No Action		Development need		Accomplished	

RECOMMENDATIONS (Priority noted in bold.)	**STATUS**
1: The Department of Mental Health (DMH) should develop an updated mission, vision, values, and principles statement that not only aligns and adheres with those in Act 79, but goes beyond to articulate DMH's core values, principles of recovery, and key tenets of service provision.	
	AHS is working to align all of its Department Strategic Plans Additional DMH development work is part of work plan, but has been delayed given operational priorities that have remained in the forefront.
	Ongoing DMH incorporates elements of Act 79 into documents, publications, and events that it supports or sponsors (i.e. System of Care Update being finalized for this fall, Act 79 and other legislative reporting, Requests for Proposals, DA Master Grant Language, other grants and contracts, Conferences, and the MH Advisory. DMH recently filled its Director of Health Care Integration position. This position works closely with the Medical Directors and the Policy Director and will be bringing a public health approach to mental illness prevention and mental health promotion.
2: The Department of Mental Health should develop a detailed ACT 79 implementation plan.	
	Initial plan created. Broad overview update provided at 10/3/14 MHOC meeting.
3: Establish a set of broad "system" performance measures that include reports on service and support "process" delivery, as well as outcomes of these changes. All of this data should be used to compile and deliver monthly or quarterly dashboard reports that can be used to track progress and identify needed changes.	
	A monthly snapshot report is regularly produced and included with MHOC reports.

4: DMH should provide real-time web access to the Act 79 implementation plan and the measures that will be used to gauge implementation progress.	
	DMH provides key performance indicators identified for monthly reporting and a monthly snapshot of system measures on the DMH website. Annually, the Act 79 implementation report is provided to the legislature and posted to the DMH website.
5: The Administration and Legislature should develop a communications strategy for sharing with the public the progress made to implement Act 79.	
	Consistent posting of meeting agendas and meetings on the Department of Libraries website DMH needs to develop a work plan to address recommended organization improvements for better utilization for our public website.
	The DMH Advisory communication provides at least monthly or more frequent updates on DMH activities, milestones, and public meeting schedules. It is distributed broadly to 400+ stakeholders. The Department of Libraries is utilized for public meeting schedules
6: There should be an established single point of clinical responsibility and authority within the State's mental health system.	
	The DMH Medical Director was hired and is a single point of contact for issues requiring clinical collaboration and involvement/guidance of the State mental health authority, in consultation with the DMH Commissioner.
7: The State should undertake a "high utilizer" study to identify those individuals who cycle through community and state inpatient psychiatric facilities, homeless shelters, emergency departments, prisons, and other costly settings.	
	Ongoing interagency collaboration for identification of high utilizers.
	DVHA analysis of high end users for Chronic Care Initiative supported local teams funded by Blueprint and

	DA providers in coordinating mental and physical health services. Blueprint is looking at high utilizer ED usage and involving mental health resources for identified users who may need ongoing mental health support and follow-up. As part of Act 87, DMH conducted a study to identify the mental health treatment needs and supports needed by incarcerated SFI inmates and provided recommendations. Planning work with DOC and BGS for permanent Secure Residential Program for collaborative model of meeting both secure and complex mental health needs.
8: The Department of Mental Health should consider using contractual performance measures to incentivize Providers to meet system level outcomes by allocating a small percentage (2-5%) of all service dollars tied to ACT 79 funding.	
	Incentive payment is under consideration and dependent on available funding resources.
	Contracts with DHs and the Master Grant with DAs include performance measures and there is ongoing planning to further develop.
9: The Department of Mental Health should enhance its capacity to hire sufficient and competent staff with the expertise to aggressively monitor the utilization of all services currently financed under the State's mental health system, including Community Rehabilitation and Treatment clients and clients receiving adult outpatient services.	
	DMH is considering the re-classification of an existing vacancy for unmet audit functions in fee-for-service Medicaid billings in community-based programs.
	DMH added care management coordinators, a psychologist, a Director of Quality Management, a Clinical and Operations Director, an additional quality management coordinator, General Counsel, and a health care reform liaison to address identified department development and program oversight needs. Most are master's level and hold clinical licensure.

10: Based upon the "high utilizer" review (see Recommendation 7), the Department of Mental Health should enhance its care management capacity to include sufficient staff and expertise to identify and coordinate behavioral health and medical care for the top (10-20%) of high-risk/high-cost consumers with serious mental illness and high risk/high cost consumers receiving adult outpatient services.	
	DMH's work to integrate mental health with primary care involves the DA's and their interest in providing primary care as part of their services. DMH has been primarily consultative in this ongoing health reform work.
	Care management team works closely with DA's and DH's to coordinate care and facilitate movement. The SFI care manager focuses on individuals in DOC custody and coordination of services with care management team. Nursing care manager, a component of the earlier technical assistance team, maintains involvement with complex community individuals and informs/assists with medical and physical care support resources.
11: The Department of Mental Health should work with the Department of Vermont Health Access, Department of Health, and the Division of Alcohol and Drug Abuse Programs to expand the scale and scope of Blueprint activities as they relate to the integration of mental health and substance abuse services with primary medical care.	
	Pending revision of Intergovernmental Agreement for monitoring and oversight with DVHA
	DMH is working with DVHA and ADAP to address possible payment reform models of DA services DMH participates with DVHA on quality improvement methodologies. VHCIP Quality and Performance Committee- helping establish, with a broad coalition, the ACO quality outcomes for public and commercial ACO's VPCIP Steering Committee- review and recommend innovative ideas in improving service delivery and healthcare integration to the Green Mountain Care Board DMH participates in the oversight and quality outcomes committees for Medicaid members assigned to each of the ACO's in Vermont. Consultation and collaboration with regional providers

	on how to integrate mental health into Patient Centered Medical Homes (PCMH) Blueprint Executive Committee – advising on better care integration and quality improvement at PCMH's and Blueprint sites. DMH is working closely with DCF and ADAP on the MH and SA Reach-up Initiative DMH is working closely with ADAP on the Substance Abuse Treatment Coordination initiative to ensure timely and effective screening and referral in AHS points of contact. With regard to children, DMH is a lead member on an Early Childhood Trauma workgroup with VDH and community partners that has developed and launched a trauma screening pilot in a local Blueprint primary care practice that leads to treatment referral and follow-up. The pilot is designed to create a replicable model that other Blueprint practices can use. There will be a presentation on the model at the Semi-annual Blueprint Conference.
12: The Department of Mental Health should create a set of system objectives that ensures that both inpatient and community services align. This should include the establishment of clearly defined clinical expectations relative to admission, discharge, and continuity of care.	 Work with the DHs and DAs to define expectations is ongoing. Minimum Standards Review no longer deemed and is undertaken at all DA's. Level I inpatient criteria established DMH UR unit is actively involved in determining thresholds for level of care authorization. Crisis beds and IRR's (including Secure Residential) have uniform referral forms and admission consideration. IRR's have developed more standardized criteria for

	discharge and clinical outcome measures. Crisis Beds and IRR's have developed brochures with program descriptions and criteria for referral from communities and hospitals
13: The Department of Mental Health should establish comparative performance targets and measures (e.g., admission, discharge, re-admission) that document how well providers manage patient flow between inpatient and community based care. DMH should develop methods for incentivizing its providers to attain specific system level outcomes aimed at aligning inpatient and community care.	
	Dashboard performance measures and target development is still underway. Given that many system components have incrementally come on line or only recently been completed, performance targets need to be determined over accurate baseline levels.
	Incentive payments have been and will continue to be added to the Master Grant for DAs and contract with the DHs.
14: The Agency of Human Services should continue to seek written clarification from the Centers for Medicare and Medicaid Services on the opportunity for Medicaid reimbursement for the future psychiatric Hospital.	
	The VPCH is a 25 bed inpatient facility that is CMS certified and TJC accredited and is eligible for state funding via the State's Global Commitment Waiver.
15: The Department of Mental Health should immediately develop a workgroup led by its medical director to develop appropriate polices, procedures and plans for the operation of the new Vermont state psychiatric hospital that meet federal standards of care and are directed by the ADA and the Olmstead Decision, for example, in terms of discharge planning. The workgroup should prioritize the development of new services that will prevent people from entering the inpatient care system, and provide intensive services and supports to those being discharged from care to help them become integrated in their communities.	
	As referenced in 14. Policies, procedures, and operating plans meet certification and accreditation requirements. The hospital personnel working with FAHC psychiatry staff are implementing program services emphasizing recovery and reintegration into communities in a timely manner.
16: The State should formally establish "use liens" for any space where state capital funds are being used to renovate non state-owned or -controlled space as alternatives to the state psychiatric hospital.	"Use Liens" have not been utilized
	Services contracts with Level I hospitals that received state capital funds are in place and have been renewed annually.

17: Evaluate the clinical eligibility criteria and raise the cap on Community Rehabilitation and Treatment (CRT) to accommodate increased need for CRT services.	Clinical Eligibility Criteria has not been modified. Non-Categorical case management services have been introduced for the adult population who previously were ineligible. Seriously Functionally Impaired funding addressed a number of individuals with complex needs who were previously ineligible and currently remains in base funding.
18: Consider the benefits and drawbacks of "Medicaiding" most or all of mental health services for the Community Rehabilitation and Treatment program and adult outpatient population.	 Alternative payment methodology is being considered by DMH, ADAP and DVHA referenced in 11. Above, Non-categorical case management service expanded via enhanced funding.
19: Immediately direct Act 79 funds toward ensuring timely statewide access to quality crisis services. This should entail the establishment of access and quality standards for these services that can be used to identify and direct new resources to closing gaps in services.	 Statewide crisis response capacity has some variation and is overviewed in a separate document. Enhanced funding provided to DA's to increase outreach and mobile capacity in crisis services. Team Two training to increase law enforcement and mental health services response are in process. Team Two has completed the first phase of "train the trainer" and is now providing local trainings throughout the state. All crisis staff receive standardized QMHP training for consistent interpretation of statutes and clinical criteria for hospitalization.
20: The Department of Mental Health should expand jail diversion and crisis intervention teams available to work with local and state police.	 As referenced in 19. above, mobile capacity and Team Two trainings are helping address local diversion needs. As part of Act 87 study, DMH recommended the expansion of mental health treatment courts as diversion opportunities from incarceration.

21: The Department of Mental Health should ensure adequate training and supervision of lay peer counselors as peer-run services expand. DMH should also explore the potential to certify peer counselors for quality assurance purposes and to understand potential reimbursement for these services under Medicaid.	
	State-wide peer coalition *(Wellness Workforce Coalition)* coordinating planning for possible creation of certified peer service providers.
	DMH utilizing Act 79 funding to contract with VCIL to operate the *Wellness Workforce Coalition (WWC)* to provide core training, co-supervision, workforce development, quality improvement and mentoring to existing and new peer programs and service providers.
22: The Department of Mental Health should establish a relationship with a nonprofit support center or other similar organization to help consumers develop new peer-operated services.	
	DMH working with WWC to promote development and expansion of new peer-operated services (e.g. ER-based peer support).
	Numerous new peer-operated programs were developed through Act 79 and other federal funding (e.g. Community Links, Northeast Kingdom Youth Services peer outreach, Wellness Coop). DMH has long-standing grant with Vermont Psychiatric Survivors for development of local peer-run initiatives.
23: Create a quality assurance unit within the Department of Mental Health to develop standards and to assess the clinical efficacy, capacity, and effectiveness of current and new services provided under contract to the State.	
	Considering reclassification of Audit functions. Referenced in 9. above. Quality Management plans to review validity and reliability of designation processes at the end of the current designation cycle.
	Quality Management Director position was re-instated in September 2012. Two quality management positions were also re-instated. QM staff currently review all critical incident reporting, review all emergency involuntary procedure (EIP) information submitted by hospitals, oversee hospital and agency designation, review grievances and appeals, and review ECT treatment in conjunction with the DMH Medical

	Director. DMH Quality works closely with DVHA and AHS to align oversight through both the DVHA Quality Committee (Performance Improvement Projects related to HEDIS measure performance) and the AHS Performance Accountability Committee (Agency Improvement Model, Results-Based Accountability (RBA), and AHS STAT)
24: The Department of Mental Health should establish a dedicated program development team that can provide training, technical assistance, and support to new and existing providers in the development of new programs and services across the State.	DMH and DA's have partnered to create *Vermont Cooperative for Practice Improvement and Innovation* focused on coordinating training, TA and support for providers to implement and sustain the use of evidence-based programming and practices. Current focus includes reduction of seclusion and restraint, Open Dialogue, Dialectical Behavior Therapy, Team Two, Integrated Dual Disorder Treatment, Results-Based Accountability, treatment of first-break psychosis, Vermont Family-Based Approach, and core community mental health workforce competencies.