

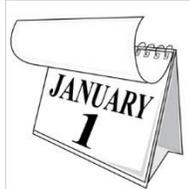


Supporting Vermonters to lead healthy and satisfying lives community by community

Legislative Update for January 27, 2020



The Governor's Budget address was Tuesday. Vermont Care Partners was glad to hear about a few mental health initiatives and that there is funding for developmental services caseload growth. Unfortunately, no rate increase was requested to better compensate staff at designated and specialized service agencies and address inflationary pressures. This Wednesday is Mental Health Advocacy Day, please come to speak out on funding and policy issues. Make your voice heard!



SAVE THESE DATES

Wednesday, January 29th, Vermont State House, Montpelier - Mental Health Advocacy Day

Mental health advocates, peers, family members, professionals, providers, community members and mental health stakeholders will urge “Support Your Community ~ Invest in Mental Health”. The agenda includes activities that will be of interest for every mental health and developmental disabilities advocate and supporter including advocacy training, opportunities to interact with legislators, Award presentations, providing testimony and listening to personal stories of lived experience. For information on participating in Mental Health Advocacy Day including the agenda, how to make nominations for the Community Advocate Awards, signing up to share your story, testifying at a committee or volunteering for the day of the event Click this link:

https://vermontcarepartners.org/evrplus_registration/?action=evrplusegister&event_id=26

Tuesday, January 28th, Vermont State House – Medicaid Assembly at the Statehouse

The Vermont Workers Center is hosting an opportunity for low-income people to share our stories, meet with legislators, and learn together. They will talk about how to protect Medicaid and guarantee health care and the right to live with dignity for everyone in Vermont. For information click here:

<https://www.workerscenter.org/MedicaidAssembly>

Monday, February 10th, 6 – 7 PM Public Hearings on the Fiscal Year 2021 State Budget

The Vermont House and Senate Committees on Appropriations public hearings locations:

- Barre City: Downstreet Housing and Community Development, 22 Keith Ave, Suite 100

- Morrisville: People’s Academy High School, Auditorium, top of Copley Avenue
- Rutland City: Rutland Public Schools, Longfellow School Building, Board Room
- St. Johnsbury: St. Johnsbury House, main dining room, 1207 Main St.
- St. Albans City: St. Albans City School, Library, 29 Bellows Street
- Winooski: (VSAC, 10 East Allen Street (follow the signs when entering the building)
- Springfield: Town Hall, 96 Main Street, 3rd floor Selectmen’s Hal [5:30 p.m. to 6:30 p.m.]

Time limits on testimony may apply depending on volume of participants. If you have a story you would like to share privately with the committee members, please contact Theresa to schedule this at the end of one of the hearings. To view the proposed budget, available after 2:00 p.m. on January 21, go to the Department of Finance and Management’s website. For more information about the format of these events, contact Theresa Utton-Jerman at tutton@leg.state.vt.us or Rebecca Buck at rbuck@leg.state.vt.us, or call 802-828-5767 or toll-free within Vermont at 1-800-322-5616. Written testimony can be submitted to Theresa or Rebecca by e-mail or mailed to the House and Senate Committees on Appropriations, 115 State Street, Montpelier, VT, 05633

Thursday, February 13th Vermont State House, Montpelier – Suicide Prevention Day

Thursday, March 12th, Vermont State House, Montpelier – Disability Awareness Day

Friday March 13th, Davis Center, University of Vermont – STEPPING FORWARD TOGETHER 2020: Creating Solutions that Promote Health Equity

Vermont Care Partners Annual conference will enable you to join national and regional experts to learn how to promote equity in your community. The conference includes over 20 workshops on topics:

- Promotion of Cultural and Linguistic Competence
- Collaboration with Faith Based Leaders to Promote Health Equity for All
- Tracking “isms” in Systems for People with Disabilities
- Disrupting White Supremacy Culture Organizations
- LGTBQ+ Inclusion in the Behavioral Health System
- Making Room at the Table: A Model for Real Peer Leadership
- Understanding the Impact of Untreated Adverse Childhood Experiences on the Health and Well-being of Vermonters with Intellectual and Developmental Disabilities
- Understanding Adoption Competent Care
- Leading from Where You Are: How to Affect Policy and Legislative Decisions

This year’s featured speakers:

Sydney Hankerson, MD

Co-Director, Columbia University Wellness Center Assistant Professor of Clinical Psychiatry, Columbia University, Vagelos College of Physicians and Surgeons Assistant Attending, New York-Presbyterian Hospital Research Scientist, New York State Psychiatric Institute

Vivian H. Jackson, Ph.D., ACSW

junct Assistant Professor, Senior Policy Associate National Center for Cultural Competence Georgetown University Center for Child and Human Development Washington, DC

Maria Mercedes Avila, Ph.D.

Associate Professor of Pediatrics, Larner College of Medicine, University of Vermont

For information and registration go to: <https://vermontcareSTEPPING FORWARD TOGETHER 2020: Creating Solutions that Promote Health Equitypartners.org/2020conference/>

What's Happening

Governor Scott's Budget Address

The Governor started his speech by promoting his interest in making Vermont affordable. His budget request will require no tax or fee increases. It does not appear that cost of living increases were requested for contracted human service programs. Until the Secretaries and Commissioners testify to the House Appropriations Committee, few specifics are available.

In total he is proposing a \$6.3 billion budget, an increase of 2% over the current year, including a \$1.6 billion in general fund (GF), a 2.8% increase over last year. Reductions were necessary to address the \$70 million funding gap between expected revenues and expenditures. He spoke about prioritizing investment in the root causes of problems rather than focusing on symptoms. He said we need to examine the true costs of programs funded by the State and ask, "Are programs reducing need and promoting fiscal independence".

The Governor said \$1 million is proposed for infant home visiting program, universal after school and expanding mental health services in schools. Suicide is a growing risk, so the Governor is investing \$575,000 for suicide prevention and mental health services such as zero suicide, creating capacity for a Vermont Suicide Prevention Lifeline and expanding the Vet to Vet visitor program that pairs older veterans with younger veterans in Brattleboro. Additionally, the Governor is proposing development of a pilot mental health mobile response unit to begin in Rutland with \$600,000 in one-time funds. If it is successful it could be expanded statewide. Another proposal is for creating partnerships between social workers and state troopers using existing public safety funds.

At the end of the speech the Governor said improved coordination and prevention can reduce health care costs. That's the reason for the investment in the accountable care organization in which payments are based on quality of care not volume. In 2018, there was a \$7.7million reduction in spending for ACO providers, while non-ACO providers' costs grew by \$1.5 million. The budget authorizes \$5.7 million of delivery system related (DSR) funds for OneCare on the condition that it operates as a non-profit or acts as such.

Afterwards the Commissioner of Finance and Management, Adam Greshin spoke to the House Appropriations Committee about the proposed budget. It includes \$11 million in base funded initiatives and another \$14 million in one-time investments, including \$1 million for the housing incentive program.

It appears that there may be a small funding increase to the Eldercare mental health program and PNMI rate increases in the budget adjustment act will be rolled forward.

Senate Judiciary Committee Continues Testimony on Insanity Plea

State's Attorney James Pepper said there are gaps between the mental health system and the criminal justice system. Specifically, he has concerns about the orders of non-hospitalization (ONH), because the Department of Mental Health (DMH) is concerned about 'treatment, not public safety'. Due to the lack of beds there is a pressure to move people into the community and James Pepper pointed out that there is also a lack of community resources to follow people in the community. A primary concern of his is that after the first 90 days of hospitalization there is no process for victim notification after release from inpatient or any time there is a downgrade in care. He sees insufficient oversight of individuals on ONHs by designated agencies.

Defender General Matt Valerio said the bill has a number of constitutional violations. The rights of the defendant must be addressed. The bill would put the burden of proof on the defendant to show they should be released, but the burden must be on the state to prove confinement is necessary. The state standard is 'clear and convincing' evidence.

The Defender General noted that the proposed mandatory commitment does not relate to the individual's circumstances, but the law requires the least restrictive environment. Another flaw in the bill is that it sets up separate civil confinement (through hospitalization) from other people due to their acts which violates equal protections under the law. If one is adjudicated as not criminally responsible, it doesn't matter what the act was. All people hospitalized due to being a danger to self or others need to be held in the least restrictive setting due to their treatment status.

Homicide is an act, murder is a crime. Homicides do not always result in a criminal charge. It requires other elements like mental state. People with mental illness may not be responsible for what they did. They may be confined due to mental illness, but it's not a criminal confinement. He did recommend allowing victims and families notice when a person is placed in the community after hospitalization.

Karen Barber, General Counsel, and Mourning Fox, Deputy Commissioner of the Department of Mental Health, explained that people can be under care and custody of the commissioner under two circumstances:

1. Involuntary hospitalization – found to be in danger to self or others
2. Order of non-hospitalization – a patient in need of further treatment which is also involuntary and is most often, but not always, after hospitalization. These orders are made when a person is found to be in need of further supervision.

The Court sets up guidelines for the order: e.g. take medications, meet with providers, live in a particular place, etc. Most people in the custody of the commissioner are on ONHs. If an individual begins to falter or violates the orders the providers, the Department may petition the court to revoke the ONH. This is a long process and may result in amendment of the order or a new order of hospitalization.

Karen Barber said that since DMH is a health care provider the HIPAA rule prevents the sharing of patient information. There is a catch-all provision that allows a state law to adjust the requirements, but it must be consistent with HIPAA. There are significant sanctions by the federal government if DMH were to violate HIPAA. Deputy Commissioner Fox said DMH is looking at whether DMH could have party status in the criminal court, that could be an avenue to address some of the Governor's concerns, but they are not sure if victim notification will be possible.

Senator White asked if we have enough resources at designated agencies (DAs) to work with these patients or do we need to beef up our mental health system? Deputy Commissioner Fox said the community supervision is treatment oriented to help the person remain stable in the community. They do not have the ability to ensure public safety. He said it's tough, because in general, case managers have large caseloads. There are generally 300 people on ONHs in the community. It was also noted that people can be a danger to self or others due to other factors, not just mental illness.

Vermont is an outlier compared to other states nationally in relation to its lack of a forensic system of care. Senator Sears said many of us are concerned about a lack of a forensic facility in the State.

Commenting on the proposed 3-year initial commitment, Deputy Commissioner Fox said it violates the need to treat people in the least restrictive environment possible. "This would fly in the face" of federal requirements. CMS also requires a person in a hospital to require hospital level of care; to be "in need of

treatment”. Additionally the Olmsted Decision by the Supreme Court does not allow for arbitrary timeframes for hospitalization.

The Interim Commissioner of the Department of Corrections James Baker identified 50 inmates that have acute mental health issues that shouldn't be incarcerated. He explained that inside our facilities it is about security because it's hard to build in a high level of treatment and it would not be in the best interest of the individual. Committee Chair Sears added that nationally people with mental health conditions are held the longest. “It's a sad use of beds”. They discussed that the population is very challenging between opioids and mental health conditions.

Dr. Cynthia Raven, a forensic psychiatrist from Putney, said her work with level one patients at the Brattleboro Retreat has enabled her to identify areas for improvement:

1. The need for inpatient or community care should be informed by clinicians. A blanket period of commitment would confuse the role of hospital and treatment providers. It makes jailers of hospitals when the treatment is no longer needed.
2. We need more resources in the community.
3. The CT Psychiatric Security Review Board (PSRB) review board is a good model used for people who have committed serious offenses and were found to be insane at the time of the crime. They oversee the care of people in the hospital and community. They also release people. The Board includes attorneys, clinicians, parole review board, and members of the public.
4. The Bill has the court assessing risk to public safety. Forensic psychiatrists and psychologists do a violence risk assessment to inform the court to determine the risk of violence.
5. These individuals should be able to be hospitalized even when they don't meet the current thresholds for treatment.
6. The bill should be expanded to include other serious offenses in addition to homicide.
7. Resources should be allocated to a workgroup to ensure there is access to expertise to inform the proposed study.
8. Vermont wouldn't benefit from a forensic facility. She would want it to be a treatment facility and not part of the correctional system. Forensic and other psychiatric patients both benefit from the same inpatient treatment and can be treated together.

Forensic psychiatrist Peg Bolton from Bolton does assessments for insanity and incompetence. She supported all that Dr. Raven said and acknowledged that we need facilities that are unhooked from treatment. Her view is that the community does not have a robust system to oversee the people that have public safety needs citing the need to beef up the expertise in the community. She would like a good study to look at what we have done right and what we should do given the uniqueness of our State.

Emma Harrigan, Director of Policy Analysis and Development at Vermont Association of Hospital and Health Systems (VAHHS) reiterated that the bill was taken up to improve accountability and transparency and suggested looking at other state models. VAHHS supports the language for forensic care with the right level of resources. Emma spoke about the growing bottleneck of people with psychiatric needs stuck in hospital emergency departments because of insufficient inpatient beds and supply on the back end to release people from the hospitals, for example nursing homes, that will accept discharges. Emma said, we also need community resources for people who leave the emergency room and return directly to the community. The need for hospital care must be clinically warranted and meet federal conditions of participation. Forensic stays are not eligible for Medicaid match. Additional forensic capacity is needed, she said, but we must be mindful on the inpatient capacity knowing that Medicaid funds will not be available. Adequate community capacity is needed too.

Ena Backus, Director of Health Reform explained that there are Institutions for Mental Diseases (IMDs) for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED). The recently awarded 1115 Amendment enables Medicaid federal financial participation (FFP) for short-term stays at IMDs for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED). Stays must be 60 days or fewer with a statewide average length of stay of 30 days or fewer. IMD waivers available through CMS DO NOT provide FFP for forensic mental health patients. There are four categories of patients who receive “forensic” psychiatric care:

1. Individuals who are awaiting a psychiatric evaluation as part of a trial
2. Individuals who have been found incompetent to stand trial
3. Individuals who have been found to be insane at the time of the crime, were tried and found not guilty by reason of insanity
4. Individuals who are pre-adjudication or have been convicted and are in DOC custody who develop the need for acute psychiatric care on either a voluntary or involuntary basis

Senator Sears said future testimony will be on a redraft of the bill. At this point it looks like there will be study on creating a forensic unit and the CT system and victim notification.

House Health Care Learns about Institutions for Mental Diseases (IMDs)

Mental Health Commissioner Sarah Squirrell gave an overview on the IMD rule. At this time 57% of inpatient beds in Vermont are in IMDs. Average length of stay at the Brattleboro Retreat was 8 days and the average length of stay for Vermont Psychiatric Care Hospital (VCPH) is 110 days. By combining both it enables the statewide average to fall within the 30 day limit. The statewide average length of stay for all inpatients is 15 days. At the end of 30 days the hospital readmission rate average is zero. This shows that we are not reducing hospital stays by too much.

Ena Backus presented with Tracy O’Connell, Director of Financial Services for AHS. Medicaid prohibits payment to IMDs for services provided to Medicaid covered individuals age 21-64. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs).

Vermont has historically funded care at IMDs with “Managed Care Organization investments,” now referred to “Investments,” made available through the Global Commitment to Health 1115 Demonstration Waiver. In the 2017 renewal of Vermont’s 1115 Demonstration Waiver, the State was required to submit a phase-down schedule for the VCPH and other IMD expenditures covered by investments.

Sarah Squirrell said we are the only State without a forensic facility. Those other states fully fund their facilities with state funds. Ena added that the federal government may be willing to fund IMDs in the future. Currently, Vermont is an exception in being allowed to receive Medicaid for IMDs due to our 1115 waiver. However, the State was required to propose a lower amount of IMD expenditures for Calendar Year 2021 and to begin a phase down of funding leading to the elimination of investment expenditures on IMDs by 12/31/2025. Now we are using Medicaid program funds instead of investment funds. Vermont has submitted a phase down schedule that has not yet been accepted. At the negotiation for the next waiver that starts in 2022, this funding will be on the table. We will submit our waiver request at the end of 2020 and one year is spent negotiating the waiver that starts 2022. The All Payer Model agreement goes through calendar year 2022.

Commissioner Squirrell said the long term plan is to strengthen our community-based system of care to reduce reliance on inpatient care. Work to strengthen the system of care in the 10 year vision will include:

1. Quality of care in hospitals and psychiatric settings
2. Improving care coordination and transition to community-based care, expansion of peer services, expanding the peer warm line
3. Increasing access to community-based care and reduced wait time in emergency departments and improving residential capacity
4. Expansion of mobile response
5. Payment reform
6. Earlier Identification and treatment. Including services in public school, early childhood services

Representative Donahue reminded her peers that it is the policy of the state to improve integration of care. The IMD issue is a problem only because Vermont is not meeting this policy goal. Many people should be in a comprehensive hospital, in part, due the presence of co-morbid conditions. The Brattleboro Retreat does not have a physician on site on a 24/7 basis. She believes “We need to keep our eye on the prize”.

Council of State Government Presents Justice Reinvestment II

Justice Reinvestment I focused on reducing incarceration rates by addressing the front end through diversion and prevention. Justice Reinvestment II is about the dynamics in the facilities and those released to the community under the supervision of the Department of Corrections. The goal is to reduce use, save money and reinvest that money in programs that are effective.

The Senate Judiciary Committee will start the development of a Justice Reinvestment initiative with a Committee Bill which will then move to the Senate Appropriations Committee. In the House the Judiciary and the Corrections and Institutions Committees will then take it up.

Analyst Ellen Whelan-Wuest pointed out it is a grant funded project and grant funds will be available for implementation. They focused on people in the community. 80% of admissions to correctional facilities are people who were on community supervision, most commonly furloughs. At present, 50% of inmates are there on community supervision violations rather than criminal behavior. Among 668 furlough returns with technical violations only: 46% included program or work failures, 42% included a loss of housing, 35% included drug or alcohol issues, 22% included OOP or curfew violations, 7% included violent or threatening behavior, 4% included a sex offender condition violation, and 3% included a DV condition violation. Women returning for probation and furlough violations have higher criminogenic risk than new court admissions, underscoring the importance of targeting supervision programming and treatment for people based on risk rather than offense. Risk factors relate to the needs of the individuals and could be criminogenic thinking, behavioral health needs, housing issues, etc.

Probation – the person goes back to court if there is a violation and 50% of the time it is for new crimes.

Furlough – is an extension of correctional sentence. The individuals can be returned to prison on a short-term basis or their furlough could be fully revoked.

Parole – parole board sets requirements and determines if they are violated - 50% go back for new crimes.

The researchers see gaps in supports for inmates with behavioral health needs. DOC is using a model for high-risk inmates with a focus on the last months before they reenter. The resource is limited, so the

programming is only for those who have committed serious offenses. Community resources to address risk are very limited and there is geographic disparity in access.

There are critical gaps in how people within the corrections system with behavioral health needs are identified and connected to resources with much geographic disparity. There are particular gaps in treatment for co-occurring disorders which impacts housing stability. When inmates are not identified as seriously mentally ill (SMI), it's hard to access necessary programming inside or in the community. DOC facilities have worked hard to develop mechanisms for behavioral health screening and assessment, but there are still gaps in identifying people with co-occurring disorders and mental health needs that do not rise to the level of serious mental illness (SMI). It was found that despite case planning policies aimed at ensuring that behavioral health information guides treatment and programming, referrals and information sharing challenges prevent this information from being appropriately used in a way that would best support effective reentry planning.

Mental health and substance use counseling resources are limited within DOC facilities and in the community, requiring the department to use a "triage" approach focused primarily on SMI and MAT populations. Current cross-system mental health training does not adequately focus on training for responding to people with co-occurring disorders. Poor information sharing results in a lack of care coordination and increases the failure rate, thus punishing the person by not addressing or understanding their needs.

Appropriate housing is a significant challenge for people with behavioral health needs in the criminal justice system. DOC does not currently have resources to screen for housing needs among detainee and sentenced populations. There are funds for transitional housing, but there has been no assessment of housing needs for the population. The network of sober housing has rules for relapse that differ from evidence-based practices. For instance, some do not allow people to be on MAT. As a result 20% of beds are unused. Only a limited number of DOC's population accesses Pathways, and there is no formal funding bridge to support people finding and maintaining stable services after they leave community supervision.

Recommendations (selected from the report):

- Develop more robust identification and connections for people with behavioral health needs who move through the corrections system.
- Use nationally validated behavioral health screening tools for all people who are sentenced to incarceration for any period of time, and add mental health screening questions to the Supervision Level Assessment (SLA) tool for people on probation.
- Strengthen the impacts of DOC case managers by establishing an appropriate caseload and defined role that will enable them to immediately connect people with appropriate and effective services upon their release to community supervision.
- Standardize behavioral health and reentry information policy and procedures between DOC contracted health care staff, case managers, reentry officers, hubs and spokes, designated mental health agencies, and other community service providers.
- Develop care coordination and case management protocols for agencies that serve people with behavioral health needs who are under DOC custody.
- Pursue opportunities to expand access to substance use counseling services for people in the criminal justice system who receive MAT inside DOC facilities and within community settings.

- Explore how the Department of Health's Division of Alcohol and Drug Abuse Programs can participate in crisis training for law enforcement to ensure that this training includes information on substance addiction and co-occurring disorders.
- Expand the Community Outreach program, currently operating only in Chittenden County, embedding social workers within local law enforcement agencies across all Vermont counties to respond to behavioral health crisis calls.
- Expand mental health services for the non-Serious Mental Illness (SMI) population.
- Create more services for people with co-occurring disorders.
- Explore providing counseling services for people receiving MAT.

House Human Services Hears OneCare Overview

Representative Pugh wanted her committee to learn about the ACO. Vicki Loner, the CEO of OneCare, gave a history of ACO development nationally and OneCare's development in Vermont. A summary of the presentation can be found in the January 21st update. The Power point presentation can be found at:

<https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Human%20Services/OneCare/W~Victoria%20Loner~OneCare%20Overview~1-23-2020.pdf>

Vicki said the DSR funds must come through the ACO. Upfront investments were agreed to be necessary. In response to a question about risk, Vicki said the ACO is on the hook to address risk. Each hospital service area has a certain level of lives and each hospital is responsible for a share of the \$44 million risk. The Medicare program has the highest level of risk at \$26 million. Vicki believes that providers benefit by having the majority of their patients in the ACO address risk and avoid the burden of inconsistent administrative expectations. Part of the goal is to offer similar high-quality care experiences for all patients using evidence-based practices. The model enables greater flexibility for physicians to improve patient experience quality, as well as better use of resources. The practitioners receive real-time data on their practices.

Vicki said this year there is \$43 million available to invest in improving care, such as SASH. Committee Chair Ann Pugh asked why not have the money go directly to the community for the people doing the work. Vicki said OneCare can fund any provider in its network without anti-trust issues. SASH can only get funding from Medicare through the ACO because it can absorb the required risk. The investments need to be sustainable over time because the DSR funds go away in 2021. The hospital diversion program pilot funded by the investment funds and provided by United Counseling Services was highlighted. When asked about funds for DAs, she said the \$3.4 million for DAs goes to specific functions such as care coordination and innovations.

To take action or for more information, including the weekly committee schedules:

- Legislative home page: <https://legislature.vermont.gov/>
- Sergeant-at-Arms Office: (802) 828-2228 or (800) 322-5616
- State House fax (to reach any member): (802) 828-2424
- State House mailing address (to reach any member):
Your Legislator
State House
115 State Street, Drawer 33
Montpelier, VT 05633-5501
- Email, home address and phone: Legislators' email addresses and home contacts may be found on the Legislature home page at <https://legislature.vermont.gov/>
- Governor Phil Scott (802) 828-3333 or <http://governor.vermont.gov/>

The purpose of the legislative update is to inform individuals who are interested in developmental, mental health and substance abuse services about legislative advocacy, policy development and activities that occur in the State Legislature. The Vermont Council is a non-profit trade association which works in partnership with Vermont Care Network to form Vermont Care Partners. Together our mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Our membership consists of 16 designated developmental and mental health agencies.