Vermont Department of Mental Health

Fiscal Year 2015

Budget Request

February 4, 2014

Vermont Department of Mental Health

VISION

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

MISSION

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

VALUES

We support and believe in the Agency of Human Services values of respect, integrity, and commitment to excellence and express these as:

Excellence in Customer Service

- People receiving mental health services and their families should be informed and involved in planning at the individual and the system levels
- Services must be accessible, of high quality and reflect state-of-the-art practices.
- A continuum of community-based services is the foundation of our system.

Holistic approach to our clients

- We can promote resilience and recovery through effective prevention, treatment, and support services.

Strength Based Relationships

- It is important to foster the strengths of individuals, families, and communities.

Results Orientation

- Strong leadership, active partnerships and innovation are vital strategies to achieve our mission.
- We are accountable for results.

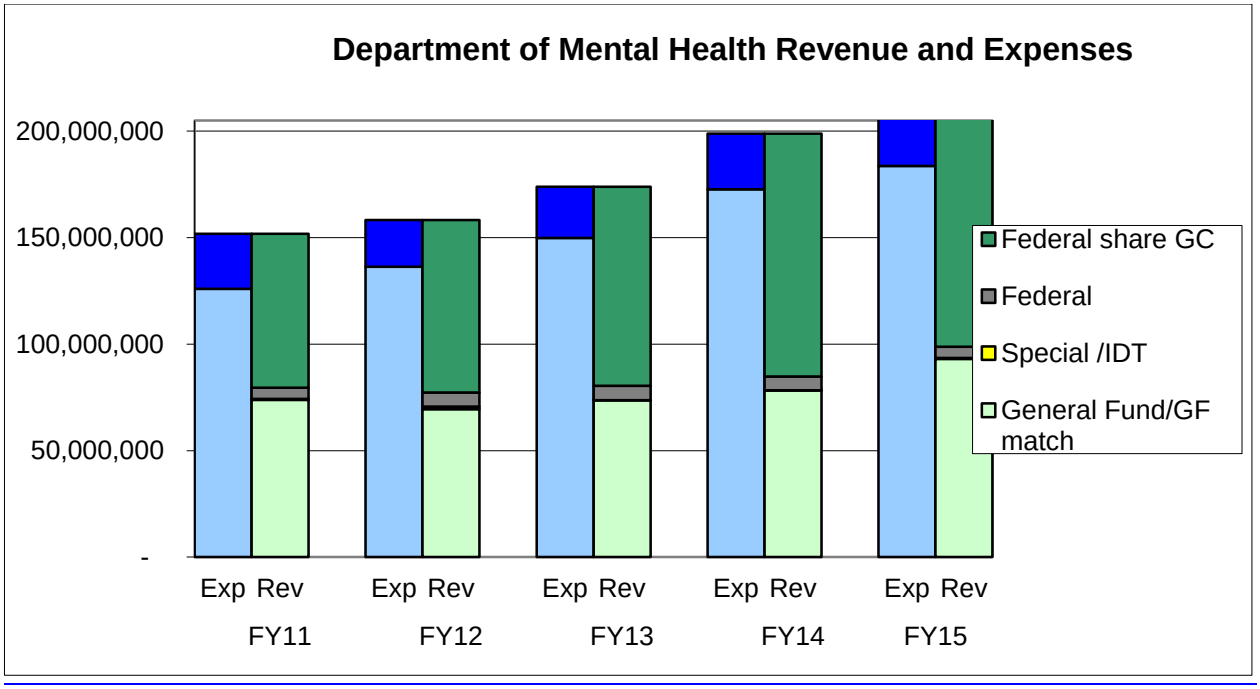
<u>Organizing Functions of DMH</u>

The Department of Mental Health (DMH) commitment to direct services and community-based mental health care and treatment is reflected by the following organizing functions:

- A key organizing function for DMH is the operations of the central office for the identification of mental health service and development needs, resource acquisition and budget allocation, and oversight of the system of mental health service delivery and care.
- The Designated Agency (DA) community-based mental health service delivery system holds the organizing functions for the state funded system of care in the communities.
    - The system of care for the Community Rehabilitation and Treatment (CRT) programs serving adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED).

- The availability of the 24/7 mental health crisis response capability of the Emergency Services Programs at each DA.

- The final organizing function of the DMH is supporting access to acute inpatient psychiatric care for persons needing involuntary hospitalization at the VPCH and within the 5 designated hospitals system of inpatient care.



Program expansion is up $42M post Hurricane Irene, yet GF increase is only up $8.9M, $4.2M of which is due to the increased state Medicaid match rate (from .4128 to .4351)

DEPARTMENT OPERATIONS AND PROVIDER MANAGEMENT

State law specifies that Vermont's publicly funded community services system for individuals of all ages with mental health disorders be provided through contracts between the DMH and private, nonprofit community provider agencies. Currently, DMH contracts with 11 such provider agencies, ten of which are known as Designated Agencies (DA s) and one of which is a Specialized Service Agency (SSA). There is only one DA per geographic region. The DA's have, by statute, bottom line responsibility for assuring that a comprehensive range of services is available for the following priority populations within their defined service area: Adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED). The DMH also contracts with one SSA to provide services only for children and adolescents.

Operations

The central office of the Vermont Department of Mental Health ensures that internal and external program operations pursuant to its statutory responsibilities under 18 V.S.A. Chapter 173 are adequately resourced, monitored, and that development activities sustain and promote the existing public mental health adult and

child services network. Operations functions include administrative support, financial services, legal services, provider monitoring, care management and utilization review, system development and technical assistance, and community housing.

The **Administrative Support Unit** staff are often the first point of contact and triage for incoming inquiries from consumers, family members, and service providers. Administrative Support Services staff respond to the daily internal and external communication flow with operations and clinical services staff, AHS and our community partners. Support staff work closely with program staff in the development and execution of service provider contracts and grants, as well as, ordering, production, document management, and other clerical services necessary to support their respective units within the DMH.
The **Financial Services Unit** works closely with all staff; internally overseeing the budget development process as well as invoicing, coding, accounting, and ensuring payment authorizations for sub-contractors and grantees while externally tracking and monitoring financial reporting and accountability of the DMH, the DA provider system and community-based advocacy, family, and consumer-run organizations.
The **Legal Services Unit** is comprised of staff from the Attorneys General Office and DMH paralegals. It supports the DMH with legislative and policy review activities, tracking individual court orders and petitions, and various other proceedings requiring attorney representation.

Provider Oversight/Performance Indicators
Central office staff members from both the Adult Services Unit and the Child, Adolescent and Family Unit (CAFU) are responsible for monitoring community program services, designating agencies every four years as outlined in the *Administrative Rules for Agency Designation*, and DMH designation of hospitals for involuntary psychiatric care through various oversight activities of the Department. Additionally, the DMH, under the statutory responsibilities of the Commissioner of Mental Health (18 V.S.A. § 7408), oversees Electroconvulsive Therapy (ECT) treatment. Staff members ensure that review activities for DA's and hospitals are conducted and corroborating program, policy, and outcomes information compiled.

Research and Statistical Unit personnel provide routine and ad hoc data review and analysis from various provider services information and data submissions. The activities include agency reviews, records documentation of minimum standards, and tracking agency or hospital information reporting for the ten DA's, one SSA, and the five Designated Hospital psychiatric inpatient programs, as well as the state psychiatric hospital.

Quarterly, key financial performance indicators are composed and reviewed for signs of fiscal weaknesses. In particular, days of net assets, current ratio, gain/loss, days of cash, and admin cost ratio are closely examined. Monthly financial data and client-level encounter data are submitted to DMH for purposes of tracking both financial health of the organization and service delivery to persons served by the DA. Any agency highlighted as having potential shortfalls is contacted and dealt with on an individual basis. Provider grant agreements are developed annually to outline service delivery level expectations.

Clinical Care Management and Utilization Review
The review activities of this unit are guided by the State's Medicaid Global Commitment Waiver and Managed Care Organization (MCO) requirements and focused on the use and authorization of inpatient care for adult clients with the most intensive mental health services needs- Community Rehabilitation and Treatment (CRT) program clients and notification of persons subject to involuntary emergency examination hospitalization. Subsequent to the closure of the VSH, the care management team has been

required to expand its support activities with the Designated Hospitals to facilitate both admission and diversion to clinically appropriate alternative care settings as well as timely transfer to community services from inpatient care. Two staff members are directly responsible for acute CRT and Medicaid psychiatric inpatient authorization and continued stay reviews with five Designated Hospitals (DH's).

The remaining care managers work directly with the Designated and community hospitals and the Designated Agencies to address the needs of any person in the care and custody of the Commissioner of Mental Health with complex mental health needs or voluntary psychiatric inpatients who are experiencing barriers to community services and timely discharge. This team works closely with Emergency Services Programs to identify needed community services and alternative levels of care to respond to crises. This unit, in conjunction with legal services, provides training to the Qualified Mental Health Professionals who screen admissions into involuntary care and the custody of the Commissioner of Mental Health.

System Development and Technical Assistance
The DMH actively explores funding opportunities, as well as, community collaboration and mental health practice improvement initiatives. These efforts are designed to bring supplemental federal and other grant resources to our mental health provider system and assure that the work force is current with new treatment approaches and evidence-based practices in the field of community mental health services. In addition, the DMH technical assistance staff; licensed psychologists, provide consultation to program development initiatives and technical assistance for the implementation of specific practices.

Community Housing
Access to safe, affordable housing is critical to the well being of Vermonters with disabilities and especially, those who live on extremely limited incomes. The DMH assumes a leadership role in the development and preservation of, and access to affordable housing. Staff coordinates the continuation of existing HUD funding and actively pursues opportunities for new funding for housing. These activities require close working relationships with Vermont's not-for-profit housing developers and with the local and state housing authorities. In addition, DMH works closely with the shelters and service providers who assist Vermonters who are homeless to gain housing.

DA utilization for each program is identified in the chart below.

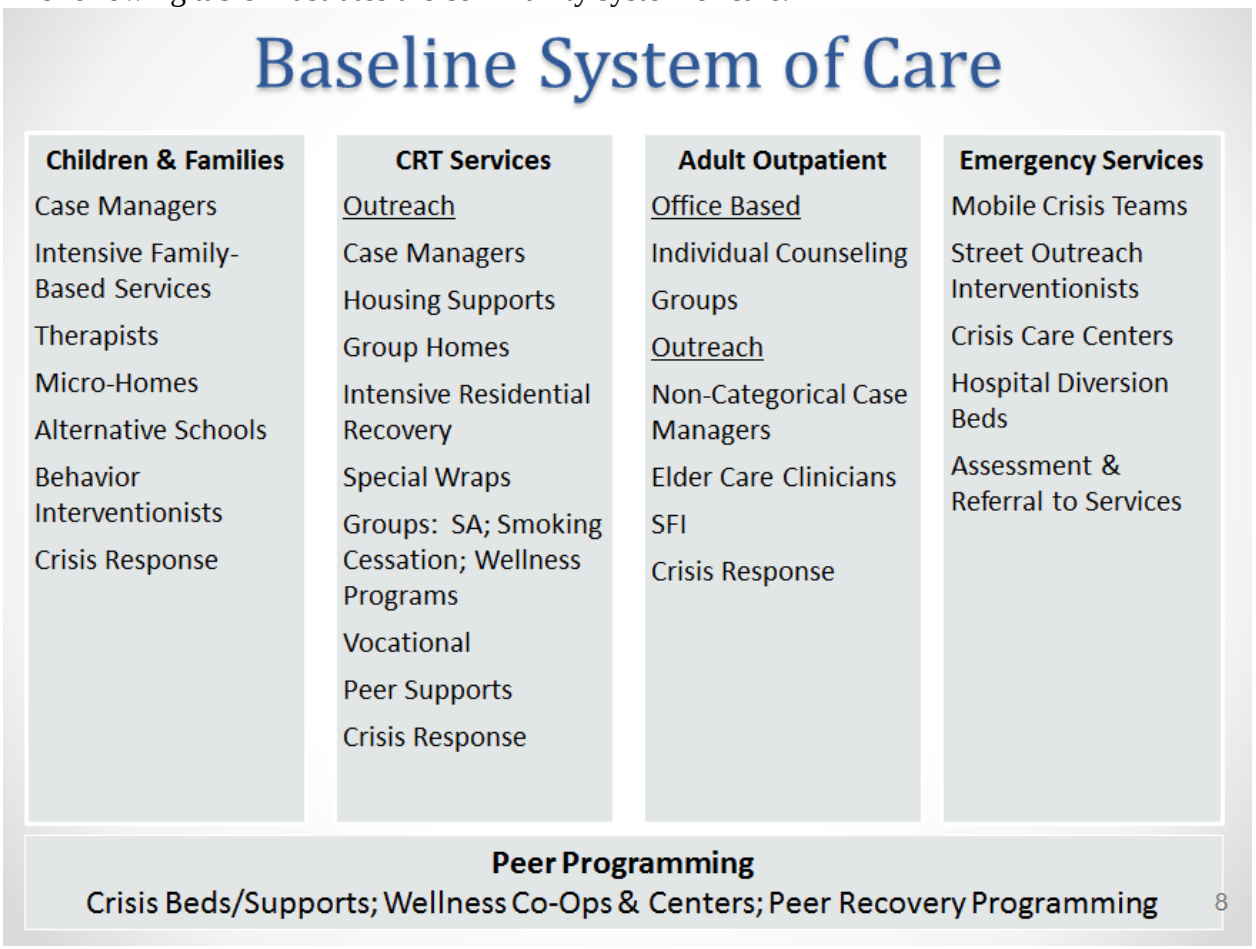
The highest number of persons served by a program offered by the DAs is in services for children and families, while the lowest numbers of persons served by a DA program are those in the CRT programs. The volume of clients served in CRT programs has been fairly static over time. It is still a bit too early to see changes from enhanced funding that began in May 2012. The DMH will report on changes in the next FY 2015.

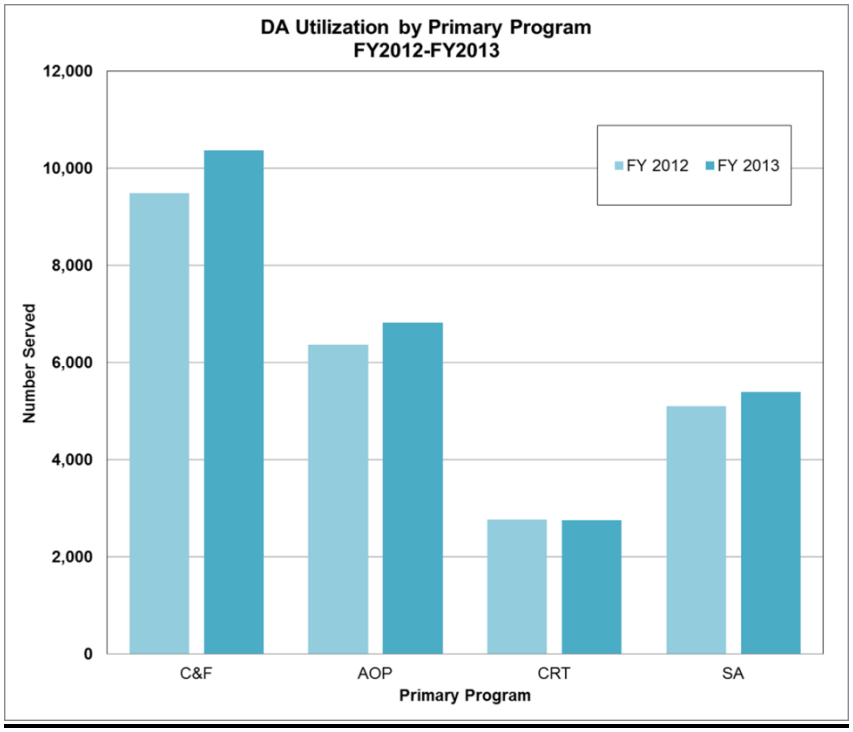
The format of the following section of this report refers to and is framed by tenets of *Results Based Accountability,* (RBA)(Friedman, 2009) as a tool for review of the programs and related budget for DMH in FY 2015. The sections represent the programs for which the DMH has oversight.

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

COMMUNITY PROGRAMS

The following table illustrates the community system of care.





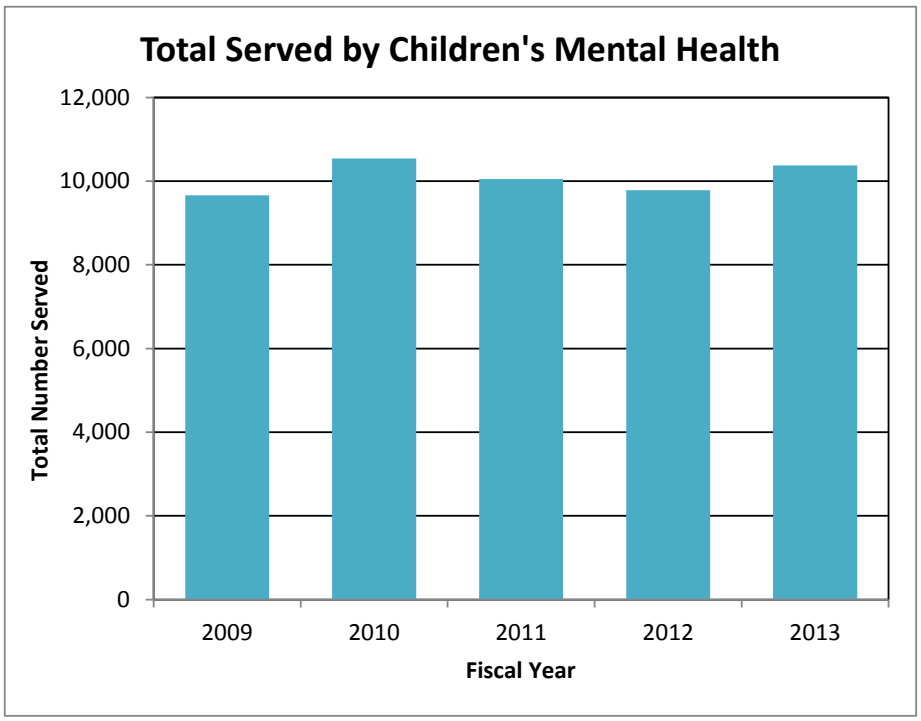
CHILD, ADOLESCENT, AND FAMILY SERVICES

How much did we do?
How well did we do it?
Is anyone better off?

What is the program?
The Child, Adolescent, and Family Unit (CAFU) oversees a system that provides evidence-based mental health services and supports to families so that children can live, learn, and grow up healthy in their family, school, and community. CAFU works closely with its network of DAs and one SSA to provide services that include:

- prevention and early intervention,
- family supports,
- clinical treatment,
- immediate response,
- acute care, and
- intensive residential placement.

CAFU also works closely with interagency partners, including the state's 60 supervisory unions and 12 AHS regional offices for child welfare, to assure that needed supports and services are available when and where needed. The total number of services provided through children's services is depicted in the graph below.



How does the program meet a core mission: ***How well did we do it?***

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. Pursuant to 18 V.S.A. § 7401 and § 8907, the Department of Mental Health, under the authority of the Commissioner of Mental Health and contracts with designated public or private non-profit agencies, assures planning and coordination of services "needed to assist children and adolescents with or at risk for a severe emotional disturbance." In addition, under Vermont's Act 264, DMH is mandated to work with families, child welfare, and education as partners at both the state and regional levels for this population. Under the 2005 Interagency Agreement between the Agency of Human Services and the [then] Department of Education pursuant to the federal Individuals with Disabilities Act (IDEA), the scope of the interagency system of care expanded to include children and adolescents with any of the 14 disabilities covered by state and federal special education law.

What does success look like for a child- ***How is the person better off?***
"Success" for a child or adolescent is growing and thriving in their own home, school, and community. Some children and adolescents have to work through more challenges than others to do this. Mental health services can help children and adolescents develop the ability to accept and overcome challenging or adverse circumstances, supporting their "resiliency," which is a fundamental and natural characteristic essential to healthy development. Resiliency can be nurtured and supported by caring adults who take a strength-based approach to foster and empower a child's efforts to cope effectively with hardships.

What does success look like to the community-*How is the community better off*?
In a healthy community, its members, organizations, and schools know available resources for children and families that can be readily accessed for assessment and support. They work together to build and maintain an interagency system of care that provides high quality services and supports so that children,

adolescents, and young adults develop the skills necessary to be contributing and caring members of their communities.

What performance measures are used to determine progress: *How well did we do it?*

As part of its on-going efforts to more effectively and efficiently support Vermont's families as they work to raise healthy children, the CAFU is pursuing the following initiatives.

Trauma

Situation:

Brain research in the last decade has revealed that experiencing severe and/or complex trauma alters the way the brain functions and any subsequent treatment must take this into consideration to achieve successful outcomes.

Action and Results:

DMH applied for, was awarded, and implemented a grant from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services to develop effective treatment and support services for children and adolescents who are experiencing or experienced severe and/or complex trauma. As a result, CAFU:

1. joined a new national network—the *National Child Traumatic Stress Network*;
2. established the *Vermont Child Trauma Collaborative* to implement and sustain the *Attachment, Self-Regulation and Competency (ARC) Framework* in Vermont's community mental health system;
3. consulted with The Trauma Center at the Justice Resource Institute in Massachusetts for the statewide dissemination of ARC;
4. trained over 600 individuals in the ARC framework;
5. provided over 70 clinicians 2 years of additional training and consultation; and
6. trained 20 individuals to become official trainers of the framework which will allow Vermont to sustain the training of professionals without relying on outside providers.

This grant has ended and the work of applying the knowledge and furthering the skills of the mental health workforce continues.

Young Adults in Transition (YIT)

Situation:

Making the transition from adolescence to adult life successfully is not always easy in our world, as evidenced by the number of young adults who end up dropping out of school, unemployed, using alcohol and drugs, and/or involved with corrections, It is especially difficult if the young adult also experiences mental health challenges.

Action and Results:

DMH applied for and was awarded a $9 million, 6-year, competitive federal grant to assist adolescents and young adults who have experienced mental health issues and provide the supports necessary to access health care, post-secondary education, employment, housing, and caring relationships with adults who

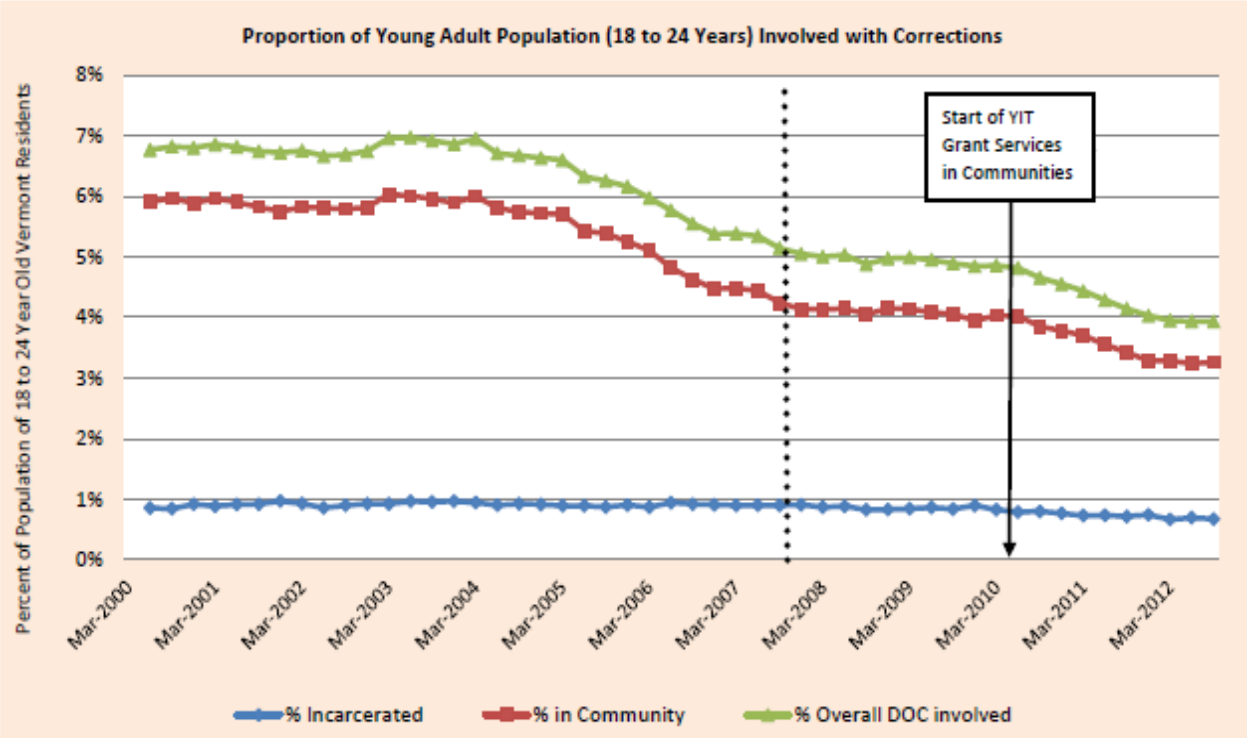
nurture positive youth development. All 12 AHS regions have implemented the following proven strategies.

1. Young adults have been empowered throughout the state to help design a young adult driven system of care.
2. All agencies/departments serving young adults aged 16 – 23 have worked together to create a young adult driven system of care.
3. Mental health and substance abuse services have been designed for this young adult driven system of care and a recent grant to ADAP is enabling implementation in two pilot regions.
4. Reached out to young adults with SED who are out-of-school through teen centers, recovery centers, and homeless youth programs, and by intercepting them at critical intervention points with the juvenile and criminal justice systems.
5. Improved access to mental health services for the young adults most at risk for poor outcomes and used the power of the courts to increase their likelihood of use of those services.
6. Provided cross-system case management and individualized service plan development, ensuring that young adults are engaged in planning for their own futures.
7. Adopted one or more evidence-based practices that are consistent with and build upon the JOBS program in the region.
8. Linked and/or provided young adults and their families/adult allies with:

    a. access to health care (including insurance and especially for co-occurring mental health and substance abuse treatment);
    b. post-secondary education (also training, and options for completing high school)
    c. employment;
    d. housing (safe, stable, and adequate)*; and
    e. caring relationships (with adults who nurture positive youth development).

[* Though the federal grant funds cannot be used to pay for housing *per se*, they can be used for the service coordination and community supports that may make it possible for youth to stay in housing.]

Making these linkages requires efforts to integrate AHS services for young adults of transition-age and to collaborate with other public and private service (including housing) providers, substance abuse prevention coalitions, Workforce Investment Boards, law enforcement, and criminal and juvenile justice officials.



Analysis of outcome evaluation data have shown positive results, including the following.

- The percentage of young adults involved with the Department of Corrections has gone down from approximately 7% in 2000 to less than 4% in 2012. While gradual, this trend represents a significant decrease in corrections involvement over time.
- Over time, young adults in the Vermont YIT evaluation reported fewer delinquent and illegal behaviors. They also reported a decrease in their involvement in Vermont's criminal justice system with the largest reductions for bullying and purposely damaging property; police contact, arrests, and court involvement. Both Department of Corrections' trend data and self-report data from young adults indicate that Vermont is bending the curve on justice system involvement!
- Even in a difficult economy, after 6 months of YIT services, young adults looking for employment who found it and were working rose from 38% to 44%.

PNMI

Situation

PNMI is a funding mechanism for residential assessment and treatment of children and youth. Each AHS Placement Authorizing Department is responsible for funding youth placed; referrals go through a centralized AHS Case Review Committee (CRC) for statewide matching with programs and triage for available openings.

DMH continues to see an increase in PNMI spending, a trend that has been occurring over the past several years. The increase in DMH spending does not correspond to a notable increase in the use of PNMI

statewide when looked at from an AHS/ IFS perspective. The two major factors contributing to DMH's spending are the increase in *numbers* of children placed in residential programs and *length of stay* in out-of-home placements. These factors have progressively increased for DMH placed children every year for the past several fiscal years. In the context of the Early and Periodic Screening Diagnosis and Treatment Program, (EPSDT), we know that the determination of medical necessity for residential assessment and treatment is addressed through several processes including the local team's decision to make a referral, and the DMH and CRC processes to review the request. As AHS moves forward with the Integrated Family Services (IFS) initiative, it is our hope that we will begin to look at PNMI and waiver funding for out-of-home placements from an integrated approach with one budget to manage all requests.

a. The DMH spending increase is seen in **number** of children/youth referred for and placed by DMH in residential facilities, acuity of need, and referrals to out-of-state facilities due to increased acuity and complexity. Out-of-state programs are explored after in-state options have been considered and ruled out.

DMH Total # Children in PNMI Placements by FY (in-state and out-of-state)

FY14*	FY13	FY12	FY11	FY10	FY09	5 year average
66	75	68	63	56	59	64**

*FY14 as of 1/28/14

** 5 year average is 64 admissions; up from last year's 5-yr average of 62 admissions.

b. Division of Rate Setting tracks **bed day utilization** by each placing department for in-state residential programs. This shows the increase in DMH utilization of in-state PNMI facilities across fiscal years. It also illustrates that, compared to the DMH changes, there has *not* been significant change in total AHS in-state bed days.

	FULL YEAR SFY11				FULL YEAR SFY12				FULL YEAR SFY13			
	SFY11 - July 1, 2010 through June 30, 2011				SFY12 - July 1, 2011 through June 30, 2012				SFY13 - July 1, 2012 through June 30, 2013			
	DCF	DMH	ADAP	Total Days Utilized	DCF	DMH	ADAP	Total Days Utilized	DCF	DMH	ADAP	Total Days Utilized
TOTALS w/ Closed Facilities	52,483	6,662	1,538	60,683	51,369	7,489	1,670	60,528	48,562	9,757	1,475	59,794
Change from prior FY					(1,114)	827	132	(155)	(2,807)	2,268	(195)	(734)
NOTE: DRS began tracking census data in SFY11.												
NOTE: As SFY12 was a leap year, there is one extra day available for services in February con												
NOTE: Eckerd Camp E-Wen-Akee closed 2/29/2012.												

c. This has resulted in a significant increase in DMH **spending**.

PNMI	Budget	Projected Spending	Difference
FY14*	$4,698,424	$4,519,347	$324,780
FY13	$2,051,251	$4,041,174	($1,989,923)
FY12	$2,051,251	$3,014,842	($963,591)
FY11	$2,649,038	$2,723,209	($74,171)

*FY14 projected spending as of 1/28/14

Action and Results

We must ask why these increases have occurred. DCF, DS, DMH and all community services have seen an increase in the acuity of clinical need in the children and their families. When the community-based array of clinical and support services have not been able to adequately address the clinical needs, children are referred for residential treatment. While fewer children are entering DCF custody, those children and their families still have very high needs that are often addressed through the DMH system.

If a provider determines that residential treatment is a "medical necessity" to address the child's mental health needs, and the DMH concurs, the request is approved following the EPSDT mandate.

Approvals, utilization review, and length of stay:

DMH conducts a clinical review of the request for residential placement. The case is brought to the inter-departmental Case Review Committee. CRC was "established as a subcommittee of the State Interagency Team to achieve two objectives applying consistent criteria:

1. to provide assistance to local teams as they identify, access and/or develop less restrictive treatment alternatives; and,

2. to assure the best possible match between child and residential treatment facility when less restrictive alternatives are not appropriate ."

DMH conducts utilization review of children/youth placed in residential (PNMI) programs to evaluate treatment progress and review discharge plans. Lengths of stay in placements continue to be high and some children may be in more than one out-of-home placement over the course of many years. Children in out-of-home placements funded by DMH are still in the custody of their parent/legal guardian and are placed for clinical treatment purposes. However, some of these children/youth do not have a clear permanency plan; their families indicate that the child is not able to return home for a variety of reasons. In FY13, 36% of PNMI placements were children who were adopted or under guardianship by someone other than their biological parents. Of the children remaining in residential placements beyond one year, 62% are from adoptive or guardianship homes.

Is There a Better Way?

Child and family services under AHS have been undergoing significant systems change to better serve Vermont families, including practice changes at DCF resulting in fewer children in the custody of the Commissioner. At the same time, more families are accessing supports within DCF and AHS, and all of us within AHS continue to look at how to more effectively and efficiently integrate services. In this system development, there is consideration of integrating the numerous necessary processes: information collection, tracking, and even funding of PNMI placements across AHS placing departments. Rather than having separate budgets for each AHS Department that are managed independently to fund placements of children in PNMI residential facilities, pooled funding for such residential placements across all AHS placing departments could result in a unified management and oversight process. This would strengthen the efforts towards more fully implementing Integrated Family Services.

Youth Suicide Prevention

Situation:

According to the results of the *2013 High School Youth Risk Behavior Survey Report,* in the previous 12 months, 21% of all students felt sad or hopeless almost every day for at least two weeks, 11% made a suicide plan, and 5% attempted to die by suicide; females were twice as likely in each of the three categories as males.

Action and Results:

Working in collaboration with the Center for Health and Learning, CAFU has just completed a federal grant for youth suicide prevention, which included the following objectives, all of which have been achieved.

1. Created the *Vermont Youth Suicide Prevention Platform* with strategies that can be used by individuals, communities, and collaborative groups to prevent deaths by suicide. (See http://mentalhealth.vermont.gov/sites/dmh/files/publications/Youth_Suicide_Prevention_Platform_2012.pdf.)
2. Developed a public education program about mental health entitled *UMatter*. It is aimed at individuals and service professionals and based on the concept that it is important to get and to give help when people are in emotional pain. (See http://www.umatterucanhelp.com/ and http://www.umatterucangethelp.com/.)
3. Administered the evidenced-based Gatekeeper Program's *Lifelines* curriculum in selected schools.
4. Established protocols using the *Connect* curriculum for first responders, faith-based organizations, and primary care providers in selected communities.

Situation:

Analysis of Vermont data by the advisory group to the work above showed that, in terms of deaths by suicide in the last decade, males between the ages of 30 and 59 outnumber other age categories.

Action and Results:

In FY2014, both CAFU and AMH teamed up with the Center for Health and Learning to expand awareness and use of evidence-based prevention strategies such as those above across the lifespan using a new federal grant and funding from the previous Vermont Legislative session.

Family Mental Health Model

Situation:

Growing a family that is physically and mentally healthy, economically secure, and supported by a positive network of community relationships has become increasingly complicated and challenging in our fast-paced world. It is difficult for parents to "know all the answers" at a time when many of the answers (and even a good number of the questions) keep changing.

Action and Results:

The DMH, the Vermont Children's Health Improvement Project (VCHIP), and the Department of Child Psychiatry at the University of Vermont (UVM) have been collaborating for several years to develop a collaborative vision of family mental health. This vision includes the following elements and results to date.

1. Child Psychiatric Fellowship Program at UVM to train and retain child psychiatrists.
    - Although there is a national shortage of child psychiatrists, Vermont has retained 3 from this program in the last 2 years.
2. A Family Mental Health Program that includes evidenced-based practices to provide mental health wellness, prevention, and treatment services.
    - The Family Mental Health model is being discussed with the developers of the Vermont Blueprint for Health for use with pediatric practices.
3. Co-location of mental health professionals in primary care offices.
    - Currently in 8 sites.
4. Psychiatric consultation provided for complex cases.
    - Currently in 41 sites.
5. Psychiatry telemedicine.
    - Currently in 4 sites.
6. DMH, UVM Child Psychiatric Fellowship Program, and AHS Department for Children and Families worked to develop and implement policy and procedures to improve informed consent for use of anti-psychotic medications for children in foster care.
    - Policy and procedures implemented April 1, 2014, including resources for required and optional consultation with child psychiatrist.

This model dovetails very well with the new AHS business model of Integrated Family Services.

Integrated Family Services (IFS)

Situation:

AHS services for children fall in 11 divisions across 6 departments. Divisions and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for serving specialty populations as new mandates and funding sources developed.

Action and Results:

AHS has developed a business model which takes the interagency system of care to the next developmental level. Integrated Family Services seeks to bring all agency child, youth, and family services together in an integrated and consistent continuum of services for families. The premise is that giving families early support, education, and interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end funding* streams which often result in out of home or out of state placement.

The first pilot region came on-line July 1, 2013: Addison County.

- With all providers working together, there is no "wrong door" for a family with needs.
- A uniform, standardized assessment is done with the family at the outset to outline the family's strengths, needs, and current resources. If multiple needs are discovered, the family can share the information from the initial assessment with multiple providers.

- One *Family Plan* is created rather than separate, perhaps conflicting or overwhelming, plans from each provider for each person.

- A *Master Grant*, coupled with the flexibility of the Global Commitment Medicaid Waiver, allows providers to focus more time and energy on achieving outcomes with families and less on documenting units of services provided.

The second pilot region will come on-line in March 2014: Franklin/Grand Isle Counties.

Success Beyond Six (SBS)

Situation:

Although the US Surgeon General estimated that 1 in 5 children and adolescents may have mental health needs in any given year, Vermont faces several challenges in meeting the mental health needs of its young citizens. This is a rural state with minimal public transportation and with only 10 designated agencies to provide mental health services. Vermont also has 360 schools in communities, which provide transportation for the school day. Data show that, historically, students with an emotional disability are the most likely of all 14 disabilities under special education law to drop out of school, a very negative outcome with multiple correlated negative outcomes over the person's lifespan.

Action and Results:

Vermont has been actively developing its partnerships between mental health, education, and students and their families under the Success Beyond Six (SBS) partnership since 1992. In Success Beyond Six, school districts or supervisory unions contract with their region's designated agency to provide services which enable students to remain in their local school and to benefit from the education offered there. SBS:

- operates from a basic state-wide contract template with detailed local work requirements;

- provides state-wide training and skills guidelines for the position of Behavioral Interventionist;

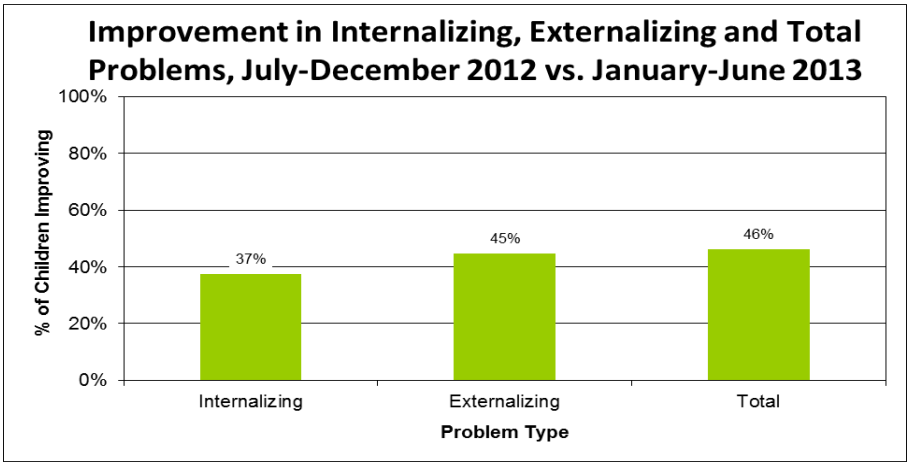
- collects data on children served;

- works to support the Agency of Education's efforts to implement Positive Behavioral Interventions and Supports (PBIS, also known as PBS), an evidence-based education practice;

- in FY13 provided school-based services to 3,726 students, which constituted 33.9% of all children served by designated mental health agencies; and

- in FY13 the cost of the program , including Medicaid dollars, was $46,414,624.

One Aspect of Results from Success Beyond Six Behavior Interventionist Service



*Includes individuals with at least one score reported for July-December 2012 and at least one score reported for January-June 2013, with at least 5 months between first and last assessment.
**Improvement based on lower t-score during the last reported problem checklist during January-June 2013 as compared to the first reported problem checklist during July-December 2012. The first completed ASEBA questionnaire completed during 7/1/2012 - 12/31/2012 and the last ASEBA questionnaire completed during 1/1/2013 - 6/30/2013 was used for each unduplicated client. Clinical level internalizing, externalizing, and total problems are indicated by t-scores greater than or equal to 64. Borderline level internalizing, externalizing, and total problems are indicated by t-scores greater than or equal to 60.

Is There a Better Way?
DMH CAFU continues to be a key partner in the development and implementation of Integrated Family Services (IFS), an AHS effort to consolidate all child and family services so that IFS can issue one contract to each of the AHS regions. The goal is to achieve overall wellness for all children and families in each region, allowing providers more flexibility in meeting each family's needs while improving the system's effectiveness and efficiency.

Recommended specific *next steps to continue bending the curve toward more successful outcomes* include the following.

1. Move ahead with all deliberate speed to implement IFS in pilot regions.
2. Coordinate trauma services across AHS/IFS.
3. Build on strong foundation of YIT grant at the state and regional levels to continue development of interagency system of care for Vermont youth transitioning to adult life.
4. Pool funding across all AHD Departments for a unified management and oversight process to fund placements of children in PNMI residential facilities rather than having separate budgets for each AHS Department that are managed independently.
5. Expand application of evidence-based strategies in *Vermont Youth Suicide Prevention Platform: A Public Health Approach to Suicide Prevention* (2012).
6. Develop and apply evidence-based strategies for suicide prevention strategies for adults, especially males aged 30 - 59.

7. Continue to support UVM's Child Psychiatric Fellowship Program to expand recruitment of child and adolescent psychiatrists for Vermont's designated mental health agencies.
8. Continue to grow collaboration across mental health and education through Success Beyond Six and in expansion of the Positive Behavioral Interventions and Supports (PBIS) framework.

ADULT MENTAL HEALTH SERVICES: ADULT OUTPATIENT, CRT, EMERGENCY SERVICES

ADULT OUTPATIENT SERVICES

How much do we do?

As defined by 18 V.S.A. § 7252 "Adult outpatient services means flexible services responsive to individual's preferences, needs, and values that are necessary to stabilize, restore, or improve the level of social functioning and well-being of individuals with mental health conditions, including individual and group treatment, medication management, psychosocial rehabilitation, and case management services."

The Adult Outpatient Program (AOP) provides counseling and psychotherapy services to individuals experiencing a variety of stressors and coping difficulties and are requesting mental health services. Services may include evaluation, individual, family and/or group counseling, medication prescription and monitoring. This service is also provided by individual private practitioners who operate independently throughout the state as well.

Increasingly the Designated Agency adult mental health programs are expanding services as funding levels appropriated by the legislature and allocated by DMH allow for the expansion of services to more complex individuals with ongoing mental health needs. People in AOP's have a wide range of problems including having attempted suicide within the past year, or having thoughts they may do so. Alcohol and drug abuse is often an additional challenge to many persons in AOP services. Many also have histories of psychological trauma, with lingering impairments to their ability to cope with everyday living, or disabling depression which may pose challenges with such basic activities as eating, bathing, and dressing daily. Other common difficulties include maintaining a household, parenting, managing money, accessing community supports, and needing access to medication prescribing and supports. An additional challenge to the capacity of the AOP's is the priority population of individuals with serious functional impairments who are eligible for release from the Department of Corrections. These individuals often have complex needs that require significant investments in resources and staff time, further competing with the availability of services to the general public. Expansion of "non-categorical" case management services to adults with traditional Medicaid benefits was added and has been growing in availability within DA's.

How Does this Program meet a Core Mission? *How are People Better Off?*

Pursuant to the same provision referenced above, the Department of Mental Health provides program funding for "individuals with mental illness" who experience a lesser degree of severity and ongoing disability from the mental health condition than individuals served by the CRT Programs, but still have needs requiring stabilization, restoration and functional improvement

How are people and the community better off?

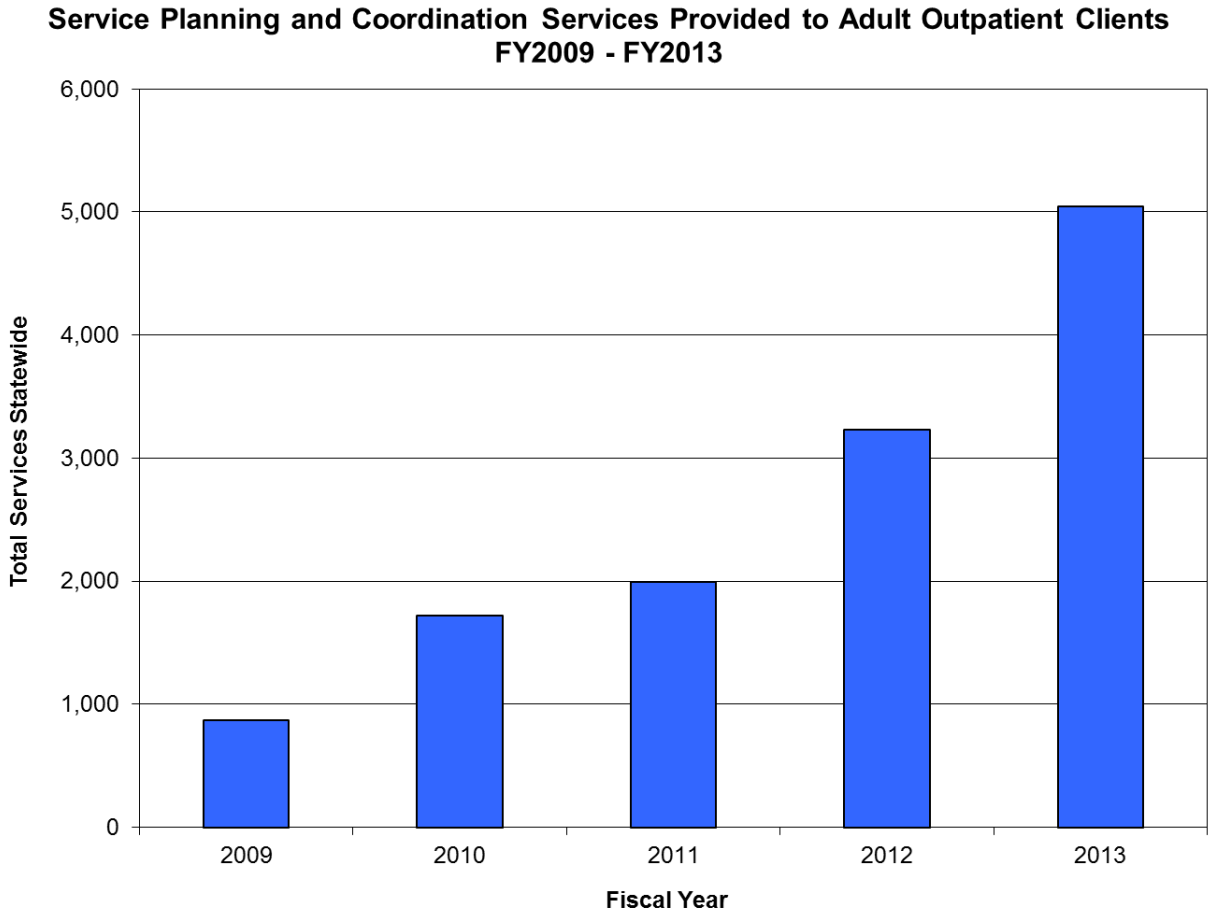
Much like individuals served by the CRT Programs, individuals served by AOP are often seeking the same level of mental health recovery, stability, and engagement in meaningful interpersonal and social activities.

Services for individuals seeking mental health treatment, whether publicly funded or through private providers, are seamlessly interwoven and readily available from any referral point within the community. The individual's needs are met with an array of formal and informal assessment and support services that bring about positive outcomes for the individual.

How well did we do it? **What performance measures are used to determine progress?**

Key financial performance indicators are composed and reviewed for signs of fiscal weaknesses on a quarterly basis. In particular, days of net assets, current ratio, gain/loss, days of cash, and admin cost ratio are closely examined. Monthly financial data and client-level encounter data are submitted to DMH for purposes of tracking both financial health of the organization and service delivery to persons served by the DA. Any agency highlighted as having potential shortfalls is contacted and dealt with on an individual basis. Provider grant agreements are developed annually to outline service delivery level expectations.

What does the data show? The graph measures "non-categorical" case management



The total served by the Adult Outpatient Program has remained relatively stable over the past five years. This overall stability may reflect that the program has been at capacity, neither growing nor shrinking substantially, and contributing to longer waiting lists for individual services and referrals to the equally stressed private practitioner community. The allocation of additional resources late in FY 2012 should have some impact on individual access to Designated Agency community mental health services funded by DMH.

Fiscal years 2009 through 2013 have shown a significant upward trend in the amount of case management services, called "non-categorical" case management, available to clients assigned to Adult Outpatient programs (AOP). When first introduced without additional funding for this service, there was a 98% increase in services into FY 2010 across 70% of the DAs. Service levels remained steady through 2011 and showed a sharp increase again in FY 2012 with the introduction of enhanced funding levels allocated into FY13. Service levels between FY2011 and FY2012 again showed a 62% increase in case management services expanded across 90% of the DAs. In contrast with FY2009 service levels, FY 2013 case management services showed a 400% increase as more DAs developed this capacity in their Adult Outpatient programs. These numbers are expected to remain steady or show an upward trend in FY14 as well.

What is needed going forward?

- Funding should be maintained and expanded over time for outpatient case management programming.

- Funding streams are still separate for mental health and substance abuse services. While many DA's are expanding their co-occurring treatment (mental health and substance abuse) capabilities, funding stream limitations can impact service availability. Steps may be:
  - Increasing access to mental health and substance use screening, early intervention, referral, support and treatment within the Vermont Blueprint for Health primary care practices, as well as increasing care coordination between DAs and primary care practices.

  - Working with community mental health and substance abuse providers to support the inclusion of mental health and substance abuse health information into Vermont's development of a comprehensive Health Information Exchange.

  - Developing capacity within specialty substance abuse and mental health settings to provide coordinated health care services for individuals who are receiving significant treatment services through a designated/preferred community provider.

  - Providing leadership within Vermont's health care reform efforts to ensure that mental health and substance abuse care is accessible and integrated within the unified health system that is being developed (this includes current efforts to integrate public mental health and substance abuse services into Vermont's unified health system).

- Ongoing coordination between DMH and DOC is a priority for this Fiscal Year in order to enhance collaboration and continuity of care for inmates returning to the community, as well as for those who may be incarcerated from the community and in need of mental Health care.

COMMUNITY REHABILITATION AND TREATMENT (CRT) PROGRAM

What did we do? What is the program?

The CRT Program provides a range of comprehensive mental health services through Designated Agencies to clients with severe and persistent mental illness. Adults served by the program must meet eligibility criteria that include psychiatric diagnosis, service utilization and hospitalization history, severity of disability, and significant functional impairments. Psycho-social services include: case management, evidence-based interventions to support recovery, psychiatric care, employment support and life skills, medication management and other supportive care.

How well did we do it? How does this program meet the core mission to serve individuals with mental illness?

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. Pursuant to 18 V.S.A. § 7401 and § 8907, the Department of Mental Health, under the authority of the Commissioner of Mental Health and contracts with designated public or private non-profit agencies, assures planning and coordination of services "to individuals with mental illness to become as financially and socially independent as possible."

How are people better off? What does success look like for the person?

Individuals served by the program are engaged in their personal course of mental health recovery and utilize their individualized support systems. Individuals have access to stable housing and economic benefits necessary to meet their basic needs. Individuals participate in meaningful daily activities and social relationships.

How is the community better off? What does success look like to the community?

Services for individuals with complex mental health service needs are seamlessly interwoven and readily available from any referral point within the community. The individual's needs are met with an array of formal and informal assessment and support services that bring about positive outcomes for the individual decreasing potential for negative attention and stigma.

How well did we do it? What performance measures are used to determine progress?

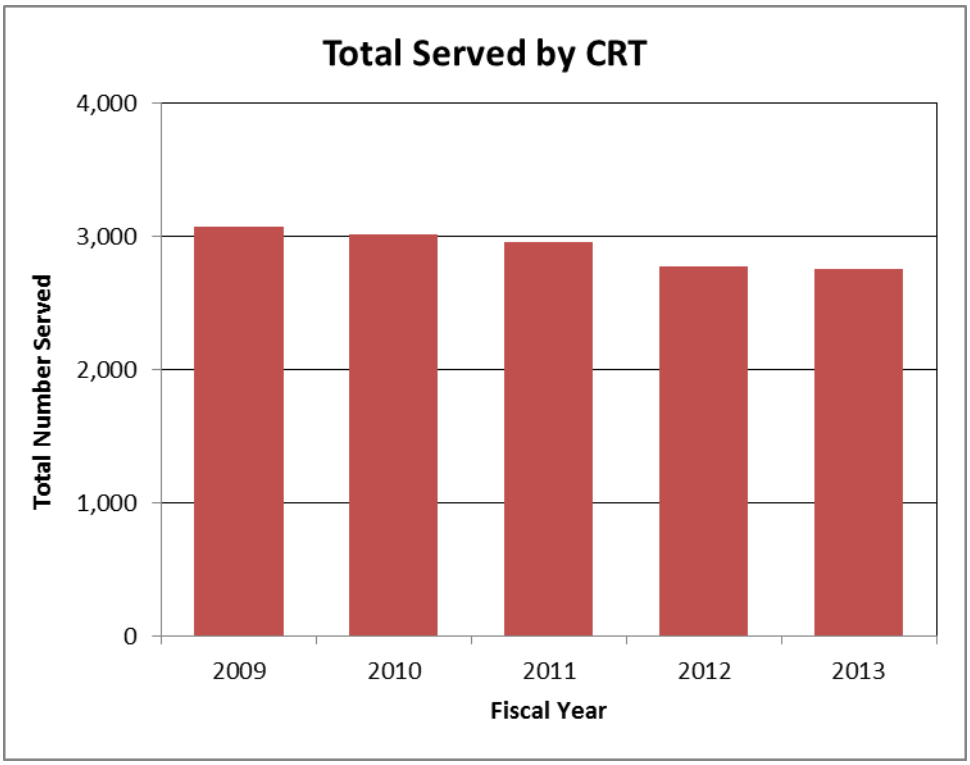
- Reduction in acute psychiatric symptoms
- Annual visits for health care
- Ability to maintain functioning without need for hospitalization
- Employment skills and work
- Stable living situation
- Social supports

- Reduced law enforcement involvement
- Follow-up from hospitalization

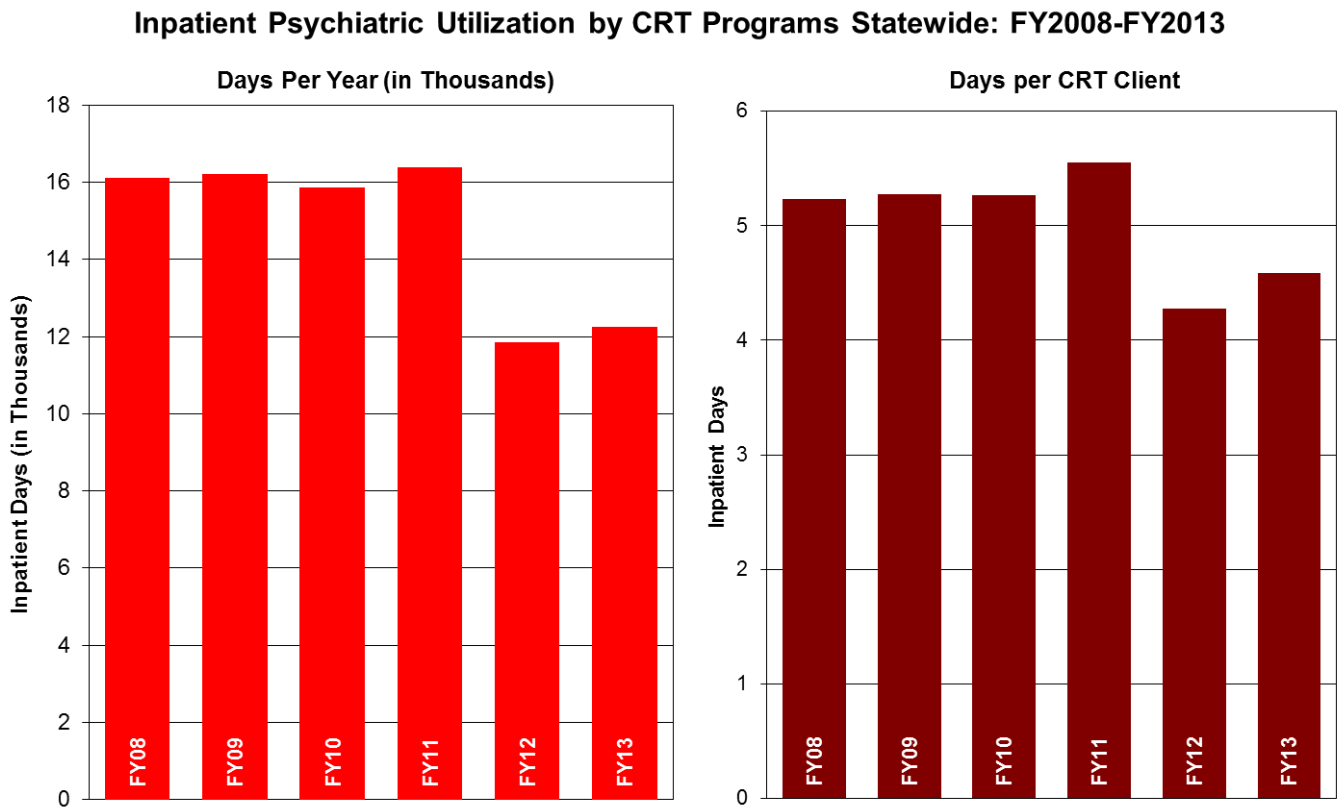
How much did we do? **What does the data show?**

- CRT programs are reviewed and monitored based on the Administrative Rules for Agency Designation.
- Designated Agencies providing CRT programs are under contract to provide service deliverables for the CRT Program enrollees.
- Monthly Service Data and financial reports are submitted on a monthly basis and analyzed through the DMH Research and Statistics Unit and the Business Office.

Over the past five years, the Designated Agencies are decreasingly serving just under **3000** CRT eligible clients per year, with **2,800** clients receiving services in FY 2013..



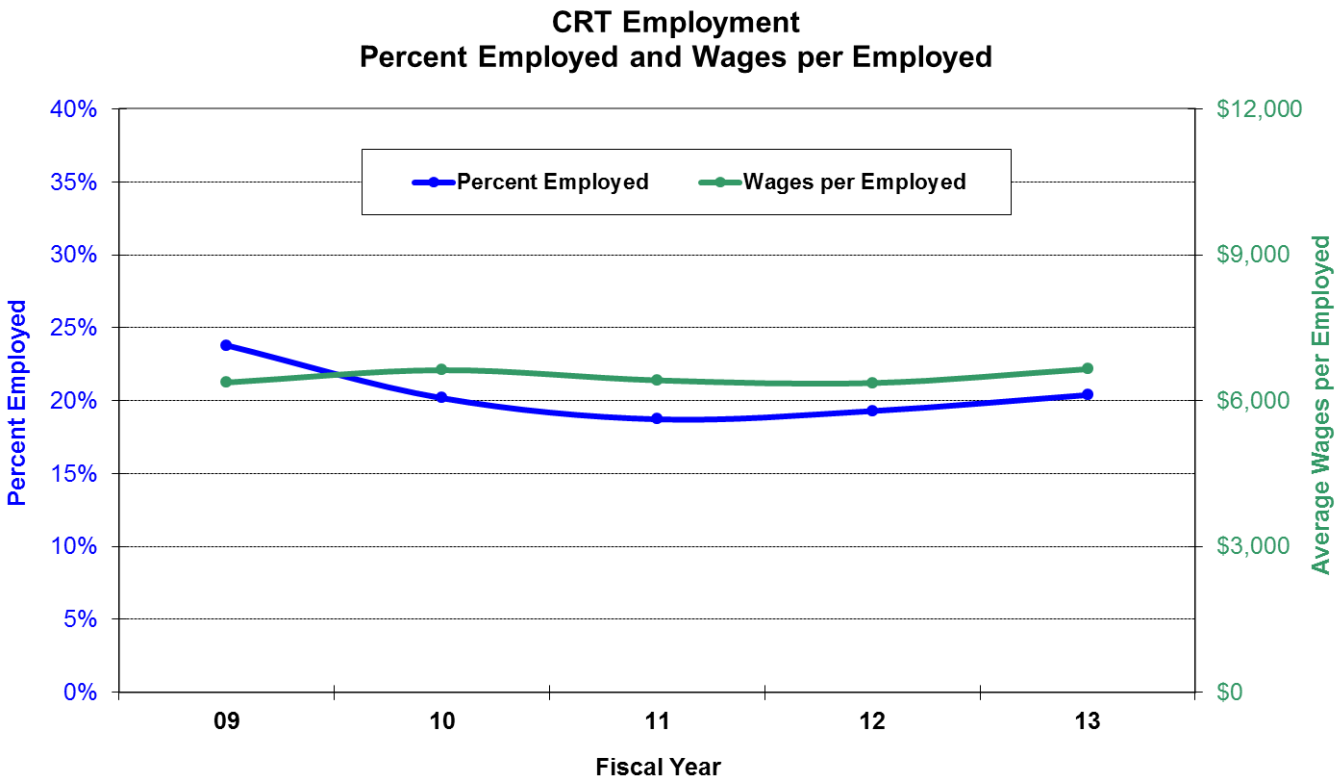
The CRT Program Statewide has experienced just over 10% decline in its enrolled population over the past 5 years. Increasingly, program resources are serving individuals with more challenging and complex mental health support needs, which may impact program capacity to bring in new individuals who may need comprehensive mental health support services. The decline, combined with the average age of CRT enrolled service recipients, might also suggest that the traditional CRT Program services are not engaging as effectively with younger individuals who might prefer different treatment and support options. This is an area which the DMH intends to review in the next fiscal year.



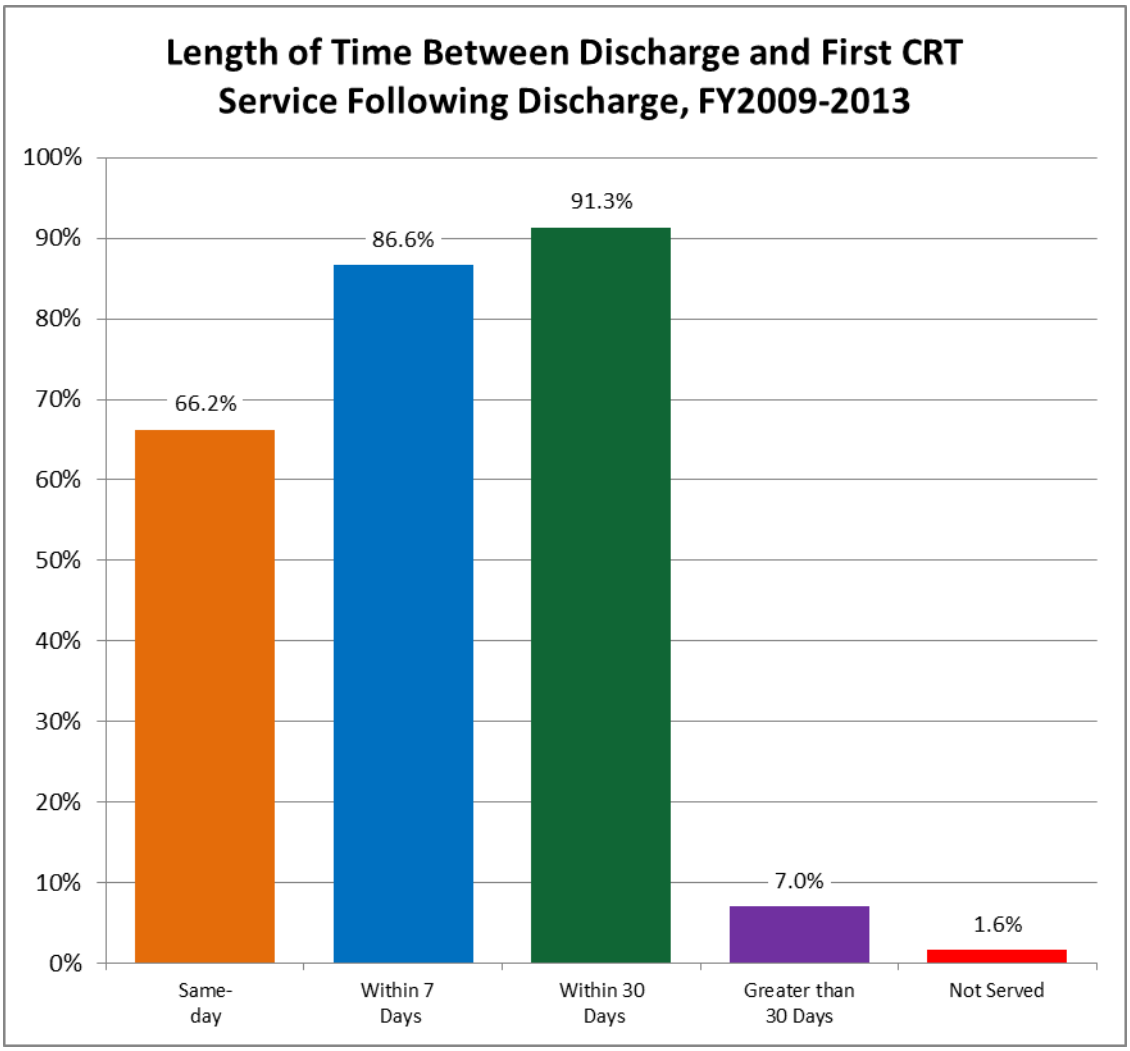
Analysis based on the "CRT Inpatient Data" set maintained by the VT Department of Mental Health (DMH) Care Management Team and Monthly Service Record (MSR) data provided to DMH by the designated community agencies (DA). Includes CRT client patient days at the Vermont State Hospital (VSH) and other hospitals during each fiscal year during July 2007 through June 2013. Community Rehabilitation and Treatment (CRT) status based on program status at admission to inpatient. Days include the day of admission but exclude the day of discharge. Days per CRT client is based on the number of clients with a program assignment of CRT and the total number of psychiatric inpatient days during each fiscal year.

The decrease in inpatient utilization for CRT clients in FY 2012 is likely due to the closure of the VSH which had 54 beds.

The employment rate for all people with mental illness has dropped across Vermont and the nation over the past four to five years, likely due to the economic downturn and decreased employment services. The graph below illustrates the employment information for all CRT clients across the 10 Designated Agencies.



Analysis includes Community Rehabilitation and Treatment clients aged 18 - 64 who were active during any part of the annual reporting periods and includes all employment reported for the annual reporting periods.This report is based on analysis of the Department of Mental Health (DMH) and the Department of Labor (DOL) databases. DMH client data are submitted by Community Rehabilitation and Treatment Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal unemployment laws. Workers who are excluded from DOL reporting are the self-employed, firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.



Community Housing

How well do we do it?

- Access to safe, affordable housing is critical to the well being of Vermonters with disabilities and who live on extremely limited incomes.
- The DMH assumes a leadership role in the development and preservation of, and access to affordable housing.
- Staff coordinates the continuation of existing HUD funding and actively pursues opportunities for new funding for housing.
- These activities require close working relationships with Vermont's not-for-profit housing developers and with the local and state housing authorities.
- In addition, DMH works closely with the shelters and service providers who assist Vermonters who are homeless to gain housing.
- DMH now participates in a statewide inventory of housing through AHS leadership

Is there a Better Way?

The efficiency of blending CRT programs and AOP programs combined with more flexible service delivery may be a way to expand access and meet the needs of more individuals in communities. DMH believes it is less important what we name the program than to have sufficient service provision.

Continue the DMH technical support team as described above, to build on individualized and intensive residential placements for individuals who need extensive mental health and substance abuse supports. The direct outreach to service providers on a regular basis to maintain newly developed wraparound programs has proven to be a pivotal support in helping individuals to be successfully supported in their communities.

Training throughout the community and hospital systems is an ongoing need. The evolving DMH Coop for Workforce Development and Practice Improvement which is funded through a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is increasingly accessible to the entire state provider community. The program development thus far exemplifies the partnerships that have been forged between DMH, other state departments, and public and private providers.

Continue efforts to include stakeholders in change processes through various communication and input forums. Peer services have continued to expand in the past year and will continue to develop. DMH has increased funding for peer programs to provide additional outreach, community support, crisis intervention and respite, linkages to Recovery Turing Point Centers, hospitals, and the correctional system, and a statewide telephone warm-line support has been set up.

Community Housing

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	2013											
	FY13 Q3			FY13 Q4			FY14 Q1			FY14 Q2		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
# Clients permanently housed as a result of new Act79 housing funding	18	21	14	11	14	5	0	5	0	2	0	0
Total # enrolled to date	98	119	133	144	158	169	169	176	176	168	123	123

Prior to November, 2013 housing totals reflected DMH's financial obligations for housing subsidies which included applications pending, applications approved, and leased status. Beginning in November 2013, the totals reflects only the actual leased numbers.

Is There a Better Way?

Through the opening of the new hospital, continue the DMH technical support team consisting of three psychologists, one psychiatrist, and a nurse care manager to build on individualized and intensive residential placements for individuals who need extensive mental health and substance abuse supports. The direct outreach to service providers on a regular basis to provide consultation and support to emergency departments, intensive residential recovery programs, and individual wraparound programs has proven to be a pivotal support in helping individuals to be successfully supported in their communities.

Training throughout the community and hospital systems is an ongoing need. The evolving DMH Cooperative for Workforce Development and Practice Improvement which is funded through a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is increasingly accessible to the entire state provider community. The program development thus far exemplifies the partnerships that have been forged between DMH, other state departments, and public and private providers.

Continue efforts to include stakeholders in change processes through various communication and input forums. Peer services have continued to expand in the past year and will continue to develop. DMH has continued funding for peer programs to provide additional outreach, community support, crisis intervention and respite, a support-line, linkages to Recovery Turing Point Centers, hospitals, and the correctional system, and is running at full capacity. In addition, DMH developed and implemented core workforce development and core training capacity for these peer services.

PEER SERVICES

"Peer", according to Act 79, means an individual who has a personal experience of living with a mental health condition or psychiatric disability. "Peer Services" means support services provided by trained peers or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery. Peer support services are a growing area of individuals and support resources provided by persons with "lived mental health experience".

How does this program meet a core mission?

Within the principles for mental health care reform outlined by Act 79, a coordinated continuum of care that includes peer partners is codified as part of ensuring that individuals with mental health conditions receive care in the most integrated and least restrictive settings available.

Over the past year, DMH has expanded the availability of services provided by individuals with the lived experience of mental illness (peers). These services include: community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital, corrections, and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. DMH also funds family-to-family peer support for people who have a family member with severe mental illness.

How much did we do and how well did we do it?

The organizations and services that were funded by the Act 79 allocation are as follows:

Peer Organization	Services Provided	Utilization
Another Way	Community center providing outreach, community and network building, support groups, service linkages, employment supports.	Serves an average of 100 unduplicated individuals each month.
Alyssum	2-bed program providing crisis respite and hospital diversion.	Serves approximately 6 unduplicated individuals per month.
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings.	Provides a per month average of: -150 outreach visits in the community for support and advocacy; -100 warm-line support calls; -65 calls for information or referral.
NAMI-VT	Statewide organization providing support groups, educational and advocacy groups.	Serves an average of 232 unduplicated individuals per month

Additionally:

Northeast Kingdom Youth Services (Community Outreach Program in St. Johnsury): New community outreach, support groups and crisis intervention for young adults at risk of hospitalization.

Pathways – Peer Support Line: New statewide telephone peer support to prevent crisis and provide wellness coaching.

Vermont Vet-to-Vet (Statewide outreach and support): New community outreach, support groups and crisis intervention for veterans at risk of hospitalization due to mental health and substance use challenges.

Wellness Workforce Coalition (WWC): New organization for individuals offering peer-based services and supports to individuals with mental health and other co-occurring challenges. Supports expansion, coordination, and quality improvement of peer services in the state, including:

- Coordinating core training (Intentional Peer Support, Wellness Recovery Action
- ♦ Planning)
- Workforce development (e.g. recruitment, retention, career development)
- Mentoring
- Quality improvement
- Coordination of peer services
- Communication and networking
- Systems advocacy.

How are people better off?

Individuals accessing peer services exercise choice in selecting the necessary component of their support and services network and how they choose to improve their health and wellness or strive to reach their full potential.

How is the community better off??

Services for individuals, whether peer-based or through formal service systems, are readily known, easily accessible, and effective in meeting the individual's needs within the community. The support services bring about positive outcomes for the individual.

DMH is piloting the use of individual recovery outcomes tools at contracted peer-run programs through a federal Mental Health Transformation grant. Two programs are currently collecting National Outcome Measures (NOMS) and the Peer-Operated Protocol (POP), and outcome data will be available in the coming months.

What still needs to be done?

Continuing to develop collaborations between the existing mental health services network and/or further development of peer-run service organizations.

Peer-provided transportation services is still an area for exploration and development.

Continue efforts to implement a "warm line" operated by trained peers for the purpose of active listening and assistance with problem-solving.

Peer supported alternative treatment options for individuals seeking to avoid or reduce reliance on medications in a recovery- oriented housing program (Soteria House) is still to be developed.

Opportunities for training and supervision for peer providers needs further development.

EMERGENCY SERVICES

What is the program?

The program provides mental health emergency services twenty-four hours a day, seven days a week to individuals, organizations, and communities. Essential emergency services include telephone support, face-to-face assessment, referral, and consultation. Emergency Services Programs provide assistance to people who are in need of crisis services for emergent issues such as depression, suicidal thoughts, dangerous behaviors, family violence and symptoms of serious mental illness. Emergency Services Programs also serve communities, schools, or other organizations trying to cope with events such as suicide, natural disaster and other traumatic events. By definition, emergency services respond quickly to avoid poor outcomes so that average response time is within 5 minutes by phone and within 30 minutes when face-to-face assessment is needed. The primary purpose of these crisis programs is to assess the immediate mental health situation and arrange for care as necessary.

How does this program meet the core mission?

Emergency Services Programs serve as a key portal in accessing the publicly funded mental health system of care, as well as, often being the emergency response for individuals seeking psychiatric inpatient admission who are in treatment with private practitioners in the community.

How are people better off?

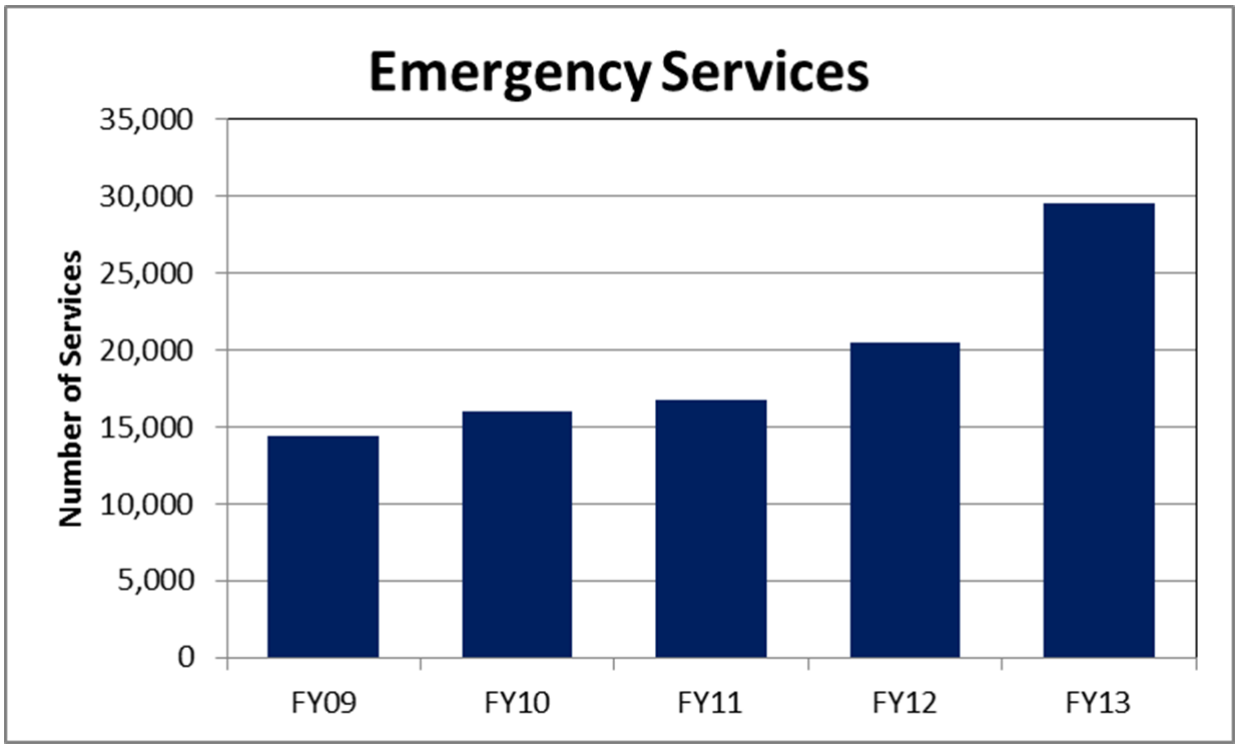
Individuals experiencing a mental health crisis know who to call and can quickly access a qualified individual to assess and support them with their emergency, offer information and options, and help them in taking control of decisions/actions necessary to stabilize their crisis

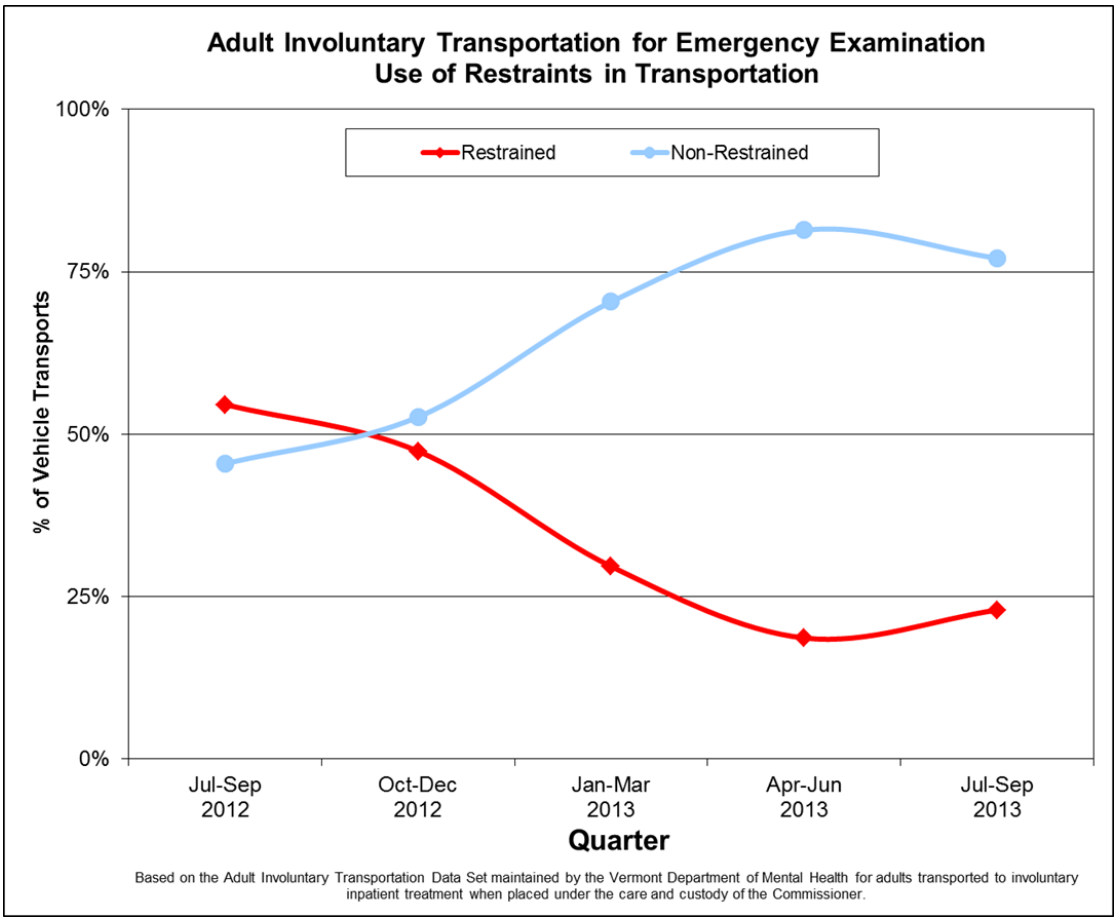
How is the community better off?

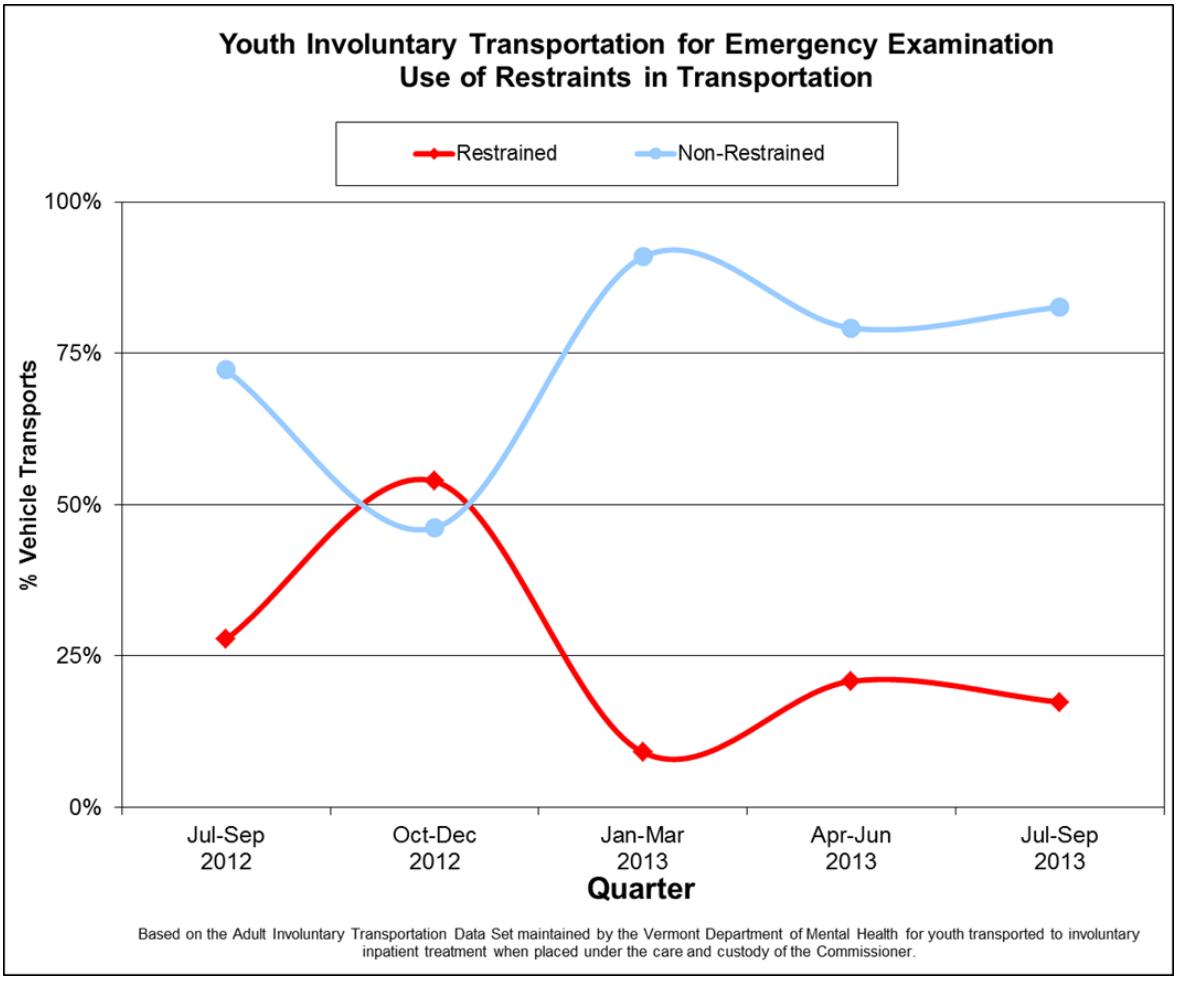
In addition to individual success, communities look for service that promotes education, support, and safety for significant others who may be the support system to the individual and the community, individual and public services, at-large who may continue to interact with the individual.

How much did we do and how well did we do it?
Performance measures determine progress:

- Emergency Response time
- Reduction in Secure Transport for adults and youth
- Number of services provided


Emergency Services
Number of Services
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
FY09
FY10
FY11
FY12
FY13

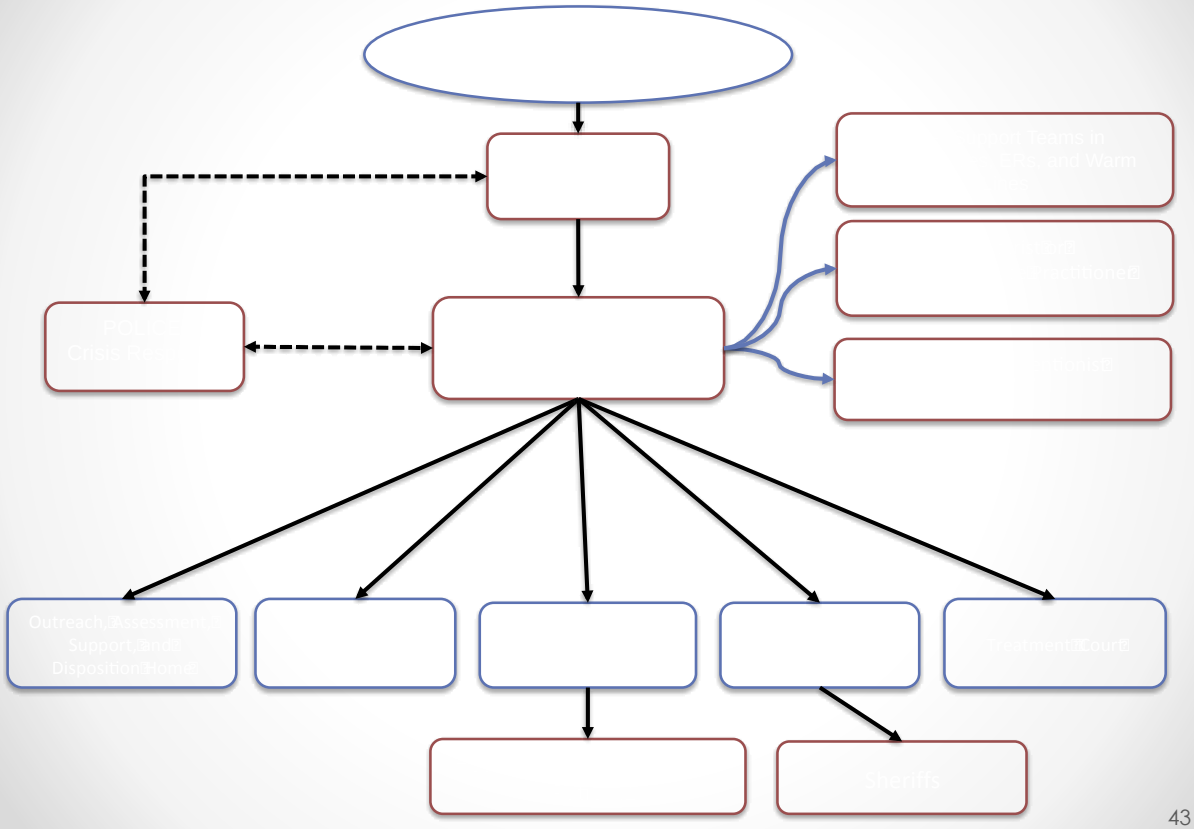

Adult Involuntary Transportation for Emergency Examination
Use of Restraints in Transportation
100%
75%
50%
25%
0%
% of Vehicle Transports
Restrained
Non-Restrained
Jul-Sep 2012
Oct-Dec 2012
Jan-Mar 2013
Apr-Jun 2013
Jul-Sep 2013
Quarter
Based on the Adult Involuntary Transportation Data Set maintained by the Vermont Department of Mental Health for adults transported to involuntary inpatient treatment when placed under the care and custody of the Commissioner.

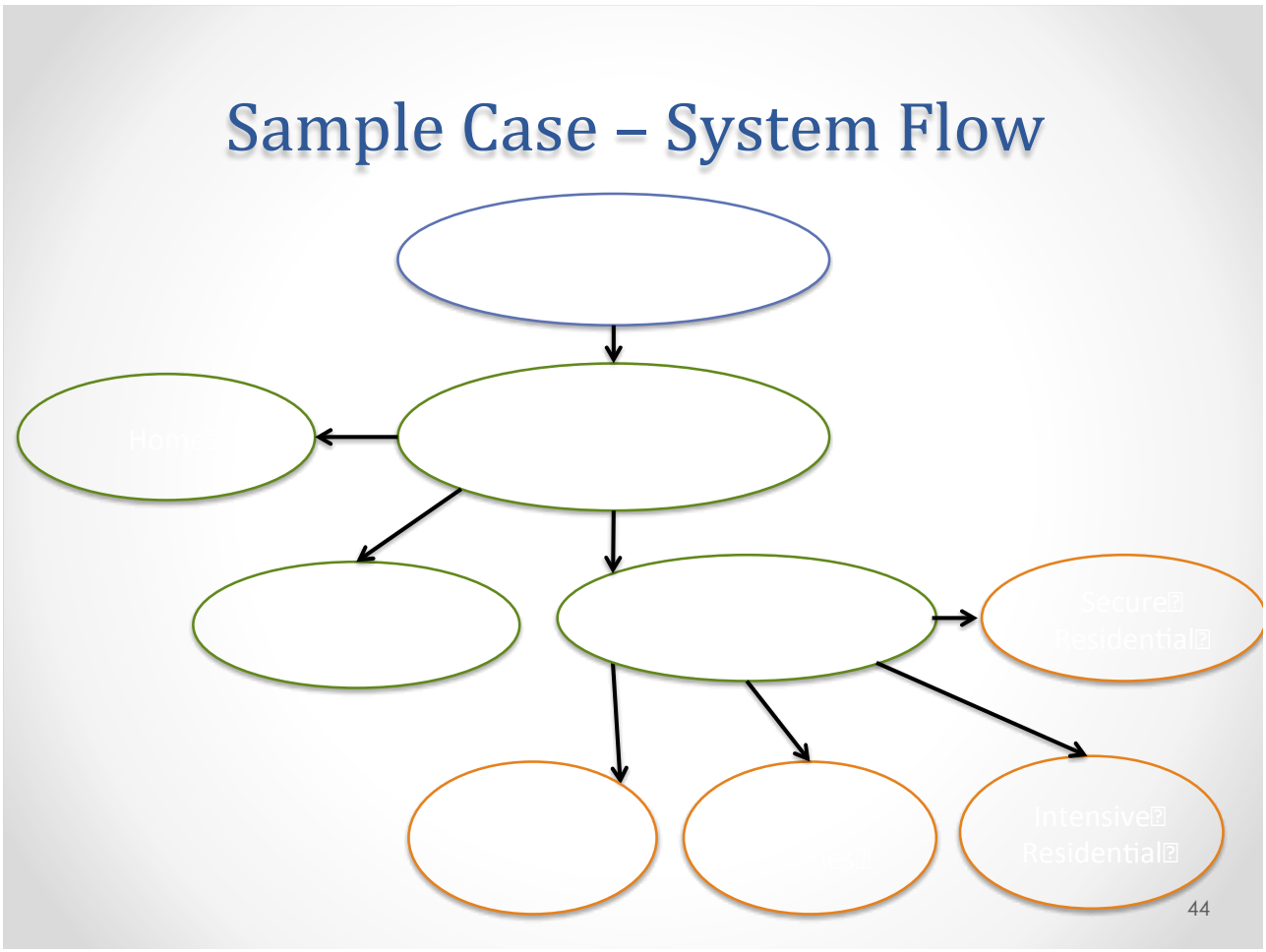


Baseline data is being collected in the areas of outreach response, particularly collaboration with law enforcement, and mobile crisis response capability being developed across the designated agency system. Increases in allocations late in FY 12(enhanced services) to support greater emergency services outreach and mobility of emergency services teams should be reflected in these service capacities in this current and upcoming fiscal years.

Mental Health Crisis Response

Crisis Care Management System Assistance





ENHANCED SERVICES

With the assistance of expanded funding to the DA's for enhanced emergency and case management services, new services were developed in a state-wide effort to increase capacity to assess and treat individuals with mental illness in the communities. The program services that were implemented by all of the DA's included:

- Enhancements to the Emergency Services through additional staff and implementation of mobile/community crisis and assessment capacity.
- Adding Peer supports in either crisis settings, or in some areas, hospital emergency rooms.
- Diversion from Emergency Departments
- Collaboration with Law enforcement and participation with law enforcement training
- Emergency respite and crisis beds
- Non-categorical case management (in all but one DA)
- Special services such as new programs developed to manage more complex clients in the community, extending services to those not previously covered through CRT and/or AOP, and additional psychiatrist/Nurse Practitioner time for medication evaluation and administration.

Performance measures: *What did we do?*

Quantitative Data

The DA's receiving enhancement funding, sent quarterly reports of persons and/or services provided, when data was available. Due to differences in definitions and in services provided, it is difficult to capture quantitative outcomes. The primary outcome measures to be reported were mainly descriptive:

- # Assessed in Emergency Department
- # Assessed in the Community
- # Total Assessments
- # Diverted from ED
- # Diverted from Hospitalization
- # Voluntarilyhospitalized
- # Involuntarily hospitalized

# Assessed in ED	# Assessed in Comm	# Total Assessments	Diverted from ED	Diverted from Hospital	Vol hospital	Invol hospital
3185	2972	6651	4267	1129	972	462

How well did we do it?

Qualitative Themes

- ***Increased Access***:
  Several of the DA's reported that the numbers of persons served through their emergency and crisis services, as well as in the Adult Outpatient services increased between FY12 and FY 13. This was also impacted in some areas, by the time required to bring services up to speed.
- ***Diversion from hospitalization****:*
  DA staff report that through diversion case managers, services are being provided to those at risk for hospitalization in community settings, such as in motels or other services for those who may be homeless.

  Increased home-based services through increasing the number of case managers for those who fail to meet criteria for CRT and/or DS programs.
- ***More crisis intervention capacity****:*
  " We have been able to have staff respond to many different situations where clients and non-clients were at risk for hospitalization and been able to provide the support needed to divert these higher level care needs. In addition, "these resources have made….this shift possible", to "changing the approach of staff and their response to the person in need through adopting a prevention philosophy of recovery and resiliency". (CMC)
- ***Collaboration with Law Enforcement has resulted in increased capacity to manage complex clients in the community****.*

Emergency team clinicians are screening, assessing and providing case management services through police departments, primary care providers and others to prevent escalating crises and further decompensation for persons in need.

- ***Expanded capacity to provide higher levels of support and supervision in the community as a way to prevent higher cost institutional services.***
  Utilization of an interagency team approach to serving persons who repeatedly utilize costly institutional services has provided the structure and support to reduce hospitalizations.

  The ability to provide outreach and home based services to fragile people who might otherwise have been admitted to higher level of care.

Challenges to implementation of enhanced programs

- Challenges in hiring qualified staff
- Difficulty siting programs in communities that are sensitive to having programs for persons with mental health problems in their neighborhoods

RESIDENTIAL, CRISIS, AND INPATIENT SYSTEM OF CARE

How much did we do?
How well did we do it?
How were people and the community better off?

The map below illustrates the Psychiatric Beds in our System of Care:

CRISIS BEDS

- DMH has crisis beds in each designated agency catchment area bringing the total to 40 (2 are peer run-Alyssum in Windsor County)
- DMH has supported the development of 8 additional crisis beds:
  - 2 operated by Lamoille County Mental Health
  - 2 by the Clara Martin Center
  - 2 by Healthcare and Rehab Services of SE VT
  - 2 by Rutland Mental Health Services

(Two of these are Commissioner's beds directed by the care management team for individuals with higher needs)

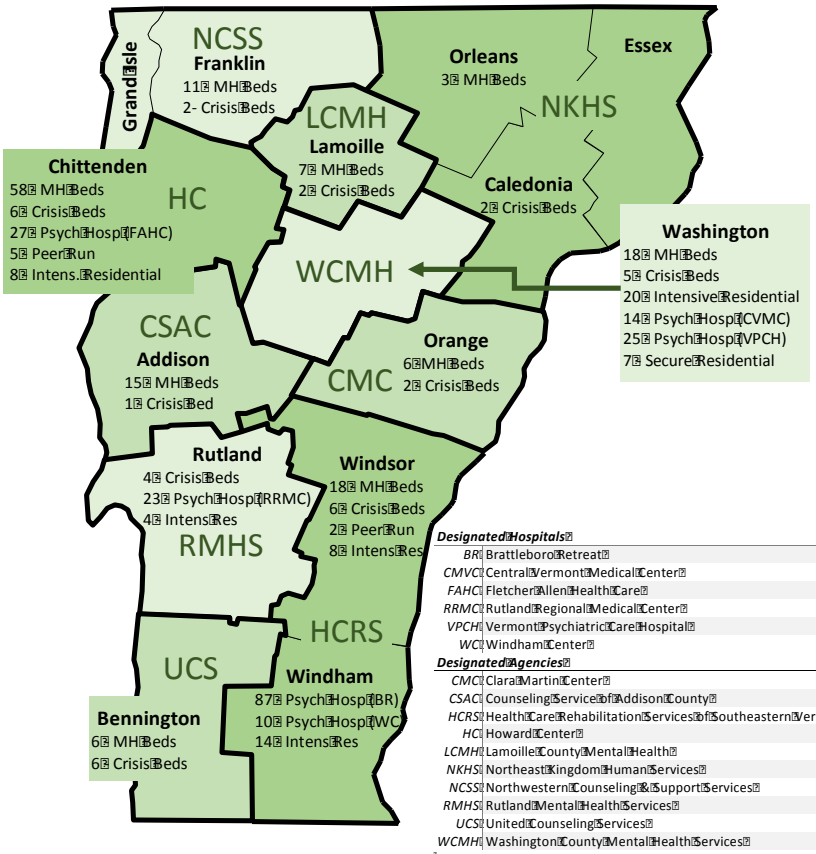
INTENSIVE RESIDENTIALS

- At the end of FY15, DMH will have 45 intensive residential beds (including 5 that are peer run)

RESIDENTIAL

- The DMH operated secure residential opened in June, 2013 with 7 beds: the
  MTCR is a therapeutic recovery residence for individuals requiring security and observation in a locked setting. It is a transitional program, with every effort put forth to return individuals to their communities

DMH will be closely monitoring on-going need for this program as it goes forward and will make recommendations accordingly



Designated Hospitals	
BR	Brattleboro Retreat
CMVC	Central Vermont Medical Center
FAHC	Fletcher Allen Health Care
RRMC	Rutland Regional Medical Center
VPCH	Vermont Psychiatric Care Hospital
WC	Windham Center

Designated Agencies	
CMC	Clara Martin Center
CSAC	Counseling Service of Addison County
HCRS	Health Care Rehabilitation Services of Southeastern Vermont
HC	Howard Center
LCMH	Lamoille County Mental Health
NKHS	Northeast Kingdom Human Services
NCSS	Northwestern Counseling & Support Services
RMHS	Rutland Mental Health Services
UCS	United Counseling Services
WCMH	Washington County Mental Health Services

Types of Beds:

- Crisis Beds
- Psychiatric Hopsital Beds
- Peer Run Beds
- Intensive Residential Beds
- Mental Health Beds

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INPATIENT HOSPITALIZATION

What is the program?

The Department of Mental Health, pursuant to 18 V.S.A. § 7205 operated the Vermont State Hospital (VSH) until August 29, 2011. Subsequent to closure, former patients of VSH were discharged, moved to hospitals, recovery residences or crisis bed programs, and secure facilities throughout Vermont. The Commissioner of the Department of Mental Health remains statutorily responsible for the supervision of patients receiving involuntary mental health treatment at the five designated hospitals throughout the state:

Designated Hospitals

- DMH contracts with Fletcher-Allen Health Care for an average of up to 7 Level I beds in its total adult psychiatric inpatient bed capacity of 27*
- Central Vermont Medical Center provides no Level I beds in its total adult psychiatric inpatient bed capacity of 14
- DMH contracts with Rutland Regional Medical Center for 6 Level I beds. Its total adult psychiatric inpatient bed capacity is 23
- Windham Center provides no Level I beds in its total adult psychiatric inpatient bed capacity of 10
- DMH contracts with Brattleboro Retreat for 14 Level I beds. Its total adult psychiatric inpatient capacity is 87
- GMPCC provides 8 adult Level I beds and will transition to Vermont Psychiatric Care Hospital (VPCH) with a total of 25 adult beds in July 2014

* Once VPCH is open, it is expected that FAHC will reduce capacity for Level I.

The Commissioner's responsibilities include persons undergoing emergency examinations, court-ordered or forensic evaluations, and ongoing treatment for individuals whose mental health needs are beyond the community's capacities.

For people who are most acutely ill, Brattleboro Retreat, Rutland Regional Medical Center, and Fletcher Allen Health Care entered into contracts with DMH to identify and treat the most acute patients, now identified as Level I patients. Reimbursement for these services has been developed based on real, actual costs. This system is well underway since the first quarter of 2013. This now includes the Green Mountain Psychiatric Care Center, which will transition to the Vermont Psychiatric Center Hospital in July. The new state-run hospital is being built in Berlin and is scheduled for opening in July, 2014.

How does the program meet a core mission?

Pursuant to 18 V.S.A. § 7401, the powers of the Commissioner of Mental Health include the authority to "designate, control, and supervise the property, affairs, and operation of hospitals and institutions equipped and otherwise qualified to provide inpatient care and treatment for individuals who are mentally ill."

How are people better off?

An individual admitted to a hospital, whether voluntary or involuntary, feels safe, supported, respected, and an active participant in their treatment and aftercare plans during their admission.

How is the Community better off?

Individuals in need of psychiatric hospitalization, whether voluntary or involuntary, are able to access the right level of care when they need it and receive treatment, stabilization services, and have an aftercare plan that will allow them to successfully return to their community when discharged.

How well are we doing?

- Hospitals providing involuntary treatment services are monitored for adherence to legal and statutory requirements for involuntary hospitalization, current policies and procedures for delivering care, and other guidelines outlined under hospitalization designation for designation by the DMH Commissioner.
- Decreasing wait time for hospitalization
- Adherence with requirements of Act 114, administration of court-ordered involuntary medication

Performance Measures

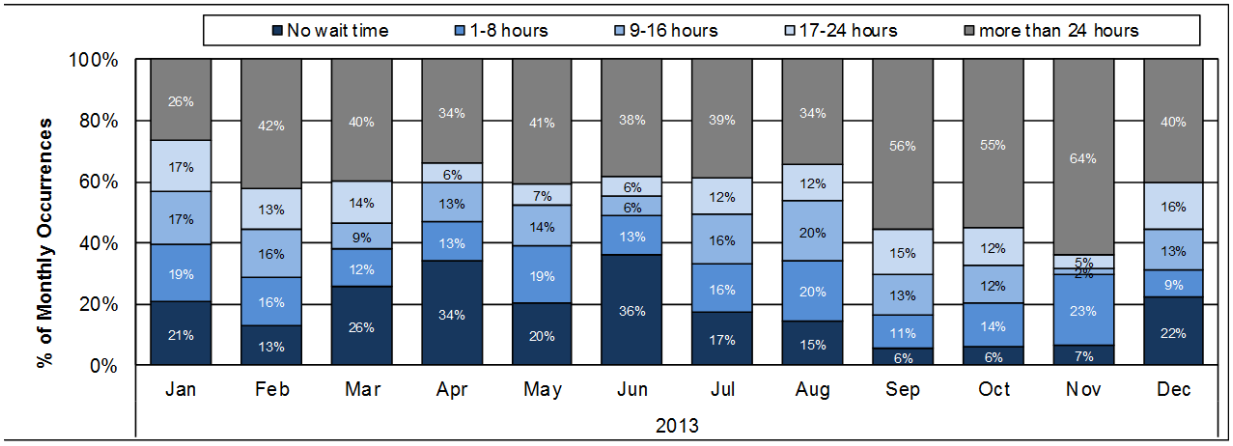
Legislative Report to Mental Health Oversight Committee and Health Care Oversight Committee
Level 1 Inpatient Utilization: Statewide and By Hospital

	2012						2013											
SYSTEM TOTAL	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Level I Beds	27	27	27	27	27	27	35	35	35	35	35	35	35	35	35	35	35	35
Average Daily Census	15	19	23	25	24	24	29	29	32	37	45	44	38	39	40	36	32	31
Total Level I Admissions this Month	23	17	9	25	13	21	22	13	20	22	26	10	19	18	12	11	7	11
Level 1 Admissions to Non-L1 Units	-	-	-	-	-	-	-	-	-	-	-	4	8	10	6	4	3	4
Total Level 1 Discharges this Month	6	15	7	19	21	15	17	17	13	15	19	17	19	18	15	14	11	10
Highest Census this Month	19	22	24	31	29	28	32	31	34	41	48	48	41	41	44	41	36	33
Over/Under for Total Planned Beds	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	UNDER	UNDER
BY HOSPITAL																		
Brattleboro Retreat																		
Total Level I Beds	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Average Daily Census	11	14	18	18	17	15	14	16	19	18	21	20	16	17	19	18	17	15
Total Admissions during Month	16	13	8	13	9	14	7	9	10	3	11	3	3	4	3	5	1	2
Level 1 Admissions to Non-L1 Units	-	-	-	-	-	-	-	-	-	-	-	2	1	2	2	2	1	1
Total Level 1 Discharges this Month	4	9	6	12	14	13	7	7	7	5	7	8	3	3	3	5	3	3
Highest Census this Month	13	16	19	21	20	17	16	18	20	20	22	22	17	18	19	20	18	16
Over/Under for Total Planned Beds	UNDER	UNDER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	OVER
RRMC																		
Total Level I Beds	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Average Daily Census	3	4	3	4	4	4	4	1	3	9	9	10	8	8	8	7	6	6
Total Admissions during Month	7	4	1	5	1	4	2	0	5	8	8	2	4	5	5	3	4	5
Level 1 Admissions to Non-L1 Units	-	-	-	-	-	-	-	-	-	-	-	0	1	2	2	0	0	0
Total Level 1 Discharges this Month	2	6	1	3	3	1	5	2	0	4	8	2	6	6	5	4	4	5
Highest Census this Month	5	6	4	5	5	6	6	3	6	11	11	11	10	9	8	8	7	8
Over/Under for Total Planned Beds	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	OVER	OVER	OVER	OVER	OVER	OVER	OVER	UNDER	OVER
GMPCC																		
Total Level I Beds	-	-	-	-	-	-	8	8	8	8	8	8	8	8	8	8	8	8
Average Daily Census	-	-	-	-	-	-	5	5	4	4	6	6	7	6	6	7	6	6
Total Admissions during Month	-	-	-	-	-	-	8	0	0	2	2	3	6	2	2	1	0	1
Level 1 Admissions to Non-L1 Units	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Level 1 Discharges this Month	-	-	-	-	-	-	2	2	1	0	1	3	4	4	1	2	0	1
Highest Census this Month	-	-	-	-	-	-	7	6	4	5	6	6	8	7	7	7	6	6
Over/Under for Total Planned Beds	-	-	-	-	-	-	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER
FAHC																		
Total Level I Beds	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
Average Daily Census	1	1	1	4	3	4	6	6	6	6	9	9	7	9	8	5	4	4
Total Admissions during Month	0	0	0	7	3	3	5	4	5	9	5	2	6	7	2	2	2	3
Level 1 Admissions to Non-L1 Units	-	-	-	-	-	-	-	-	-	-	-	2	6	7	2	2	2	3
Total Level 1 Discharges this Month	0	0	0	4	4	1	3	6	5	6	3	4	6	5	6	3	4	1
Highest Census this Month	1	1	1	5	4	5	8	8	8	8	11	10	8	9	11	6	5	5
Over/Under for Total Planned Beds	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	UNDER	OVER	OVER	UNDER	OVER	OVER	UNDER	UNDER	UNDER

Analysis is based on the Inpatient Tracking Spreadsheet maintained by the Department of Vermont Health Access (DVHA). Includes psychiatric hospitalizations with Level 1 Designations for hospitalizations occurring at adult inpatient psychiatric units. Level 1 designation is reserved for patients with risk of imminent harm to self or others and requiring significant resources. 'Over/Under for Total Planned Beds' is computed using the difference between total level 1 beds and average daily census for each hospital and statewide. Unit of admission is available from June 2013 onward.

Wait Times for Inpatient Care

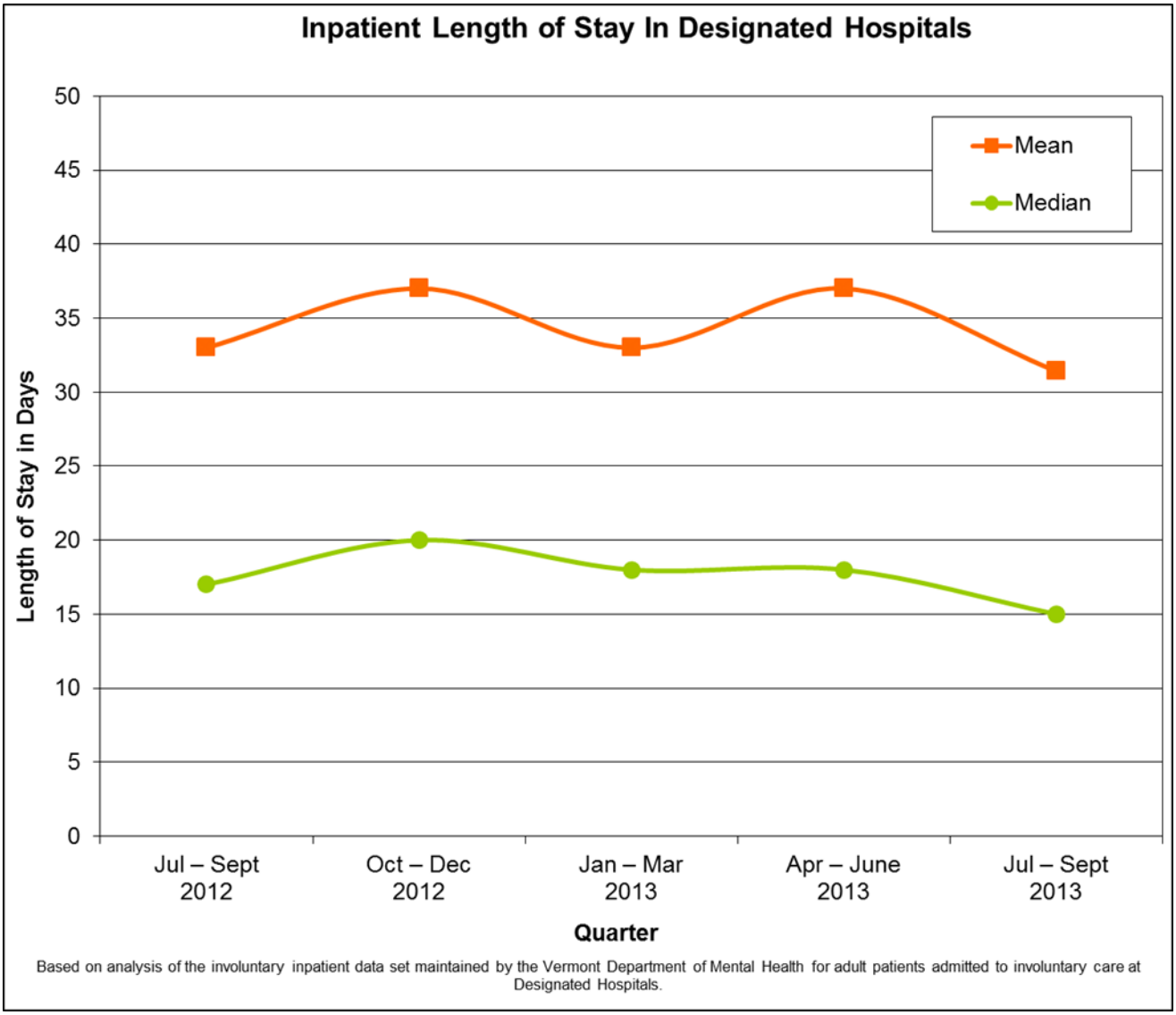
Emergency Exams and Warrants, Court Ordered Forensic Observations, and Youth
Wait Times in Hours for Involuntary Inpatient Admission
2013



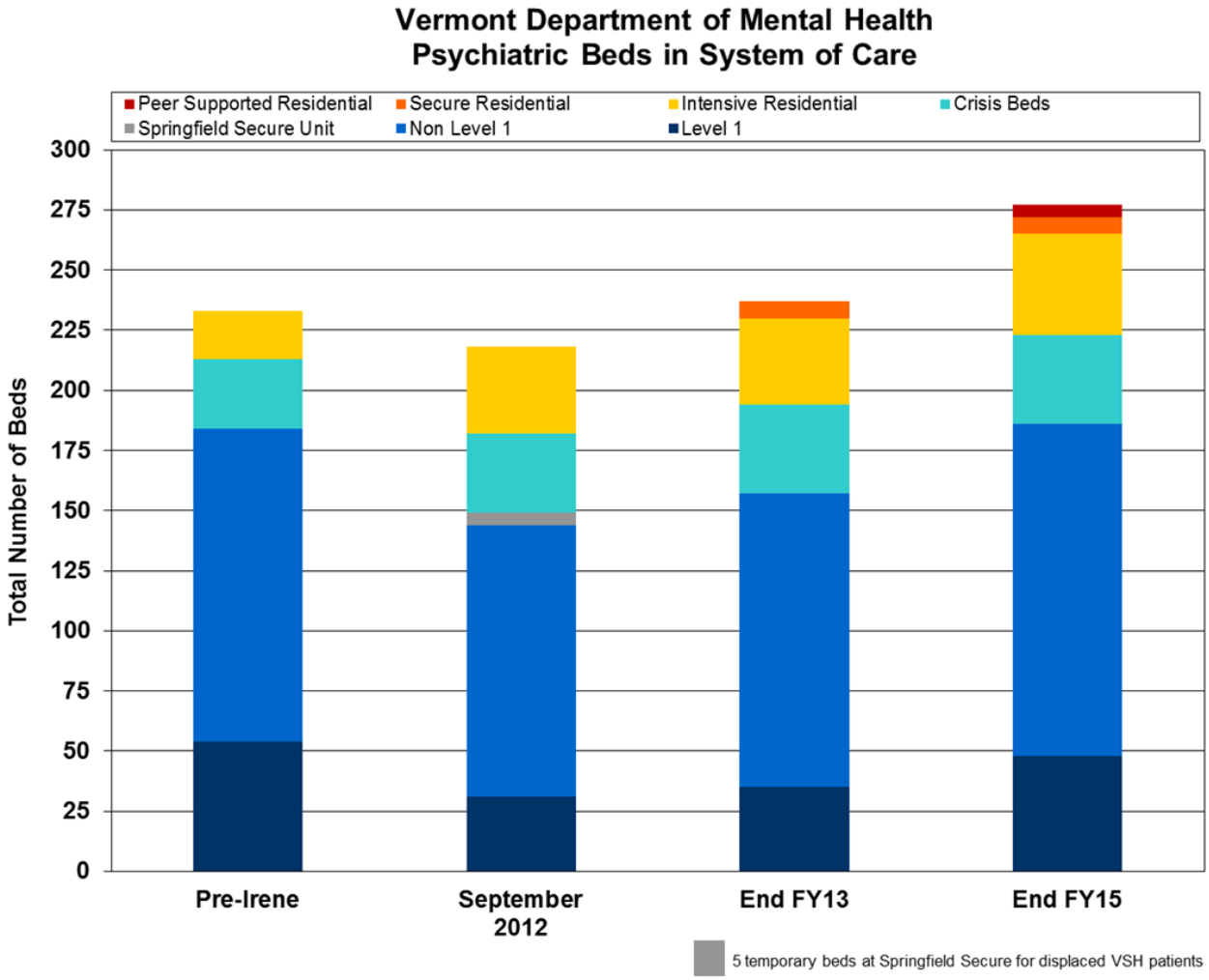
2013												
Wait time	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
No wait time	11	5	15	16	12	17	13	6	3	3	3	10
1-8 hours	10	6	7	6	11	6	12	8	6	7	10	4
9-16 hours	9	6	5	6	8	3	12	8	7	6	1	6
17-24 hours	9	5	8	3	4	3	9	5	8	6	2	7
more than 24 hours	14	16	23	16	24	18	29	14	30	27	28	18
Total	53	38	58	47	59	47	75	41	54	49	44	45

Emergency Room holds tracked over the past 12 months shows the number of persons proposed for emergency examination admissions and wait times ranging from less than 8 hours to over 72 hours as acute care inpatient bed capacity remains constrained. The data show that over the past six months, close to half of those individuals waited for inpatient admission less than 24 hours.

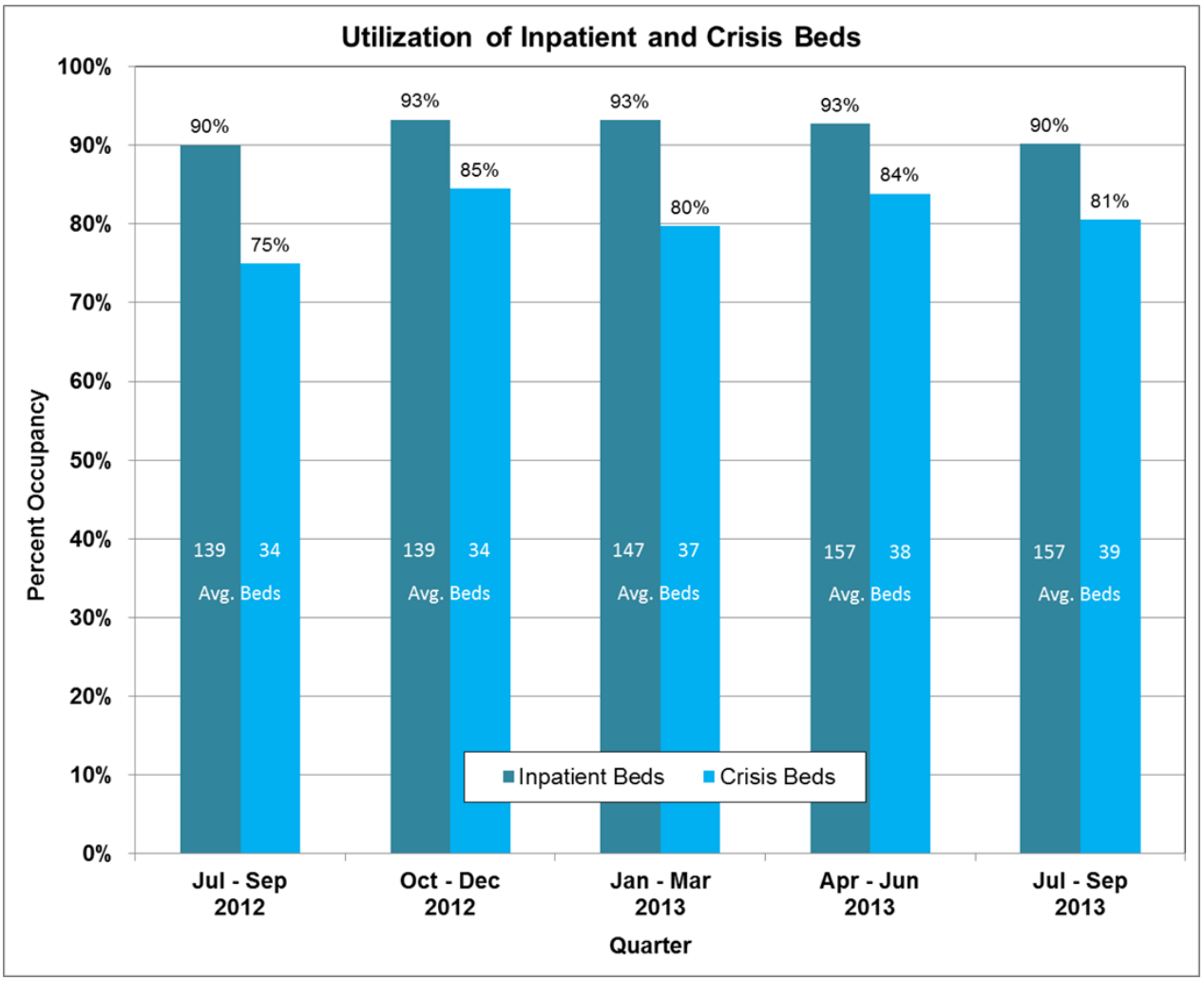
ED wait time calculates the time an individual enters the ED for services until placement in a psychiatric bed or discharge from the unit. ED screening routinely includes medical assessment in conjunction with considering a psychiatric admission, so wait times above do not differentiate the routine wait for medical assessment that anyone experiences in the ED from the wait time associated with psychiatric bed availability. While any wait is undesirable, wait time for ED services nationally is in excess of 4 hours on average, with longest waits of over 8 hours for emergency care (Press Ganey Health Report 2010).



This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients since the 4th Quarter of FY 2011, before the closing of VSH, to the most recent 2nd Quarter of FY 2013. The trend is to a decreased length of stay in hospital settings, despite some initial concern after the closing of VSH that the length of stay would possibly increase as a result of the systemic changes including the decrease in available beds. It appears that patients with higher acuity are being treated on an inpatient basis and others are appropriately being treated in the community through continuum-of-care alternatives such as crisis beds and/or enhanced wraparound services through the DA programs. The median length of stay is fairly stable while the average length of stay has steadily declined over the reporting period. The Care Management Team's active facilitation of discharge planning might be reflected in the decrease LOS figures.



Occupancy of inpatient and crisis beds is shown over time preceding the closing of VSH to the present. It is important to note that occupancy is determined at a moment in time (midnight) and does not include the time to "turn over" a bed. Occupancy reached its highest level immediately following the closure of VSH and is now stabilizing. Occupancy of crisis beds has remained fairly consistent with the addition of new crisis beds (25 to 34 beds) documenting the need for the increased capacity at this level of care. As the care management team better identifies the level of care available at crisis bed programs, it is anticipated that the overall occupancy rates will increase.



How much did we do?

An electronic bed board was established in August 2012 as a means to track availability of inpatient, residential and crisis bed capacity for placement of patients in need of treatment. It is used by the screeners and others at the DAs, DMH care management staff, and the DHs for daily monitoring and management of the needs and resources for patients, and it provides key measures of capacity. Each weekday morning DMH leadership and care management team staff meets to discuss individuals in need of or in the process of hospital placement. The staff works collaboratively with the DAs, the hospital staff, law enforcement, Corrections and other involved agency personnel. DMH provides 24/7 admissions information and support services through DMH Admissions Unit staff and after-hours clinical and administrative staff availability to community providers.

How well did we do it?

Addressing High utilizers of hospital:

- DMH engaged in an ongoing process to review readmission trends in order to identify specific factors and develop a plan to reverse the increase in readmission rates.

- The care management and technical support teams work together to identify the best living environment match to assist a person in gaining stability within the community.
- DMH will continue to consider wraparound programs on a case by case basis. Although expensive, these programs are highly successful investments in the recovery of the individual. Among the individuals placed in wraparound programs, hospitalization rates are negligible.

What still needs to be done?

- VPCH needs to be completed for the system to have the number of Level 1 beds planned to meet the current inpatient demands
- Options to decrease wait times in ED's need to be explored
- Ensuring a robust care management system to move individuals to the right level of care at the right time remains a priority
- Expediting the right treatment for patients that will allow them to discharge to the next level of care into the community needs to be pursued
- Utilization and continued support of alternatives to hospitalization, including robustly staffed crisis bed programs
- Consideration of peer/provider home-support models

VPCH will open in July, 2014. Proposed staffing is outlined below:

Comparison of Staffing Patterns between VPCH and VSH

VPCH (FY 15)

Staffing Request - FY15

				Total FTEs
Indirect/Admin Staff				56.0
	Unit 1 - 9 Beds	Unit 2a - 8 Beds	Unit 2b - 8 Beds	Total FTEs
Total FTE's Needed for 24/7 facility to Include Leave Factor '*				
Total Nurses	14.0	10.0	10.0	34.0
Total Psychiatric Technicians	39.0	27.0	27.0	93.0
Total Direct Care FTE's	53.0	37.0	37.0	127.0
				183.0

* A leave factor of 1.7 is used which includes sick, vacation, and workman's comp leave

VSH (FY 12)

Staffing Pattern - FY12

				Total FTEs
Indirect/Admin Staff				76.0
	BR - 14 beds	B1 - 19 beds	B2 - 21 beds	Total FTEs
Total FTE's Needed for 24/7 facility to Include Leave Factor '*				
Total Nurses	14.0	15.0	14.0	43.0
Total Psychiatric Technicians	23.0	44.0	34.0	101.0
Total Direct Care FTE's	37.0	59.0	48.0	144.0
				220.0

FACTORS INFLUENCING STAFFING AT VPCH:

- Open building design / small patient units
- Acuity of Patients
- Reducing Mandatory Overtime
- Reducing Emergency Involuntary Procedures
- JCAHO Accreditation and CMS Provider Status

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