

VSH Futures Project Crisis Bed Development Work Group Report

To the Futures Advisory Committee
and Agency of Human Services Secretary Cynthia LaWare

October 11, 2006

Introduction

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented mental health system. The plan was developed through an inclusive, statewide planning process that brought together all stakeholders, forming the VSH Futures Advisory Committee in 2004. Work groups were formed to address many parts of the Futures Plan, including the critical issue of how best to develop new crisis bed programs in the community that are integral to the plan.

The Futures Plan calls for replacement of the Vermont State Hospital with a new array of inpatient, rehabilitation, residential and support services for adults. A core concept of the Futures Plan is to create new community services and supports while strengthening the existing services infrastructure to reduce Vermont's use of involuntary, inpatient psychiatric services.

In November 2005, the Futures Advisory Committee endorsed the overall plan concept with the full complement of community supports that are vital to the plan and must, at a minimum, be funded at a level to meet both existing program needs and the new components outlined in the Secretary's February 2005 Futures Plan report. The Secretary of the Agency of Human Services accepted the recommendation of the Futures Advisory Committee. The Legislature's Mental Health Oversight Committee and the Joint Fiscal Committee approved the plan.

Executive Summary

A transformed mental health system would recognize "the intense need for services during the first hours of a psychiatric crisis and the reduction in inpatient admissions that could occur as a result of a well-coordinated emergency services system."¹

The crisis bed work group agrees with the HRAP that this is one of the two highest priority needs of the system. The existing diversion and step-down programs in Vermont reduce pressures on the voluntary and involuntary inpatient systems, resulting in more

¹ Health Resource Allocation Plan for the State of Vermont, adopted August 2, 2005.

efficient use of resources and more integrated, trauma-informed, and recovery-oriented care in home communities

The crisis bed work group concludes that the goals of a transformed system require a greater investment in increased community services, particularly for integrated emergency and diversion programs.

Crisis Beds Component of the Futures Plan

Ten new diversion beds are planned to augment 19 existing diversion beds in programs run by Designated Agencies (DAs) around the state.² The existing beds are used for crisis stabilization and hospital step-down. The new voluntary program will be associated with existing inpatient and/or community programs that already operate 24-7 and have access to mental health and medical services. The plan envisions that the programs be flexible and that they utilize blended peer and staff models.

In addition to offering crisis stabilization and respite to individuals with mental health needs, then Secretary Charles Smith pointed to the significant need for care of public inebriates. That some of the diversion beds could be swing beds for this purpose is part of the Futures report and the scope of inquiry of the Crisis Beds Work Group.

Formation of Work Group

The Crisis Bed Work Group convened in May to provide input to the VSH Futures Advisory Committee and the Secretary of Human Services regarding options for the development of new crisis bed programs to enhance Vermont's system of care.

Members of the group are:

Sheryl Bellman, HCHS, Emergency Director
Rep. Anne Donahue, advocate
Marian Greenberg, CSAC Emergency Director
Graham Parker, HCRS, CRT Director
Jeff Rothenberg, CMC Adult Services Director
Judy Rosenstreich, VDH/DMH Futures Staff
Cindy Thomas, VDH/DMH Acute Care Manager
Sandy Smith, CSAC, CRT Director
John Stewart, RMHS, CRT Director

² There is budget authorization for four new crisis beds at \$100,000 each in fiscal year 2007, beginning in the second half of the fiscal year. Beginning January 2007, \$200,000 will be available for new crisis bed capacity.

The Work Group's Charge

Beth Tanzman, VSH Futures Project Director, met with the group in May 2006 to review the crisis bed component of the Futures Plan and to give the group its charge:

- To assess the existing inventory of hospital diversion beds in our system;
- To determine the services they provide, the geographical areas they cover, and the unmet needs of existing capacities; and
- To review data indicating where new resources may be needed.

After establishing this baseline,

- To develop programmatic and fiscal recommendations to optimize resources for the 10 additional beds in the Futures Plan.
- To also consider the need for public inebriate beds.

The group decided at its first meeting to approach the charge by looking holistically at crisis services in the community. Rather than limiting its inquiry to the 10 beds called for in the Futures Plan, the group would develop a more comprehensive recommendation to define what would be necessary to meet the needs of a transformed mental health system. This would include analysis of service gaps and changes to the existing system for crisis de-escalation and stabilization. Opportunities to improve access to crisis services on a statewide basis would be explored. System principles and priorities would be identified.

Consistent with these decisions, the report addresses program, funding, and system priorities for developing crisis services.

Background

The work group met nine times from May to October, 2006. During that time, it visited three of the four existing crisis bed programs: Home Intervention in Barre, the Assist Program in Burlington, and Alternatives in Bellows Falls. The only crisis bed program that was not visited was Battelle House in Bennington; the work group had conversations with Battelle program staff. The work group compared all four programs.³ The work group also surveyed all Designated Agencies, CRT and emergency programs, asking agencies to respond to surveys designed to determine the level of need in different areas of the state.⁴ The work group also looked very carefully at emergency services across the state, and used data previously gathered by the VDH/Mental Health Division's Acute Care Team to see how much additional support should be directed to existing emergency programs. In addition, the work group had conversations with representatives from the division of Alcohol and Drug Abuse Programs (ADAP) and consistently took into

³ See Attachment A.

⁴ See Attachments B and C.

account the needs of dually diagnosed individuals including the potential overlap of crisis beds and individuals being diverted from an INCAP.

Health Resource Allocation Plan (HRAP) Standards

The group considered Vermont's HRAP standards which specified that:

1. Short term psychiatric care (not necessarily in a dedicated unit) and psychiatric emergency care should be available to most Vermonters within the geographic areas served by the designated agency system.
2. Psychiatric services in dedicated units should be available to most Vermonters within the hospital service areas for the regional and tertiary hospitals.

Other pertinent notes from the HRAP include ranking as a high state priority, "allocating more resources to emergency services, given the intense need for services during the first hours of a psychiatric emergency and the reduction in inpatient admissions that could occur as a result of a well-coordinated emergency service system."

Options identified in the HRAP emergency services priority include:

1. Develop secure triage and assessment facilities in hospital emergency rooms
2. Add training and support for first responders to psychiatric emergencies
3. Increase resources for Designated Agency Emergency Services
4. Increase resources for psychiatric services at general hospitals
5. Consider proposal identified in the 2005 ADAP public health report⁵
6. Increase resources for crisis/triage/diversion beds for mental health and substance abuse

Principles (Program Guidelines) for Crisis Beds

The work group identified the principles that could serve as a basis for planning and implementing new crisis bed program capacity, and for increasing consistency among existing programs.

All crisis bed programs are:

- completely voluntary
- part of the larger care management system
- open to the greater need of the system while primarily focused on
 - a) decreasing inpatient psychiatric admissions and/or
 - b) decreasing the number of inpatient days

⁵ "Substance Abuse: A Public Health Problem Requiring Appropriate Intervention" and the accompanying addendum entitled, "Law Enforcement Response" (Vermont Division of Alcohol and Drug Abuse Programs, February 2005)

- available to individuals 18 years or older, not limited to CRT consumers

All crisis bed programs have available:

- daily medical oversight
- daily access to a psychiatrist
- peer services and support

All crisis bed programs need:

- funding for all services provided

All crisis bed programs will be responsible for:

- appropriateness for admission to their program within the context of the care management system
- operation of the program using the most cost-effective approaches, coordinating with existing facilities, and sharing medical resources

All crisis bed programs will embody the principle of:

- seeking input from local program standing committees for program development and policy.

Characteristics of Crisis Bed Programs

The work group visited three crisis bed programs to meet with staff, see the facilities, and learn about the services they provide.⁶ In Vermont, crisis bed programs are licensed therapeutic community residences that provide short-term individualized treatment to three or more residents with major life adjustment problems, such as alcoholism, drug abuse and mental illness.⁷

SIMILARITIES

The work group identified similarities among the crisis bed programs.

All programs have these characteristics in common:

- o Operate as a component program of a Designated Agency (DA)
- o Serve CRT and non-CRT consumers
 - At least 75% admissions are CRT
 - Three programs' admissions are at least 90% CRT

⁶ Assist Program, Burlington; Home Intervention, Barre; and Alternatives, Bellows Falls. The group did not have a chance to visit Battelle House, Bennington.

⁷ Licensing is under authority of the Department of Disabilities, Aging & Independent Living/Division of Licensing and Protection, Agency of Human Services.

- Provide some level of nursing and physician oversight
 - Three programs have two full-time nurses on staff
- Obtain reimbursement from health insurance in addition to the CRT case rate
- Consider 4 to 5 beds an optimal number for a crisis bed program
- Accept admissions for hospital diversion
- Provide step-down from Vermont State Hospital
 - Three programs take step-downs from designated hospitals' psychiatric units
- Accept out-of-county referrals
 - All programs take less than 10% admissions from out-of-county
 - Three programs take less than 5% admissions from out-of-county
 - Two programs take less than 1% admissions from out of-county
- Estimate an average of four individuals a month who meet admission criteria but declined admission
- Three programs may be interested in serving individuals taken into the custody of the public inebriate program if a payment source and skilled nursing funding were available

DIFFERENCES

The work group also identified differences among the four crisis bed programs.

- Home Intervention has more on-site physician coverage than the other programs with a psychiatrist coming daily to the program.
- The Assist Program has less nursing coverage than other programs.
- Community settings differ:
 - The Assist Program occupies part of a building that is connected to Howard Center offices.
 - Battelle House is connected to other United Counseling Services/CRT programming.
 - Alternatives and Home Intervention are in neighborhoods just outside the town centers of Bellows Falls and Barre, respectively. They also are in relative proximity to a designated hospital.

Crisis Network Components Integral to a Transformed Mental Health System

Based on visits to crisis bed programs, data from CRT and Emergency Services programs, input from one designated hospital and the Division of Mental Health's Acute Care Team, the work group concluded that a comprehensive crisis network is essential for a transformed mental health system.⁸ Locally responsive services are essential

⁸ The data indicated that (a) up to 38% of individuals screened by Emergency Services teams and admitted to psychiatric hospitals could have been diverted to a crisis bed if one was available; (b) 30% of CRT

resources for Vermonters coping with psychiatric crises. Crisis beds support the goals of safety, stabilization, and recovery. They serve as alternatives to days spent in psychiatric inpatient settings. They are clinically appropriate, preferable to the consumer, and cost effective.

The Crisis Beds Work Group envisioned the key aspects of such a network to be:

- Establishment of standards that would apply to existing and future crisis bed programs that describe a standard of care,⁹ including admission criteria, referral process, insurance authorizations, discharge planning and criteria within context of locally identified needs
- Connection of existing and future crisis bed programs to the planned care management system, including VSH, designated hospitals, community recovery residences, and programs serving people in the corrections system
- Accessibility of crisis bed programs to all Vermonters
 - Within 30 minutes of 90% of Vermonters
 - Within 1 hour of 100% of Vermonters
- Adequate funding of existing and future crisis bed programs
- Increased funding for existing Designated Agency Emergency Services to reach the levels envisioned in the Acute Care Teams report of 2001, adjusted for inflation
- Safe triage and assessment facilities for individuals experiencing a psychiatric crisis provided in all hospitals
- Observation beds for psychiatric and INCAP purposes in all hospitals
- Availability of on-call peer support systems in all parts of the state
- Availability of transportation for individuals in crisis
- Availability of housing with supports for individuals

Gaps in the Present System Compared to a Transformed System

- Current funding of existing programs only partially meets the need for crisis bed services, leaving individuals without access to beds and impacting admissions and discharges from VSH as well as designated hospitals.
- Lack of adequate housing options has the effect of precipitating and exacerbating crises, delaying discharges and tying up needed crisis beds.
- A cadre of peers for a peer support system has not yet been developed.
- Funding levels for DA Emergency Services only partially meets the need.¹⁰

consumers' length of stay at hospitals could have been diverted to a crisis bed if one was available; and (c) 65% of individuals who were incarcerated to jail could have been diverted to a crisis bed if one was available.

⁹ Criterion #5 Inpatient Work Group "The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions, etc."

¹⁰ "The Sustainability Study of the State's designated agencies noted that the number of clients served by the emergency services programs increased by 21.8% from fiscal year 1998 through fiscal year 2004. At the same time, State-funded revenues declined by 10.5% (some of these resources were reallocated to the

- Of the ten DAs, only four have crisis bed programs. There are no DA crisis bed programs in the following catchment areas:
 - Northwest Counseling and Support Services
 - Northeast Kingdom Human Services
 - Clara Martin Center
 - Counseling Service of Addison County
 - Lamoille County Mental Health
 - Rutland Mental Health Services
- Existing diversion programs may identify a need for more capacity.
- The geographic areas of some designated agencies may require more than one program site to provide access within one hour.
- Lack of standardization, admission and discharge criteria, and definition of crisis bed programs.
- Vermont's 14 general hospitals do not have observation beds for psychiatric care or for a public inebriate (INCAP) program.
- An interconnected care management system is under development.

Priority Areas and Action Steps

The Crisis Beds Work Group recommends the following priority areas to move towards a transformation that would unify emergency services, crisis beds, and overall care management:

1. Reassess funding and cost projections for existing and additional emergency services and crisis beds to meet the levels, adjusted for inflation, indicated in the 2001 Acute Care Team model.¹¹
2. Add at least two crisis beds¹² within each Designated Agency catchment area that does not currently have one as well as additional beds as needed to meet access recommendations and locally identified capacity needs. Criteria for the phase-in of crisis beds in the plan should consider:
 - a) Geographic access data indicates highest priority locations in the corridors between White River Junction and north, and between Burlington and Bennington;

CRT program for emergency services). This disparity between revenue growth and caseload growth has resulted in total losses of \$5.7 million in the designated agency emergency services programs.” (HRAP, p. 47)

¹¹ Barlow, Patti, LICSW, Acute Care Program Chief, “Vermont Community Mental Health Center Emergency System Capacity Needs,” *Vermont Department of Developmental and Mental Health Service/Division of Mental Health, Acute Care Unit*, August 2001

¹² The stated ideal capacity of 4 to 5 beds is based upon the minimum to meet staffing overhead; however, lower numbers can be efficiently served through creative integration of staffing coverage within other existing services.

- b) Agencies most prepared to develop a program on an immediate time frame.
3. Define the level of care provided and standardize policies within the care management system, with flexibility for regional differences and needs.
4. Ensure that the care management system planning includes collaboration with existing crisis beds and addresses the role of emergency services and diversion programs.
5. Propose to the peer services work group that it review the option of creating a cadre of peers for crisis support.
6. Explore opportunities to form alliances between hospitals and Designated Agencies to collaborate to
 - a) Ensure local capacity for crisis triage, and
 - b) Further develop the concept for one to two observation beds for psychiatric and substance-related treatment and stabilization.
7. Explore the status of the INCAP program and the ability to collaborate with the Department of Health/Division of Alcohol and Drug Abuse Programs to assess program and medical issues and the funding for capacity of the diversion programs to help move from a law enforcement approach to a public health approach.¹³

¹³ As referenced in the final bullet under “similarities,” three existing crisis bed programs might be interested in collaborating in a public inebriate function. The Crisis Beds Work Group did not obtain sufficient information at this time to identify whether the ADAP proposal, referenced under the HRAP emergency services options, should be included as a component of a comprehensive system. However, the work group does recommend further exploration as a priority area.

Summary

The work group examined existing crisis bed programs to identify their characteristics and to envision the needs of a transformed community-based system. Vermont has four creative, warm and recovery-oriented programs where individuals receive excellent care, housing and treatment as an alternative to more expensive treatment further from home in an inpatient psychiatric hospital setting.

The work group concluded that the 10 new crisis beds called for in the Futures Plan would only partially address the critical need for statewide accessibility to crisis services. A more robust emergency system is needed to reach the goal of a fully transformed system. Investment in a more comprehensive and integrated crisis intervention system, including emergency services, hospital triage and observation, crisis substance abuse resources, and a full geographic distribution of crisis bed programs would serve two vital purposes: recovery-oriented treatment choices closer to home communities, and higher system efficiency.

The initial Futures Plan maintained the current statewide psychiatric bed capacity based on the planned expansion of community supports. The current Futures Plan projects an increase of inpatient bed capacity with correspondingly higher cost projections. The new inpatient bed capacity projections were derived from actuarial analysis and the clinical judgment of Vermont's inpatient psychiatric and community mental health clinical leaders. Data developed for this report indicates that if more community supports were in place, there would be less need for inpatient psychiatric bed capacity.

The Crisis Beds Work Group concluded that full implementation of more comprehensive crisis resources would address the Futures vision to reduce the need for inpatient psychiatric care. Furthermore, the vision of a transformed system could be achieved at no greater cost than current projections for inpatient bed capacity would require. The work group suggests that the apparent need for more inpatient bed capacity could be met by an equivalent investment in community programs. The net effect would be to allow a far greater expansion of crisis diversion, housing, outpatient and other support services per dollar to enable those needs to be met in the community.

#

ATTACHMENT A:
Results of Survey of Existing Hospital Diversion Programs

	Battelle	Alternatives	Assist	Home Intervention
Do you take only CRT admissions?	No	No	No	No
What percentage of admissions is CRT?	95-99%	90%	77%	90%
Do you accept admissions for both diversion from a hospitalization and / or as a step-down from a hospital placement?	Yes	Yes	Yes	Only step-down from VSH
What are the most significant elements of your programs that enable you to divert people from hospital admissions?	24 hour nursing, coordinated planned admissions, access to CRT groups, psych consult	awake staff, psych consult, coord admits, homelike atmosphere, nurse oversight	24 hour awake staff, psych consult, right next to CRT	medical model, Dr & nursing coverage, staff-client ratio, low stimulus
What are the most significant elements of your programs that enable you to shorten individuals' lengths of hospital stays by providing a step-down placement?	same as above	same as above, medical mngt, link to CRT	Same as above, though they prioritize diversion	not locked
What are the most significant barriers to diverting a individual from a hospitalization?	desire of ind. to go to hospital. Past conflict with staff	availability of beds, client refusal	client refusal	
What are the most significant barriers to decreasing a hospital length of stay by stepping a individual down to a crisis bed?	difficulty of Dr. to Dr. communication	same as above, hospital reluctance to d/c to them	same as above	too much transitioning / too full
What is the optimal number of clients you would want in a crisis facility?	5	4	4	5 2/3 pod
What is the optimal ratio of staff to clients at a crisis facility?	1-6 or 3-1 depending on situation	1 to 2	1 to 4	2-Jan

**ATTACHMENT A:
Results of Survey of Existing Hospital Diversion Programs**

	Battelle	Alternatives	Assist	Home Intervention
How much Dr. coverage is necessary in your opinion to run a crisis facility?	3-5 hours per week	5 hours on premises, plus PRN consult	PRN	10-15 hours
How much nursing coverage is necessary in your opinion to run a crisis facility?	24/7/365	We have 2 full time and that works well	Don't have any	2 FT nurse
Besides care rate funding, what other sources of income does your crisis bed generate?	Medicaid, some insurance	Medicare, some insurance	Cigna, Magellan, MVP	Cigna, Magellan, Children's Funding
Have you approached all private payers?	Not all	yes	yes	yes
Do you accept out of county referrals?	yes	yes	yes	yes
What percentage of admissions is from out of county?	less than 1%	1%	less than 5%	less than 10%
If there was a payment mechanism would you consider taking individuals who presently are being incapped?	yes	probably not	no need due to ACT I	if separate apt. and with nurse
Why / Why not?		would need more training		
If you could give one piece of advice to implementing a successful crisis bed program what would it be?				nursing / nursing

**ATTACHMENT A:
Results of Survey of Existing Hospital Diversion Programs**

Crisis Beds Development Work Group Report

October 11, 2006

Page 13 of 15

	Battelle	Alternatives	Assist	Home Intervention
How many individuals could you accept at present who don't want to go to your crisis facility?	1-2 a week	1-2 a week	1-2 a week	3x a month
Do you ever need to turn away admissions because you are full? If so, how often?	Yes 2-3 a month	yes about 6 a month		yes, 20 a month
Daily Occupancy Rate	68.30%	66.50%	58.50%	88%

*** based on daily crisis bed availability report sent out by DMH from April-September 2006

Crisis Beds Development Work Group Report

October 11, 2006

Page 14 of 15

ATTACHMENT B:
Six Month Survey of CRT Directors' Responses to Having Crisis Beds in their Catchment Areas

	# of CRT Hospitalizations	# who length of stay could have been reduced by a step down to a crisis bed	How much could the length of stays have been reduced (in days)
CSAC	17	10	57
HCRS	45	5	20
CMC	31	21	138
Northeast	29	19	198
Lamoille	8	4	24
Northwest	9	5	unsure
WCMH	29	15	30
UCS			
Howard	84	0	0
Rutland	45	12	82
Total	297	91	549

ATTACHMENT C:
Six month Survey of Emergency Services Directors' Responses
to Having Crisis Beds in their Catchment Areas

	# of Adults Hospitalized	# who could have been diverted from hospital	# who could have been diverted from hospitalization who were clients of the agency	# who could have been diverted from hospitalization who were CRT	# Incapped to jail	# who could have been diverted from incap
CSAC	73	20	18	7	17	8
HCRS	111	20			11	3
CMC	42	21	19	17	6	1
Northeast	52	27	18	8	258	197
Lamoille						
Northwest						
WCMH	162	78	78	48	120	60
UCS						
Howard						
Rutland						
Total	440	166	133	80	412	269