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## LEGISLATIVE UPDATE FOR FEBRUARY 22, 2023

Over the last week legislative committees worked on the Fiscal Year (FY) 24 budget request, adult protective services, suicide prevention, school mental health, quality requirements, expansion of the Blueprint for Health, changes to independent school statutes, and housing.

### TESTIMONY

#### House Human Services Committee Marks Up Adult Protective Services Bill

Katie McLinn, Legislative Counsel, reviewed preliminary changes and clarifications for the House Human Services Committee. A key shift is that the statutory language will reflect current practice and clarify that APS does not typically provide the follow-up support but will refer or suggest resources.

The Committee reviewed revisions to definitions, changing terms to ‘maltreatment’ to reflect current terminology to be used interchangeably with specific categories of maltreatment. Sections D(i) and D(ii) were discussed extensively to carefully define whether sexual acts by a professional caregiver would always be considered abuse, and how to factor in the ability of a vulnerable to give consent. A carve-out for spouses was in the original language. The committee discussed language where the vulnerable adult has selected and hired the caregiver and can consent. The definition of household member was reviewed and included specifics around relationship types that would also be excluded.

In further work on definitions, the committee considered the term “wrongful” in reference to denial of necessary medication and agreed to remove ‘wrongful’ as the term ‘necessary’ covers the issue if denied. Denial does not cover when a certain medication is not available. The committee also discussed whether to add banking personnel as mandatory reporters, since they are heavily regulated by federal authority and it would require extensive work to define limits between state and federal laws. Banking representatives are willing to discuss further with APS to determine how to work with APS as fraud frequency increases among vulnerable Vermonters. The Committee agreed to remove banking personnel as mandated reporters at this time.

The Committee discussed alternative terms for “unsubstantiated” to separate the investigation from the credibility of the victim. When the case is unsubstantiated, there are negative impacts to the victim, as if it didn’t happen. When referring to substantiation, the statute will use the term “alleged perpetrator”.

Under the definition of “vulnerable adult”, the Committee discussed the proposed new language that would add a 30-day eligibility requirement. The new phrase reads that the vulnerable adult must have

been either a facility resident, eligible for Home Health Services, psychiatric unit, or hospital resident, receiving personal care services from a designated home health agency, or physical, mental or developmental impairment within 30 days following the incident.

Jill Olson from VNAs of Vermont and on behalf of the Healthcare Provider Association Coalition, also voiced concerns about vulnerable adult definition and reporting language but had not seen the latest revision. Chair Wood suggested that DAIL and Healthcare Provider Association Coalition work together on the definition language.

VT Legal Aid submitted a statement regarding a language change in the definition of “vulnerable adult” that would add the word “the” before “abuse, neglect or exploitation.” While it seems like a minor change, it would change the law in that DAIL intends to require a linkage between the alleged abuse and the person’s ability to protect themselves from abuse. It is not clear whether the Vermont Supreme Court ruled on this distinction, or how they would interpret it. Chair Wood asked Legislative Counsel, Katie McLinn, to assess the language based on DAIL and VT Legal Aid concerns.

The Committee reviewed the reporting definition, which is proposed to change to 2 business days instead of 48 hours. Earlier dispute was around APS response time, and this is a different requirement focused on the reporter obligation. Also, within the reporting requirements, DAIL proposed to remove “orally or written” to allow a range of reporting options. However, the lack of distinction could cause confusion and allow only the interpretation of the person taking the report. Current statute requires that APS requests written reporting, but the reporter is not obligated to report in writing. Phone reports follow a series of questions, but it wasn’t clear how answers were interpreted. The Committee agreed it is okay to leave the language broad, as investigation results are used in legal actions or other follow-up, not the initial report.

### **Testimony on Suicide Prevention in House Health Care Committee**

House Health Care took testimony from national experts on firearm safety policy and its effects on suicide prevention. Andy Morral, a Behavioral Scientist from the RAND Corporation, testified on RAND’s analysis of 18 laws that have been enacted nationally. RAND found that there was weak or inconclusive evidence on efficacy for most of them. Just one law has supportive evidence: laws requiring gun owners to store their weapons locked or where children cannot access them appear to reduce gun injuries among young people, as well as gun suicides, gun homicides, and gun assaults. Laws enacting waiting periods and minimum age for purchase had moderate effects. He testified that people who own guns are far more likely to die by suicide, as well as their non-gun-owning partners or family members.

Dr. Jeffrey Swanson, Professor in Psychiatry, Duke University, has been involved in the development of Extreme Risk Protection Orders [ERPOs], whereby a judge determines probable cause to remove guns or prevent people from purchasing them. Swanson stated that more research is needed. ERPOs are a versatile legal tool he said, and nationally two-thirds of ERPOs are used for suicide risk, with half of cases coming from concerned family members. 50% of people who were subject to an ERPO had a record in public behavioral health system, often substance use, and engagement with mental health treatment increased after the ERPO. For ERPOs to be effective, providers such as law enforcement and clinicians need to know about them.

Matthew Miller and Deborah Azrael, Directors at the Harvard Injury Control Research Center, testified on Suicide Rates in the United States. To prevent suicide in any society, the single most effective thing

you can do is remove access to lethal means in that society. They shared data that while rates of psychological distress are even among all states, rates of suicide deaths increase with gun access, with Vermont in the top quartile. For adolescents, the risk is 4.4x greater if they live in a home with a gun, and that risk can be mitigated by storing guns locked and unloaded. Gun owners hold misperceptions about risk: they don't understand that having a gun in the home increases risk. 75% of guns used for suicide are handguns, but male adolescents in rural areas have high rates of use of long guns, at 50%. Miller noted that it's impossible to know when people at risk are particularly impulsive, so safety measures are important, not only when a child is in suicidal crisis, but at all times. Suicide rates in Vermont are twice those of Massachusetts, with five times the rate of firearm ownership.

Rep Demar wants to support suicide prevention but not limit gun ownership. Rep Peterson supports ERPOs and would like to see more messaging out in public. Rep Black said the most important part is not the enforcement, it's the education. She wants people to understand the real face of suicide. She removed firearms from her own home after the suicide of her son as a prevention measure.

On February 17, the committee walked through a draft of [H230](#), which prohibits a person from keeping an unsecured firearm where it can be accessed by a child; adds family members to the list of people who can request an Extreme Risk Protection Order; and establishes a 72-hour waiting period. They will continue to take testimony on this bill. Rep Houghton said that there will be education and prevention components added. Houghton said their priorities as a committee over the next ten days are suicide prevention, COVID-19 flexibilities, and the Governor's Budget.

### **Mental Health in Schools in House Education Committee**

Cheryl Huntley, Children, Youth and Family Services Director at the Counseling Service of Addison County (CSAC), offered House Education a four-part framework for thinking about how to address the mental health needs of students and schools (starts at 48:00 [here](#)): workforce, systems, environment, and families.

On workforce, Huntley shared that hiring has been extremely challenging. Last year's rate increase helped people stay at the agency who would have otherwise left. She noted the lack of Master's-level applicants for school-based services, also pointing out that CSAC's children's clinician vacancies of 2.5 FTEs equates to 75 kids who aren't being served. The State will continue to see significant demand and agencies are going to continue to need rate increases. This reinforced the testimony House Education heard from schools on adequately funding the mental health system.

Huntley said that working together as systems allows both schools and providers to do this work more efficiently and effectively. Post-COVID, there is work to do to rebuild those relationships – to “slow down to speed up.” There are a variety of roles in schools, so teaming is key. It's also important that everyone understands the resources for kids who need high levels of care and how to access those resources. Chair Conlon noted that relationships are strong in Addison County—what needs to happen there? Huntley emphasized that whenever there are inadequate resources, it creates tension, and proactive problem-solving is essential.

Regarding the environmental component, Huntley testified to the impact home life has on school life. Providers must be attuned to these components and work in these areas. Teachers are key and are juggling enormous demands. Reflective supervision is a cornerstone of the mental health system, and

she sees an opportunity for mental health to offer that part of mental health culture to teachers, for example, to reflect on how they handled a difficult experience with a student, which could help reduce teacher burnout. Flexible staffing and behavior consultation could also be invaluable but may require a different type of funding.

Regarding families, Huntley shared that parents are stressed and CSAC has had more requests than they have ever had. While family treatment is critical, it is more time consuming, and doesn't work well in schools. Waitlists for family services are much longer than Huntley would like. She noted that agencies provide mental health and substance use services for adults, and parent mental health is one of the best predictors of child mental health. Zoom has helped and is a tool for broader school engagement and psychoeducation. For example, agencies could use this tool for skill teaching parents about anxiety. Huntley concluded by emphasizing that partnerships work, and House Education has a key role in creating the funding to help us fill in the gaps.

Chair Conlon said he hears Huntley loud and clear. "Our role is allocation of money, and your services need more money, especially in your core services, that goes beyond kids." Rep Buss asked about Mental Health First Aid. Huntley shared that Addison County has focused on a strength-based Resiliency Program. Rep Williams wondered about "grouping together" designated agencies. Huntley responded that each agency has their own catchment area and is not duplicating services. Each agency is empowered to meet the needs of their communities. Chair Conlon asked about schools duplicating mental health services due to gaps. Huntley testified that mental health supports should be offered within a continuum of care with access to higher-end care. Unlike schools, mental health agencies can provide crisis services, and screening. When parallel systems are created, it pulls agency clinicians away to schools and healthcare.

Rep Brady asked about shortcomings and bright spots in prevention. Huntley said that's not where the funding is; right now, we are focusing on the high-end needs. It's a challenge to do the population health work. She would love to work in doctor's offices and childcare sites. Over time it would bend trend lines. Now, resources must be spent on reacting because children and families are in crisis.

### **Blueprint Expansion in House Health Care, February 15**

Blueprint Executive Director John Saroyan, as well as Department of Health Commissioner Mark Levine and Maternal and Child Health Director Ilisa Stalberg, testified on the Blueprint expansion proposal. The goal is to increase access to integrated substance use and mental health care. An increase of \$10.5 million (\$4.6 million general fund) would include increasing per member per month payments to primary care providers for

- Community health team staff (composed of "community health workers" (not MA-level), social workers, and counselors) – \$5.98 million
- Expanded hub services (outpatient and intensive outpatient services, capital improvements, clinical education) – \$2.3 million
- DULCE programmatic oversight – \$1.13 million
- Clinical training and learning collaboratives – \$350K
- Quality Improvement Facilitators \$400K for 4 FTE

Investments would be measured through 30-day follow up after discharge from the ED for mental health and substance use; 7-day follow up after hospitalization for mental illness, initiation and

engagement of SUD treatment, total resource use index; and qualitative evaluation of providers and patients. The pilot would be Medicaid only, with an evaluation component. Saroyan noted that there is an absence of reimbursement mechanism for the community health worker role now. Community Health Workers [CHWs] can meet with patients in the community, in offices, and provide social support. Rep Black wondered why the State is not asking Medicare and commercial payors, but rather “using State dollars for everyone.” She noted that the proportion of Vermonters with Medicare Advantage is increasing.

Stalberg provided an overview of the DULCE model, describing it as a beautiful partnership that provides an essential bridge to the system of early supports, that has 99% engagement. The goal is to get to 12 clinical sites. Rep Berbeco noted that this proposal doubles staff when we are in a workforce crisis, pulling staff with unique skill sets from other providers. Stalberg said that this is a really attractive role to take, and they feel confident that they can recruit. The starting salary is \$55,000 plus benefits (without a Master’s degree).

Levine spoke about the hub proposal. He is co-chair of the Mental Health Integration Council, which can inform, but should not delay. Hubs already provide services but have staffing and workforce shortages. People they serve have complicated lives, with mental health and legal challenges, and children. The goal is “one-stop shopping” to deliver more at one location to address core issues of engagement and retention. Rep Black asked, “instead of wraparound, what about making opioid use disorder treatment more accessible?” Levine said recommendations are coming soon from the Opioid Settlement Advisory Council, including “hublets” and more outreach.

The committee discussed suicide screening in primary care, warm hand-offs, and a whole community approach. Rep Houghton appreciates the proposal but wonders why there is no increase to primary care providers. Saroyan said they followed the directions of Act 167 and looked at community health teams and quality facilitation.

### **Support for Blueprint Expansion in House Health Care Committee**

House Health Care heard testimony from three primary care providers in support of the expansion of community health workers and DULCE in primary care settings. Dr. Ashley Miller, a pediatrician, spoke of the mental health crisis for youth in the state and the lack of resources, as well as the high social determinants of health needs. The care coordinator in her office funded by the Blueprint is essential, and she could use three of them. Dr. Kristin Connelly testified about the value of the DULCE program in her pediatric office, which is “strengthened by our medical legal partnership with VT Legal Aid and community partnership with NCSS and Milton Family Community Center, with whom we meet weekly.” Dr. Peter Hogankamp advocated for more community health team support for his primarily older population. He shared an example of an older man with substance use disorder and frequent ED usage. His community health team worker was able to support this patient in securing permanent housing and quitting smoking and drinking. He spoke of the value of independent primary care practices compared to hospital-owned practices, but is worried about whether his practice, which provides primary care to a large portion of patients in Rutland County, will survive when he retires.

### **Public Funding of Independent Schools Testimony in the House Education Committee**

Rep Edge Graning of Jericho and the chair of Mt Mansfield School District Board provided House Education with a high-level overview of [H258](#), which she said supports high quality education, transparency and accountability in funding, and maintains the long-standing and critical role for therapeutic schools. While this represents a shift in the funding model for other approved independent schools, “school districts will continue to contract with therapeutic schools which meet the requirements of our most needy students.”

The bill proposes that towns that don’t have an elementary or high school can choose three schools as designated schools for public tuition. The bill would narrow what is available for public tuition to schools who meet three of four eligibility criteria: schools that are currently tech centers; schools that were established through a charter of the Vermont general assembly, schools that have been public in the past, and schools whose staff are part of teacher retirement funding. No more public tax dollars would go to schools that don’t meet those criteria. Any current private school could become a public school. Graning said that current public and private schools in Vermont perform about the same. This bill ensures that funds that have been siphoned to private schools go to support the public school system. The bill would define a private therapeutic school as someone who is on a IEP or 504: “(36) ‘Therapeutic school’ means a recognized independent school that limits enrollment to students who are on an individualized education program (IEP) or plan under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 10 § 794 and who are enrolled pursuant to a written contract between a local education agency (LEA) and the school.” The intent is not to change that system.

The committee then heard testimony from a student at Sharon Academy who spoke in support of the way the school environment there nurtured her mental health after being bullied in public school.

### **House Human Services Committee Learns about Quality Requirements**

Ashley Berliner, Director of Medicaid Policy, and Wendy Trafton, Deputy Director of Health Care, gave an overview of the home and Community based services (HCBS) quality improvement requirements to the House Human Services Committee. Ashley Berliner began by clarifying that it wasn’t until 2022 that it was clear how these requirements impacted Vermont because of the Global Commitment waiver.

1. Conflict Free Case Management (CFCM): Must be fully compliant by 5/2026.
2. HCBS Settings Rule: Originally VT was supposed to be compliant with most regulations by 3/17/23, but compliance with regulations were impacted by public health emergency and extended until 12/31/23.
3. HCBS Quality Improvement Strategy: AHS will notify CMS of State's choice to be an early adopter of a new national HCBS measure set. Vermont is working with CMS on which and how the performance measures will be implemented.

Committee Chair Theresa Wood asked if the SIS A will meet the CMS requirements. Ashley said that will be discussed with CMS. Chair Wood expressed concern about the SIS A implementation before we know what CMS will require and had similar concerns about the changes in the adult protective services (APS) statutes, which will also need to meet the evolving CMS requirements. DVHA as a managed care entity has certain quality measures required by CMS for the waiver. It was clarified that the Departments can go beyond those to assure quality. The State is anticipating CMS requiring improved critical incident reporting. Chair Wood was concerned that the measures seem very institutional rather than focusing on individual experience and family perspective. Ashley Berliner didn’t disagree but noted that AHS is looking at measures indicating if people are better off, in addition to the CMS requirements.

## **House and Senate Committees on Housing Hold Public Hearing on Housing**

The Senate Committee on Economic Development, Housing and General Affairs Chairs Ram Hindsdale and the House Committee on Housing and General Affairs Tom Stevens began the hearing expressing their concerns about Vermont's housing crisis, as well as highlighting their progress and commitment to continue to address the crisis.

There was robust testimony from Cathedral Square and SASH.

Leo Schiff of Brattleboro spoke about the need for support services funding to enable unhoused people to transition into and maintain secure housing.

Maura Lane spoke about her son who lived with a shared living provider (SLP). She wants him to have the option of staff supported housing so that he doesn't have the heartbreak of losing his SLP family again, as he did after losing his SLP of 10 years. Susan Aronoff of Vermont Developmental Disability Council spoke in favor of improved funding for SLPs who took a hit during covid when they needed to provide 24/7 supports. The Council would like them to be able to access resources for renovations to improve their homes. The Council also made a plea to make all housing programs fully include people with disabilities. David Frye, a member of the VT DD Council policy committee, shared his experience with his SLPs. The first one didn't fully support him and in the second one he didn't have adequate privacy. After living with his case manager, he moved into independent living but is not getting all the services he needs.

Senator Ram's committee will be finalizing their housing bill this coming week and Rep Steven's Committee will begin work on the bill shortly. Both Committee Chairs promised to use what was learned from the testimony in the housing bill.

## ***LEGISLATIVE RESOURCES***

### **Vermont Care Partners Advocacy Fact Sheet**

Here is a link to our Advocacy Fact Sheet: [Vermont Care Partners Advocacy Fact Sheet](#). The critical points are the rising demand, the impact of the ongoing workforce crisis and need for improved funding.

### **You Tube link for Mental Health Advocacy Day:**

<https://www.youtube.com/watch?v=S3ml6skUE4A>

### **NAMI-VT Fact Sheet on Mental Health**

Here is the [NAMI-VT fact sheet on mental health](#).

### **Vermont Care Partners Legislative Advocacy Webinar**

In case you missed it, here's a link to the [recording](#) of our Legislative Advocacy Webinar to help guide you through the process of working with legislators. In just 40 minutes you can learn the basics for effective advocacy.

### **Key Committees in relation to Network Agencies**

Here are the key Committees in relation to our network services with the Agencies in each legislator's region noted. We encourage everyone to reach out to your local legislators to introduce yourself and share the issues most important to you: [Legislative Committees by DA and SSA Region](#).

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.