Department of Mental Health
Fact Sheet

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.

ORGANIZATION STRUCTURE:
DMH is one of several departments that constitute the Agency of Human Services. DMH is comprised of multiple units (e.g. Child, Adolescent, and Family Unit; Clinical Care Unit) that are each responsible for oversight of different components of Vermont's publically-funded mental health system of care.

CORE RESPONSIBILITIES:
DMH is responsible for mental health services provided under state funding to special-needs populations including children with severe emotional disturbances (SED) and adults with severe mental illnesses. Operating under Administrative Rules for Agency Designation (June 2003), DMH contracts with ten private nonprofit community mental health centers or Designated Agencies (DAs) to provide service coverage to all areas of the state and with one private nonprofit Specialized Service Agency (SSA). The Commissioner of DMH confers designated agency status when he or she confirms that an agency meets state and federal laws, regulations, and quality standards for the provision of mental health services. Each DA is responsible for providing core capacity services in a given region, which include:

- Children's Services for children and adolescents with SED and their families;
- Community Rehabilitation and Treatment services (CRT) for adults with severe mental illness;
- Crisis Services for anyone, regardless of age, in a mental-health crisis; and
- Adult Outpatient Programs (AOP) for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions.

DMH operates Vermont's only state operated psychiatric hospital (Green Mountain Psychiatric Care Facility) and contracts with several designated community hospitals for intensive inpatient psychiatric beds ("Level I") for individuals who would have received treatment at the Vermont State Hospital.

A full description of the Department of Mental Health and its system of care can be found at:

http://mentalhealth.vermont.gov/

Act 79: Core Requirements and Status Updates

Requirement	Status:
Establish **Clinical Resource Management System** to coordinate movement of individuals to appropriate services throughout the continuum of care and perform ongoing evaluations/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.	-Care Management team meets weekly with hospitals to review all patients involuntarily hospitalized, monitor transitions between levels of care, and facilitate expedited patient transitions to appropriate of care level. -DMH monitors treatment and outcomes of all involuntary hospitalizations, as well all individuals who are on Orders of Non-hospitalization in community placements. -DMH is contracting with Vermont Psychiatric Survivors for two .5 FTE patient representatives. -Electronic web-based system operating since August 2013 and continues to be upgraded for increased responsiveness to system needs. -Criteria for Level I patients written and procedures implemented within DMH. -DMH providing Utilization Review for all Medicaid beneficiaries needing inpatient psychiatric hospitalization. -DMH and law enforcement implementing approaches to providing 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 development of peer services; and peer-run transportation services.	- State support line operating 8 hours per day. - Peer outreach teams established in St. Johnsbury and Rutland; veterans outreach in development. - Increased service capacity at Another Way, Alyssum and Vermont Psychiatric Survivors. - Peer workforce initiative (Wellness Workforce Collaborative) established and sponsoring core peer training.

Attachment B

Improve DA **Emergency Response, Non-categorical Case management, Mobile Support Teams, Adult outpatient services, and Alternative residential opportunities.**	- Enhancements at DA's include: ♦ Expanded mobile outreach and crisis intervention and stabilization capacity, ♦ Expanded residential crisis alternatives to hospitalization, Enhanced case management services for those in Adult Outpatient services, who need that level of assistance, but are not meeting eligibility requirements for CRT or DS programs, ♦ Increased use of peer support services to provide care and social support to those in need, ♦ Improved interface with Law enforcement where there is overlap with persons who have mental health problems and have come in contact with the criminal justice system.
Develop at least four **Short-term Crisis Beds** in designated agencies to prevent or divert individuals from hospitalization when clinically appropriate,	-Developed 10 additional crisis beds: 4 in Rutland; 2 in Orange County; 2 in Lamoille County; 2 in Springfield.
Develop voluntary five-bed residence (**Soteria House**) for individuals experiencing an initial episode of psychosis or seeking to avoid or reduce reliance on medication.	- Planned opening in January 2014.
Develop **Housing Subsidies** for individuals living with or recovering from mental illness.	-133 individuals currently being supported.
Develop **15 Intensive Residential Recovery Beds** in northwestern Vermont	- 8-bed facility to open in Summer 2013. - 7 on hold while evaluating ongoing need.
Develop **8 Intensive Residential Recovery Beds** in southeastern Vermont	8-Bed facility (Hilltop) operating in Westminster (focus on first episode psychosis w/minimal meds)
Develop **8 Intensive Residential Recovery Beds** in either central or southwestern Vermont.	- 4-bed facility in Rutland under construction. - 2 beds added to Second Spring in Williamstown. - 2 beds converted to crisis beds in Rutland
Establish a **14-Bed Inpatient Unit** in southeastern Vermont (**Brattleboro Retreat**)	- Complete

Establish **6-Bed Inpatient Unit** in southwestern Vermont **(RRMC)**	- Complete
Construct and operate a **25-bed Acute Inpatient Hospital** in central Vermont **(Berlin)**	- Facility under construction; first 16 beds scheduled to open in May 2014.
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.	- Services contract complete.
Develop **8-bed Temporary Acute Inpatient Hospital in Morrisville**, which will be discontinued when the state-owned and -operated hospital is operational.	- Complete
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.	- Facility complete and accepting patients as of June 19, 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.	- Protocol for review has been recently re-written and implemented.
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 Procedures.**	- Rules to be filed with LCAR.

Mental Health Oversight Committee: Progress during FY 2013 in implementing *Enhanced Emergency Services*

10 Designated Agencies submitted proposals for enhanced emergency services funding for FY 2013. They are listed below with a list of program enhancements services provided.

Summary: The Enhancements across the system of care were intended to increase the capacity of our community mental health system to provide much needed emergency response to those in need of intensive services during periods of destabilization and/or crisis. Each of the Designated Agencies proposed programmatic changes with the funding available. In general, the DA's all focused on the following areas:

- Expanding their capacity to provide mobile outreach and crisis intervention and stabilization
- Expand residential crisis alternatives to hospitalization
- Enhancing case management services for those in Adult Outpatient services, who need that level of assistance, but are not meeting eligibility requirements for CRT or DS programs
- Increasing use of peer support services to provide care and social support to those in need
- Improve interface with Law enforcement where there is overlap with persons who have mental health problems and have come in contact with the criminal justice system.

By Designated Agency:

1. CMS
    a. Developed a system of emergency response/ doubled staff to respond across all programs with improved linkage to ongoing care after crisis intervention
    b. Mobile crisis implemented
    c. Increased interface with law enforcement
    d. Still working on developing 2 additional crisis beds; plans in place to purchase a house
2. CSAC
    a. Hired a Stabilization Coordinator and forming an E Team to cover all populations/programs served
    b. Non-categorical case management initiated
    c. Report reduction in ER visits and police intervention, reduction of hospital admissions, and increased individual satisfaction
    d. Recruiting for peer mentors
3. HCRS
    a. Increased residential services for alternatives to hospitalization and community treatment- ~40 positions
    b. Enhanced crisis care centers
    c. Increased mobile support outreach

d. Implemented non-categorical case management
e. Expanded police social worker program
f. Interfaces with law enforcement, and health care reform programs

4. HC
    a. Decrease hospitalization of CRT clients
    b. Non-categorical case management
    c. Enhanced nursing services
    d. Enhanced/supportive housing, shared living partner program, enhanced case management
    e. STEPPS IOP and START
    f. Mobile Crisis Services
5. LCMHS
    a. Enhanced AOP services
    b. Non-categorical case management
    c. Mobile crisis team and interface with law enforcement
    d. Increased peer supports
6. NKHS
    a. Flexible Cadre Staffing
    b. Embedded case workers with law enforcement/intercept I
    c. Non-categorical case management
    d. Diversion space
    e. Working on STB beds
7. NCSS
    a. Mobile outreach and increased coordination with other programs with additional staff
    b. Non-categorical case management
    c. Crisis stabilization
8. RMHS
    a. 2 additional crisis beds
    b. Increased mobile crisis capacity
    c. Non-categorical case management
9. UCS
    a. Mobile crisis
    b. Increased peer support
    c. Non-categorical case management
    d. Outpatient capacity increased for AOP
    e. Expand access to crisis stabilization center
10. WCMHS
    a. Increased psychiatric nurse practitioner time
    b. Street intervention/mobile crisis enhanced
    c. More involvement with Law enforcement
    d. ER diversion center planned
    e. Provision of respite to divert from hospitalization

~Plan of Analysis for MHOC Data Reporting~

"... each month between June and December 2013, the Department of Mental Health shall provide information to the Mental Health Oversight Committee and the Health Care Oversight Committee on..."

(1) The number of Level 1 patients receiving acute inpatient care in a hospital setting other than the renovated unit at Rutland Regional Medical Center, the renovated unit at the Brattleboro Retreat, and the Green Mountain Psychiatric Center in Morrisville, including the number of individuals treated in each setting and the single combined one-day highest number each month

Starting July 1, on the first weekday of the new month, DMH will pull the level 1 inpatient spreadsheet for all admissions for the previous month by unit. The report will detail total episodes for the month and the highest daily census by unit.

(2) The number of individuals waiting for admission to a Level 1 psychiatric inpatient unit after the determination of need for admission to emergency departments, correctional facilities, or any other identified settings is made and the number of days individuals are waiting;

For those level 1 patients identified in item 1, the wait time in days from the issuance of emergency papers (EE/Warrant) to admission. DMH will get these numbers from the core data elements master list populated by GMPCC admissions.

(3) The total census capacity and average daily census of new intensive recovery residence beds opened in accordance with 2012 Acts and Resolves No. 79, and the annual daily census of the secure residential recovery facility in Middlesex. The census capacity shall not include a duplicate count for beds that replace those currently in operation elsewhere.

Starting on July 1, on the first week of the new month, Keith will pull total census capacity and average daily census for the new intensive recovery residence beds: identified as Second Spring, Hilltop, and Meadowview in our data meeting. Middlesex will be added to this list once the facility is reporting.

VERMONT

Vermont Department of Mental Health System Snapshot (June 18, 2013)

* data is forthcoming

2013

Reporting Category	FY13 Q3 Jan	Feb	Mar	FY13 Q4 Apr	May	Jun	FY14 Q1 Jul	Aug	Sep	FY14 Q2 Oct	Nov	Dec
Adult Inpatient Hospital												
% Occupancy	94%	91%	92%	84%	87%							
Avg. Daily Census	136.7	132.2	136.4	133.9	135.2							
Adult Crisis Beds												
% Occupancy	74%	73%	79%	82%	83%							
Avg. Daily Census	27.5	27.7	29.4	28.8	30.7							
Applications for Involuntary Hospitalizations (EE)												
Children	-	-	-	9	*							
Adults	50	32	55	41	55							
Total adults admitted with Level 1 Designation (% of Total applications)	19 38%	10 31%	20 36%	18 44%	22 40%							
Total adults admitted with CRT Designation (% of Total applications)	13 26%	13 41%	27 49%	19 46%	14 25%							
Adult Episodes when Placement Unavailable & Client Held in ED	27	21	43	27	38							
Adult Involuntary Medications												
# Applications	2	3	3	2	9							
# Granted Orders	2	3	2	1	3							
Mean time to decision (days)	22	12	20	17	13							
Adult Forensic Screenings												
# Requested	11	13	9	10	11							
# Inpatient Ordered	3	7	5	5	6							
VT Resident Suicides												
Youth (0-17)												
Total	0	0	0	0	*							
# with DA contact within previous year	-	-	-	-	*							
Adults (18+)												
Total	4	6	10	8	*							
# with DA contact within previous year	0	3	2	0	*							
Housing												
# Clients permanently housed as a result of new Act79 housing funding	18	21	14	11	14							
Total # enrolled to date	98	119	133	144								
Involuntary Transportation												
Adults (total transports)												
# of Transports	19	17	18	11	*							
% Non-Secure	58%	94%	61%	82%	*							
% Secure	42%	6%	39%	18%	*							
% all transports using metal restraints	16%	6%	6%	9%	*							
% all transports using soft restraints	26%	0%	33%	9%	*							
Children Under 10 (total transports)												
# of Transports	3	3	0	0	*							
% Non-Secure	100%	100%	-	-	*							
% Secure	0%	0%	-	-	*							
% all transports using metal restraints	0%	0%	-	-	*							
% all transports using soft restraints	0%	0%	-	-	*							
CRT Employment												
% Employed	available July 2013			available September 2013								
Wages per employed client												

Vermont Department of Mental Health System Snapshot (June 18, 2013)

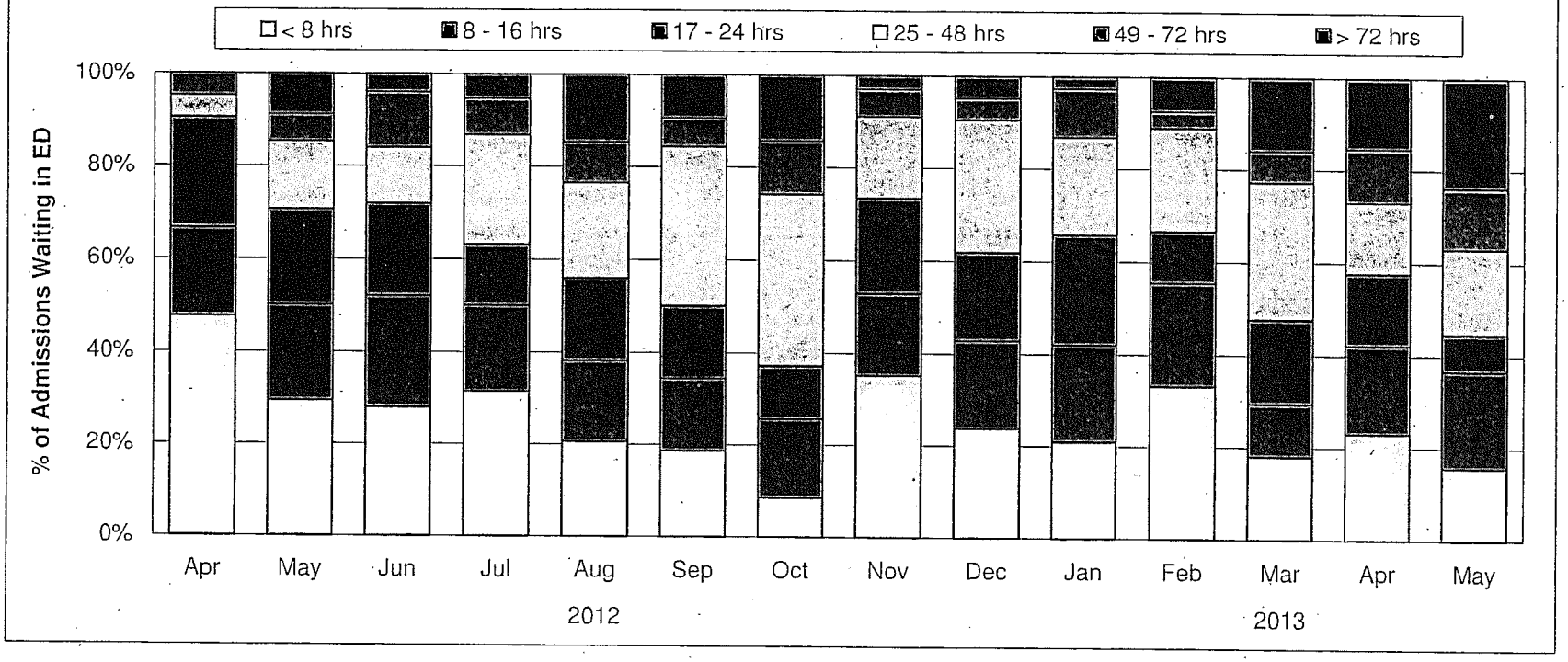
Reporting Category	2012 (PRIOR YEAR) FY12 Q3 Jan	Feb	Mar	FY12 Q4 Apr	May	Jun	FY13 Q1 Jul	Aug	Sep	FY13 Q2 Oct	Nov	Dec
Inpatient Hospital												
% Occupancy		-		89%	92%	90%	89%	89%	91%	91%	88%	89%
Avg. Daily Census		-		-	-	-	-	-	-	-	-	-
Crisis Beds												
% Occupancy		-		72%	80%	80%	77%	75%	72%	78%	82%	86%
Avg. Daily Census		-		-	-	-	-	-	-	-	-	-
Applications for Involuntary Hospitalizations (EE)												
Children		-		-	-	-	-	-	-	-	-	-
Adults		-		28	45	32	43	40	43	44	39	32
Total adults admitted with Level 1		-		-	-	-	13	11	10	17	11	13
Designation (% of Total applications)		-		-	-	-	30%	28%	23%	39%	28%	41%
Total adults admitted with CRT		-		7	15	18	18	11	24	22	14	11
Designation (% of Total applications)		-		25%	33%	56%	42%	28%	56%	50%	36%	34%
Instances when Placement Unavailable & Client Held in ED												
Involuntary Medications												
# Applications	4	3	7	3	6	4	4	3	4	6	0	2
# Granted Orders	3	2	5	2	4	3	4	2	1	6	-	2
Mean time to decision (days)	20	16	19	15	22	20	11	15	14	13	-	11
Forensic Screenings												
# Requested	-	-	-	-	-	-	17	19	11	8	8	14
# Inpatient Ordered		-	-	-	-	-	4	6	4	5	6	9
VT Resident Suicides												
Youth (0-17)												
Total	0	0	0	0	0	0	0	1	1	0	0	0
# with DA contact within previous year	0	0	0	0	0	0	0	0	0	0	0	0
Adults (18+)												
Total	7	6	11	8	9	7	6	4	7	4	3	9
# with DA contact within previous year	2	1	2	3	1	2	2	1	1	1	0	3
Housing												
# Clients permanently housed as a result of new Act79 housing funding		-		5	10	6	18	20	13	8	0	
Involuntary Transportation												
Adults (total transports)												
# of Transports	24	14	19	11	23	15	14	13	17	8	15	15
% Non-Secure	33%	36%	11%	27%	22%	47%	57%	46%	35%	38%	67%	47%
% Secure	67%	57%	89%	73%	74%	40%	43%	54%	65%	63%	33%	53%
% Metal	46%	50%	63%	73%	48%	20%	21%	31%	35%	13%	20%	27%
% Soft	21%	7%	26%	0%	26%	20%	21%	23%	29%	50%	13%	27%
Children Under 10 (total transports)												
# of Transports		-	-	-	-	-	5	1	0	2	1	1
% Non-Secure		-	-	-	-	-	80%	100%	-	100%	0%	100%
% Secure		-	-	-	-	-	20%	0%	-	0%	100%	0%
% Metal		-	-	-	-	-	0	0	0	0	1	0
% Soft		-	-	-	-	-	1	0	0	0	0	0
CRT Employment												
% Employed		**14%**			15%			**15%**			**16%**	
Wages per employed client		**$2,308**			$2,363			**$2,379**			$2,486	

Vermont Department of Mental Health System Snapshot (June 18, 2013)

Definitions

Inpatient Hospital	The hospitals designated by the Commissioner of Mental Health for involuntary psychiatric treatment: Brattleboro Retreat (BR), Central Vermont Medical Center (CVMC), Fletcher Allen Health Center (FAHC), Rutland Regional Medical Center (RRMC), Windham Center at Springfield Hospital (WC), and Green Mountain Psychiatric Care Center (GMPCC).
Designated Agency Crisis Bed	Emergency Services beds intended to provide crisis intervention, respite, or hospital diversion that are staffed by and under the supervision of a designated community mental health agency (DA). Prior to May 2013, census is measured from the average census reported per day for each crisis bed unit. Going forward, census will be measured from the highest census reported per day for each crisis bed unit.
Forensic	Forensic patients are designated when there is criminal justice involvement and when there are questions concerning competency/sanity of an individual being arraigned. A screening is requested by a community mental health agency pursuant to §4815 13 VSA.
Emergency Examination (EE)	An application for emergency examination has been completed for involuntarily admission (§7508 of 18 VSA) to a designated hospital for psychiatric treatment (danger to self or others) subsequent to an evaluation by community mental health agency screener & medical doctor.
Secure Transport	Transport via law enforcement utilizing either metal or soft restraints.
Non-Secure Transport	Transport not utilizing restraints; this can include plain clothed law enforcement, DA transport teams, or other means of transport such as family members.
VT Resident Suicides	Based on PRELIMINARY data from the Vital Statistics System maintained by Vermont Department of Health and Monthly Service Report (MSR) data provided by the Department of Mental Health (DMH). Cross-sector data analysis was conducted using LinkPlus, a probabilistic statistical linkage software developed by the CDC for linking records across databases. Suicide data is current as of March 5, 2013 and includes cases up to and including January 2013. MSR data includes services provided by community designated agencies for clients served by DAs within the year prior to death. Primary Program is defined as the primary program assignment on the client's last service with DMH. Monthly counts are subject to change as more information is made available.
Housing	Based on the number of applications approved, in the months the program has been operating and the total approved to date.

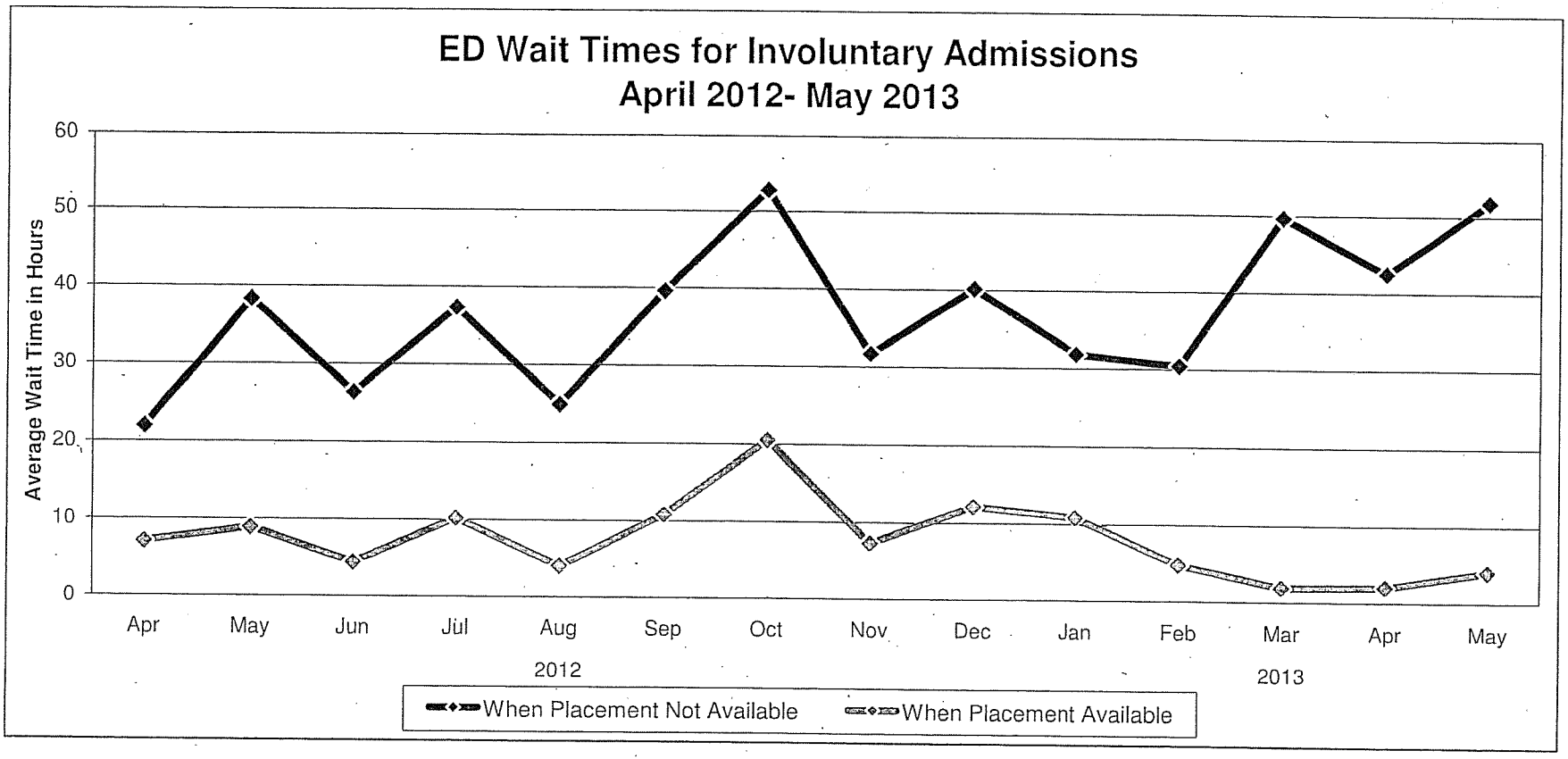
ED Wait Times for Involuntary Admissions
April 2012- May 2013



	2012									2013				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Average ED Wait Time	10.67	22.71	18	26	33.5	31.8	42.4	24.3	22.5	26	22.4	39.4	26.9	50.8
< 8 hrs	10	10	7	12	7	6	3	12	5	8	9	8	6	6
8 - 16 hrs	4	7	6	7	6	5	6	6	4	8	6	5	5	8
17 - 24 hrs	5	7	5	5	6	5	4	7	4	9	3	8	4	3
25 - 48 hrs	1	5	3	9	7	11	13	6	6	8	6	13	4	7
49 - 72 hrs	1	2	3	3	3	2	4	2	1	4	1	3	3	5
> 72 hrs	0	3	1	2	5	3	5	1	1	1	2	7	4	9

Analysis includes all EE/Warrants with notation of time in ED. This is complete time from when a client arrives at ED until departure.

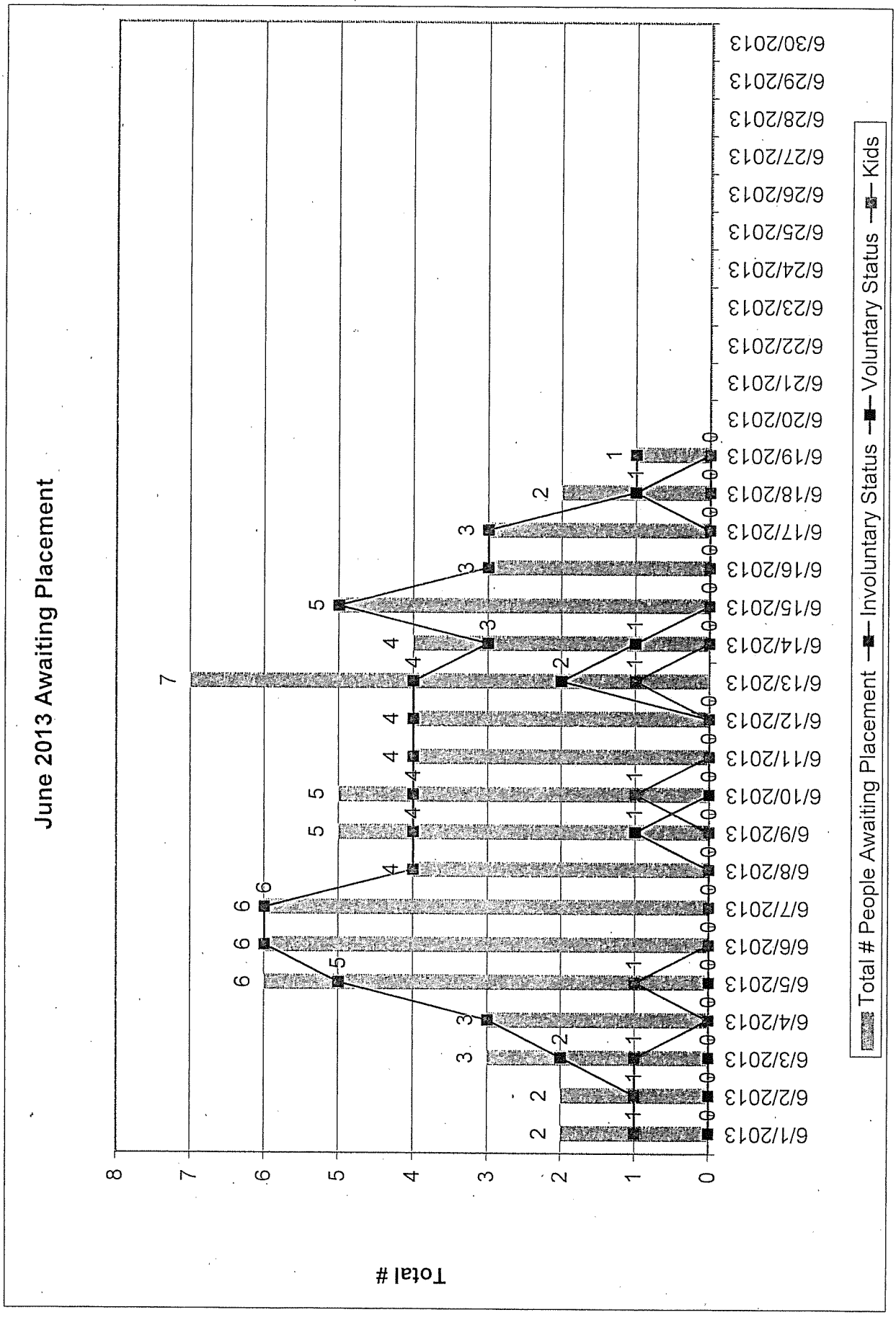
Attachment F



Wait Time in Hours	2012 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2013 Jan	Feb	Mar	Apr	May
Average ED Wait Time	11	23	18	26	34	32	42	24	23	26	22	39	27	51
When Placement Available	7	9	4	10	4	11	21	7	12	11	5	2	2	4
When Placement Not Available	22	38	26	37	25	40	53	32	40	32	31	50	43	52
When Placement Not Available (From time of no placement)	18	33	20	31	36	34	46	28	33	29	27	47	42	47
Maximum Wait Time	58	88	48	120	106	121	236	245	111	145	113	218	282	330
# Clients with Unavailable Placement	10	19	15	22	24	22	30	20	14	27	21	43	26	38

"When placement unavailable" includes all EE/Warrants with notation of time in ED and for whom placement was not immediately available. "When placement available" includes all EE/Warrants with notation of time in ED and for whom a placement was available at the time of first referral. Both times reflect complete time from when arrival at ED until departure. "When Placement Not Available (From time of no placement)" reflects time from placement deemed unavailable to until departure.

Attachment G


June 2013 Awaiting Placement
Total #
Total # People Awaiting Placement
Involuntary Status
Voluntary Status
Kids
6/1/2013
6/2/2013
6/3/2013
6/4/2013
6/5/2013
6/6/2013
6/7/2013
6/8/2013
6/9/2013
6/10/2013
6/11/2013
6/12/2013
6/13/2013
6/14/2013
6/15/2013
6/16/2013
6/17/2013
6/18/2013
6/19/2013
6/20/2013
6/21/2013
6/22/2013
6/23/2013
6/24/2013
6/25/2013
6/26/2013
6/27/2013
6/28/2013
6/29/2013
6/30/2013

Census Report - HOSPITAL BEDS OCCUPIED 4/1/2013~4/30/2013

Intensive Residential - (Adults 18+)

	HRR		Meadowview		Second Spring		State Avg	
Beds	8		6		22		36	
	Census	Daily %	Census	Daily %	Census	Daily %	Census	Daily %
4/1/2013	7	88%	6	100%	21	95%	34	94%
4/2/2013	7	88%	6	100%	21	95%	34	94%
4/3/2013	7	88%	6	100%	21	95%	34	94%
4/4/2013	7	88%	6	100%	22	100%	35	97%
4/5/2013	7	88%	6	100%	22	100%	35	97%
4/6/2013	7	88%			22	100%	29	81%
4/7/2013	7	88%	6	100%	22	100%	35	97%
4/8/2013	6	75%	6	100%	22	100%	34	94%
4/9/2013	6	75%	6	100%	22	100%	34	94%
4/10/2013	6	75%	6	100%	22	100%	34	94%
4/11/2013	6	75%	6	100%	22	100%	34	94%
4/12/2013	6	75%	6	100%	22	100%	34	94%
4/13/2013	7	88%			22	100%	29	81%
4/14/2013	7	88%	6	100%	22	100%	35	97%
4/15/2013	6	75%	6	100%	22	100%	34	94%
4/16/2013	6	75%	6	100%	22	100%	34	94%
4/17/2013	6	75%	6	100%	22	100%	34	94%
4/18/2013	6	75%	6	100%	22	100%	34	94%
4/19/2013	6	75%	6	100%	22	100%	34	94%
4/20/2013	6	75%			22	100%	28	78%
4/21/2013	6	75%			22	100%	28	78%
4/22/2013	6	75%	6	100%	22	100%	34	94%
4/23/2013	5	63%	6	100%	22	100%	33	92%
4/24/2013	5	63%	6	100%	22	100%	33	92%
4/25/2013	5	63%	6	100%	22	100%	33	92%
4/26/2013	5	63%	6	100%	22	100%	33	92%
4/27/2013	5	63%	6	100%	22	100%	33	92%
4/28/2013	5	63%	6	100%	22	100%	33	92%
4/29/2013	5	63%	6	100%	22	100%	33	92%
4/30/2013	5	63%	6	100%	22	100%	33	92%
Monthly Avg.	6.03		6.00		21.90		33.13	
Monthly % Occupancy	75.4%		100.0%		99.5%		92.0%	

Wednesday, June 19, 2013 11:50:58 AM

Census Report - HOSPITAL BEDS OCCUPIED 5/1/2013~5/31/2013

Intensive Residential - (Adults 18+)

	HRR		Meadowview		Second Spring		State Avg	
Beds	8		6		22		36	
	Census	Daily %	Census	Daily %	Census	Daily %	Census	Daily %
5/1/2013	5	63%	6	100%	22	100%	33	92%
5/2/2013	5	63%	6	100%	22	100%	33	92%
5/3/2013	5	63%	6	100%	20	91%	31	86%
5/4/2013	5	63%	6	100%	20	91%	31	86%
5/5/2013	4	50%	6	100%	20	91%	30	83%
5/6/2013	6	75%	6	100%	21	95%	33	92%
5/7/2013	6	75%	6	100%	21	95%	33	92%
5/8/2013	6	75%	6	100%	22	100%	34	94%
5/9/2013	6	75%	6	100%	22	100%	34	94%
5/10/2013	6	75%	6	100%	22	100%	34	94%
5/11/2013	6	75%	6	100%	22	100%	34	94%
5/12/2013	6	75%	6	100%	22	100%	34	94%
5/13/2013	6	75%	6	100%	22	100%	34	94%
5/14/2013	6	75%	6	100%	22	100%	34	94%
5/15/2013	7	88%	6	100%	22	100%	35	97%
5/16/2013	7	88%	6	100%	22	100%	35	97%
5/17/2013	7	88%	6	100%	22	100%	35	97%
5/18/2013	7	88%	6	100%	22	100%	35	97%
5/19/2013	7	88%	6	100%	22	100%	35	97%
5/20/2013	7	88%	6	100%	22	100%	35	97%
5/21/2013	7	88%	6	100%	22	100%	35	97%
5/22/2013	7	88%	6	100%	22	100%	35	97%
5/23/2013	7	88%	6	100%	22	100%	35	97%
5/24/2013	7	88%	6	100%	22	100%	35	97%
5/25/2013	7	88%	6	100%	22	100%	35	97%
5/26/2013	7	88%	6	100%	22	100%	35	97%
5/27/2013	7	88%	6	100%	22	100%	35	97%
5/28/2013	7	88%	6	100%	22	100%	35	97%
5/29/2013			6	100%	22	100%	28	78%
5/30/2013	7	88%	6	100%			13	36%
5/31/2013			6	100%	22	100%	28	78%
Monthly Avg.	6.31		6.00		21.73		32.94	

Monday, June 10, 2013 8:37:15 AM

Attachment I

Level 1 Inpatient Care
Length of Stay for Current Patients

Hospital	# Patients	Length of Stay in Days As of June 19, 2013 Minimum	Maximum	Mean	Median
BR	17	8	252	80	84
FAHC	9	12	98	47	41
RRMC	9	19	99	52	41
GMPCC	5	12	168	105	140
Statewide	**40**	**8**	**252**	**69**	**50**

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 the Brattleboro Retreat (BR), Fletcher Allen Medical Center (FAHC), Rutland Regional Medical Center (RRMC), and Green Mountain Psychiatric Care Center (GMPCC). Level 1 designation is reserved for patients with risk of imminent harm to self or others and requiring significant resources. Length of Stay is calculated from admission to date of report for clients still in inpatient care.

Act 79 Consultant report crosswalk to document

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.	Planned with the installation of the new Commissioner. This work is included in the Quality Management Unit plan.
2: The Department of Mental Health should develop a detailed ACT 79 implementation plan.	Established and updated regularly
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.	In progress. The Quality Management Unit is establishing dashboards for each area within the DMH. Currently, there is a monthly snapshot for significant measures pertinent to Act 79.
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.	Planned.
5: The Administration and Legislature should develop a communications strategy for sharing with the public the progress made to implement Act 79.	To be planned.
6: There should be an established single point of clinical responsibility and authority within the State's mental health system.	This role is the responsibility of the DMH Medical Director. An RFP was issued for clinical services for both the new state hospital and the DMH central office. In the interim, contracts are in place for a Children's Medical Director and DMH psychiatrist who is available for consultation to the care management team. Psychiatry services are in place for GMPCC and consultation is available as requested.

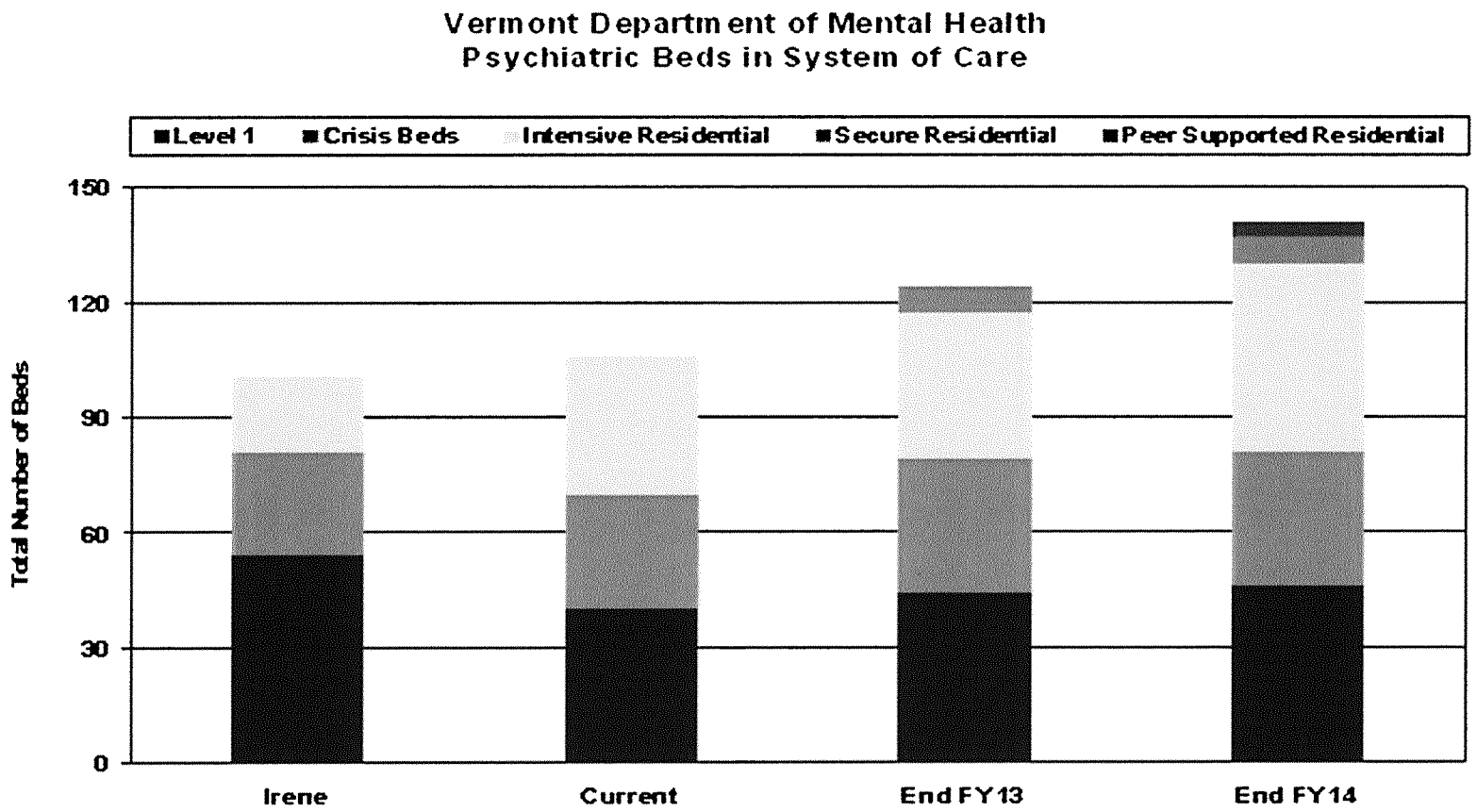
Attachment K

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.	In process. The Care Management Unit and the Research and Statistics Unit are exploring mechanisms to capture this data for analysis as it exists in multiple locations.
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.	In process. Contracts with DHs and the Master Grant with DAs includes performance measures and there is a plan to expand these. Incentive payment is under consideration.
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.	In process. The Care Management Unit is undergoing a review of activities and responsibilities. Recommendations from this review will include a comprehensive staff plan. A new care management director has been hired, as well as, a new Research and Statistics Chief. An additional Nurse Quality Management Coordinator has also been added to the QM Team.
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.	In process. See 9 above.
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.	In process. Plans to expand the scope of the Blueprint are underway. The development of the "Hub and Spoke" model for substance abuse treatment has started. DMH has created and hired a Health Care Liaison position whose responsbilities will be both monitoring and participating in

	reform activities and representing mental health as planning evolves.
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.	In process. Work with the DHs and DAs to define expectations continues. Minimum standards are currently being revised, and the DMH UR unit is actively involved in determining thresholds for level of care authorization.
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.	In process. Dashboard development is underway. Small incentive payments have been and will continue to be added to the Master Grant for DAs and other contracts
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.	In process. The new hospital is designed to meet current requirements and will operate under the 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.	In process. Workgroup meetings ongoing.
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.	Under consideration
17: Evaluate the clinical eligibility criteria and raise the cap on	In process.

Community Rehabilitation and Treatment (CRT) to accommodate increased need for CRT services.	
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.	In process.
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.	Complete. Included in DH contracts and enhanced funding for DAs.
20: The Department of Mental Health should expand jail diversion and crisis intervention teams available to work with local and state police.	Complete. Mobile crisis capability has been established across the state.
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.	In process.
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.	In process.
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.	Complete Quality Management Unit Director was hired in September 2012.
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.	The DMH Technical Assistance team is established and working with provider agencies in developing new programs for high need or complex individuals in the service system.

Psychiatric Beds in System of Care



BANK BED 4/20/13

Housing Subsidy & Care Program

January 1st, 2012 to June 19th, 2013

Agency	County	Client Count	Average LOS*
Another Way	Washington	3	266
Brattleboro Area Drop In Center	Windham	10	153
Clara Martin Center	Orange	2	124
Community Health Center of Burlington	Chittenden	10	63
Counseling Services of Addison County	Addison	13	183
Health Care and Rehabilitation Services	Windsor	9	144
HOPE	Addison	3	219
Howard Center Human Services	Chittenden	1	83
Lamoille County Mental Health	Lamoille	3	159
Northwest Counseling Support Services	Franklin	13	226
Pathways to Housing	Addison	11	99
Pathways to Housing	Chittenden	9	110
Pathways to Housing	Franklin	3	181
Pathways to Housing	Washington	10	244
Pathways to Housing	Windham	54	221
Pathways to Housing	Windsor	1	99
Rutland County Housing Coalition	Rutland	3	199
Rutland Mental Health Services	Rutland	4	242
United Counseling Services	Bennington	9	179
Total		171	
Total Unduplicated*		169	

* Two Clients have transferred between programs

Gender	Client Count
Female	83
Male	83
Unknown	4
Refused	1
Total	171
Total Unduplicated*	169

FRANK REED 6/20/13