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Public comment on a potential modification of a FY2017 University of Vermont Medical Center enforcement action to permit the University of Vermont Health Network to use the balance of the remaining self-restricted funds from that enforcement action (approximately $18 million) to increase capacity for mental health services in the State, not limited to increased inpatient mental health capacity… This special comment period will be open until the end of the day March 7, 2023.

Proposed:
Move to modify the UVMMC FY17 enforcement action to permit the self-restricted funds to be used to increase capacity of mental health services in the state (not limited to inpatient capacity), and require UVMHN to develop a proposal, in consultation with the Vermont Department of Mental Health, for planned use of those funds and submit the proposal to the GMCB by May 31, 2023.

Members of the Green Mountain Care Board:

I have been following and advocating for the needs of Vermonters regarding mental health care since the mid-1990's: first as a psychiatric survivor/advocate after many years in and out of hospitalization; then beginning in 1997 as editor of *Counterpoint*, the newspaper of Vermont Psychiatric Survivors; and beginning in 2003 as a Vermont state legislator. I have been a past member of the Statewide Standing Committee on Adult Mental Health at the Department of Mental Health, the mental health Act 129 committee on parity at BISHCA/DFR, the GMCB mental health advisory committee, the UVMHN planning group for the proposed CVMC inpatient expansion, and, in the most recent past, vice-chair of the House Health Care Committee with jurisdiction regarding mental health care. Put simply, I am among the people in Vermont who has most consistently and for the longest period of time followed issues regarding the development of equitable and quality health care related to mental health in the state. I also developed the terminology for Vermont's vision of care that is now included in every component of state statute, including as one of the fundamental principles for health care reform under the Green Mountain Care Board enabling legislation, that, *"The health care system must ensure that Vermonters have access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care."* (Emphasis added.)

Despite efforts at health care reform, Vermont remains stalemated on these goals, because our health care financing continues to under-reimburse mental health care. As the Board knows well, some parts of our system are overpaid and others are underpaid, forcing hospital internal cost-shifting as well as resulting in prioritization of revenue-building care rather than care that works towards population-based health improvement. One outcome is that mental health care – both inpatient and outpatient – remains the only sub-specialty that is significantly supported by direct state investments rather than as a financially integrated component of our health care

system. Our hands are partially tied in resolving this, because state law cannot compel reimbursement changes among self-funded insurance plans.

At this moment in time, several events are coinciding that demonstrate this disparity and that suggest at least one avenue of opportunity. UVMHN has recently announced intention to develop new surgery center capacities. Although possibly quite needed, part of its need is acknowledged to be for financial stability due to current funding stream mechanisms. Thus, this project likely is not the most urgent care need in the northwest region of the state. Our CON process requires proof of need, but not proof that a project represents the *greatest* need for the hospital service area. Simultaneously, the state's Department of Mental Health has recently issued RFPs for urgently needed mental health resources: mobile crisis services, urgent care centers, and an inpatient pediatric unit. In a reformed and functioning health system, the state would not be funding any of these services – unless it was the single-payer for all of health care.

Most to the immediate point, DMH has identified the most urgent inpatient need to be a pediatric unit that can address co-occurring medical and psychiatric needs. No such integrated care exists in Vermont for children, despite the fact that integration of care is what is state-of-the-art and a state priority. The only current inpatient care for children is at the Brattleboro Retreat, a dinosaur model that segregates care and has no ability to address acute overall health needs. Although this integrated model and care for children is a clear priority for the state, UVMHN ended its dialogue about the RFP with DMH last summer because it was suspending any new capital projects given its financial situation – despite agreeing that this was a particularly high need as a health care resource. When DMH reissued the RFP, it heard from one prospective bidder only: Southwestern Vermont Medical Center. The legislature has appropriated $9 m in state general funds towards construction, pending competition of a feasibility study later this month.

For the past century, children from throughout Vermont who needed inpatient psychiatric care have only had access to care in Brattleboro. For the majority of the population of the state, that is between a 2-to-3 hour drive away; 4-to-6 hours round trip, meaning a full day for parents seeking to visit or engage in supported treatment for their children. The need for care in northwestern Vermont, where more than a third of the state's population resides, has been well known for decades.

Yet this state investment (which should be a health care systemic investment) will place the new unit in Bennington! SWMC will need to develop inpatient psychiatric care from scratch, and though it is recognized for its excellent work in the recent past, it does not even have a general pediatric specialty inpatient unit. Very clearly, this highest-level-of-need unit belongs adjacent to and in collaboration with the state's only Children's Hospital, located at UVMMC in Burlington. The UVMHN has agreed with this point but says it can't afford it in the near future. Insurance reimbursement for psychiatric care is wholly inadequate and forces hospitals to cost shift from revenue-rich areas of care.

It is my belief that DMH has not placed a high enough priority on the physical location of this much-needed children's unit, because it felt forced to go where there was a willing partner. That partner is willing only if financially sustainable through state funds, however, while the most appropriate location would be a more expensive capital investment, for which UVMHN has said there is not adequate funding available.

On that basis, I belief the draft language proposed to the GMCB does not place enough emphasis on known critical needs in contrast to existing political pressures. The language should be more directive, rather than solely directing that UVMHN develop a proposal in consultation with DMH. Specifically, I believe it should require evaluation first as a priority use of funds the urgent development of a children's inpatient psychiatric unit adjacent to the Vermont Children's Hospital.

Much has been said about the urgent need for inpatient psychiatric care for adults as well. Given the broad range of issues across the history of mental health care in Vermont, I believe that the assumption that more adult inpatient beds are needed is premature. I supported the original CVMC-site plan in the hope that expansion of that integrated care facility could replace the inadequate levels of care at the Brattleboro Retreat (along with its imminent funding cut-off in federal matching funds because the care is not integrated, as per federal policy), but not to support the validity of an asserted need for overall capacity expansion. That is quite simply because there has never been any hard data presented to support that need. Emergency department waits indicate clear gaps in the system of care, but do not necessarily equate with a need for additional inpatient care capacity.

The network developed clear data showing the existing individuals in EDs awaiting inpatient beds as the indicator for the needed number of additional beds, and the GMCB has also relied on that kind of assessment for need. UVMHN has asserted that diversion programs are important, but are not relevant to inpatient need, because those waiting in EDs are too acute for diversion programs; they demonstrably need inpatient care and it is not accessible to them.

This ignores the entire issue of the extent to which many individuals might not ever reach the acuity level of seeking out ED care if earlier care opportunities are available. When a person faces months waiting for an outpatient psychiatric appointment, or has no urgent care setting equivalent to the urgent care/ED diversion capacity for other types of health care, we must assume that if those needs were met, at least some of those persons would not reach the point of needing inpatient care. Those types of care have been routinely underfunded, under-reimbursed, or simply unavailable. In the absence of that kind of analysis – which I know has not been done, because I drafted the template for such an analysis but it was not pursued – one cannot project inpatient bed needs. It is the same as if we said we needed to significantly increase inpatient beds for diabetic patients because they were experiencing long waits for admissions from the ED, but it was due to exacerbation of their conditions resulting from lack of access to primary or urgent care prior to reaching the crisis level that brough them to the ED.

This is very, very clearly not meeting "standards of quality, access, and affordability equivalent to other components of health care."

As a result, I strongly support planning for reinvestment of remaining funds (after the pediatric inpatient unit) into expanded urgent care and diversion resources, but connected within the health care system, not as a mere contribution to a state-funded, segregated system.

DMH is the appropriate source for consultation on the gaps in this area of our overall health care system – gaps which the state currently attempts to fill rather than being funded through equitable health care reimbursements as identified in stature. However, we are still a long way from conceptually and environmentally recognizing mental health a wholly integrated, mind and body, in every aspect of our physical wellbeing as well as mental wellbeing: the vision of

"an integrated, holistic system of care." Even as we recognize that mental health, like other health needs, often requires an urgent-level response that cannot be met through primary care yet does not require an emergency room response, we are conceptualizing them as separated components within separate systems. We should be considering as well when it would be better for overall health as well as more cost-effective to deliver such levels of care under the same roof, within diagnostic subcomponents. A broken arm will be routed differently than a potentially contagious illness. An urgent mental health care need could be routed within that same center to the types of care sometimes referred to as the "living room model" (as one example), rather than being located in a separate facility elsewhere. That would enable the patient having chest pain to be screened and recognized as having an anxiety attack better addressed within the mental health urgent care subunit, and the severely depressed patient with wounds from cutting to be in the mental-health-appropriate setting while being rapidly accessible to medical care for stiches. It would also communicate the vital message of whole health care, and reduce the message of "differentness" that creates stigma and discrimination that have been long recognized as a primary reason many people are afraid to seek out mental health care. Consideration of these issues should be a part of any directive about re-focus of the UVMHN funds, perhaps as a start through inclusion of the wording of state public policy: that the re-direction of these funds be utilized towards ensuring "that Vermonters have access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care *as part of an integrated, holistic system of care."*

Finally, I note that there have been efforts by DMH and the Vermont Department of Health to move the state forward in the integration of our system through the legislatively created Mental Health Integration Council. The GMCB is a member, and the Council's mandate was to work to bring all major components of the health care system together to move forward on these goals. It is currently set to expire this July, and its initial work has scratched the surface of these issues but has not yet resulted in any major conceptual shifts systemically. The issue of state funding of a pediatric psychiatric unit in Bennington while UVMHN cannot afford to develop one in Burlington is rather spectacular evidence of this failure in the type of reform that would allow for systemic change.

We can and should be doing better, and the GMCB response regarding the current question before it offers the opportunity to help move in that direction.

Thank you for the opportunity to comment. I would be happy to discuss this further at any time.

/s/
Anne B. Donahue