Act 79: Core Requirements and Status Updates
Mental Health Oversight Committee – October 3, 2014

No Action		Development Area		Accomplished	

Requirement	Status:
Establish **Clinical Resource Management System** to coordinate movement of individuals to appropriate services throughout the continuum of care and perform ongoing valuations/improvements of system. System functions include: -care coordinators to assist crisis clinicians in the field, -an electronic bed board to track available bed space -coordination of patient transport services, -access by individuals to a mental health patient representative -periodic review of individuals' clinical progress.	-Weekday after-hours care management available through VPCH Admissions Office. -Care Management available during weekend hours to facilitate transfers and discharges. -DMH Administration and Legal available 24/7 for consultation. -Care Management team meets weekly with hospitals to review all patients involuntarily hospitalized. -Care Management monitors voluntary and involuntary individuals waiting for inpatient beds. -Care Management facilitates/monitors transitions between levels of care. -DMH tracks individuals who are hospitalized and on Orders of Non-hospitalization. -DMH contracting with Vermont Psychiatric Survivors for 1.0 FTE patient representative. -Established Electronic web-based bed board system. -DMH established MOU with Mental Health Care Ombudsman -DMH established criteria for Level I patients. -DMH and DVAH providing Utilization Review for all Medicaid beneficiaries needing inpatient psychiatric hospitalization. -DMH established contracts with law enforcement for least restrictive transportation options for those needing involuntary hospitalization.
Develop **Peer Services**, including statewide warm line access, new services to reduce need for inpatient services; quality improvement, infrastructure, and workforce	-Expansion of Warmline to 24-hours per day. -Peer-Run transportation capacity statewide.

development of peer services; and peer-run transportation services.	-Statewide Warmline operating 6-8 hours per day, seven days per week including holidays. -Community Links peer outreach in Rutland County provides community support and crisis prevention to individuals transitioning from hospitalization or incarceration. -Young adult peer outreach program in St. Johnsbury provides community support and crisis prevention to young adults at risk of hospitalization. -DMH enhanced capacity and infrastructure funding to peer organizations. Alyssum, VPS, and Another Way have increased staffing for community support, crisis prevention, hospital diversion. Peer run transport capacity increased. -DMH funded peer workforce development through Vermont Center of Independent Living (Wellness Workforce Coalition): core competency training at regular intervals. -Vermont Vet-to-Vet funded for peer outreach and support to veterans on limited statewide basis.
Improve DA **Emergency Response, Non-categorical Case management, Mobile Support Teams, Adult Outpatient services, and Alternative residential opportunities**.	-Non-categorical case management available at all Designated Agencies. -Mobile outreach capacity limited by turnover and hiring of clinicians in various parts of the state. -Night hours mobility not fully implemented as requires staffing and resources to a variable demand. -Large geographic coverage areas are still a challenge for timely mobile response again due to variable demand and resources. -Dispatch communications (connection to law enforcement personnel for response) have regional variations. -Time constraints for law enforcement encountering mental health needs and time delay in mobile response can result in ER visits. -Emergency staffing increased with enhanced funding to provide more outreach/mobility capacity.

	-All Designated Agencies are providing mobile response when requested, within the progress limits noted above. -Communications with law enforcement improved through Team Two trainings. -Peer supports have been added to some emergency services capacities
Develop at least four **Short-term Crisis Beds** in designated agencies to prevent or divert individuals from hospitalization when clinically appropriate,	
	2 additional crisis beds added in Rutland county 2 bed crisis program in Orange county 2 bed crisis program in Lamoille county
Develop voluntary five-bed residence (**Soteria House**) for individuals experiencing an initial episode of psychosis or seeking to avoid or reduce reliance on medication.	
	Soteria House 5-bed program to open early 2015.
	Location secured. All CON, permit and zoning issues resolved. Renovations under way.
Develop **Housing Subsidies** for individuals living with or recovering from mental illness.	
	HUD Section 8 vouchers in short supply for movement of individuals off housing subsidy funding.
	-DMH partnered with Vermont State Housing Authority to oversee rental subsidy and housing resource options. -133 persons who were homeless, mentally ill and at risk of needing an acute care bed have been housed and supported in the community.
Develop **15 Intensive Residential Recovery (IRR) Beds** in northwestern Vermont	7 IRR beds
	8-bed IRR opened in Westford
Develop **8 Intensive Residential Recovery Beds** (IRR) in southeastern Vermont	
	Hilltop 8-bed residential program opened in Westminster.
Develop **8 Intensive Residential Recovery Beds** (IRR) in either central or southwestern Vermont.	
	-4-bed Maplewood IRR opened in Rutland. -Funding for 2 IRR beds used to increase Rutland crisis program from 2 to 4 beds. -Funding for 2 IRR beds used to create 2 crisis beds at Second Spring in Williamstown.
Establish a **14-Bed Inpatient Unit** in southeastern Vermont (**Brattleboro**	

Retreat)	-14 Level I beds added at Brattleboro Retreat (Tyler 4 Unit Renovation)
Establish **6-Bed Inpatient Unit** in southwestern Vermont **(RRMC)**	
	-6 Level I beds added at RRMC (PICU Unit Renovation)
Construct and operate a **25-bed Acute Inpatient Hospital** in central Vermont **(Berlin)**	
	-D Unit (4 beds) pending opening
	Vermont Psychiatric Care Hospital opened in July/2014. A, B, and C Units open. Current census at 21.
Contract on a short-term basis for **7 to 12 Acute Inpatient Hospital Beds at Fletcher Allen Health Care** until the state-owned and -operated hospital becomes operational.	
	-Level I admissions ended July, 2014 -FAHC Units returning to involuntary and voluntary capacity July, 2014
	-Remaining Level 1 patients transitioning at discharge.
Develop **8-bed Temporary Acute Inpatient Hospital in Morrisville**, which will be discontinued when the state-owned and -operated hospital is operational.	-Restoration of the Morrisville facility for Lamoille County Mental Health pending.
	-8 Level I beds at temporary renovated hospital in Morrisville closed July, 2014
Develop a **Secure Seven-bed Residential Recovery Facility** owned and operated by the state for individuals no longer requiring acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time.	
	-DMH, DOC, and BGS developing report for permanent secure residential program planning for January, 2015.
	-Middlesex Therapeutic Community Residence, a secure facility, opened June, 2013.
Establish a **System to Review any death or serious bodily injury** occurring outside an acute inpatient hospital when the individual causing or victimized by the death or serious bodily injury is or recently has been within the custody of the commissioner.	
	-Event Reporting revisions drafted and under review with both designated hospitals and designated agencies. -Pending meeting of AHS Departments to review current adverse event reporting requirements, interdepartmental coordination/ communication, and state/federal laws regarding information sharing and disclosure.
	-Incident Reporting Guidelines in place -Incident review protocol in place
Initiate rulemaking process that establishes **Standards for the Use and Reporting of Seclusion or Restraint** on individuals within the custody of the commissioner, as well as requirements pertaining to the **Training and Certification of Personnel Performing Emergency Involuntary**	
	-DMH initiated rulemaking. LCAR rejected draft rules and recommended clarification of Act 79 legislative intent -DMH established a quarterly multi-stakeholder

Procedures.	Emergency Involuntary Procedures Review Committee to review aggregate trends of EIP's at hospitals and make recommendations to the DMH Commissioner. -DMH is funding an ongoing seclusion and restraint initiative with the Level I hospitals using the SAMHSA Six-Core Strategies Model with a national expert -VPCH and Designated hospital policies are fully compliant with CMS and TJC standards for EIP's.