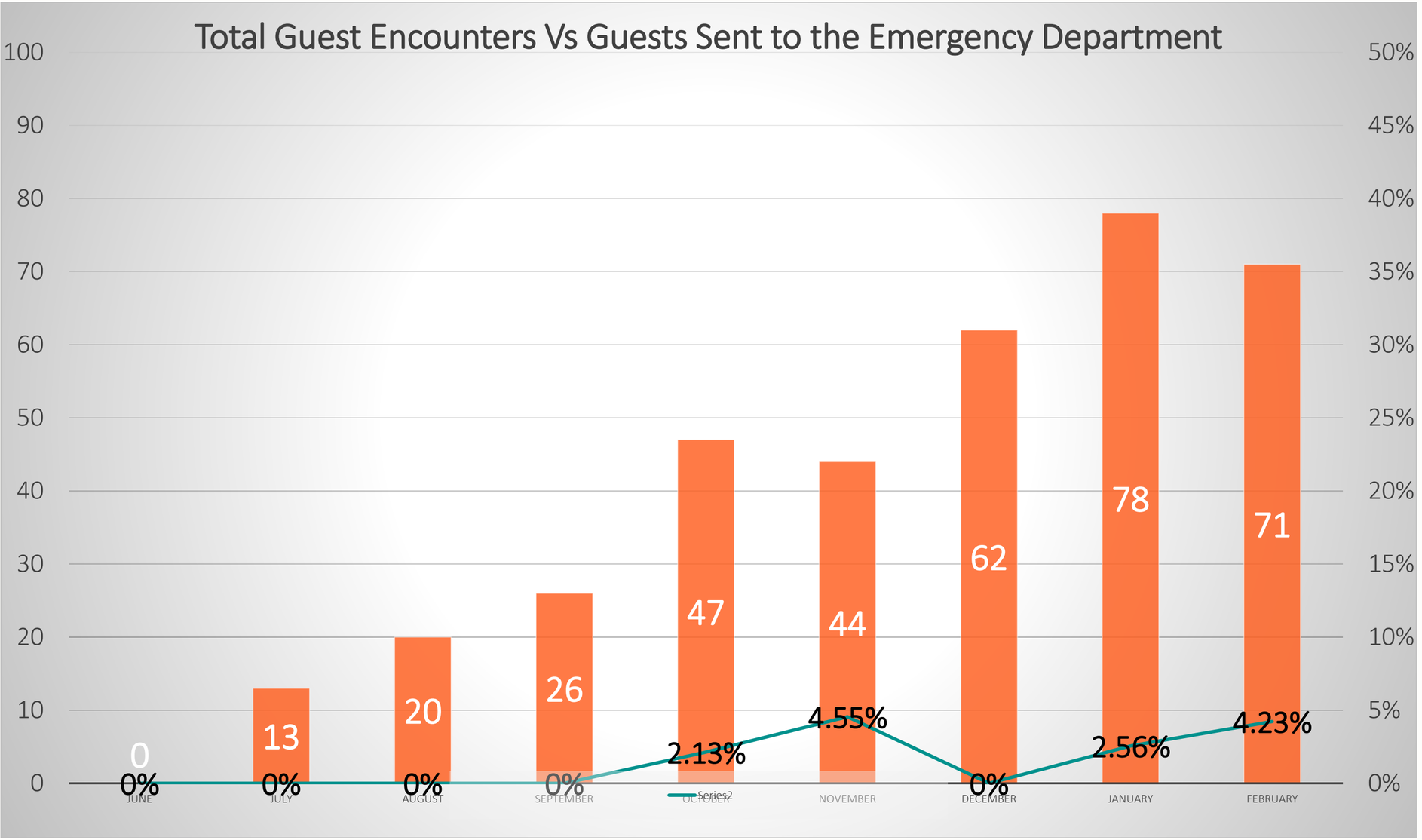
Mobile Crisis



563 Responses

224 Follow-ups

Front Porch
Mental Health Urgent Care



For adults, children, and families experiencing a co-occurring crisis needing immediate non-medical care
in a community-based, person-centered environment.

Note:

- Supported 101 individuals in March

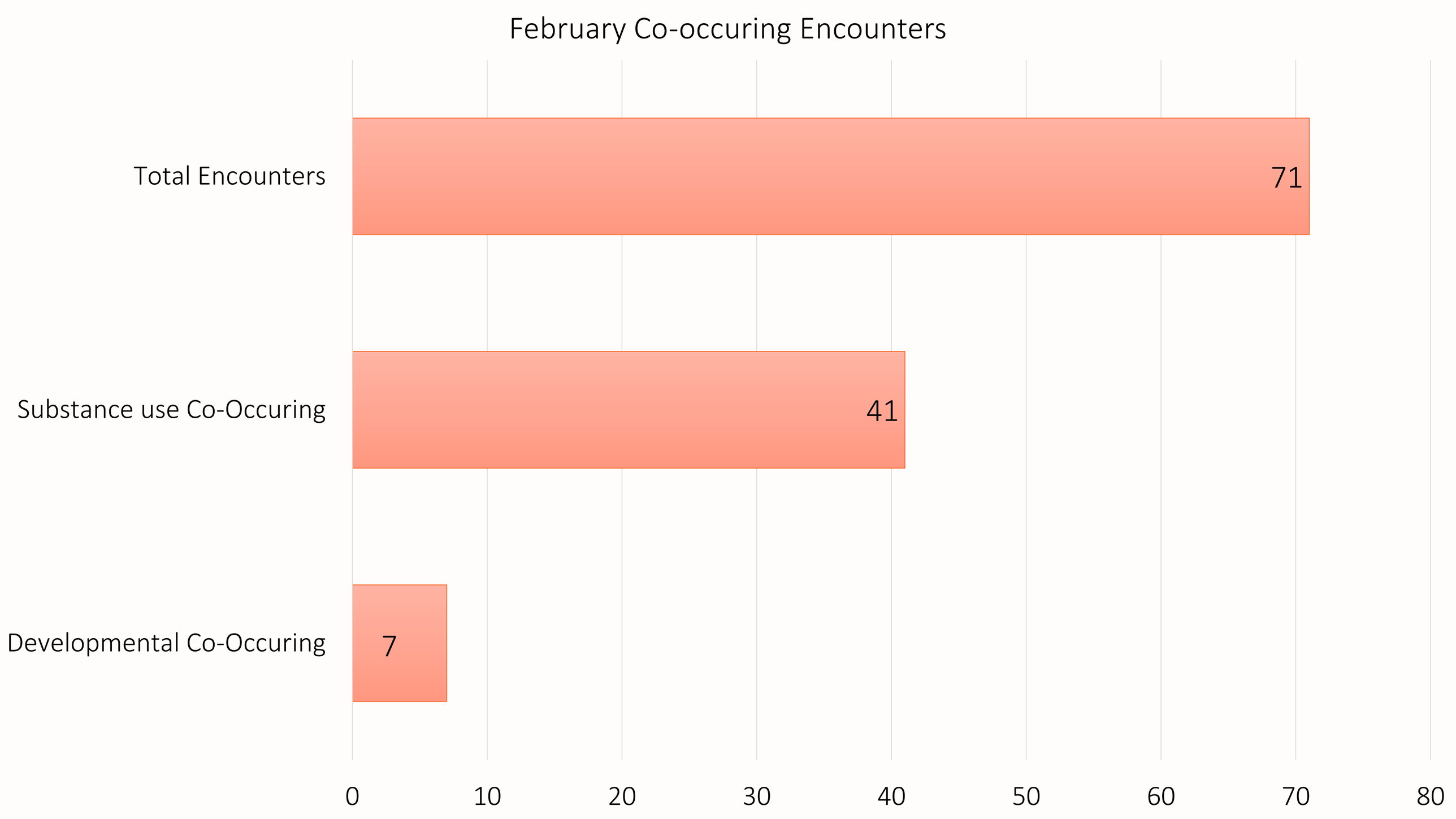

February Co-occuring Encounters
Total Encounters
71
Substance use Co-Occuring
41
Developmental Co-Occuring
7
0
10
20
30
40
50
60
70
80

Table 3D - Emergency Services

- These charges do NOT include charges for tests or procedures performed during the visit. Please check with your hospital and physician for details about pricing and your specific circumstances.
- The different "levels" in the CPT code descriptions indicate levels of complexity of the ER visit. A higher level number is more complex than a lower number.

	CPT Code	99281	99282	99283	99284	99285
Hospital	**Description**	Emergency room visit, level 1	Emergency room visit, level 2	Emergency room visit, level 3	Emergency room visit, level 4	Emergency room visit, level 5
Hospital System Averages	Hospital Charge	$344	$493	$810	$1,218	$1,692
	Physician Charge	$105	$145	$261	$388	$552
	Total Charge	$450	$638	$1,071	$1,605	$2,244

NKHS Current Public Inebriate Funding - $140k per year

- 1FTE Staff Person ($25/hour/24hours per day with benefits) = $302,222
- For Safety you really need 2 staff = $604,444
- Add 15% admin = $695,106
- Estimate 83.3 Visits per month = 1000 per year
- Current PIP Bed is underutilized due to funding and “on call” model

Cost for ER Visit at the level 3 cost (average)

- $1,071 per visit
- 83.3 visits per month or 1000 per year.
- Total Cost at ER - $1,071,000

Note:

- Non-confirmed overdose is a level 3 code*
- Suicidal and Homicidal ideation is a level 5 code*

Note:

- Cost Savings of community model vs Hospital ED
- $375,894

*CODING GUIDELINES FOR EMERGENCY DEPARTMENT | BCBSND – LAST UPDATED SEPTEMBER 2024

	CPI **Calendar** year	Inflationary Appropriation, DMH/DAIL	**Variance bet/ DMH,DAIL and CPI**	Inflationary Appropriation, DSU	**Variance bet/ DSU and CPI**
FY08	5.00%	4.00%	-1.00%	0.00%	-5.0%
FY09	-1.17%	-1.25%	-0.08%	0.00%	1.2%
FY10	1.70%	0.00%	-1.70%	0.00%	-1.7%
FY11	3.36%	-2.00%	-5.36%	0.00%	-3.4%
FY12	1.45%	-2.50%	-3.95%	0.00%	-1.5%
FY13	1.55%	0.00%	-1.55%	0.00%	-1.5%
FY14	1.90%	3.00%	1.10%	1.50%	-0.4%
FY 15	0.00%	0.22%	0.22%	0.20%	0.2%
FY 16	0.80%	0.48%	-0.32%	0.00%	-0.8%
FY 17	1.50%	2.00%	0.50%	0.20%	-1.3%
FY 18	2.60%	2.10%	-0.50%	0.00%	-2.6%
FY 19	1.60%	3.80%	2.20%	0.00%	-1.6%
FY 20	1.60%	2.29%	0.69%	0.00%	-1.6%
FY 21	3.92%	0.00%	-3.92%	0.00%	-3.9%
FY 22	6.97%	3.00%	-3.97%	3.00%	-4.0%
FY 23	3.45%	8.00%	4.55%	5.00%	1.6%
FY 24	3.38%	5.00%	1.62%	4.25%	0.9%
FY 25	3.00%	3.00%	0.00%	3.00%	0.0%
Cummulative	**42.61%**	31.14%	-11.47%	17.15%	-25.46%

Key:

CPI – Consumer Price Index

DMH – Department of Mental Health

DAIL – Department of Disability, Aging, and Independent Living

DSU – Department of Substance Use (VDH)

Community Based Supports are Best and most effective as a fully funded continuum of care

Best Practice:

1. Community based crisis care must be done intentionally and be well funded
   a) Demonstrated effectiveness of hospital diversion that is cost effective
2. Must be done in partnership with state and other local organizations including hospitals, first responders, FQHCs, schools…etc
3. Must pair with other, effective supports
   a) 988
   b) Mobile Crisis
   c) VSP Embedded Program
4. Must be closely connected to follow-up and medium to long-term care if needed.

There is a place in the middle where community-based services are adequately funded and provide savings to the system of care