Report of the Mental Health Oversight Committee
December 2012

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Senator Joe Benning

Senator Diane Snelling

Senator Jeanette White

Representative Anne Donahue, Co-Chair

Representative Mary S. Hooper

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I. Executive Summary

During the summer and fall of 2012, the Mental Health Oversight Committee met four times to hear testimony on numerous matters impacting the delivery of mental health services throughout Vermont. The Committee makes the following recommendations for the 2013 legislative session:

- The committees of jurisdiction should encourage the Department of Mental Health (DMH) to use results-based accountability practices to ensure quality throughout the mental health system.
- The committees of jurisdiction and the Agency of Human Services should strive to foster greater collaboration among the Agency's departments with regard to mental health.
- Where a gap in statutory language exists, the committees of jurisdiction should consider clarifying in statute the judicial processes necessary for moving involuntarily admitted individuals between mental health facilities.
- The committees of jurisdiction should continue encouraging equality between mental health and physical health through greater integration and parity for similar services.
- The committees of jurisdiction should investigate the nature and extent of reported staffing problems throughout the community mental health system.
- The committees of jurisdiction should explore methods of ensuring that temporary treatment is provided to individuals waiting in an emergency department or correctional facility for involuntary inpatient beds.
- The committees of jurisdiction should explore policies that would standardize the level of care provided at "no refusal" psychiatric hospital units.
- The committees of jurisdiction should recognize the impacts of substance abuse on the mental health system when developing policy that impacts these matters.
- The House and Senate Committees on Appropriations should review how funds appropriated to the DMH for fiscal years 2012–2013 were used.
- The Committee should continue its oversight of the mental health system until the components of Act 79 have been more fully implemented.

II. Statutory Authority and Responsibilities of the Mental Health Oversight Committee

The General Assembly created the Committee in 2004 to oversee the development and implementation of the Vermont Mental Health Futures Plan and to ensure that Vermonters have access to a comprehensive and integrated continuum of mental health services. (2004 Acts and Resolves No. 122, Sec. 141c.) The Committee's charge was amended in 2007 to focus on the state's mental health system more generally and to remove the Committee's sunset date. (2007 Acts and Resolves No. 65, Sec. 124b.) (*See* Appendix 1: Amended Charge of the Mental Health Oversight Committee.)

The Mental Health Oversight Committee is a bipartisan committee composed of senators who serve on the Health and Welfare, Appropriations, and Institutions Committees, and representatives who serve on the Human Services, Appropriations, and Corrections and Institutions Committees, as well as one member from each body chosen "at large." Since 2006, the General Assembly has required the Committee to provide an annual progress report to the

represented standing committees. This is the seventh progress report of the Committee to date. (2006 Acts and Resolves No. 215, Sec. 293a.)

III. Summary of Committee Activities

While the General Assembly was adjourned, the Committee convened four times in 2012 to hear testimony from a diverse array of stakeholders on a number of issues within its jurisdiction. (*See* Appendix 2: 2012 Witness List.) The Committee devoted much of its time to overseeing the implementation of Act 79, which authorized the construction of new mental health facilities and the operation of a clinical resource management system. (2012 Acts and Resolves No. 79.) The Committee also took testimony on the following subjects:

- Housing opportunities for individuals with psychiatric disabilities
- Collaboration between the Departments of Mental Health and of Disabilities, Aging, and Independent Living around elder care, particularly with regard to psychotropic drugs
- Budgetary impacts of the mental health system of care
- Integration of mental health within Vermont's health care reform efforts

The Committee also reviewed its own charge, focusing on its scope of jurisdiction and whether a need for continued oversight of the mental health system remained.

IV. Mental Health System Overview

Vermont's mental health system provides services to over 28,000 adults and children, ranging from acute inpatient hospitalization to noncategorical case management and peer services. The General Assembly redefined its vision for the system during the 2012 legislative session through its passage of Act 79 (An act relating to reforming the mental health system). Prior to the start of that session, the Vermont State Hospital (VSH) was devastated by Tropical Storm Irene on August 28, 2011, leaving the State's mental health system in crisis. The General Assembly used the devastation of VSH as an opportunity to transition from a centralized system of care to a decentralized system that emphasizes community supports and services over institutionalized treatment.

Act 79 authorized the creation of several new facilities for the treatment and care of individuals with psychiatric disabilities, enhanced new and existing community services, and established a mechanism for coordinating the movement of individuals throughout the system. At the Committee's final meeting this year, DMH reported the status of those facilities authorized by Act 79 as follows:

- *Green Mountain Psychiatric Care Center* (Morrisville): The Board of Health granted a provisional license to this temporary eight-bed psychiatric hospital. The Board will likely grant a license to operate the hospital upon completion of certain tasks in December 2012. The announcement of Dr. Jay Batra's resignation came one day after a status report was given to the Committee, and therefore the Committee was not able to

comment on this serious new development, which may delay the opening of the hospital and relief to wait times at emergency departments and correctional facilities.

- *State-Owned and -Operated Hospital* (Berlin): The new 25-bed state-owned and -operated hospital received an emergency certificate of need versus the regular statutorily-required certificate of need from the Department of Financial Regulation, for which the Commissioner of Mental Health sought input from the Committee. The Committee favored the Commissioner's decision to obtain an emergency certificate of need with the caveat that DMH hold a public hearing prior to obtaining the certificate. In addition, the collaboration between Central Vermont Medical Center and the new hospital did not come to fruition as anticipated. (*See* Appendix 3: Letter from Fletcher Allen Health Care.) The hospital is on track to open on January 1, 2014.
- *Secure Residential Recovery Facility* (Middlesex): DMH has received an emergency certificate of need application from the Department of Financial Regulation for a temporary modular facility. A neighbor of the proposed site has appealed the zoning permit granted in September 2012. DMH did not provide any information to the Committee on the anticipated impact caused if continued construction of the facility was stayed by the pending appeal.
- *Brattleboro Retreat*: Renovations for the creation of a 14-bed acute psychiatric unit are under way, and the unit is anticipated to open in March 2013.
- *Rutland Regional Medical Center*: Renovations for the creation of a six-bed acute psychiatric unit are under way, and the unit is anticipated to open in May 2013.

DMH also updated the Committee on the following community programs and supports:

- *Crisis Beds*: The General Assembly appropriated four new crisis beds during the 2012 legislative session; DMH has established six new crisis beds to date. There are now crisis beds located in each of the State's designated areas.
- *Intensive Residential Recovery Facilities*: Of the 31 intensive residential recovery beds authorized by Act 79, DMH has established eight beds to date and another eight beds in Westford have been approved with the expectation of opening next year. Once the Westford beds are on line, Second Spring in Washington County will resume its licensed capacity, and consequently close six beds originally opened to respond to the emergency created by Tropical Storm Irene. DMH is not actively pursuing the seven beds intended for northwestern Vermont.
- *Facility for no or limited reliance on medication*: A project leader has been selected, who is currently searching for a facility within Chittenden County. The facility does not have a projected opening date at this time.
- *Peer services*: Expanded capacity for peer services is under way at Another Way, Alyssum, Pathways, Vermont Center for Independent Living, Vermont Psychiatric Survivors, Rutland Turning Point Recovery Center, and Vermont Vet-to-Vet.
- *Housing subsidies*: At the Committee's December meeting, DMH granted 92 housing subsidies in 2012 and anticipates granting additional subsidies by the end of the year. It appears that these subsidies ultimately depend on receipt of Section 8 certificates to become "permanent." There are long waitlists in Vermont for these certificates, and

therefore these vouchers will have to be sustained with monies from the General Fund and Medicaid.

- *Mobile crisis services*: All areas throughout the state have developed mobile capacity. DMH's ability to expand services has been compromised to some degree by designated agencies' inability to fill vacancies on mobile crisis teams.

As of the Committee's final meeting in 2012, the design and implementation of the clinical resource management system was well under way. It was reported that while providers are currently utilizing DMH's electronic bed board, more rapid reporting of bed status is necessary before the bed board displays vacancies in "real time." DMH's care managers are actively monitoring those individuals in need of beds in order to provide services where the need is greatest. Other components of the clinical resource management system include the establishment of a Quality Management Director position within DMH, development of an executive dashboard, and adoption of a standard definition of Level I care throughout the mental health system.

V. Findings and Recommendations

A. Meaningful Monitoring of Mental Health System

The Committee heard a great deal of testimony pertaining to quality reviews of the newly reformed mental health system. A consultant hired pursuant to Act 79 to make recommendations about Vermont's mental health system suggested establishing broad system performance measures, as well as creating a quality assurance unit within DMH. Generation of a dashboard tool that provides current data of certain key measures and the hiring of a Quality Management Director have been among DMH's first steps in implementing the consultant's quality review recommendations.

A key theme touched upon during both testimony and Committee discussion was the importance of producing and relying on meaningful data versus generating data that does not provide insight into the resilience of the mental health system or lack thereof. To that end, the Committee expressed specific concerns about the usefulness of DMH's dashboard and suggested as useful improvements the addition of monthly *and* year-to-date indicators as well as symbols indicating the direction data should be moving. It is important that the information provide a context with which to understand the data, such as comparisons with the same information over time.

Recommendation

The Committee finds that monitoring the quality of the mental health system in a meaningful manner is of the utmost importance for ensuring that individuals with psychiatric disabilities are receiving the best possible treatment available and that the system is sustainably managed. In alignment with other state initiatives, DMH should consider using results-based accountability methods that articulate expected results and regularly collect and report data that indicate whether the established expectations have been achieved.

B. Intergovernmental Collaboration

Though DMH is the state agency primarily responsible for serving individuals with psychiatric disabilities, the Committee heard a great deal of testimony pertaining to individuals who received services from at least one other department within the Agency of Human Services. As a result, the Committee was reminded that individuals receiving services often do not fit into a single category, but rather require a variety of services from multiple departments. For example, individuals receiving services from DMH may also require substance abuse treatment from the Department of Health's Alcohol and Drug Abuse Program, elder care or services for a developmental disability through the Department of Disabilities, Aging, and Independent Living, or benefits from the Department for Children and Families.

The Committee heard testimony that a department's delivery of services is often disconnected from its counterparts within the Agency, which can create barriers for consumers. When responsibility is divided between departments, consumers often experience a gap in service. One illustration presented to the Committee related to inconsistent management of psychotropic drug use in nursing homes by the Departments of Mental Health and of Disabilities, Aging, and Independent Living. Testimony on this topic highlighted the need for greater collaboration among the departments serving individuals with psychiatric disabilities in various living arrangements.

Recommendation

The Committee recommends that the Agency of Human Services continue to foster greater collaboration among its departments to ensure that individuals receiving services or benefits from multiple departments are not marginalized. When possible, legislation considered by the committees of jurisdiction should facilitate interdepartmental cooperation.

C. Effect of the Judicial Process on Utilization

During the course of its oversight responsibilities, the Committee became aware of the impact Act 79 had on transitioning individuals between facilities throughout the system. While existing statutes governing orders of hospitalization and nonhospitalization continue to direct the movement of involuntarily admitted individuals throughout the newly decentralized system, some statutory gaps may exist where new facilities or treatments have been established. This issue specifically arose before the Committee in the context of the secure residential recovery facility. While DMH believes that the statutory language indicates the judicial processes necessary for admission to the facility, it remains unclear whether a court order is necessary prior to an individual's discharge from the secure residential recovery facility.

Recommendation

The Committee recommends that the committees of jurisdiction remain mindful of how reforms to the mental health system impact judicial processes. If a gap in statutory language exists, it recommends that the committees of jurisdiction consider clarifying in statute the judicial processes necessary for transitioning involuntarily admitted individuals between facilities

throughout the system. The Committee did not discuss any specific proposals for changes to statute, and therefore makes no recommendation.

D. Integration of Mental Health in Health Care Reform

The Committee heard testimony regarding the integration of mental health with the larger health care system, and more specifically with Vermont's health care reform efforts. Robin Lunge, Director of Health Care Reform, and Mark Larson, Commissioner of Vermont Health Access, reported that the Shumlin Administration is trying to create achievable, targeted initiatives for mental health integration. However, they also noted that the full extent of the disparity between mental health and the rest of the system had yet to be fully identified. One recognized barrier was the lack of integration within the mental health system itself, namely between the public and private sectors. A potential option for cultivating greater integration may be the use of mental health providers as medical homes under the Blueprint model.

The Committee also heard testimony and had discussion on a systematic integration model provided by the consultant who was hired pursuant to Act 79. (*See* Appendix 4: Levels of Systematic Collaboration Model.)

With regard to parity, the Committee was reminded of a study requested of the Department of Financial Regulation (DFR) by the General Assembly classifying primary mental health services for the purpose of aligning payment structure with primary physical health services. The stringent time line for the development of the Vermont Health Benefit Exchange served to hasten the work of DFR and, as a result, the classifications were part of the Exchange plan design proposed to the Green Mountain Care Board.

Recommendation

The Committee recommends that the committees of jurisdiction continue to foster equality between mental health and physical health through greater integration of systems and parity for similar services with respect to reimbursement, as well as the types of services provided to consumers by a continuum of providers. The committees should further investigate the utilization of mental health providers as medical homes under the Blueprint model.

After the Committee's final meeting, members became aware of the formation of a limited liability company, Vermont Collaborative Care, formed jointly by BlueCross BlueShield of Vermont and the Brattleboro Retreat to provide mental health care management for BlueCross BlueShield of Vermont. Under this arrangement, mental health and substance abuse services covered by BlueCross BlueShield will continue to be managed separately from other health care services as it was by Magellan Health Services. This approach differs from the fully integrated management model anticipated by observers, and the Committee suggests that the committees of jurisdiction investigate this arrangement in greater detail.

E. Staffing at Designated Agencies

The Committee heard from several witnesses who work within the mental health system at the community level that unfilled vacancies posed a problem with respect to implementing some of the initiatives envisioned by Act 79. The designated agencies specifically testified that some of these vacancies are related to salary level, the difficult nature of the work, geographic challenges, and high turnover. While the Committee did not have time to explore the extent of this problem, it does believe that further assessment is advisable.

Recommendation

The Committee recommends that the committees of jurisdiction investigate the nature and extent of reported staffing problems throughout the community mental health system. The committees should assess designated agencies' ability to provide services and supports that the General Assembly has required them to provide. In addition, it is recommended the committees of jurisdiction identify the specific staffing impediments and how they may be overcome.

F. Housing: Access and Services

At its September meeting, the Committee heard testimony on those housing opportunities available to individuals with psychiatric disabilities. Specifically, it took testimony from DMH, Pathways to Housing, the Burlington Housing Authority, and the Burlington Police Department. The Committee's primary concerns included whether there was sufficient housing available to meet demand and when receipt of housing vouchers should be contingent upon accepting case management services.

Then-Commissioner Patrick Flood reported that DMH anticipated spending $1.1 million on housing during the current fiscal year, and that those monies were eligible for a federal match when housing and services were bundled together. To date, over 90 housing subsidies have been granted by DMH during the current calendar year. (*See* Appendix 5: DMH Housing and Homeless Housing Rental Subsidy Types.)

Witnesses presented divergent views with regard to the necessity of linking housing subsidies with case management services. While all witnesses noted the importance of services, some felt that housing should be maintained even when receipt of services was rejected by the individual. DMH's policy is to bundle housing with services, but to allow for exceptions when an individual is unwilling to accept services. Other witnesses asserted that housing must be provided jointly with services to prevent an individual's condition from deteriorating. One such witness believed that an individual's rejection of services might be a manifestation of the psychiatric disability from which the need for subsidized housing arose.

Recommendation

The Committee agrees that housing supports for individuals with psychiatric disabilities is of great importance. However, the Committee makes no specific finding or recommendation

regarding the sufficiency of housing or necessity of bundling housing with case management services.

G. System Overflow: Emergency Departments and the Department of Corrections

The Committee heard testimony at its December meeting that there were numerous instances when an individual was in need of an involuntary inpatient bed, but no beds were available for that individual within the mental health system. Consequently, many individuals were being held at either emergency departments or at a state correctional facility until a bed became available. DMH estimated that the average wait time for an individual initially denied an involuntary inpatient bed was five and one-half days, and that approximately ten percent of individuals held at emergency departments or correctional facilities were ultimately stabilized before the required treatment became available.

The Committee was particularly interested in whether individuals awaiting a bed at an emergency department or correctional facility were receiving any type of interim treatment or services. DMH itself does not provide any treatment for these individuals; rather a crisis clinician reevaluates the individual's condition at 12-hour intervals. Treatment for individuals waiting for services or an open bed at another facility is at the discretion of the emergency department director or Department of Corrections, respectively.

Recommendation

The Committee finds that the provision of short-term treatment for individuals waiting in an emergency department or correctional facility for a bed is essential. It recommends that the committees of jurisdiction explore methods for ensuring that temporary treatment for such individuals is provided.

H. Equal Care at Level I Treatment Units

The Committee heard anecdotal testimony that the type and degree of mental health services provided at the State's "no refusal" psychiatric units varied by facility. Specifically, some members were alarmed to hear that there was variation at each acute treatment facility in terms of the physical presence of a psychiatrist on staff. Some hospital units retained the services of a psychiatrist to be on hospital premises at all times, while others had psychiatric services available to be called in if needed. The Committee noted that the success of a decentralized mental health system hinged on the provision of consistent treatment across the "no refusal" system.

Recommendation

The Committee recommends that the committees of jurisdiction explore policies that would standardize the level of care provided at "no refusal" psychiatric hospital units, both generally and with regard to psychiatric staffing. It is also recommended that the committees of jurisdiction work with DMH to establish a mechanism for measuring consistency across the mental health system and for guaranteeing uniform clinical practices throughout the state.

I. Substance Abuse

The Committee acknowledges that there are many ways in which substance abuse and mental health intersect in terms of diagnosis, care, and treatment. It further recognizes that a great deal of interplay exists between substance abuse and mental health within the State's health care, judicial, corrections, and housing systems. Therefore, the creation of a successful mental health system necessarily requires the inclusion of substance abuse prevention and treatment initiatives.

Recommendation

The Committee recommends that the committees of jurisdiction recognize the impacts of substance abuse on the mental health system when developing policy that impacts these issues.

J. Appropriations and Spending

The Committee recognizes that the General Assembly committed significant funds to the reformation of the mental health system. The two-year capital bill for fiscal years 2012–2013 included $7 million for the continuation of services and for the planning, design, and replacement of the VSH, including renovations of facilities comprising the "no refusal" system. On the operating budget side, DMH was appropriated over $73,000.00 from the general fund for fiscal year 2013. DMH reports that in some instances, funds were not used as anticipated. (*See* Appendix 6: Department of Mental Health Budget.)

Recommendation

The Committee recommends that the House and Senate Committees on Appropriations review how funds appropriated to DMH were used. The Committee further recommends that the review include an evaluation of how the expenditures furthered the provision of services close to home by a continuum of community service providers, as well as other principles adopted in Act 79.

K. Continuation of the Mental Health Oversight Committee

At its final meeting, the Committee discussed the scope of its jurisdiction and whether its continued oversight of the mental health system was necessary. The Committee reasserted its belief that mental health care is one component of an integrated health care system. To that end, several members of the Committee expressed reservations about maintaining a legislative body that reinforces the division between mental and physical health. Those members felt that the General Assembly should model the behavior it hopes to achieve by integrating the oversight of the mental health system with the other duties of the Health Care Oversight Committee.

However, it was also widely agreed by the Committee's members that in order for the mental health system to be a resilient component of the larger system, its newly envisioned facilities and services must be fully established. The General Assembly has merely laid out a blueprint for reforming the mental health system, and this plan has only partially been constructed. To conclude the comprehensive oversight function provided by the Committee at this critical

juncture would be unwise in light of the resources invested to date. As a result, it recognizes the importance of providing continued oversight on a temporary basis.

Recommendation

The Committee recommends that it continue its oversight of the mental health system until the components of Act 79 have been implemented. It further recommends reevaluating one year from now whether there is a continued need for the Committee to convene.

2012 Report of the Mental Health Oversight Committee to the Vermont General Assembly

/s/ Senator Sally Fox
Senator Sally Fox, Co-Chair

/s/ Representative Anne B. Donahue
Representative Anne Donahue, Co-Chair

/s/ Senator Joe Benning
Senator Joe Benning

/s/ Representative Mary S. Hooper
Representative Mary S. Hooper

/s/ Senator Diane Snelling
Senator Diane Snelling

/s/ Representative Thomas F. Koch
Representative Thomas Koch

/s/ Senator Jeanette White
Senator Jeanette White

/s/ Representative Catherine B. Toll
Representative Catherine Toll

Appendix 1: Amended Charge of the Mental Health Oversight Committee

THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to ensure that consumers have access to a comprehensive and adequate continuum of mental health services. The committee shall be composed of one member from each of the house committees on human services, institutions, and appropriations and a member-at-large to be appointed by the speaker of the house, not all from the same party, and one member from each of the senate committees on health and welfare, institutions, and appropriations and one member-at-large to be appointed by the committee on committees, not all from the same party. Initial appointments shall be made upon passage.

(b) Members of the committee shall serve as the liaison to their respective legislative standing committees with primary jurisdiction over the various components of Vermont's mental health system. The committee shall work with, assist, and advise the other committees of the general assembly, members of the executive branch, and the public on matters related to Vermont's mental health system.

(c) The committee is authorized to meet up to six times per year while the general assembly is not in session to perform its functions under this section.

(d) The commissioner of mental health shall report to the committee as required by the committee.

(e) Members of the committee shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(f) The legislative council, and the joint fiscal office shall provide staff support requested by the committee.

(g) The mental health oversight committee shall provide a progress report to each of the committees represented thereon no later than January 15 of each year.

Appendix 2: 2012 Witness List

Stephanie Barrett, Associate Fiscal Officer, Joint Fiscal Office

Wendy Beinner, Director, NAMI VERMONT

Catherine Benham, Associate Fiscal Officer, Legislative Joint Fiscal Office

Patrick Flood, Former Commissioner, Department of Mental Health

Brooke Hadwen, Burlington Police Department

Heidi Hall, Financial Director, Department of Mental Health

Ryan Kriger, Assistant Attorney General, Attorney General's Office

Michael Kuhn, Project Manager, Department of Buildings and General Services

Mark Larson, Commissioner, Department of Vermont Health Access

Robin Lunge, Director of Health Care Reform, Agency of Administration

Jackie Majoros, Long Term Care Ombudsman, Vermont Legal Aid

Catherine McLinn, Legislative Counsel, Office of Legislative Council

Hilary Melton, Director, Pathways to Housing

Mary Moulton, Deputy Commissioner and Interim Commissioner, Department of Mental Health

Nick Nichols, Policy Director, Department of Mental Health

Michael Ohler, Burlington Housing Authority

Susan Onderwyzer, Quality Management Director, Department of Mental Health

Ed Paquin, Director, Vermont Coalition for Disability Rights

Frank Reed, Mental Health Services Director, Department of Mental Health

David Reynolds, Health Policy Advisor, Department of Financial Regulation

A.J. Ruben, Supervising Attorney, Vermont Coalition for Disability Rights

Brian Smith, Housing Director, Department of Mental Health

Jeb Spaulding, Secretary, Agency of Administration

Julie Tessler, Director, Vermont Council of Developmental and Mental Health Services

Susan Wehry, Commissioner, Department of Disabilities, Aging, and Independent Living

Appendix 3: Letter from Fletcher Allen Health Care

Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

Via email

October 12, 2012

The Honorable Patrick Flood
Commissioner of Mental Health
Redstone Building
26 Terrace Street
Montpelier, VT 05609-1101

Dear Patrick:

In addition to continuing to care for Level 1 patients since the Vermont State Hospital was closed late last August, we have had a number of communications in the past several months about what role Fletcher Allen Partners and its members, Fletcher Allen Health Care and Central Vermont Medical Center, might be able to play in the development of the new psychiatric hospital being planned for Berlin, adjacent to CVMC. I wanted to take this opportunity to summarize those discussions to ensure that we understand and agree where they have led us.

As I wrote you in early May, in the years since the Department of Mental Health began planning for the replacement of the Vermont State Hospital, Fletcher Allen has offered to partner in various ways to maximize the contributions that we each can bring to the treatment of serious mental illness. That partnership has taken a number of forms, including participation in the development of the VSH Futures Plan in 2004 – 2005, the development of a joint proposal in 2006 to build a new hospital under Fletcher Allen's license here on our Medical Center Campus, and providing psychiatry services to the VSH and the DMH for over ten years. We also assisted the Department in improving the quality of care delivered at the VSH when it was subject to the Department of Justice's consent decree.

With the State now planning a new hospital in central Vermont, next to CVMC, our two hospitals saw an opportunity to use our clinical and administrative partnership to capitalize on our academic medical center and the formation of Fletcher Allen Partners to extend the regional integration of our inpatient mental health system. The potential benefits we outlined included optimizing the use of different units and spaces to best treat patients according to their individual needs; better integrating patients' mental health care with other clinical care, including primary, specialty, and emergency care; more efficient use of physician and other clinical staff; and the benefits of an integrated electronic health record that could bring critical medical information to multiple levels of care while in time promoting systemic analysis of quality and outcomes.

Fletcher Allen Health Care – 111 Colchester Avenue – Burlington, VT 05401

As part of our offer, we proposed that Fletcher Allen manage the new hospital under a collaborative management contract. We suggested one model, in which the State would build and own the new hospital under its own license, with the hospital being managed by Fletcher Allen under a contract that would stipulate the required performance and outcomes. Fletcher Allen would also provide psychiatry services and medical leadership. As we envisioned it, the DMH, Fletcher Allen, and CVMC would work together closely to develop goals and ensure progress toward fulfilling the vision of the regional program.

We met in mid-June with you, Secretary of Administration Jeb Spaulding and other State officials to further discuss the potential for this new and collaborative approach to treating patients under your care and custody. That meeting gave us an opportunity to brainstorm a bit more about what a management arrangement could look like, as well as identifying potential barriers that would have to be addressed to make it happen.

We understand that the State has decided it is not in a position to explore our offer at this time, in part because of issues relating to the VSEA's collective bargaining agreement. You have advised us that the VSEA contract does not permit State employees to be supervised by anyone other than a State employee, which conflicts with the management contract approach that we have put forward, which would have us fully accountable for all aspects of the care delivered in the new hospital. While we would hope that given the right set of circumstances such a barrier would not be completely insuperable, we do understand that this is not from your perspective the right time to explore that path.

While we regret that we could not find some common ground at this time that would allow a collaborative approach to the clinical management of the new psychiatric hospital, I understand you have spoken with CVMC about possibly contracting with them for some infrastructural services. I know that we are all prepared to continue these types of discussions to see what we can do to support the new hospital and the patients who will receive their treatment there.

Thank you for your consideration of our offer, and we look forward to our continued discussions about Fletcher Allen's and Fletcher Allen Partners' roles in caring for Vermont's Level 1 psychiatric patients.

Sincerely,

Robert Pierattini, M.D., Chair
Psychiatry Service

cc: Mental Health Oversight Committee

Appendix 4: Levels of Systematic Collaboration Model

	Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration/ Partly Integrated	Fully Integrated/ Merged
THE CONSUMER and STAFF PERSPECTIVE/EXPERIENCE					
Access	Two front doors; consumers go to separate sites and organizations for services	Two front doors; cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Services	Separate and distinct services and treatment plans; two physicians prescribing	Separate and distinct services with occasional sharing of treatment plans for Q4 consumers	Two physicians prescribing with consultation; two treatment plans but routine sharing on individual plans, probably in all quadrants;	Q1 and Q3 one physician prescribing, with consultation; Q2 & Q4 two physicians prescribing some treatment plan integration, but not consistently with all consumers	One treatment plan with all consumers, one site for all services; ongoing consultation and involvement in services; one physician
Funding	Separate systems and funding sources, no sharing of resources	Separate funding systems; both may contribute to one project	Separate funding, but sharing of some on-site expenses	Separate funding with shared onsite expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new flexibility
Governance	Separate systems with little or no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases	Two governing Boards with Executive Director collaboration on services for groups of consumers, probably Q4	Two governing Boards that meet together periodically to discuss mutual issues	One Board with equal representation from each partner
EBP	Individual EBP's implemented in each system;	Two providers, some sharing of information but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high utilizers (Q4) ; some sharing of knowledge across disciplines	Sharing of EBP's across systems; joint monitoring of health conditions for more quadrants	EBP's like PHQ9; IDDT, diabetes management; cardiac care provider across populations in all quadrants
Data	Separate systems, often paper based, little if any sharing of data	Separate data sets, some discussion with each other of what data shares	Separate data sets; some collaboration on individual cases	Separate data sets, some Collaboration around some individual cases; maybe some aggregate data sharing on population groups	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; data collection from one source

Levels of Systemic Collaboration Model (Adapted) © 2006 Kathleen Reynolds (Integrated Care Adaptation only) Adapted From: Doherty, McDaniel and Baird, 1995.

Appendix 5: DMH Housing and Homeless Housing Rental Subsidy Types

DMH Housing Subsidy Program	Services	Available Services
New DMH Housing Subsidy & Care * H*	Encouraged (only 2 began subsidy without a Community Support Plan)	CM CS E I&R ES SSI ap SSOM in HMIS
Federal Shelter Plus Care H*	Services are required as match for HUD funding	CM CS E I&R ES SSI ap HMIS
DMH CRT Housing Contingency	DA services are provided per CRT enrollment	CM CS E I&R ES SSI ap
DMH CRT Housing Recovery	DA services are provided per CRT enrollment	CM CS E I&R ES SSI ap

H* Homeless only

CRT = Community Mental Health Community Rehabilitation & Training

CM = Case management

CS = Community Support

E = Employment

I&R = Information & Referral

ES = Emergency Services

SSI ap = Support for filling an application for disability claim

SSOM = Self Sufficiency Outcome Matrix

HMIS = Electronic Homeless Management Information Data Collection/reporting

*Required coordination of services among community providers is a new feature of the DHM HS&C program. The provider agency supporting/submitting the client application is responsible for client outcomes housing via the SSOM in HMIS.

Appendix 6: Department of Mental Health Budget

Act 79 , 2013

Initiative	Comment	Appropriated Amount	Comment, FY13	FY 13 Projection	Difference	GF impact	Comment, FY14	FY14 Projection	Difference	GF impact
MH System Oversight		$ 1,473,684		$ 1,234,749	$ (238,935)	$ (104,104)		$ 1,321,937	$ (151,747)	$ (66,101)
DMH Psychiatric Services		$ 458,355		$ 581,943	$ 123,588	$ 53,847		$ 587,075	$ 128,720	$ 56,070
Peer Services		$ 1,000,000		$ 1,000,000	$ -	$ -		$ 1,000,000	$ -	$ -
Enhanced Community Supports		$ 8,000,000		$ 8,000,000	$ -	$ -		$ 8,000,000	$ -	$ -
Crisis Beds	4 beds		LCC 2 beds, 8 mo	$ 320,000				$ 480,000		
			CMC 2 beds, 12 mo	$ 480,976				$ 480,976		
			Alternatives 2 beds, 12 mo	$ 450,125				$ 450,125		
		$ 1,000,000		$ 1,251,101	$ 251,101	$ 109,405		$ 1,411,101	$ 411,101	$ 179,076
Peer supported residential	fy13 planning	$ 300,000		$ 300,000	$ -	$ -		$ 1,000,000	$ 700,000	$ 304,920
Housing Subsidies	approp as $500k GF, $100k GC	$ 600,000	Able to tie to treatment plan and use GC	$ 1,247,579	$ 647,579	$ -		$ 1,247,842	$ 647,842	$ -
Intensive Residential Recovery	15 beds NW VT		7 beds Chitt Cnty	$ -				$ 2,400,000		
			8 beds, Westford, 7 mo	$ 1,254,709				$ 2,575,586		
		$ -		$ 1,254,709	$ 1,254,709	$ 546,677		$ 4,975,586	$ 4,975,586	$ 2,167,365
	8 Beds Ctrl or SW VT		Rutland, 4 beds	$ -				$ 1,257,799		
			Rutland 2 crisis beds, 8 mo	$ 414,667				$ 622,000		
			Sec Spring, 8 beds 5 mo, then 2 beds 7 mo	$ 1,450,021			2 beds	$ 450,000		
		$ 3,200,000		$ 1,864,688	$ (1,335,312)	$ (581,795)		$ 2,329,799	$ (870,201)	$ (379,060)
	8 Beds SE VT	$ 2,435,506	Hilltop, 11 mo	$ 2,232,547	$ (202,959)	$ (88,429)		$ 2,435,506	$ -	$ -
Brattleboro Retreat	BR - 14 beds	$ 8,068,600	Av 26 beds thru Jan, 21 thru June	$ 10,295,809	$ 2,227,209	$ 970,395		$ 7,533,520	$ (535,080)	$ (233,081)
Other Inpatient	Rutland - 6 beds	$ 3,000,000		$ 1,544,279	$ (1,455,721)	$ (634,258)		$ 1,626,075	$ (1,373,925)	$ (598,482)
	Fletcher Allen - 7-12 beds	$ 8,000,000		$ 2,114,255	$ (5,885,745)	$ (2,564,419)		$ 1,574,379	$ (6,425,621)	$ (2,799,001)
	State Run SRR - 7 beds	$ 2,000,000	Middlesex, 7 beds, 6 mo	$ 2,143,666	$ 143,666	$ 62,595	12 months	$ 3,740,081	$ 1,740,081	$ 757,979
Pathways		$ 373,000		$ 373,000	$ -	$ -		$ 373,000	$ -	$ -
GMPCC	Morrisville -8 beds	$ -	7 months	$ 5,619,411	$ 5,619,411	$ 2,448,377	6 months	$ 4,521,388	$ 4,521,388	$ 1,969,517
Berlin Hospital		$ -		$ -	$ -	$ -	25 beds, 6 months	$ 9,065,711	$ 9,065,711	$ 3,949,024
		$ 39,909,145		$ 41,057,736	$ 1,148,591	$ 218,291		$ 61,459,486	$ 12,833,855	$ 5,308,227