

VERMONT2013

Reforming Vermont's Mental Health System **Report to the Legislature on the Implementation of Act 79**

January 15, 2013



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APPENDICES

Appendix A – Comments from Key Stakeholders

 Mr. Michael Sabourin, Patient Representative

 Mr. Jack McCullough, Vermont Legal Aid (Requested yet not received)

 Mr. Edward Paquin, Disability Rights Vermont (Requested yet not received)

Appendix B – Progress Towards the Implementation of Act 79

Appendix C – Consultant report crosswalk to document

Appendix D - NOMS (National Outcome Measures) Reporting

1. Commissioner's Opening Statement

This past year has brought tremendous challenge and opportunity to the Department of Mental Health (DMH) and its partners in service provision. The vision of DMH in the wake of Tropical Storm Irene, following the loss of 54 psychiatric beds at the Vermont State Hospital in August 2011, has been to develop sufficient capacity across a system of care. This report outlines activities that have occurred since the passage of Act 79 and provides a comprehensive plan for DMH to follow to continue towards full implementation. The data presented in this report does and will continue to inform decision-making on that system.

2. Executive Summary

DMH, with the Designated Hospitals (DHs) and Designated Agencies (DAs), believes in the potential of all individuals and the need for a continuum of care that is effective, efficient, and follows the Institute of Medicine's six aims of high-quality health care known as STEEPE: safe, timely, effective, efficient, patient-centered and equitable care.

A system of care begins with availability of strong community support for people with mental health needs in the most integrated and least restrictive setting available. Act 79, passed by the 2012 Vermont Legislature, moved to strengthen a well-respected community mental health system, bolstering supports and filling gaps to assist people living and receiving treatment in their communities. This includes a newly created capacity of case management services for designated agency outpatient clients and emergency outreach services in every community.

Peer support programs have expanded to include the development of a 24/7 warm line, outreach services, and crisis beds. Peers are also working within some designated agencies to provide supports to patients awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services.

Crisis services acts as the gatekeeper for crisis beds and hospital beds for psychiatric care throughout the state. Working closely with police is essential to this process. A statewide interdisciplinary training program between police and mobile crisis responders is about to enter the second phase of its development.

A variety of housing options has expanded, particularly for individuals most vulnerable upon discharge from the hospital. These options include transitional beds through intensive residential recovery programs, of which 18 more beds will come on line by March 2012. Supportive housing units have also developed to assist people in individual apartments with on-site supports. Specific wraparound programs have increased for high-needs mental health clients, with an eye on investment in recovery. These wraparound and supportive apartment programs target high utilizers of inpatient hospitalization. The programs have experienced a high success rate of assisting individuals to maintain stability within a community setting. It is notable that nearly all patients who were in the Vermont State Hospital (VSH) at the time of the flood now have appropriately matched housing and supports within the community.

Crisis bed programs have grown from 27 beds to 35 beds and are an excellent resource for hospital step-down and hospital diversion at a daily average of 50-75% lower cost than hospitals.

It is expected that we will see a significant increase in usage as these beds expand from a regional to a statewide resource.

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 enhanced services has been developed based on real, actual costs. Expansion and strengthening of this system is underway and will be in place within the first quarter of 2013. This now includes the Green Mountain Psychiatric Care Center (GMPCC), a new 8-bed state-operated psychiatric unit in Morrisville, Vermont.

The newly developed DMH care management system has become the driver for the entire system of care, assisting crisis services teams and providers to triage individuals into programs for admission, as well as directing individuals to step-down programs, transitional housing programs, and supportive housing units when they return to the community. To accomplish this task, the team works closely with hospitals, holding weekly clinical team meetings regarding patient status and discharge planning, creating a bridge to community programming with referral to additional technical supports, if necessary. Acting as a managed care organization in partnership with the Department of Vermont Health Access (DVHA), a segment of the team performs utilization review for Community Rehabilitation and Treatment (CRT) clients and designated agency Adult Outpatient (AOP) clients receiving Medicaid benefits who are hospitalized.

A key effort of DMH has been the re-establishment of the Quality Management Unit that now includes care management and utilization review functions. The Director of Quality Management began her work in late August. A Quality Council has been defined and will be established in January 2013 to oversee the quality functions within the Department and across the system of care.

DMH technical support team consists of two psychologists, one psychiatrist, and a nurse care manager and has consulted on nearly 200 cases this past year for individuals who need extensive mental health and substance abuse supports. The team also provides direct outreach to a small group of home providers on a regular basis to maintain newly developed wraparound programs.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through DMH at two statewide conferences, the new DMH Coop for Workforce Development and Practice Improvement is getting underway through a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and will be accessible to the entire state provider community.

Most of this work has been accomplished within the past 8 months. Policy and program development thus far exemplifies the partnerships that have been forged between DMH, other state departments, and public and private providers. DMH has heeded the advice of our consultants, Behavioral Health Policy Collaborative, in choosing to concentrate on specific program development that we felt would move the system forward. This approach allows us to evaluate areas that need strengthening as well as to identify clear gaps within the system. DMH Leadership Team works closely with all units within DMH on program evaluation and future planning based on recognizable gaps, stresses, capacity issues, and successes within the system

structure. Highlights on these issues are outlined in the “Planning for the Future” section of this report.

Current and future work includes stakeholder involvement. Throughout this past year, change processes have been transparently reported to stakeholders through various communication and input forums. DMH produces a general update weekly that provides current progress reports and identifies upcoming open public and planning meetings for different initiatives that are underway. Workgroups for a new state-run hospital, an interim hospital in Morrisville, a secure residential program, clinical resources management, and emergency involuntary procedures have met and given guidance to planning and policy efforts. DMH provides monthly updates and a discussion forum via the Transformation Council and the State Program Standing Committees for Adult Mental Health and for the Child, Adolescent, and Family Unit (CAFU). DMH sponsored conferences to bring together the mental health community and law enforcement providers, as well as innovative treatment approaches like “Open Dialogue” for consumers and the mental health treatment community. DMH also sponsored periodic Vermont Interactive Television progress updates and discussions that have been open to community providers, advocacy organizations, and consumers for feedback on the Department’s current activities and future direction. Annually, the Mental Health Block Grant Planning Council brings together multiple stakeholders to provide input on the distribution of federal mental health dollars to various state initiatives for adults with severe mental illness and for children and adolescents experiencing a serious emotional disturbance and their families.

Continuation of input from advisory groups has also been required in each of the hospital renovations contracts. These efforts have maximized input opportunities during this period of rapid progress and change to the State’s publicly funded mental health system of care.

The “Planning for the Future” section of this document outlines the path to move forward. DMH realizes that many of the new programs put into place have been recent, and careful monitoring of results will be needed to assure that we fully realize the goals of program enhancement. DMH looks to the legislature, stakeholders, and their colleagues in the DHs and DAs to continue to work together towards improving care and the quality of life for adults with severe mental illness.

3. The Mental Health System of Care

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. Clinical responsibility for care is held by the Commissioner as delegated to the DMH Medical Director and providers. Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to 10 Designated Agencies (DAs) and one Specialized Service Agency (SSA) located across the state of Vermont for the provision of Community Rehabilitation and Treatment services (CRT) for adults with severe mental illness; Adult Outpatients (AOP), adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions; Crisis Services, for anyone, regardless of age, in a mental-health crisis; and Children’s Services for children and adolescents with SED and their families. DMH also contracts with several peer and family-run

organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the DA in their catchment area.

Prior to Tropical Storm Irene, DMH was also responsible for operating the Vermont State Hospital (VSH), which provided for up to 54 patients, most of whom were involuntarily admitted, in need of acute psychiatric care. The VSH was closed following the serious damage incurred by the State Office Complex in Waterbury during Tropical Storm Irene in August of 2011. Since the closure of VSH, inpatient psychiatric care has been delivered through a decentralized system of DHs across the state. In many cases, treatment can be provided closer to patients' homes.

Patients experiencing the most severe symptoms are being treated at the Brattleboro Retreat (BR), Rutland Regional Medical Center (RRMC) and Fletcher Allen Health Care (FAHC). These higher-acuity patients are identified as Level I patients, or those individuals who would have been treated at VSH in the past. The acuity of these patients is generally marked by significant danger to themselves or others, manifestation of behaviors that are highly disruptive to the treatment milieu and require significant resources and management, or significant personal vulnerabilities in the areas of self-care and protection, thus placing them at substantially higher risk. Level I patients generally require significantly more staff time and hospital resources to meet their unique clinical needs.

The BR, RRMC, Central Vermont Medical Center (CVMC), the Windham Center (WC) and FAHC have provided inpatient psychiatric care to both voluntary and involuntary hospital placements. Local hospitals throughout the state provide screening and limited interim treatment until admission to a psychiatric placement can be facilitated. The BR, RRMC, Central Vermont Medical Center (CVMC), the Windham Center (WC) and FAHC have provided inpatient psychiatric care to both voluntary and involuntary hospital patients. Local hospitals throughout the state provide screening and emergency care until admission to a psychiatric placement can be facilitated. As part of "decentralizing high intensity inpatient mental health care"¹, DMH is also working to preserve the rights afforded to patients who would have been involuntarily hospitalized at the Vermont State Hospital. While we have not identified the need for any statutory changes, we are undertaking the following steps to help ensure that patients at designated hospitals and the secure residential recovery facility are afforded the same rights:

- DMH has initiated a rulemaking process to establish standards that meet or exceed standards set by the Centers for Medicare and Medicaid Services and the Joint Commission for the use and reporting of the emergency involuntary procedures. Within the proposed standards, emergency seclusion or restraint on individuals under the care and custody of the commissioner require that personnel performing emergency involuntary procedures receive training and certification on the use of these procedures. DMH has worked with designated hospitals and advocates to develop draft standards over the past several months. DMH will be bringing the draft standards to Vermont's Interagency Committee on Administrative Rules (ICAR) in mid-January.
- DMH is working with the Department of Disability, Aging and Independent Living (DAAIL) and relevant stakeholders to revise the state regulations for Therapeutic Community Residences (TCR) to ensure that facility will be afforded the same rights as individuals receiving involuntary treatment at the Vermont State Hospital.

¹ <http://www.leg.state.vt.us/docs/2012/Acts/ACT079sum.htm>

- DMH is contracting with Vermont Psychiatric Survivors (VPS) to hire an additional .5 FTE Patient Representative to meet with individuals at designated hospitals, the secure residential recovery program, and the intensive residential recovery programs, advocate for those patients, and foster communication between patients and health care providers.

Under Act 79, DMH has been working to strengthen Vermont's existing mental health care system by “providing a continuum of flexible and recovery-oriented treatment opportunities, which are fully integrated with substance abuse, public health, and health care reform initiatives, consistent with the goals of parity.”² This work has included the development of enhanced community, crisis, residential, housing and inpatient treatment and support capacity. Specific enhancements include:

- Increased capacity within CRT and peer programs to provide community support, outreach, and crisis response
- Development of case management services for Adult Outpatient programs
- Increased capacity to provide mobile crisis response
- Development of additional intensive residential and crisis beds for hospital diversion and step-down
- Additional supports to assist individuals in finding and keeping stable housing
- Additional inpatient psychiatric beds at the Brattleboro Retreat and Rutland Regional Medical Center
- Development of a temporary eight-bed inpatient hospital
- Development of a secure residential recovery (SRR) program

In addition, DMH has established a clinical resource management system to “coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system.”² This system includes the following functions:

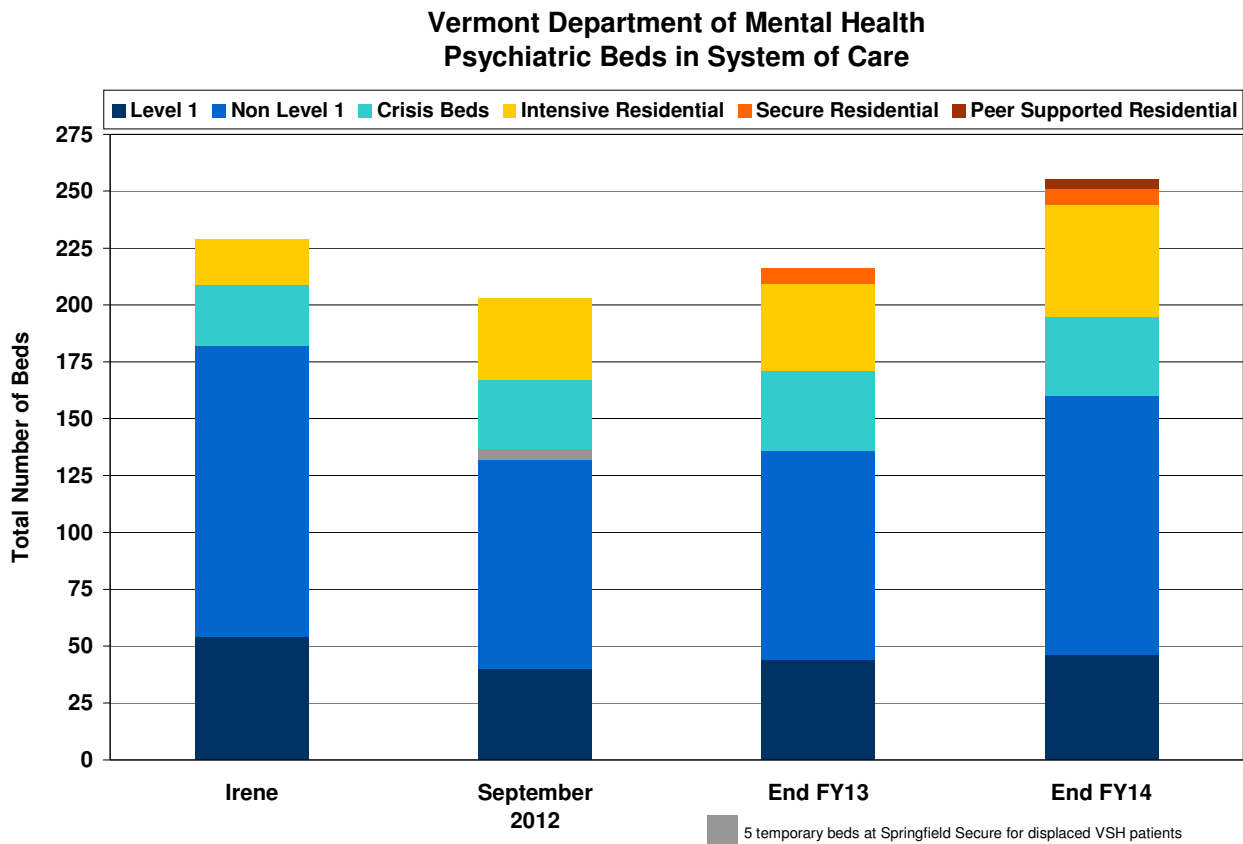
- Assistance to crisis services clinicians in the field from care coordinators on DMH central office staff,
- An electronic bed board to track available bed space
- Coordination of patient transport services
- Acting as a bridging team from hospital inpatient to community on discharge planning
- Review and approval of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress

The remainder of this report will provide more in-depth information about utilization, capacity, and outcomes of these programs within the Adult Mental Health System of Care.

² <http://www.leg.state.vt.us/docs/2012/Acts/ACT079sum.htm>

Current Utilization:

Chart One: Psychiatric Beds in the System of Care



The change in inpatient beds with the closing of VSH was sudden and required forming new relationships with DHs. DHs accepted and treated individuals entering treatment through both voluntary and involuntary hospitalization prior to Irene, and continue to do so. Following Irene, however, DHs also accepted the most acute involuntary, distressed individuals who had been previously treated primarily at VSH. These individuals are currently identified as Level I and are served primarily at the Brattleboro Retreat and Rutland Regional Medical Center, and at a lesser level, Fletcher Allen Health Care. DMH has contracted with these three hospitals for improved Level I treatment capacity. Contracts with Brattleboro Retreat and Rutland Regional Medical Center include additional physical and programmatic modifications to address the needs of this population. All DHs will continue to accept involuntary hospital admissions and operate additional psychiatric beds for patients who are not identified as Level I.

The Green Mountain Psychiatric Care Center (GMPCC), which opened on January 2, 2013, provides 8 psychiatric hospital beds to assist in bridging the gap to opening a 25 bed inpatient facility in Berlin, projected to open in 2014. The total number of inpatient beds in a state-operated psychiatric hospital will not return to the previous level, as expanded residential and outpatient services will allow a shift in care to more services in less restrictive settings.

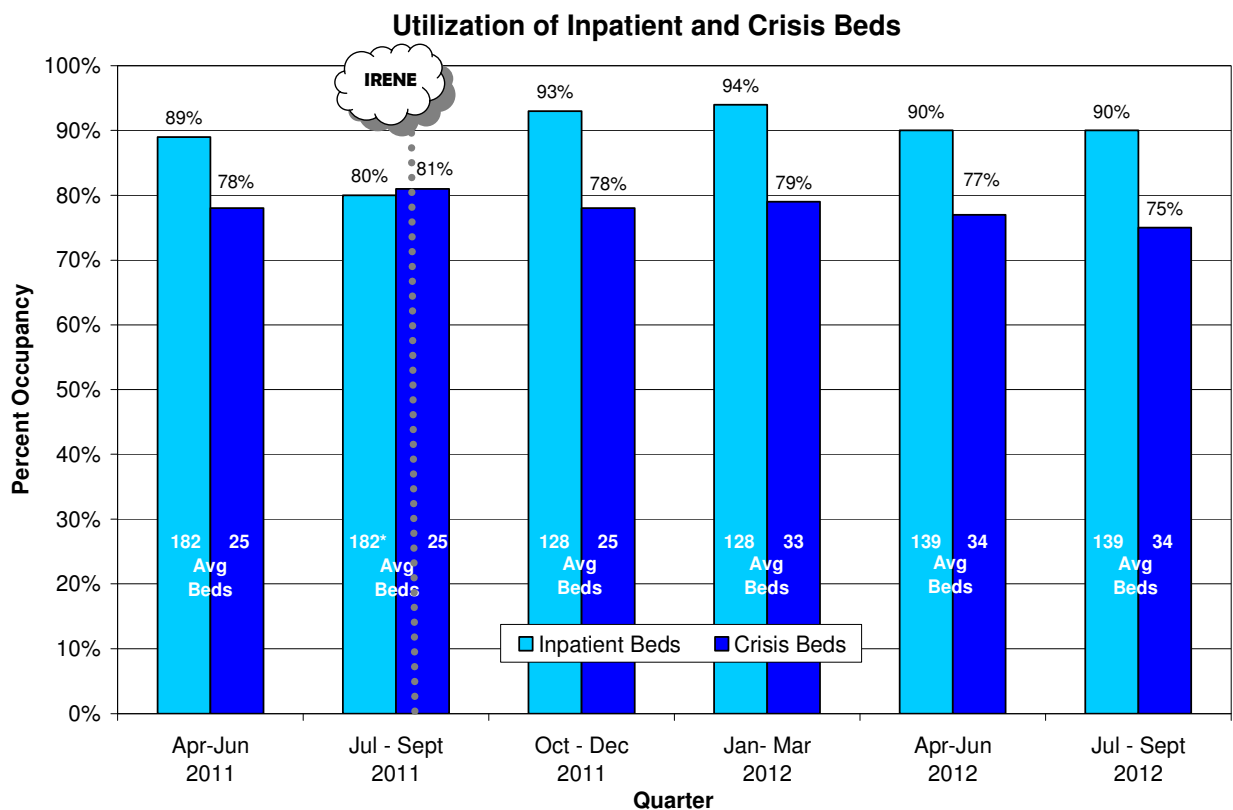
A few high-risk individuals at VSH at the time of Irene could not be served either at another hospital or in the community following the closing. These few individuals were served in a temporary placement, through Emergency Executive Order and hospital license and under full

custody of the Commissioner of Mental Health, within the Charlie Unit of the Springfield Correctional Facility until appropriate community placements could be developed. These temporary beds were closed in October 2012. A 7 bed transitional Secure Residential Facility will serve high risk individuals and is scheduled to open in Middlesex in March 2013.

Crisis and intensive transitional residential beds have increased since Irene, and there are plans for additional beds within the next two years. Additional funding supported expansion of crisis beds for hospital diversion and step-down care; these beds are now available at all 10 Designated Agencies. Increased funding also allowed expansion of 8 temporary intensive residential beds at Second Spring due to increased demand post-Irene and before the opening of a new intensive transitional residential facility, Hilltop House, in Westminster.

The number of peer-supported residential beds will also increase over the next 2 years. Alyssum currently has 2 peer-supported crisis/respite beds; increased funding will support expansion of that program and development of a peer-operated program for individuals experiencing first-break psychosis.

Chart Two: Percent Utilization of Inpatient and Crisis Beds



* Following Tropical Storm Irene (end of August) the average number of inpatient beds dropped to 128.

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.

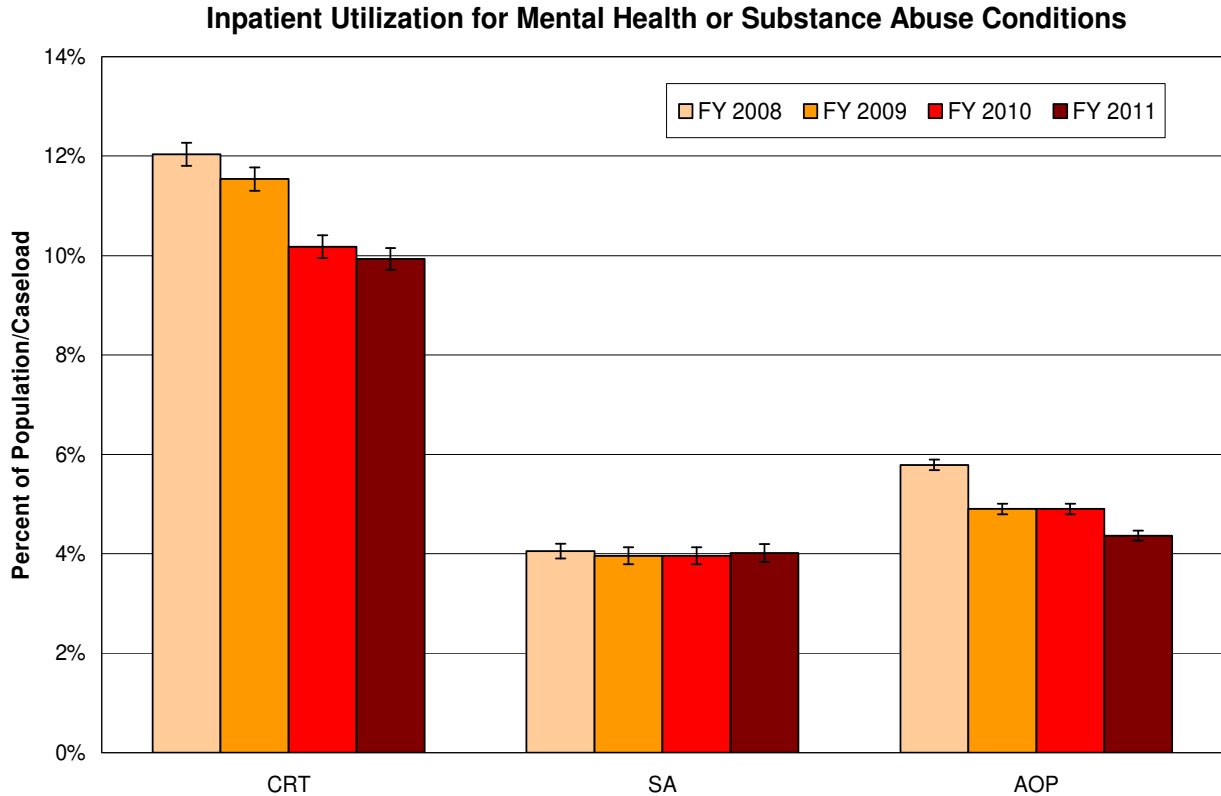
Inpatient Care

Contracts for facility renovations at the Brattleboro Retreat and RRMC will add 20 acute inpatient psychiatric beds to the current inpatient system of care, (which now also includes an additional 8 beds at GMPCC). The renovations, scheduled for completion this spring, will provide an environment of care that will fully support no-refusal beds for the highest acuity patients requiring inpatient treatment.

Timely movement from the inpatient setting to the community is also being achieved through investments in community crisis bed programs providing capacity to step-down patients, who may still require intensive supports from hospital care, or to divert patients from hospital care if intensive support is readily available in a less-restrictive setting.

An electronic bed board was established in August 2012 as a means to track availability of inpatient and crisis bed capacity for placement of patients in need of treatment. The new system replaced the previous daily bed tracking system operated by the DMH Acute Care Team. 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 meet 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.

Chart Three: Inpatient Utilization for Mental Health or Substance Abuse Conditions



Analysis based on the Uniform Hospital Discharge Dataset maintained by the VT Department of Health and Monthly Service Report data maintained by the VT Department of Mental Health. Includes adult (age 18 and over) Vermont residents with inpatient admissions for psychological health or substance abuse conditions in Vermont hospitals during FY2008-2011 and includes adult Designated Agency clients served during FY2008-2011. Adult general population rates based on 2008-2011 Vermont Department of Health Estimates. Because data sets used in this analysis do not share unique person identifiers, Probabilistic Population Estimation was used to measure caseload size and overlap (with 95% confidence intervals).

The chart depicts hospitalization of individuals across all three programs for clients served by DAs and compares the number of persons hospitalized to the total population of Vermonters. Based on this study, the average number of CRT clients who were hospitalized was fairly consistent across the time period at approximately 11%. The trend shows a decrease over the 4-year period. Hospitalization for this population is significantly higher than for the general population, however, and may illustrate appropriate use of inpatient psychiatric beds for those who are most likely to be in need of this level of care. CRT programs are designed to work with a population of adults who have serious, chronic mental illness. The table below provides perspective about the actual numbers of persons needing involuntary admissions to psychiatric hospital beds.

Chart Four: Involuntary Admissions

Reporting Period	Total # Involuntary Admissions	Unduplicated persons	# CRT	% CRT	# Non-CRT	% Non-CRT
04/2011-06/2011	127	112	38	34%	74	66%
07/2011-09/2011	135	101	32	32%	69	68%
10/2011-12/2011	105	89	31	35%	58	65%
01/2012-03/2012	111	92	32	35%	60	65%
04/2012-06/2012	99	94	37	39%	57	61%
07/2012-09/2012	106	98	43	44%	55	56%

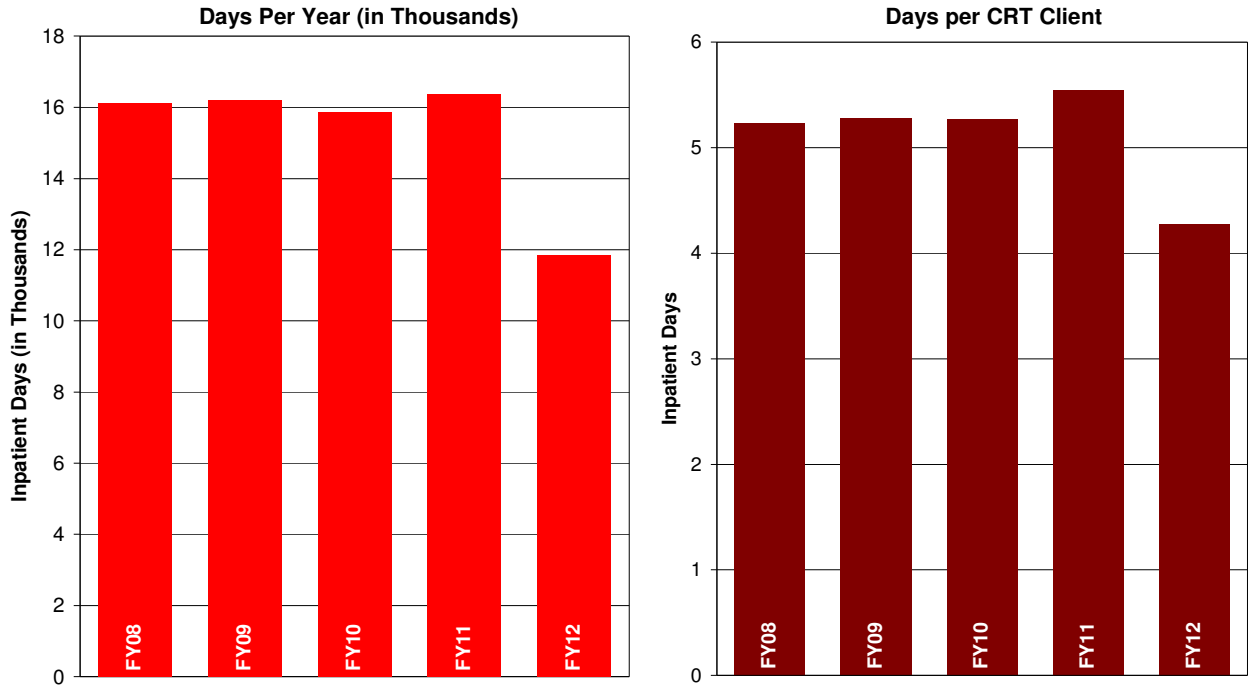
The actual number of CRT clients who were hospitalized for the 15- month period represented an average of 36.5 % of the total involuntary admissions. The range for non-CRT clients admitted to inpatient hospitalization was 63.5%. This illustrates that the majority of involuntary admissions was non-CRT clients.

DAs also provide services to individuals not meeting criteria for CRT; these include Adult Outpatients, Children and Family Services and Crisis Services. Adult Outpatient (AOP) clients were hospitalized at an average of 5%, with a slight decrease over the time period from 6% to 4%. Compared with the general population percentage of 0.4%, this figure is a 4.6% increase. For Substance Abuse clients, the rate of hospitalization was a constant 4%, or 3.6% above the general population rates.

There may be multiple reasons for the decrease in inpatient volume, including the change in available beds with the closing of VSH, the increase in community-based services that may be diverting people from hospital levels of care, and changing populations being served in Adult Outpatient programs. Further study is warranted to understand and support strategies for continuing to enhance our system of care to minimize use of hospitalization and, when needed, the length of stay for stabilization.

Chart Five: Inpatient Utilization by CRT Programs Statewide Over Time

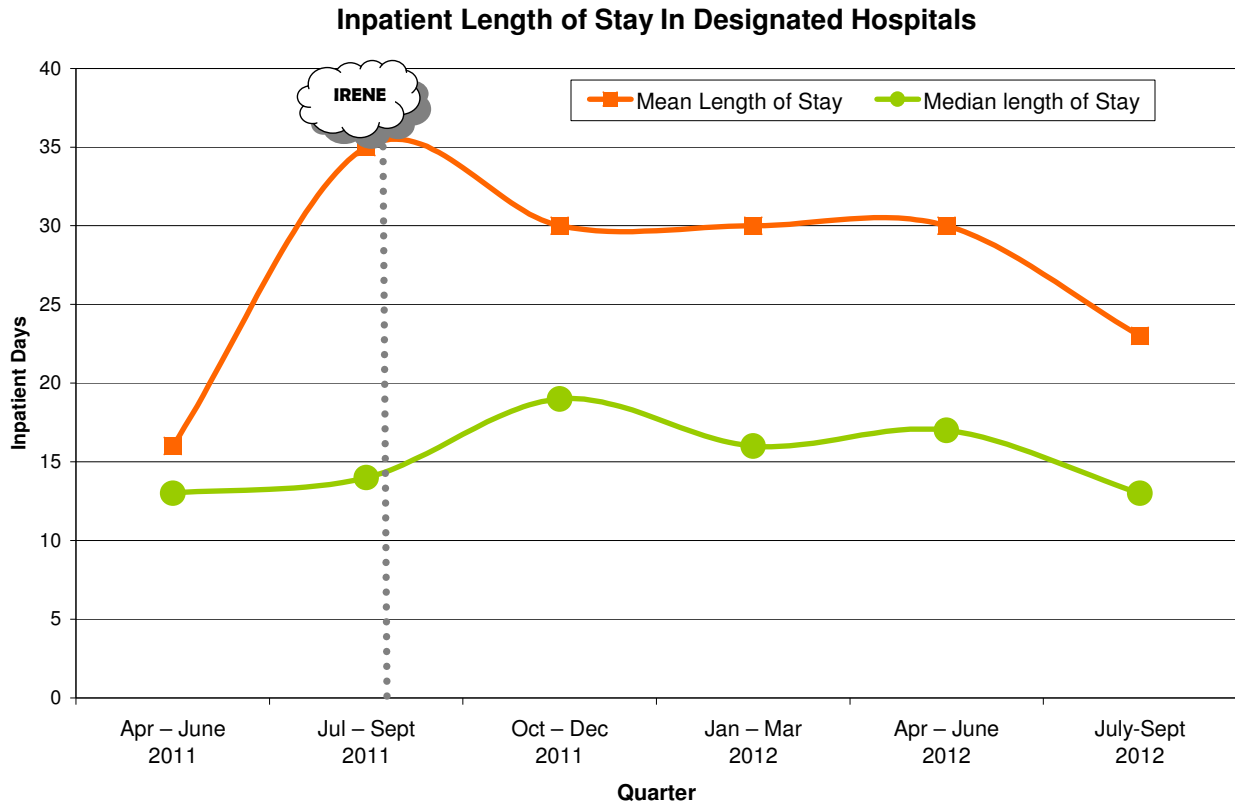
Inpatient Psychiatric Utilization by CRT Programs Statwide: FY2007-FY2012



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 2006 through June 2012. 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 rate of CRT inpatient utilization was stable from FY08 through FY11 and then fell sharply in FY12, representing both a decrease in days per year and per client, to an average of less than 5 days. The decrease in utilization was likely due to the expansion in options available in the outpatient arena including intensive residential and crisis beds as well as improved outpatient community services.

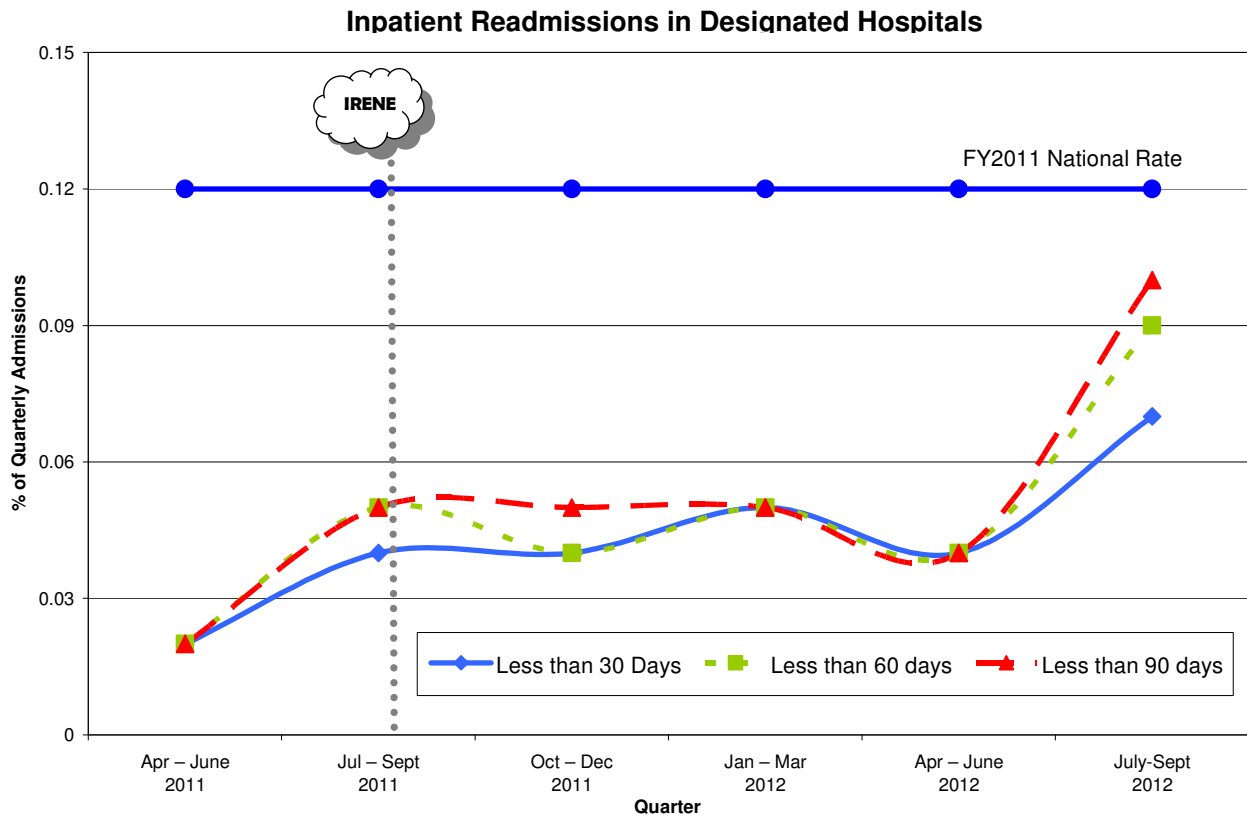
Chart Six: Inpatient Length of Stay in Designated Hospitals



Based on analysis of the involuntary inpatient data set maintained by the Vermont Department of Mental Health for adult patients admitted to involuntary care at Designated Hospitals.

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 decreased LOS figures.

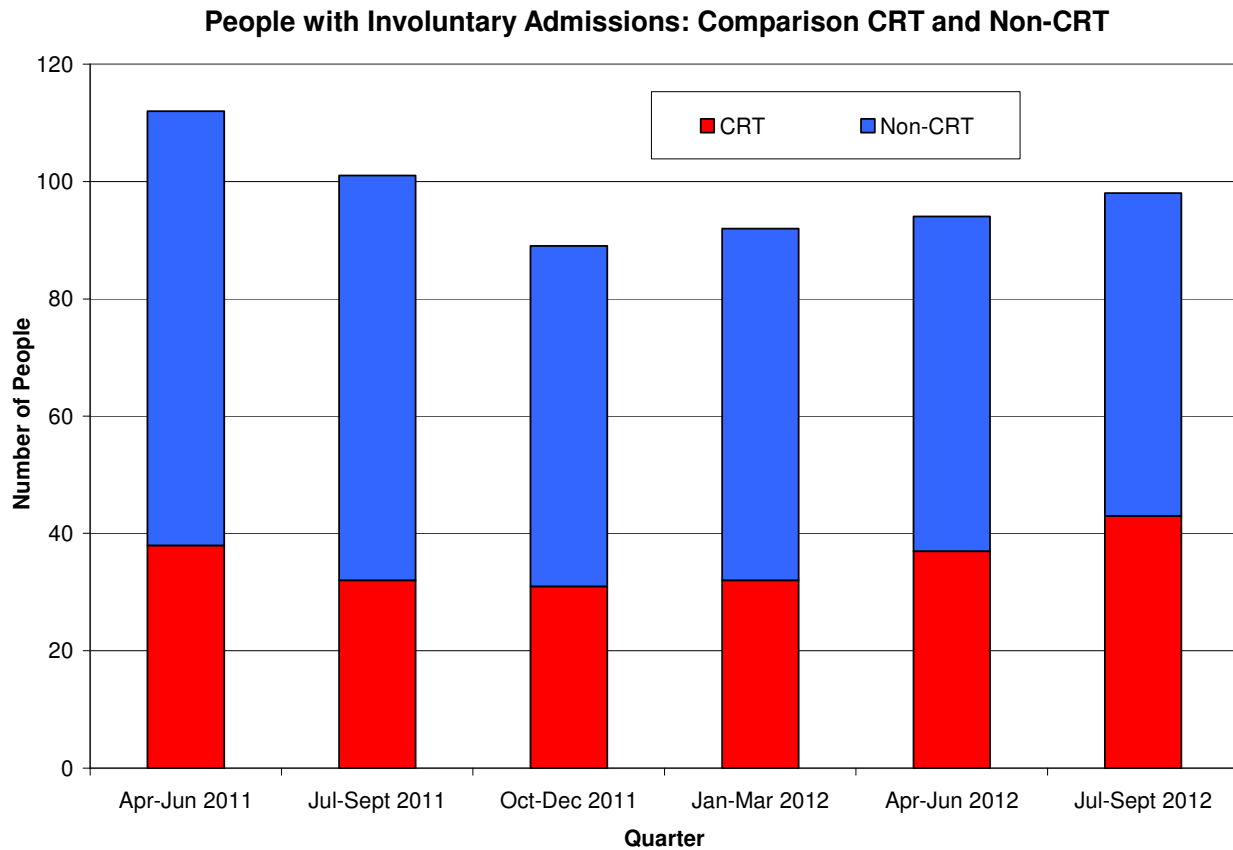
Chart Seven: Inpatient Readmissions in Designated Hospitals



Based on analysis of the involuntary inpatient data set maintained by the Vermont Department of Mental Health for adult patients admitted to involuntary care at Designated Hospitals.

Review of readmission rates shows an increase for all three time periods reviewed. As there can be multiple contributing factors to this trend, and it is of note that while the length of stay has decreased in general, the readmission rates for the periods reported have raised sharply from 2% to 10%. Still, these rates are 2% lower than the average national rate noted in the National Outcome Measures (NOMS). It may be that the increased readmission rates in part reflect the loss of VSH capacity to treat the Level I population: high-need/high-risk clients often require more intensive and more frequent hospital admissions to be stabilized. DMH will initiate a process to review these trends in order to identify specific factors and develop a plan to reverse the increase in readmission rates.

Chart Eight: Involuntary Admissions Comparison of Total Number and CRT Clients

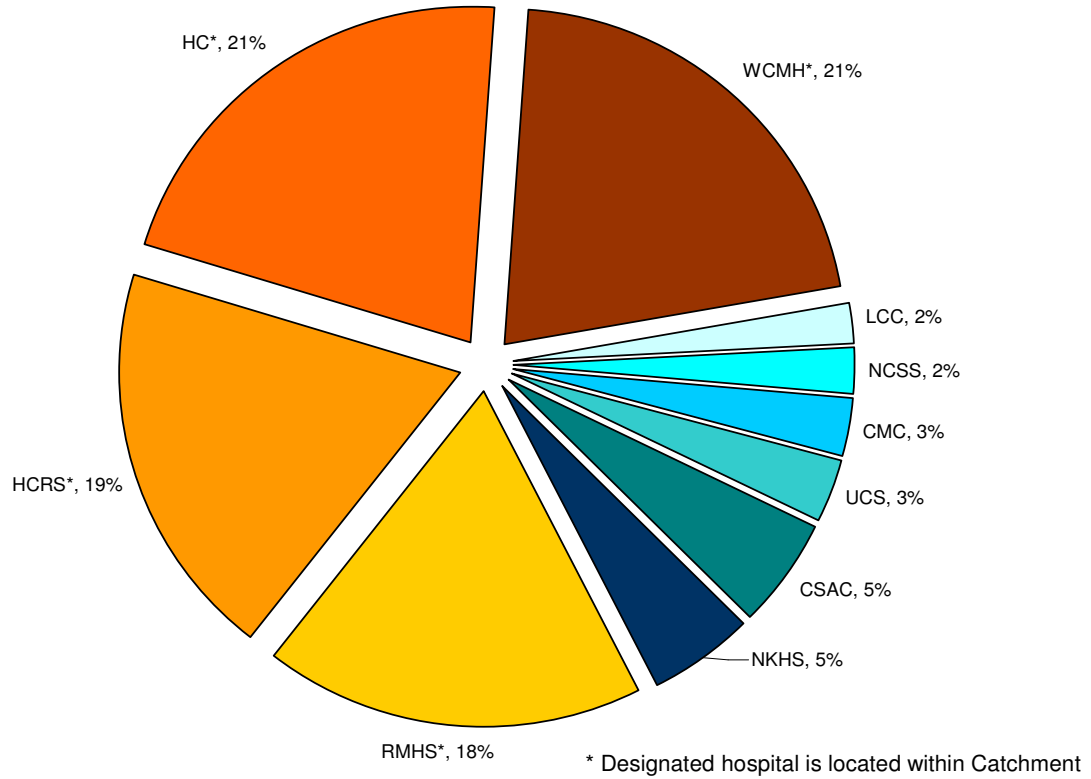


The number of involuntary applications for emergency examinations (admissions) was at its highest in the 3rd quarter of FY13 at 129, approximately the same number as the prior year's 3rd quarter. Given the reduction in capacity of inpatient psychiatric beds and their geographic placements in different parts of the state, the system of care continues to manage the challenge of access for those in need of inpatient psychiatric care. Of the total number of admissions for the 3rd quarter of FY13, the percentage of patients who were CRT clients was 25%, slightly below the average rate of involuntary hospitalization for the population. The highest rate of hospitalization for CRT patients occurred in the third quarter of FY12. It could be hypothesized that this may be a reflection of the aftermath of the closure of Vermont State Hospital and the impact of Tropical Storm Irene on individual communities affecting the life circumstances of their residents with mental health needs. The overall trend is for the inpatient admissions to be somewhat variable, with some quarters notably higher in non-CRT admissions. This may be due to the level of services provided to those who are known to the mental health system.

It is also interesting to note that a number of emergency examinations may be written but not acted upon because the patient achieves stabilization following the initial crisis through interventions that occur during the examination process. This is a relatively small percentage of the number of emergency examinations, however. Between the months of April and June of 2012, 14 individuals were effectively supported in alternative environments and diverted from hospitalization.

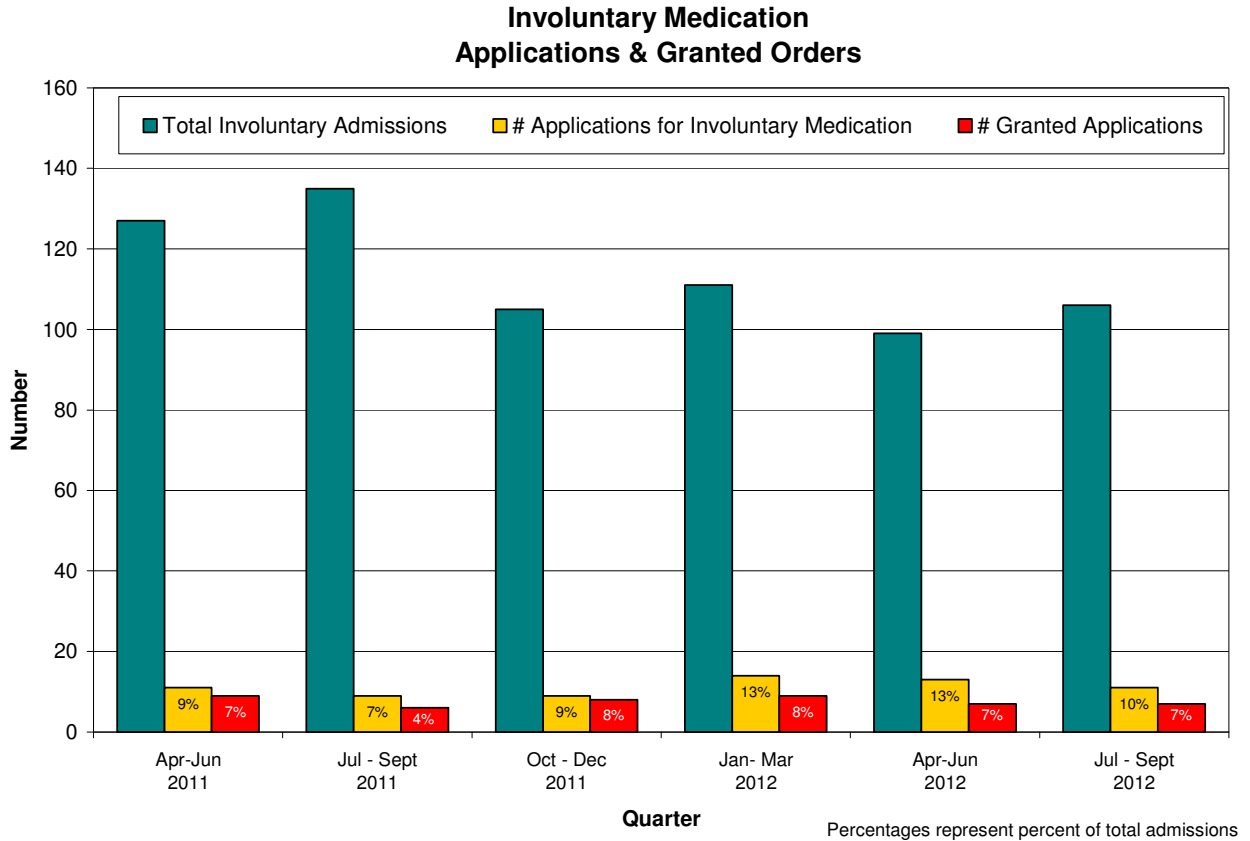
Chart Nine: Involuntary Admissions by Catchment Area of Residence

% of All Involuntary Admissions by Catchment Area of Residence



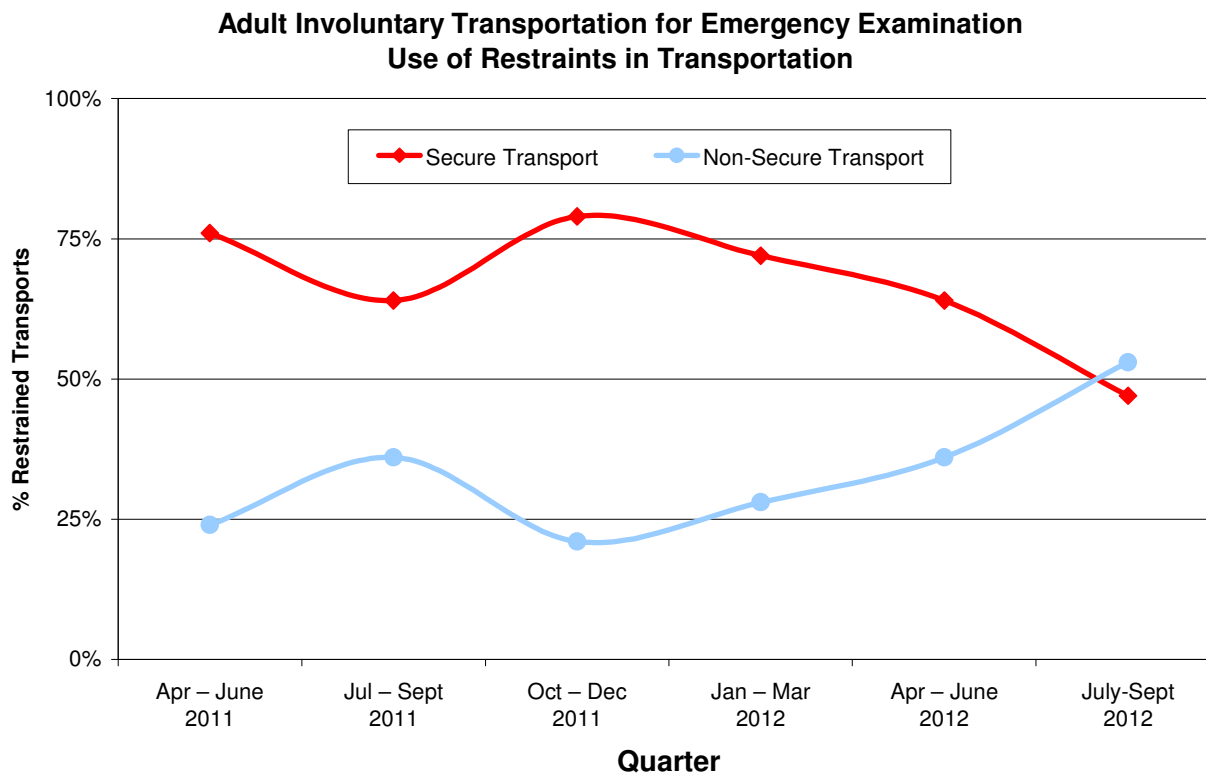
This chart provides information on the location of individuals who are admitted to the inpatient setting. As expected, larger agencies have a greater number of admissions as they are treating more individuals.

Chart Ten: Involuntary Medications



The definition of involuntary medication for a patient requires that the individual meet criteria for the presence of a mental illness and clear evidence of being in need of treatment in accordance with V.S.A. Title 18 §7624-7627. Involuntary medication in a non-emergency situation may be administered to an involuntarily admitted person only through a court order. If a treating physician feels it is necessary, formal requests are made to the court. While the number of involuntary medication applications shows a slight increase following the closure of VSH, the percentage of applications granted remains relatively unchanged for the total emergency examination admissions. The number of involuntary medication applications may reflect the upsurge of higher-acuity patients and efforts by the DHs to manage their hospital’s treatment environment and to secure timely treatment options for complex patients admitted to their units. The number of individuals requiring involuntary medication, however, remains a small percentage of those subject to an EE. This relatively stable trend may be directly related to an increase in consultation services provided by clinical staff at DMH to the hospitals undertaking these new responsibilities.

Transportation



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.

Chart Eleven: Use of Restraints in Adult Involuntary Transport

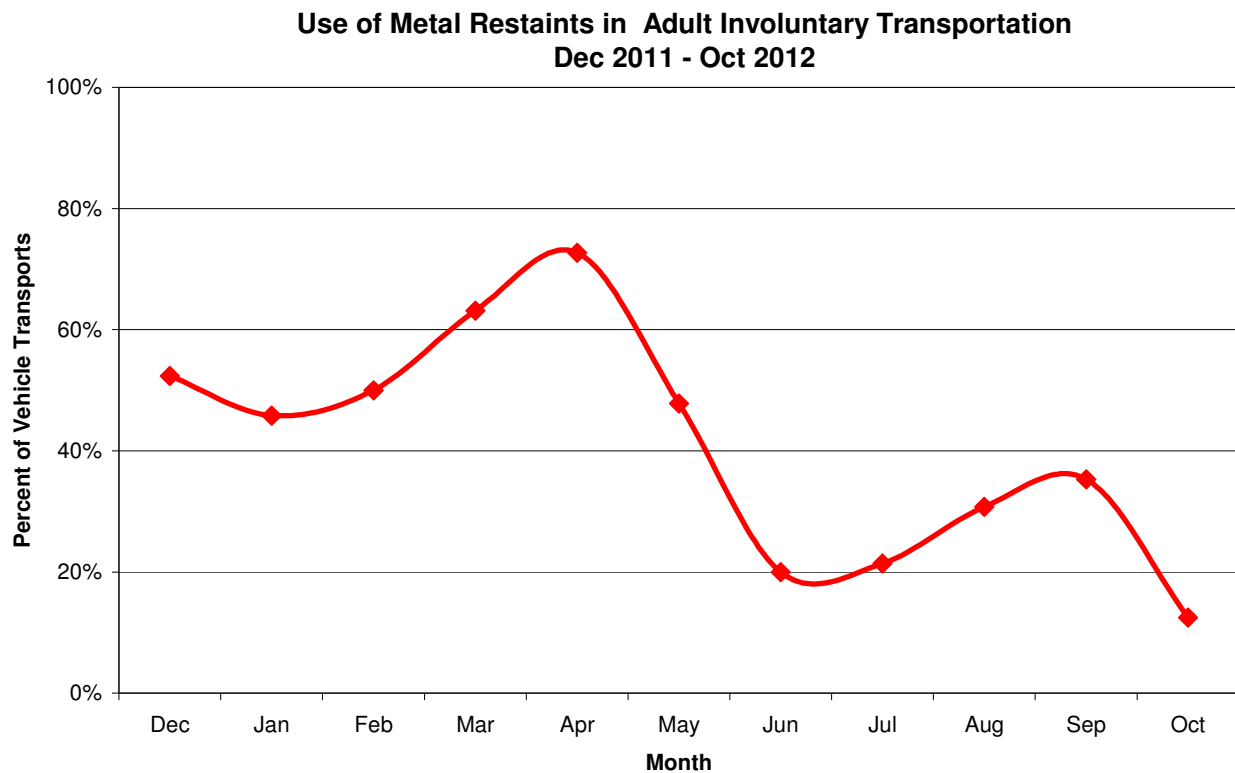
Since April 2012, DMH has developed an aggressive implementation plan for changing the manner in which individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. This plan is in response to Act 180 relative to transportation of people who are found to need involuntary psychiatric hospitalization and is directly connected to reduction in trauma for the patient in transport. The steps include:

- Development of a Transportation Work Group to outline the issues, to establish and support a plan, and to provide input on definitions, data collection, and training
- Development of a transportation protocol
- Examination of transport practice patterns throughout the state by sheriffs and ambulance
- Promotion of a policy for utilization of soft restraints in transport when restraints are necessary
- Delivery of training for sheriffs regarding “Building Rapport with People in Mental Health Crisis” and “Safe Transport Strategies”

- Support of a pilot program with sheriffs in Lamoille County using a least-restrictive approach by deputies in plain clothes with unmarked van. Progression to some type of restraint is utilized only when a no-restraint approach fails

Over the past 3 years, secure transport has been defined as utilization of restraints, either soft or metal. This same definition was agreed upon by the work group. For reporting in future years, however, the data will reflect: type of vehicle; type of restraint (if any); and transportation entity. A separate detailed legislative report on Involuntary Transport has been written on January 15th, 2012 and will be available on DMH’s website (mentalhealth.vermont.gov).

Chart Twelve: Use of Metal Restraints in Adult Involuntary Transport



Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner.

DMH approach to this initiative has proven to be effective in that there is a marked decrease in restraints used since April of 2012. Starting in 2009, DMH introduced soft restraints as an alternative to metal or polyurethane restraints. In 2012, 40% of emergency transports for 2012 utilized metal restraints. Examining the use of metal restraints by month, there are marked decreases in June and October, reflecting the effort of DMH to ensure transportations use metal restraints as an option only when other means have been exhausted.

The drop in secure transport is directly attributable to the Lamoille County pilot as it responds to the entire northern tier of the state, an area where metal restraints continue to be used by

Chittenden, Franklin/Grand Isle, Orleans, and Caledonia sheriffs as a matter of policy. All other Sheriffs' Departments have transitioned to soft or no restraints.

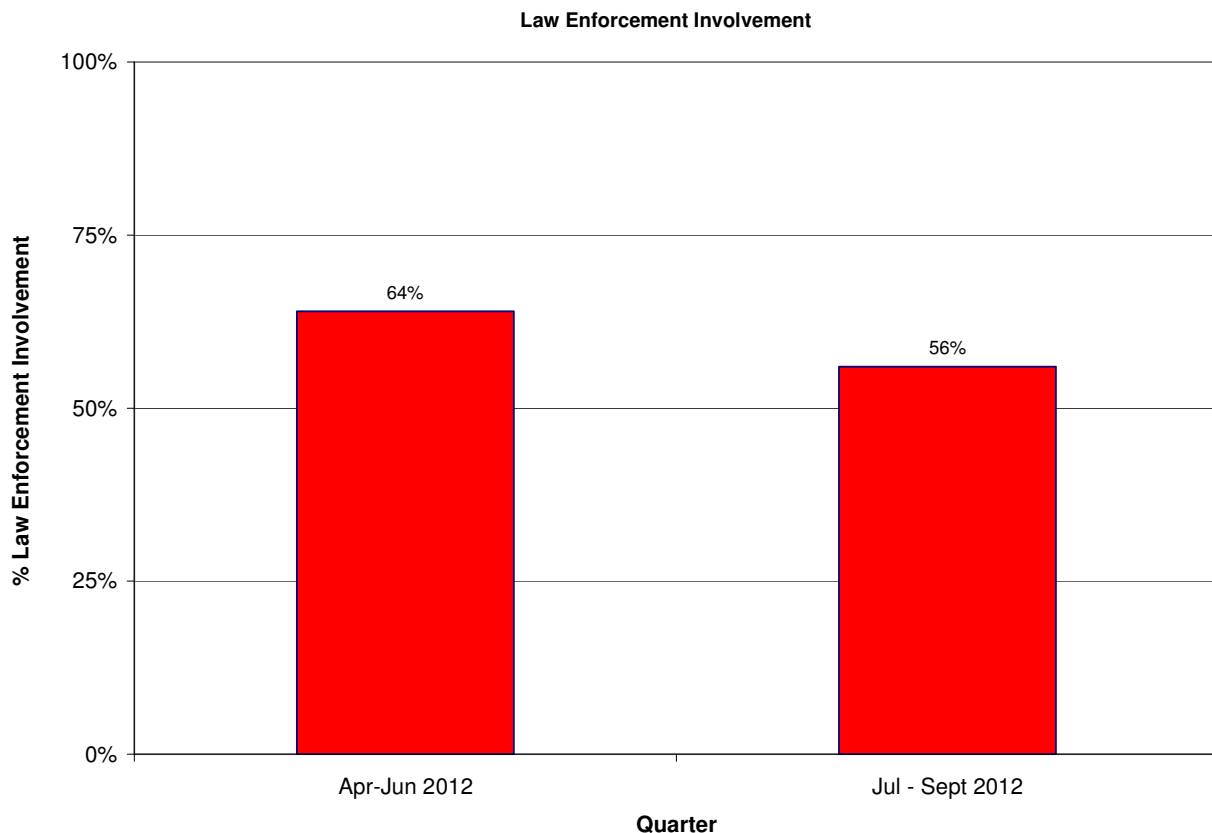
Ambulance transport is required by Rutland and Bennington counties, and all sheriffs now ride in ambulances, as requested by DMH. The specific breakdown of transport type can be reviewed in the Department of Mental Health Involuntary Transport report for the period October 2011 – November 2012. This report includes both adults' and children's transportation data.

Law Enforcement and Mobile Crisis

Act 79 also calls for a reduction of law-enforcement intervention for people in mental health crisis. The primary vehicle for this reduction is through mobile crisis outreach. Outreach to people in mental health crisis is essential to recognition of the pressure points in the lives of individuals. Proactive mobile teams will also be more readily sought by peers and families whose loved ones need intervention and treatment. Peers have also joined some of these teams and/or perform outreach through DMH grant initiatives, providing support in homes and in emergency rooms. Mental health crisis teams performed nearly 2000 face-to-face interventions statewide in the first quarter of FY 13.

Joint interventions between law enforcement and mobile crisis teams have potential benefit for service recipients in modeling de-escalation techniques. Increased communications between these 2 responder entities should also cause mobile crisis teams to do outreach without police. First-quarter statistical reporting, in fact, shows a decrease in police involvement during involuntary situations.

Chart Thirteen: Law Enforcement Involvement



To continue these efforts successfully, standards and training for police and crisis teams are being established. This year, a statewide communications protocol for deployment and safety between mobile teams and law enforcement has been established. An interdisciplinary training model has been developed by DMH and Public Safety and will be delivered regionally through a train-the-trainers model.

The following section focuses further on services provided to individuals and families as well as collaboration with multiple stakeholders in meeting the needs of individuals who are in need of treatment for mental health problems.

Outpatient Utilization

Outpatient services are provided through a system of care that includes the Designated Agencies (DAs) in addition to private practitioners and other state and local social-services agencies. The DAs provide comprehensive services to individuals with severe mental illness through the CRT programs, and they support and manage crisis beds and hospital-diversion services, intensive residential beds, residential beds, supportive housing, wrap-around programs, and peer services. In addition, DA services include Adult Outpatient counseling for individuals and families, case management and services to families with children experiencing a severe emotional disturbance. Availability of the continuum of outpatient services is limited geographically because of the rural nature of the state.

In order to maximize utilization of limited resources in the community and DHs, DMH developed a care-management system that employs social workers as key contacts and liaisons between DAs and DHs, ensuring that people in need of treatment receive the appropriate levels of care.

Peer services have expanded in the past year and will continue to expand. 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.

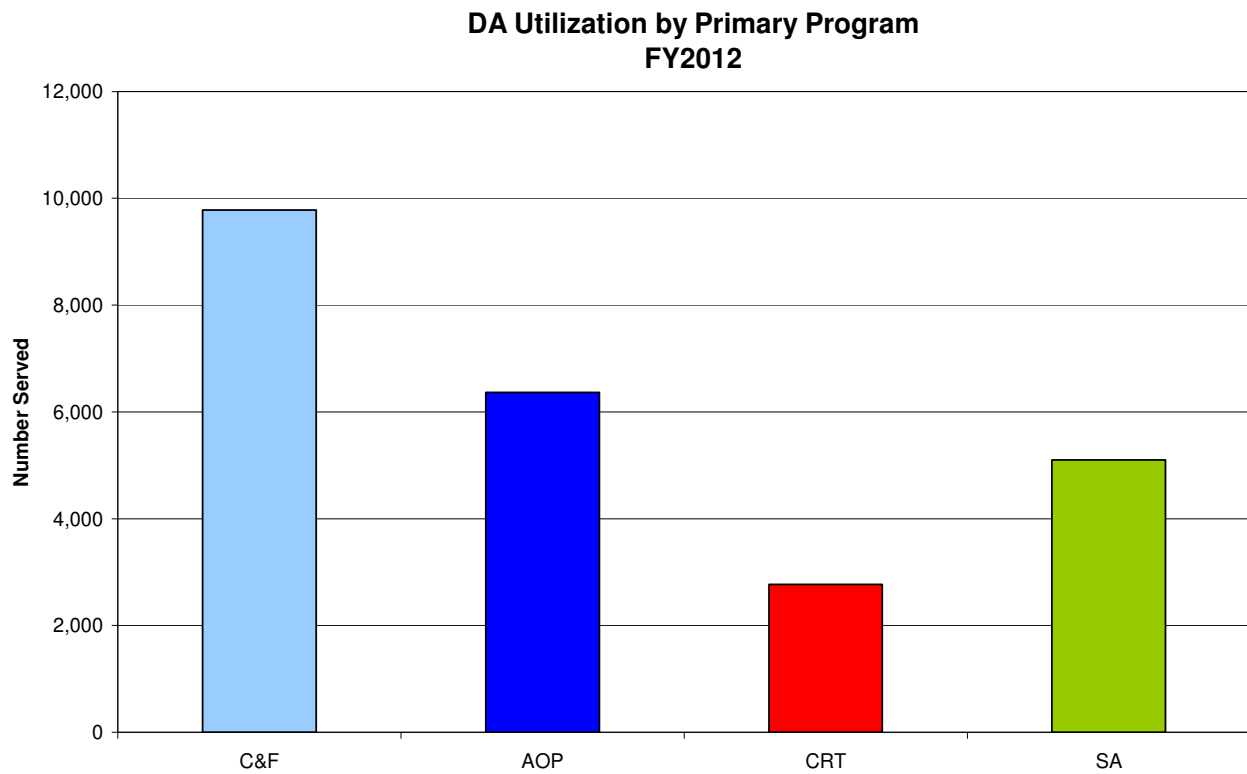
The continuity of care requires that CRT program staff within the DAs interact with those clients being discharged from the inpatient setting as soon as possible after discharge to ensure a smooth transition to the community with a range of services in place as indicated by discharge and treatment plans. This period of time ranges from 1 hour to within 1 week of discharge. The DMH expects that individuals are seen in the DA within one-week of hospital discharge, and case managers/social workers and others working with this population from both the community and the hospitals are required to work collaboratively to assure a timely visit. Trending of data indicates a slight increase in the number of persons seen within this time frame. Reasons for not being seen include decisions by the individual or family to delay or cancel appointments.

Although DMH provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY13, staff recruitment to ramp up these service levels will take time. Information provided by the DAs in the Local System of Care Plans continues to identify staffing, both recruitment and retention, as a major barrier to increasing services. Consistent with this report, the numbers served in community

programs through FY12 remained relatively stable and do not yet reflect any statistically significant upward trend in persons served.

In FY13, DMH is receiving regular reports from DAs regarding service initiatives and the numbers of people served through these new capacities. Cumulative service data reported to DMH during this fiscal year should show the impact of increased program funding and the increase in numbers served over the next several months. Service utilization will also be closely monitored in efforts to determine if the new capacity appears adequate to meet the unmet needs identified prior to the infusion of enhanced program funding for community services.

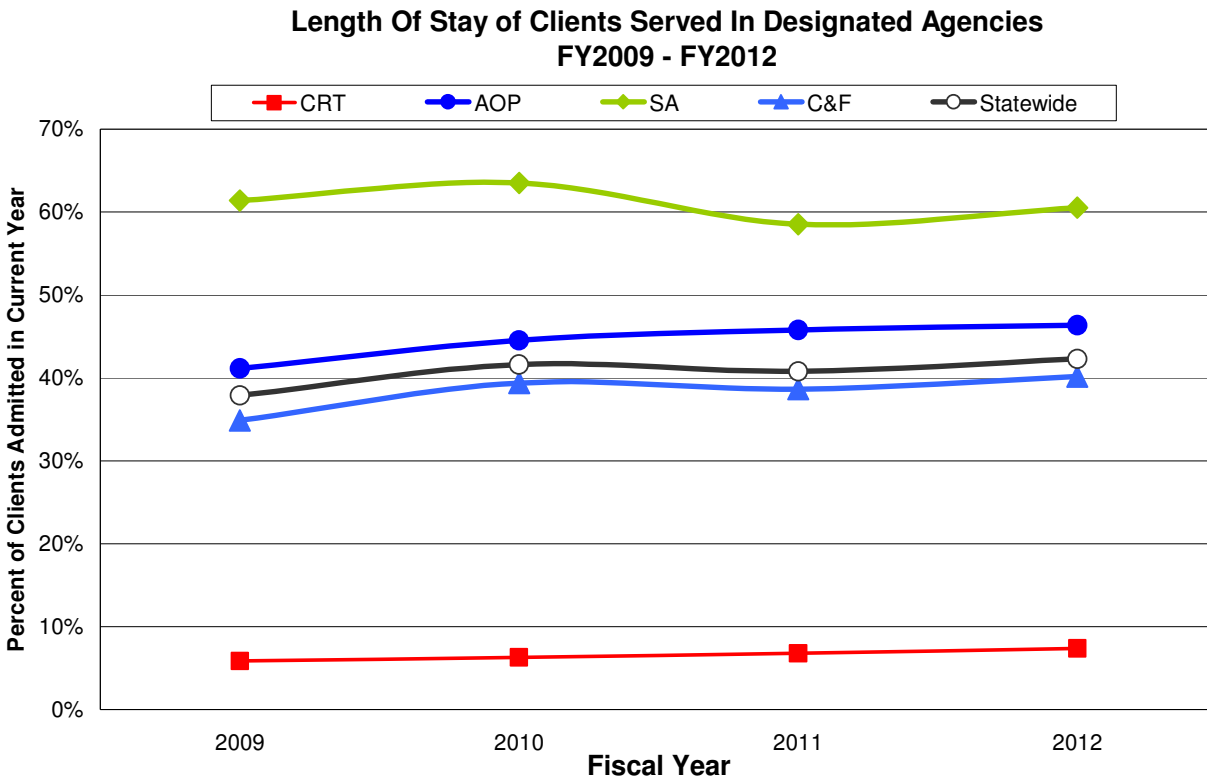
Chart Fourteen: Designated Agency FY12 Volume by Program



Based on Monthly Service Report (MSR) data submitted to DMH by designated community agencies for FY 2012 for clients served by the Children's Services (C&F), Adult Outpatient (AOP), Community Rehabilitation and Treatment (CRT), and Substance Abuse (SA) Programs.

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 too early to see all the changes from enhanced funding that began in May 2012, but a notable increase in case management services to out-patient clients is discussed later in this report.

Chart Fifteen: Length of Stay in Designated Agencies by Program

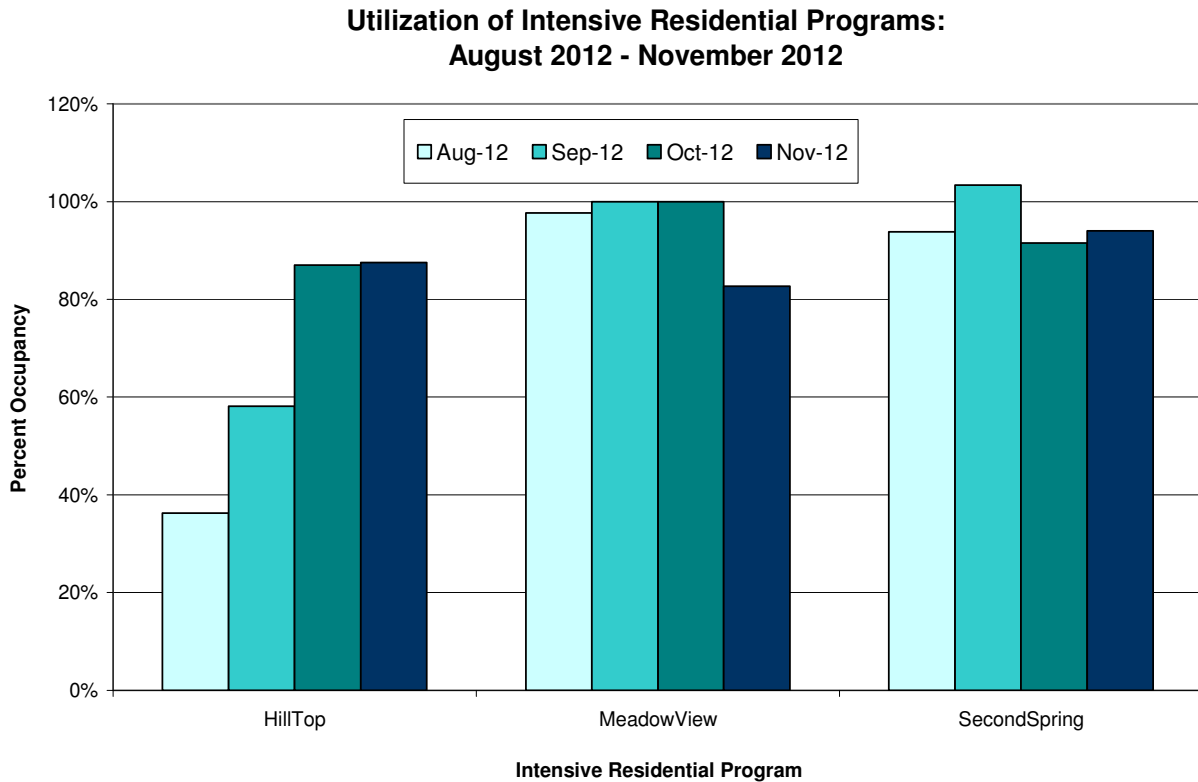


Analysis is based on Monthly Service Report (MSR) data submitted to DMH by designated community agencies for FY2009-12, for clients served by the Community Rehabilitation Treatment (CRT) Program, the Adult Outpatient (AOP) Program, the Substance Abuse (SA) Program, or the Children and Family (C&F) Program. Information on clients' length of stay is based on admission dates reported by community provider agencies. These dates represent the most recent admission for the clients, not the date of their first admission. For this reason, these figures may substantially understate the total length of time clients had been in treatment. Community provider agencies vary in their standard operating procedures with regard to discharging and readmitting clients. Some agencies routinely discharge clients after specified periods of inactivity. Other programs rarely discharge long-term clients with severe and persistent disorders.

The system of care is predicated on the recognition that people move through a continuum of needs for care. Ideally, individuals would enter, be treated, recover, and then leave the system of care. For many who have a chronic illness, this is more challenging, requiring continued service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services. In addition, clients may have co-occurring conditions and receive treatment in more than one area at any given time.

The most significant finding across the 4 years studied for this report is that over 41% of the CRT client population has been engaged and retained in treatment for 11 or more years. The next highest length of stay is 3 to 10 years. This indicates that approximately half of the seriously mentally ill population may be significantly older at this time and that the number of clients new to the system (enrolled within the last 1 to 2 years) has decreased. The clients served by the CRT programs are chronically ill and require ongoing care. The numbers of clients in the age ranges of 35-64 have increased over the past 4 years, while the numbers of clients between 20 and 34 years of age have decreased.

Chart Sixteen: Intensive Residential Bed Utilization



The HillTop Intensive Residential Program opened in August of 2012.

The intensive residential recovery programs are meeting a key transition need for a significant number of individuals who are ready to leave the hospital level of care, but who still require intensive supervision and support before taking steps toward more independent living. Second Spring and Meadowview programs pre-Irene provided these transitional supports effectively for a number of residents moving through their programs, each operating within a 12-18-month time frame for resident aftercare planning and transition. Immediately following the closure of VSH, Second Spring increased its licensed bed capacity from 14 to 22 beds temporarily to meet the emergent need of individuals who could be discharged to an intensive residential recovery environment. Hilltop, a new 8-bed intensive residential recovery environment, was added to the service continuum in the fall 2012. Future intensive residential recovery bed capacity is planned in Westford, in Chittenden County, and in the Rutland region.

Peer Services

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, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. DMH also funds family-to-family peer support for people who have a family member with severe mental illness.

Chart Seventeen: Peer Supported Programming

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

Capacity

DMH has worked to expand the capacity of the system of care in response to the closing of VSH. Tropical Storm Irene proved to be an opportunity to use this devastating event to enhance crisis, residential and outpatient services for adults with severe mental illness.

A certificate of need was approved for an 8-bed unit in Morrisville that opened on January 2, 2013. Planning continues for a permanent 25-bed hospital to be built in Berlin. A secure 7- bed temporary residential facility is under construction in Middlesex and is expected to open in early March 2013. This new secure residential program will have a direct impact on inpatient-bed capacity. Individuals who are ready to leave the hospital but who still require intensive staff supervision and a secure environment in which to continue their individual course of recovery will be able to move to this new level of care.

Demand for inpatient care frequently exceeds current capacity. An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. DMH leadership works to resolve issues as quickly as possible. Emergency departments across the state have had to hold individuals needing inpatient psychiatric care while waiting for an open bed. This is disruptive and is not a standard of care that DMH regards as acceptable. Expanding the number of inpatient beds over the next 2years will alleviate this pressure on the system.

Outpatient Care

In order to create new opportunities for community treatment for individuals who would have previously used the Vermont State Hospital, Act 79 authorized the commissioner of mental health to “improve emergency responses, mobile support teams, non-categorical case management, adult outpatient services, and alternative residential opportunities at designated agencies.” In order to best meet catchment area needs, each DA has used funding associated with the closure of Vermont State Hospital and Act 79 to develop a different mix of enhanced programming:

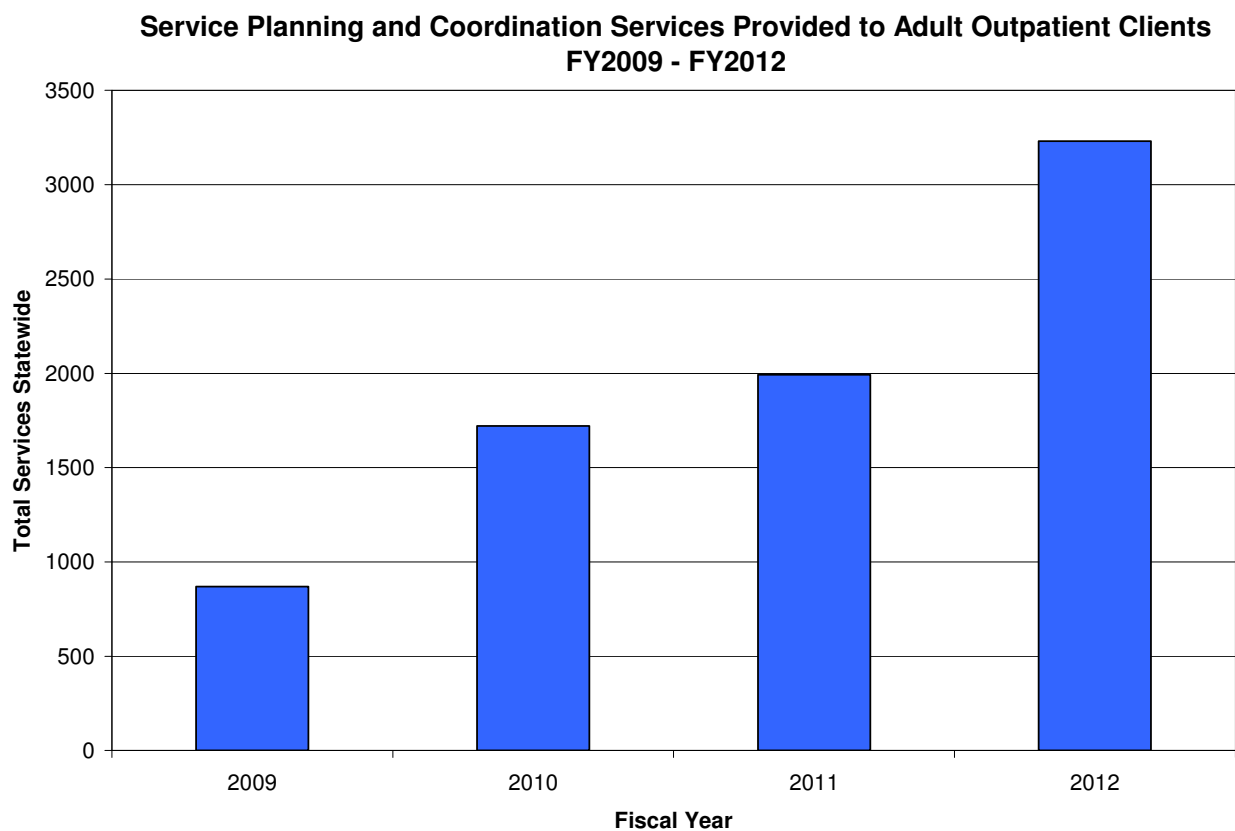
Chart Eighteen: Enhanced Programming by Designated Agency

<u>Designated Agency</u>	<u>Enhanced programming</u>
Clara Martin Center (Orange County)	Mobile emergency/crisis response, mobile outreach, care coordination, adult outpatient program (AOP) case management, hospital diversion/step down. Enhancements will include creation of crisis program with 2 beds for hospital step-down or diversion
Counseling Services of Addison County (Addison County)	Mobile emergency/crisis response, peer supports in emergency rooms and community, case management for adult outpatient program (AOP), additional staffing for existing crisis and residential beds to treat higher acuity, week-end drop-in support center
Health Care and Rehabilitative Services (Windham & Windsor Counties)	Enhancement of crisis care centers to improve access and divert emergency room use, expansion of walk-in clinics for adult outpatient (non-CRT), increased mobile support capacity, AOP case management, expansion of police social worker program
HowardCenter (Chittenden County)	Increased CRT case management, enhanced AOP and case management, development of peer staffing supports for 3 apartments (6 beds), Peer-staffed mobile crisis response and support (START)
Lamoille Community Connections (Lamoille County)	Enhanced AOP services (case management, vocational), mobile crisis team, mobile outreach for pre-crisis support, peer-run warm line and other community supports, 2-bed crisis program
Northeast Kingdom Human Services (Essex, Orleans, Caledonia Counties)	Enhanced emergency services, mobile outreach, and first intercept (e.g. police); AOP case management
Northwest Counseling and Support Services (Franklin and Grand Isle Counties)	Establish Mobile Crisis Team; case management for AOP; Enhance crisis bed into Crisis Care Center; expand peer outreach services
Rutland Mental Health Services (Rutland County)	Establish mobile crisis team; 2-bed expansion to crisis stabilization program;
United Counseling Services (Bennington County)	Develop mobile crisis program; increase peer support groups and peer warm line; enhanced AOP, including case management
Washington County Mental Health (Washington County)	Enhanced emergency services with nurse practitioner and street interventionist; develop emergency room diversion center, case management, and emergency respite care for AOP;

As described in chart eighteen, the majority of DA’s have added in case management for adult outpatient clients (non-categorical case management), which allows individuals who are not CRT eligible but are at risk of future hospitalization to receive care coordination and support. DMH began implementing non-categorical case management in FY 2009, and fiscal years 2009

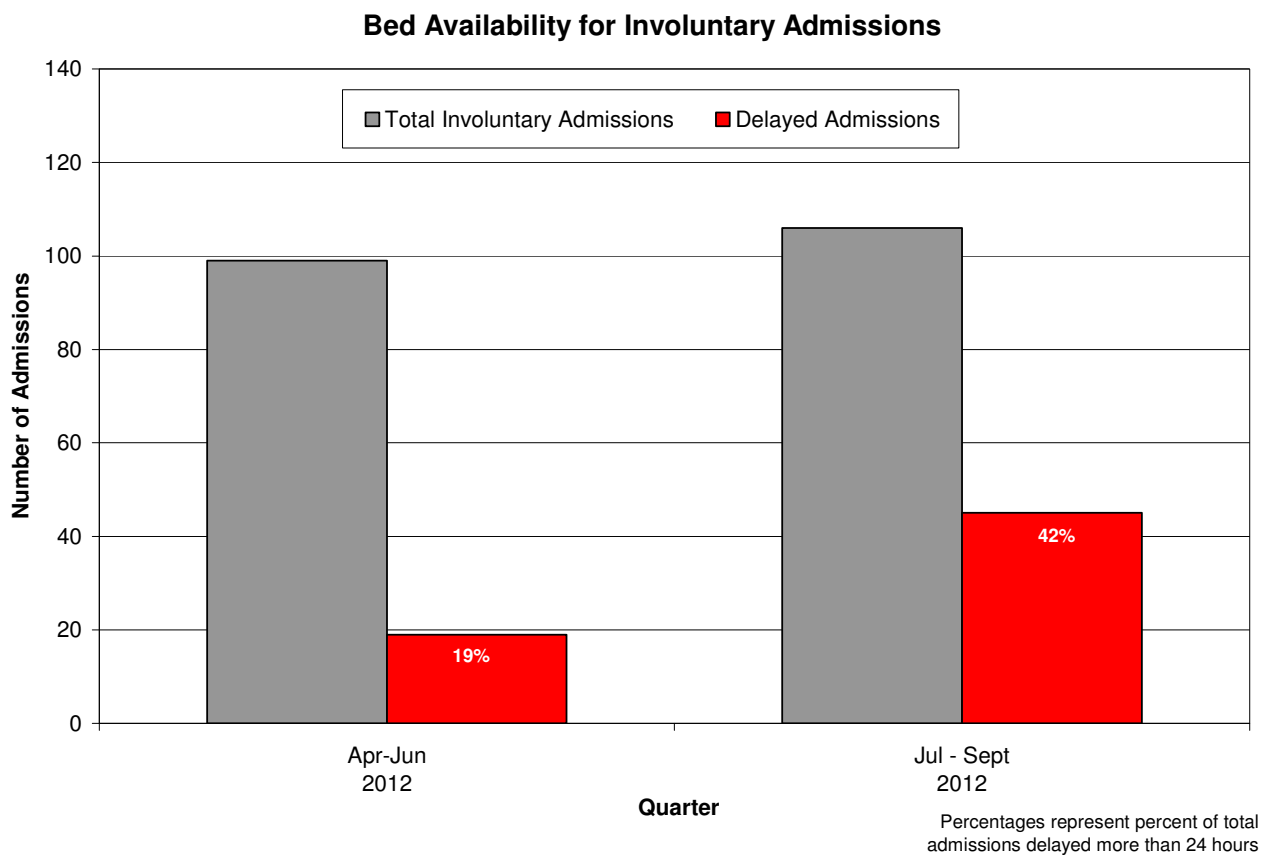
through 2012 have shown an upward trend in the amount of case management services, called “non-categorical” case management, available to clients assigned to Adult Outpatient programs,. When first introduced without additional funding for this service, there was a 98% increase in services into FY 2010 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 2012 case management services showed a 350% 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 FY13 as well.

Chart Nineteen: Non-Categorical Case Management



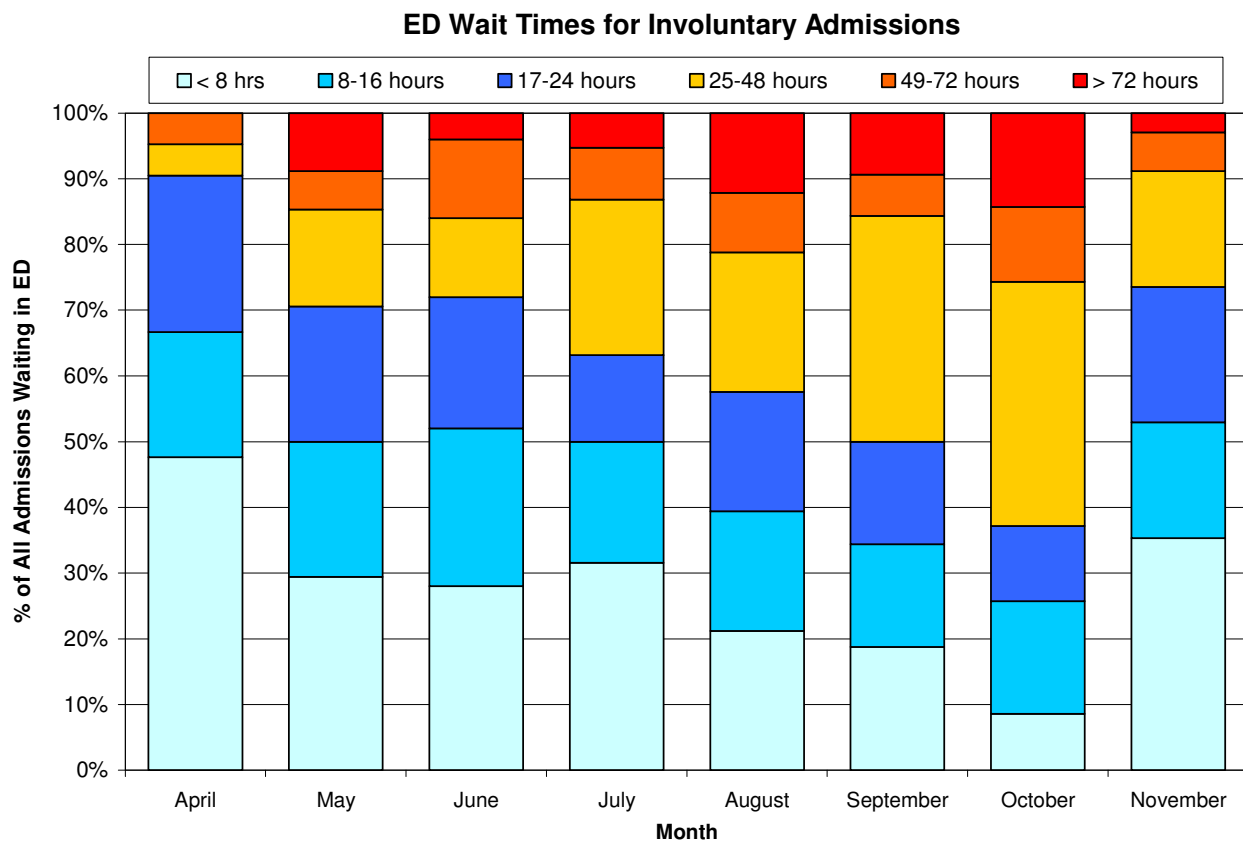
Each DA is also developing mobile crisis teams to better respond to individuals experiencing psychiatric crisis and the majority of programs have begun to perform crisis assessments and interventions in the community, as well as providing law-enforcement related crisis response and ER and hospital diversion. While DMH is still in the process of refining and standardizing data collection regarding the expansion of mobile crisis response, Designated Agencies have reported providing over 1,200 crisis assessments in the community during the first quarter of state fiscal year 2013.

Chart Twenty: Involuntary Referrals and Bed Availability



The instances in which beds are unavailable at the time requested for admission are increasing over time, as shown on the chart below. Given the reduction in total beds across the state, this requires active management on a daily basis to assure high-quality care for individuals in a mental health crisis.

Chart Twenty-One: Emergency Department Times to Involuntary Admission

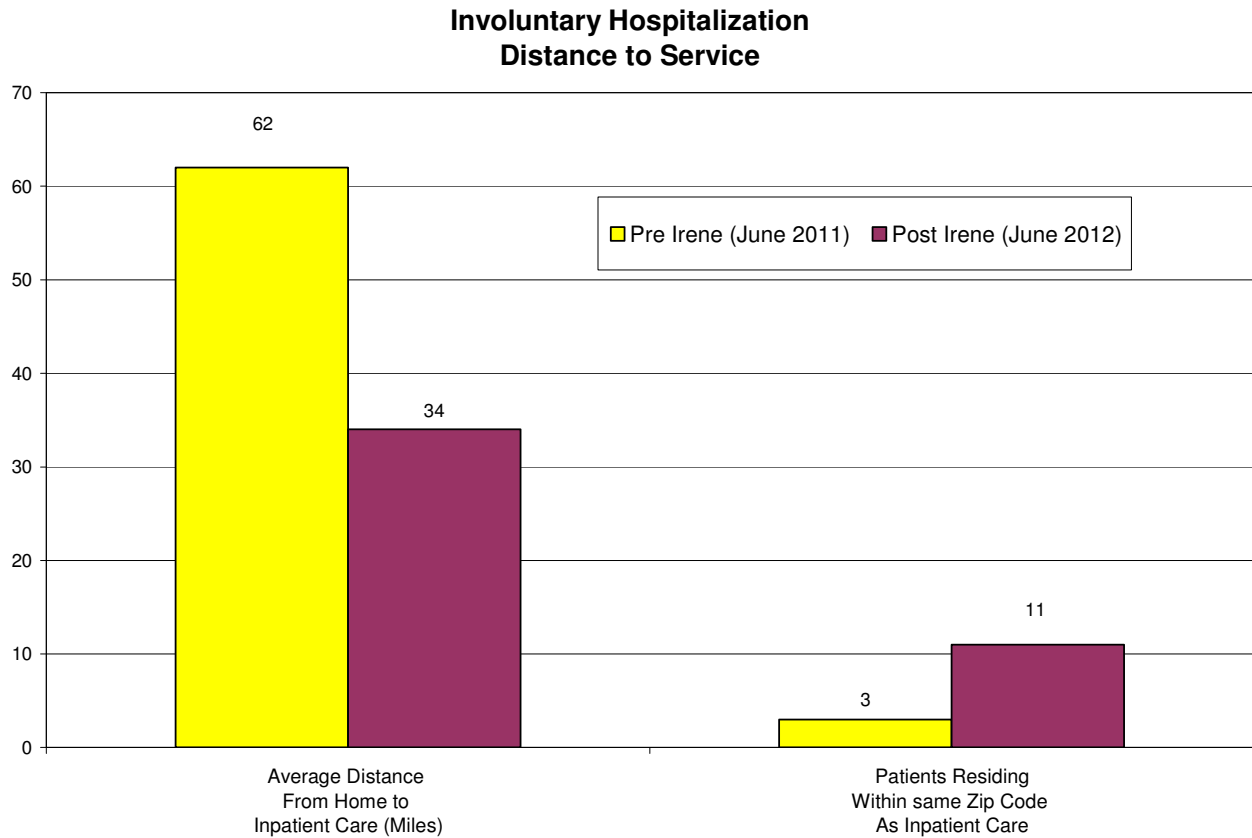


ED wait time calculates the time an individual enters the ED for services until placement in a psychiatric bed or discharge from the unit. ED screening routinely includes medical assessment in conjunction with considering a psychiatric admission, so wait times above do not differentiate the routine wait for medical assessment that anyone experiences in the ED from the wait time associated with psychiatric bed availability. Information compiled by DMH prior to September 2011 did not differentiate between individuals who required medical clearance before being ready for discharge from those who were ready to be discharged at the point of determining the need for inpatient treatment. 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.³

The rate of inpatient placement being delayed in Vermont has increased over time, though the number of involuntary applications has remained stable. This is due to the overall reduction in inpatient beds and the intensity of services required. Of the 252 waits identified during this time frame, 63% (158) were placed within 24 hours of presenting to the ED. Over the 35-week period, on average, only one wait per week exceeded 24 hours. Efforts to expand crisis-bed utilization when clinically possible facilitated the movement of inpatients to step-down facilities. In addition assertive care management and the collaboration of inpatient providers reduced the wait times overall. In November 2012, wait time improved significantly and is expected to continue to improve as the eight new beds at GMPCC are brought on line in early January 2013.

³ http://www.pressganey.com/Documents_secure/Pulse%20Reports/2010_ED_Pulse_Report.pdf?viewFile

Chart Twenty-Two: Average Distance Traveled to Designated Hospital

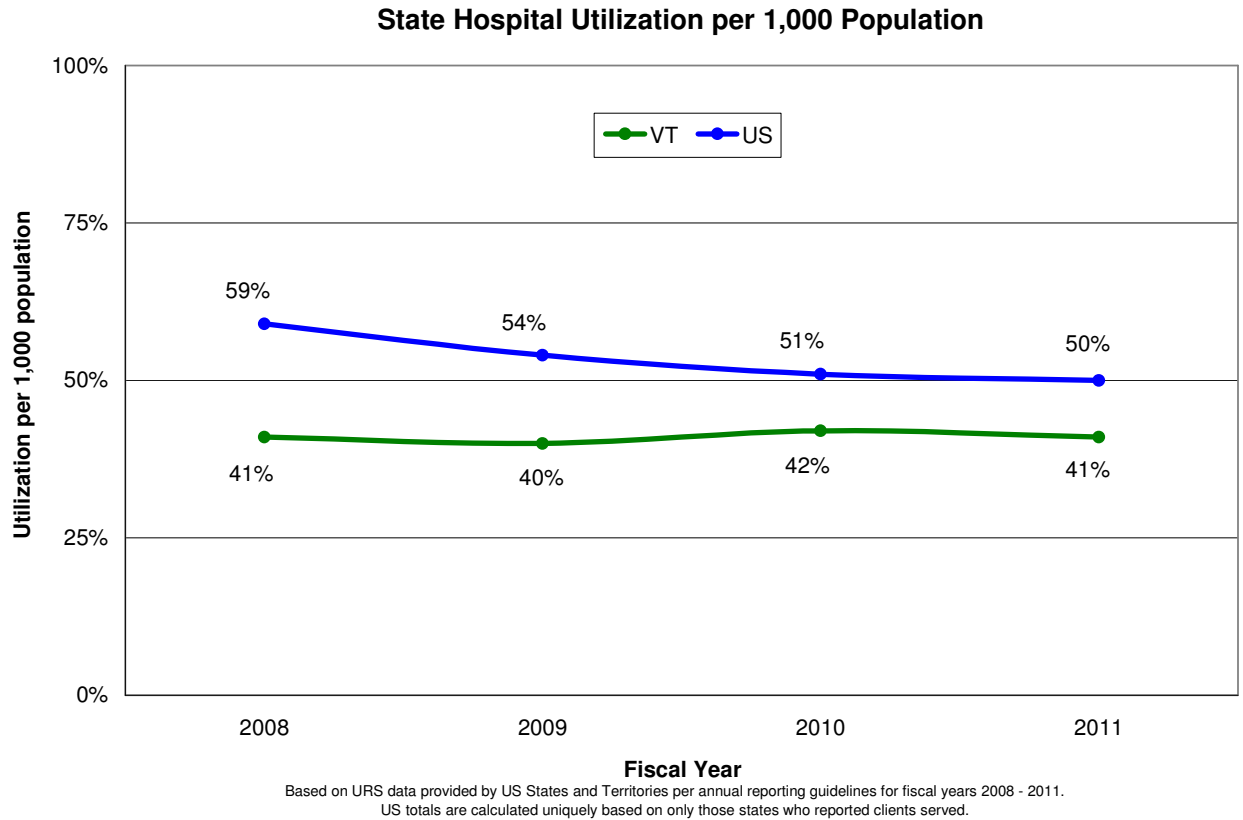


The closing of VSH resulted in an increased use of beds in DHs for involuntary psychiatric hospitalizations. The decreased distance required to travel to an inpatient bed post-Irene, as demonstrated in the graph above, reflects the greater use of beds at nearby DHs.

National Benchmarking

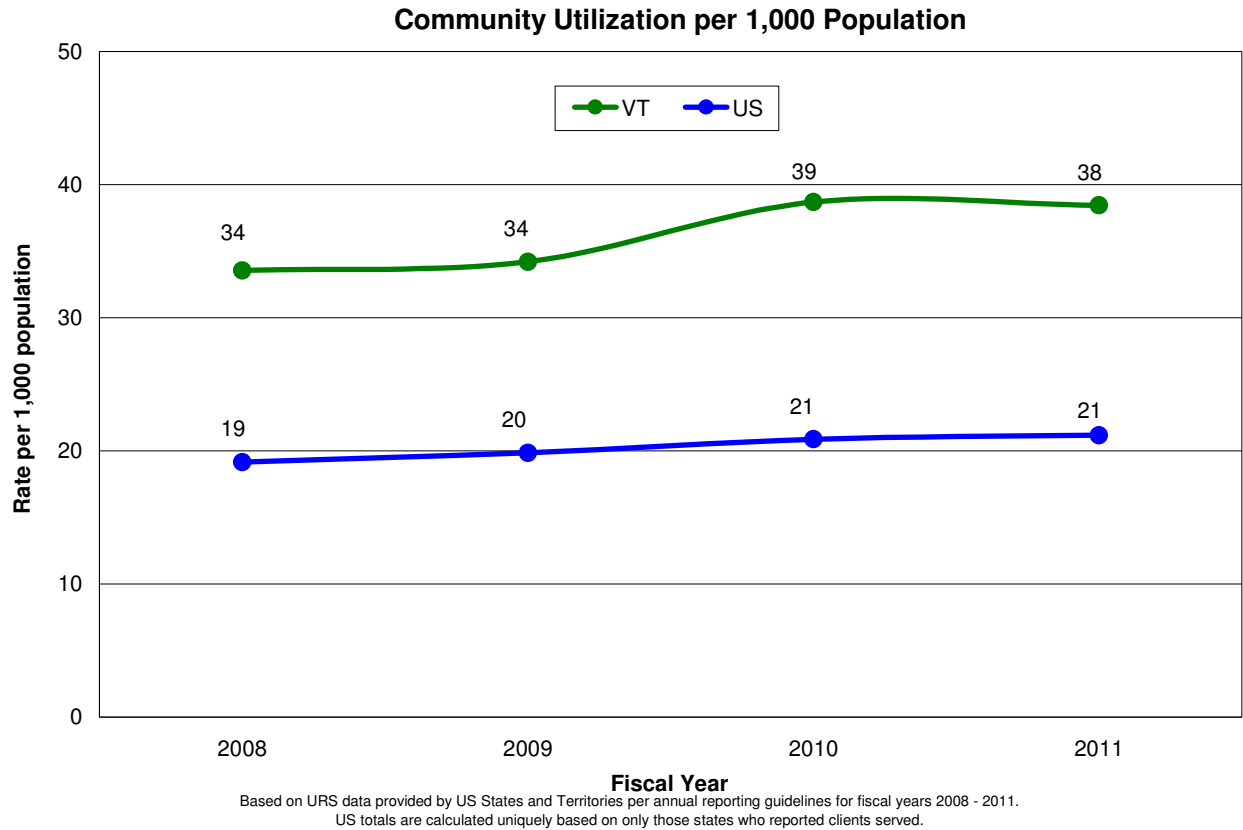
Vermont participates in the Mental Health National Outcome Measures (NOMS) that provides benchmarking against other states. Information for 2011 is provided as Attachment D. Key measures are also represented below.

Chart Twenty-Three: State Hospital Utilization per 1,000 Population



Vermont’s rate of inpatient utilization as compared to the United States is less for both the State Hospital and for other psychiatric inpatient admissions. The lower utilization rate is owing to Vermont’s national leadership in moving to advanced outpatient care.

Chart Twenty-Four: Community Utilization per 1,000 Population



The number of consumers served per 1,000 populations in Vermont is 38, or 75% higher than the national figure. There is still much work to be done to reach all individuals suffering from mental/behavioral health issues and DMH is committed to working with the Vermont Blueprint for Health to identify individuals in need and to further increase these percentages.

Individual Experience and Recovery

A significant aspect of the intent of Act 79 was to improve the care and the experiences of those receiving mental health services in the State of Vermont. The DMH routinely surveys consumers of mental health care, and staff who provide the treatment, as part of its Agency Review process. These surveys are one measure of individual experience and recovery, and the results are summarized below. In addition, various other measures are thought to illustrate how individuals

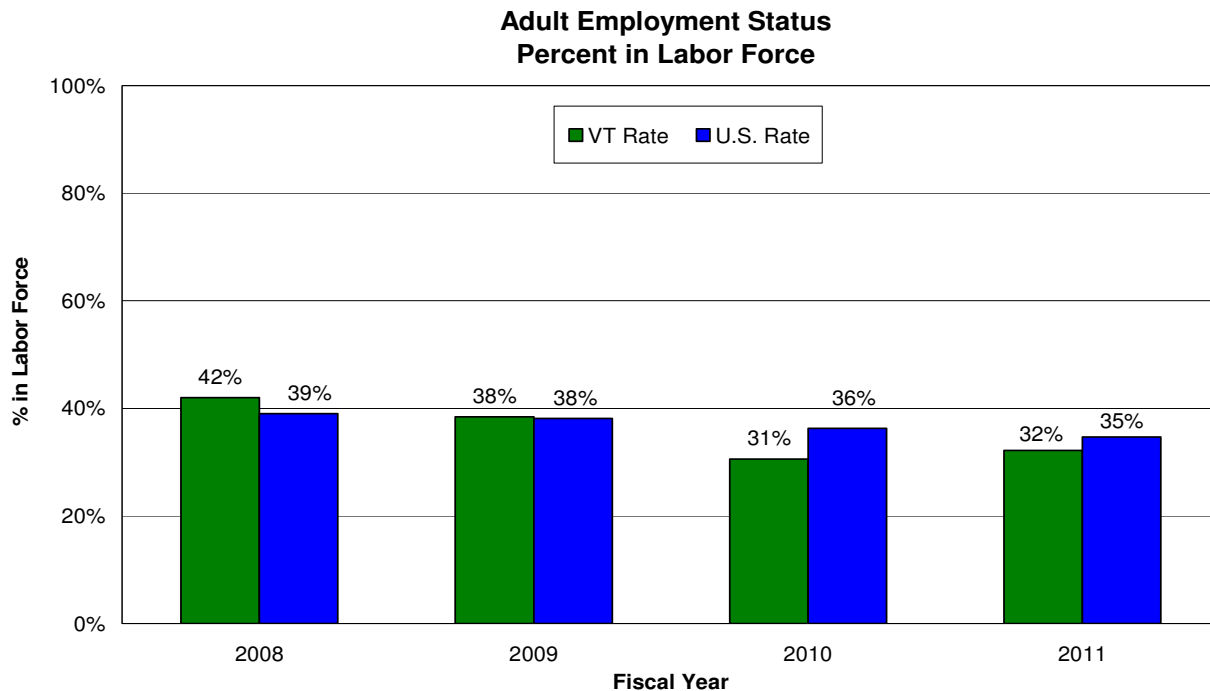
receiving care feel about the care they are receiving. Careful attention is being paid to these measures, as a means by which to improve and enhance the quality of care in VT.

Person centered care is focused upon the individual needs and movement towards stabilization and recovery. DMH tracks clinical, social and legal measures to assess experience and recovery. There are a number of measures used to quantify individual experience and recovery including employment information, consumer surveys, housing, and other metrics.

Employment

Employment is an essential part of recovery for many individuals living with a mental illness. National data has shown that employment leads to decreased involvement with corrections, decreased hospitalizations, improved physical health outcomes, decreased substance use, and better community integration.

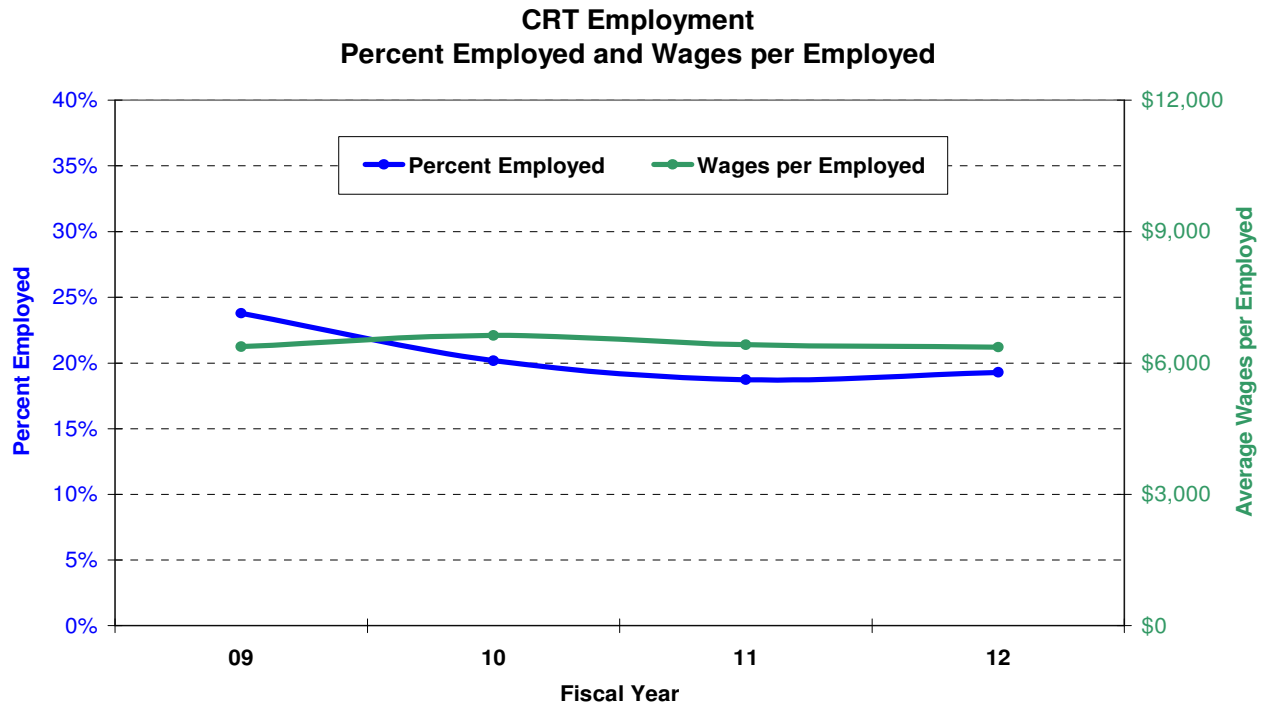
Chart Twenty-Five: Percentage of All Adults with Mental Illness Employed in U.S. and VT



Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2011. Employment status for other mental health clients is based on case manager monthly service reports.
Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2011.
US totals are calculated uniquely based on those states who reported.

Chart twenty-five shows the employment rate for all people with mental illness has dropped across the nation, including Vermont, over the past several years likely due to the economic downturn and decreased employment services

Chart Twenty-Six: CRT Annual Employment Rates and Average Earnings (2009-2012)

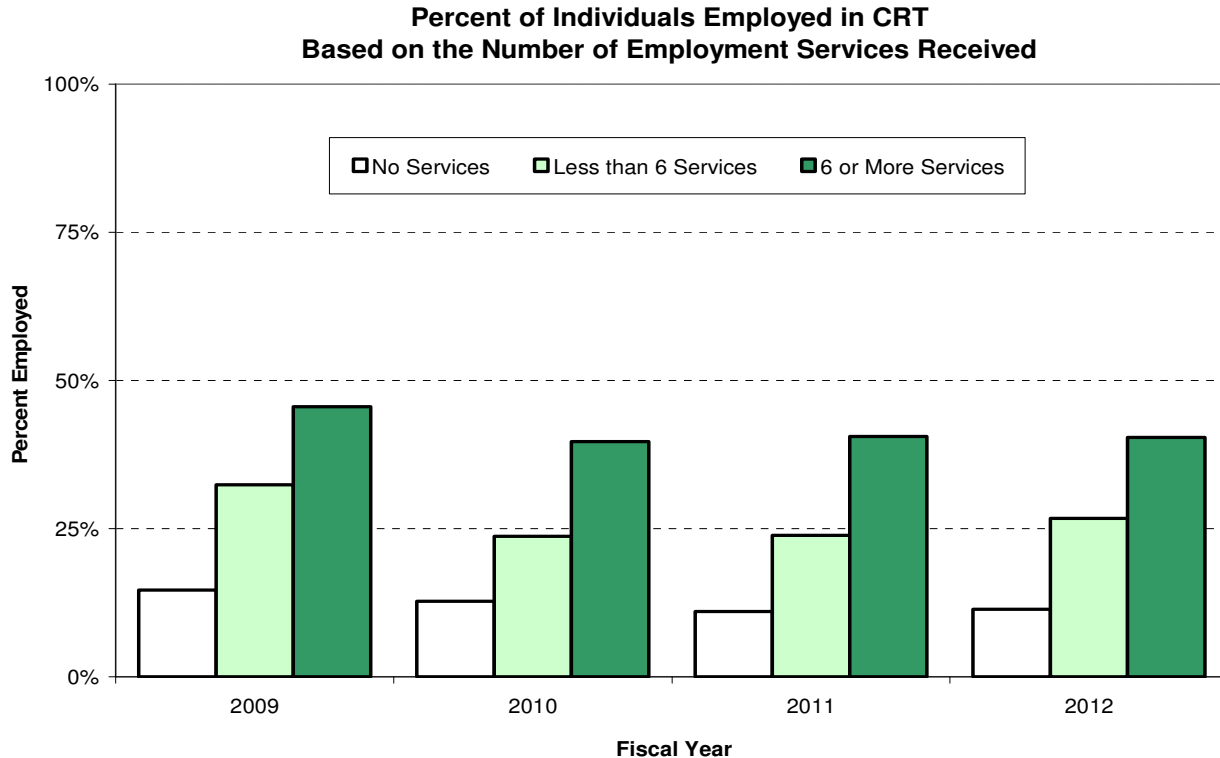


Analysis includes Community Rehabilitation and Treatment clients aged 18 - 64 who were active during any part of the annual reporting periods and includes all employment reported for the annual reporting periods. This report is based on analysis of the Department of Mental Health (DMH) and the Department 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.

Chart twenty-six indicates a stabilization of CRT employment outcomes at 19% between FY11 and FY12. CRT programs experienced significant changes during this time and yet continued to support individuals with their employment goals.

- Individuals, on average, earned \$6,400 per year (about 16 hours per week).
- Total wages earned were \$3,315,031.00 in FY12.

Chart Twenty-Seven: CRT Individuals Employed Based on Number of SE Services Received



All ten Designated Agencies' Community Rehabilitation and Treatment (CRT) programs utilize evidence-based employment services called Individual Placement and Support (IPS).

- Supported Employment services increase employment opportunities;
- 40% employment rate for those who had 6+ SE services in FY12;
- 20% of CRT population accessed SE program (had 6 or more SE services) in FY12.

Consumer Ratings and Experience

DMH conducts consumer surveys to evaluate Community Rehabilitation and Treatment services and Children and Family services provided by the 10 designated agencies in Vermont. (The survey for children and families includes parents of children and adolescents with a severe emotional disturbance as well as youth in services.) The full survey reports can be found online at: <http://mentalhealth.vermont.gov/report/survey> . The surveys focus on 5 areas with a resulting overall score constructed from responses to the 44 survey questions, and 5 additional sub-scales. These are represented in charts 28 and 29.

Overall satisfaction has generally remained the same over the years, with a slight increase for parents of children in child and adolescent programs in Vermont.

Survey results vary widely by DA. Information from surveys is used in the designation process and when working with designated agencies to improve care.

Chart Twenty-Eight: Favorable Outcomes Percentage of Child & Family (C&F)

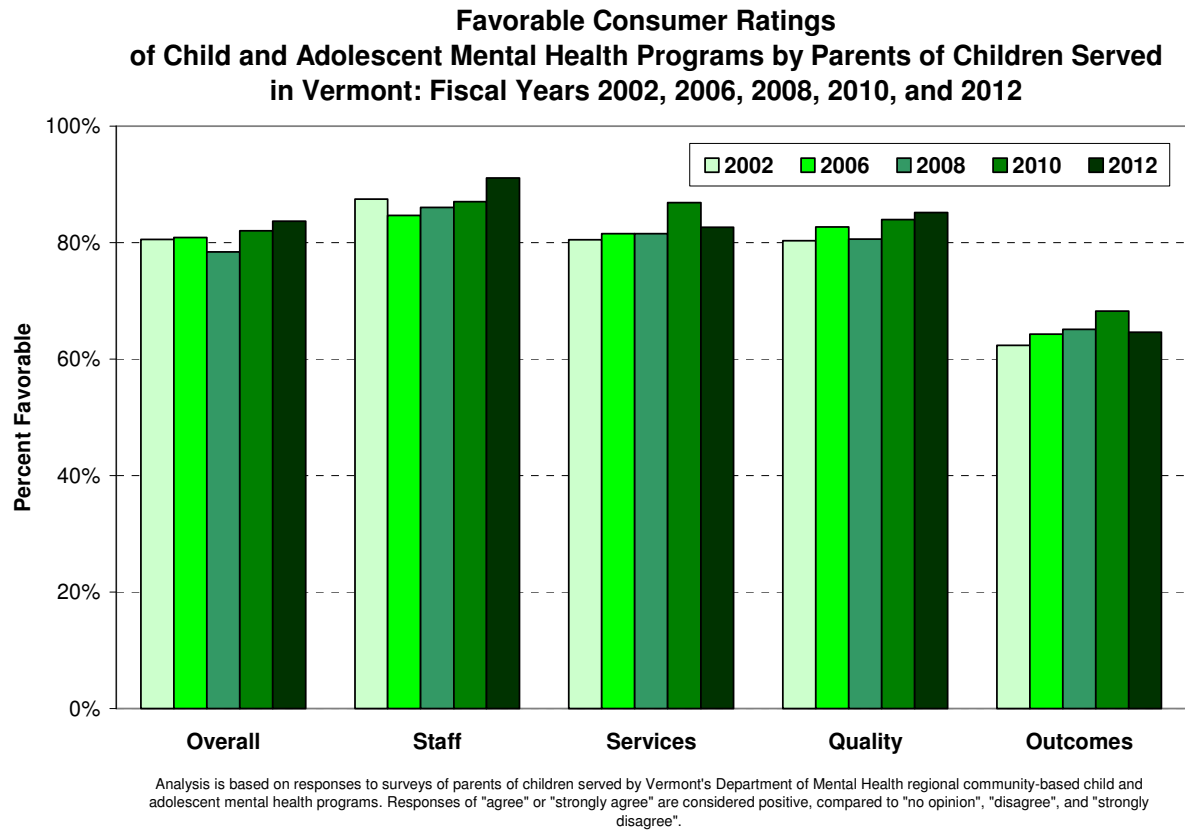


Chart Twenty-Nine: Favorable Outcomes Percentage for CRT

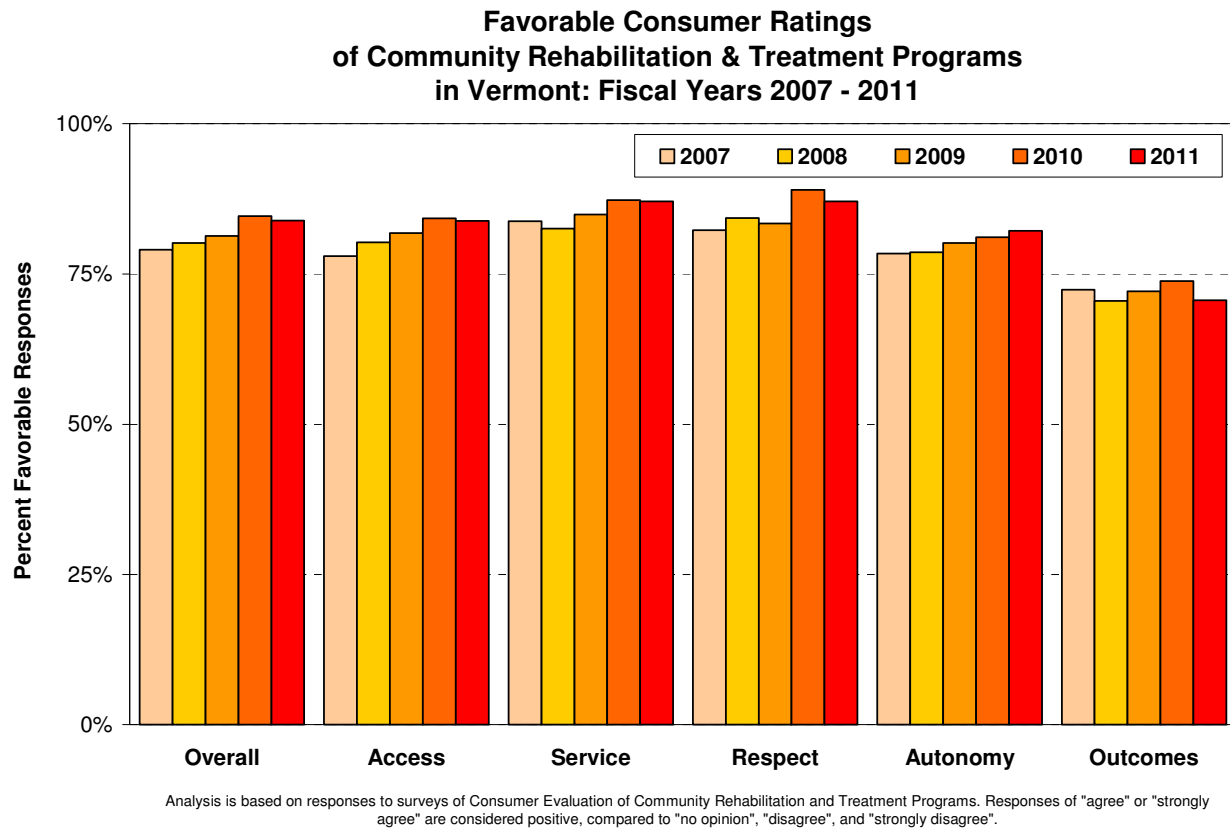
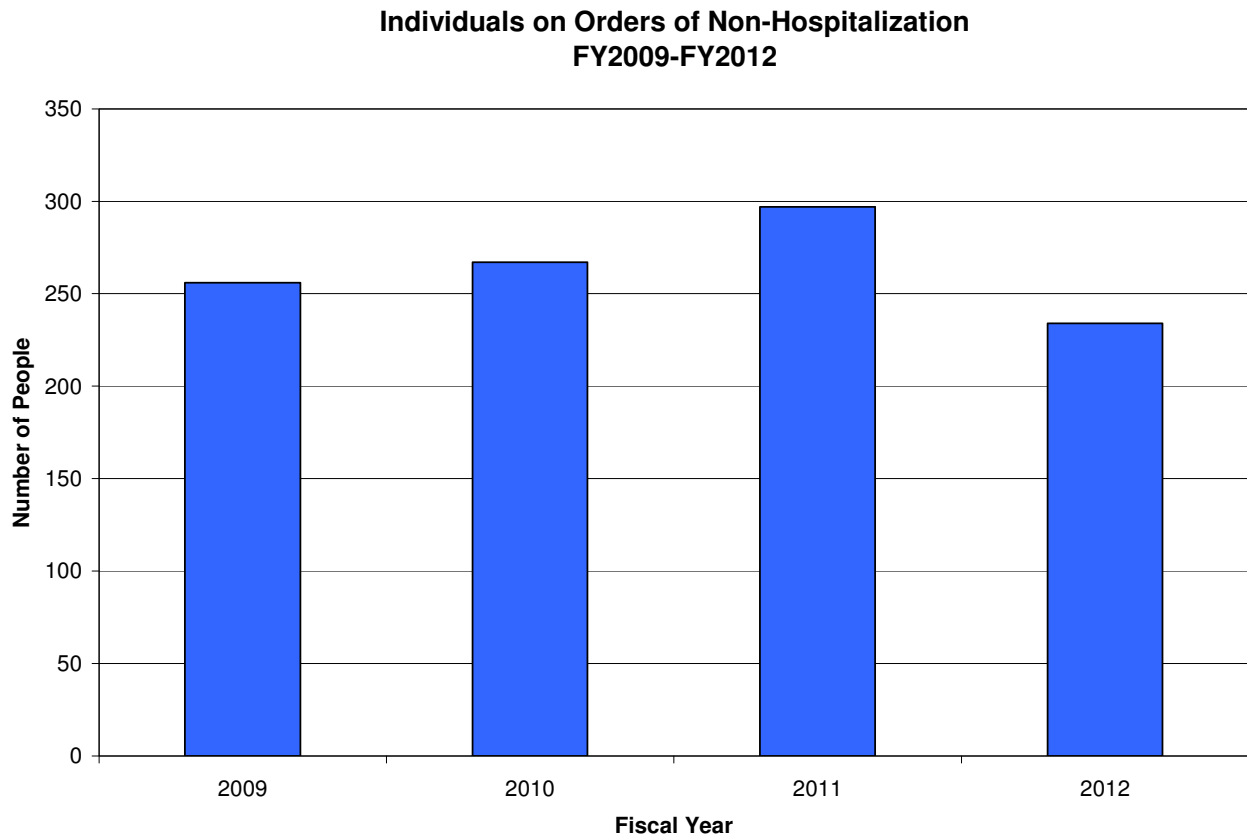


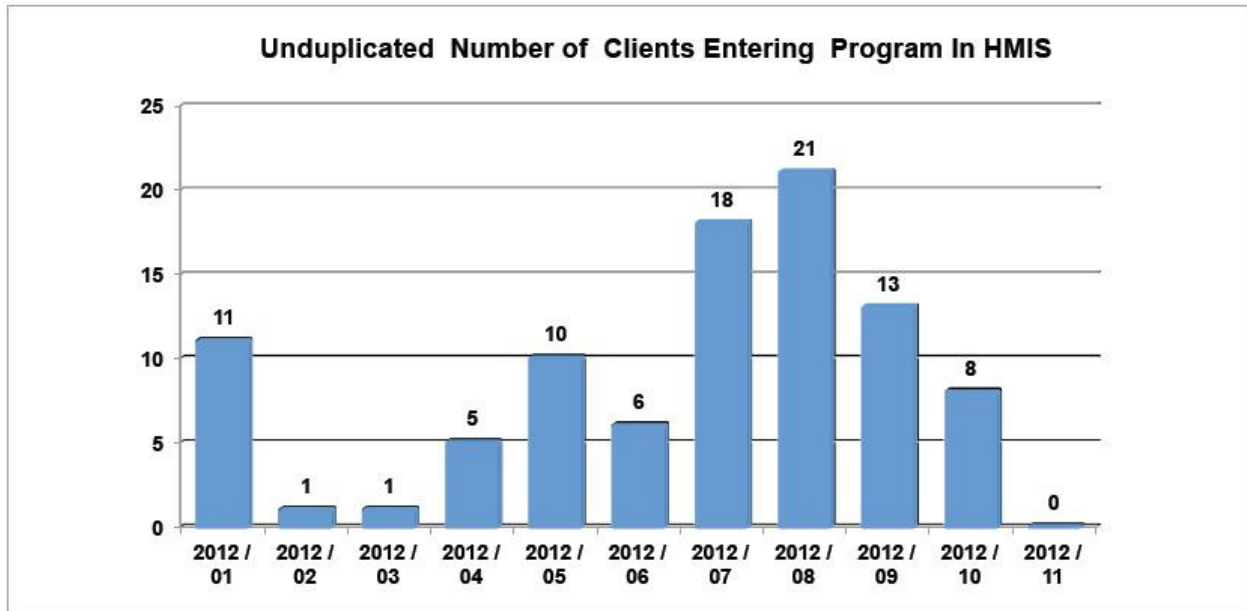
Chart Thirty: Orders for Non-Hospitalizations



DMH Orders of Non-Hospitalization (ONH's) showed an upward trend through FY 2011, approaching nearly 300. Throughout FY 2012, in addition to DMH legal staff review, DMH clinical staff routinely reviewed treatment plan and progress information with DA personnel who requested renewals of ONH conditions to better understand the reasons for continuation. Through this process, community service providers were required to provide clinical justification of ongoing need and their efforts to engage individuals around their treatment plans and conditions. The reduction evidenced in FY 2012 may be associated with these efforts. DMH plans to continue similar levels of oversight ongoing, utilizing care management staff at DMH to provide more centralized monitoring of DA support needs and timely engagement and outreach strategies that may further decrease the number of individuals served who are subject to ONH's. It is important to note that the percentage of ONH's is still extremely low when compared to the enrolled CRT Program numbers. Although not all individuals subject to ONH's are enrolled in the CRT Program, the majority are served by that community program and the number is roughly only about 7-8% of that population overall.

Housing

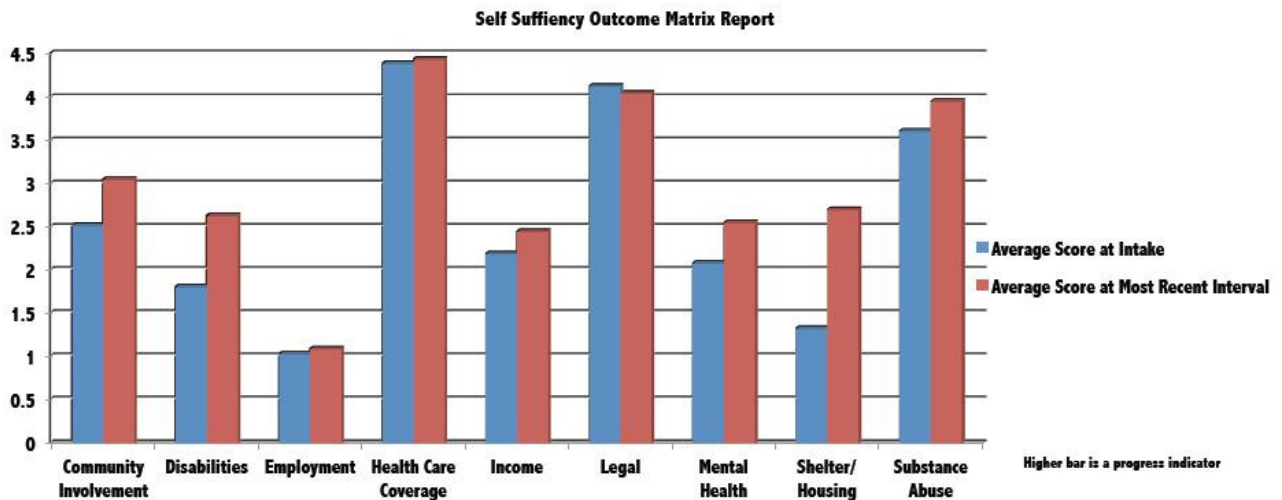
Chart Thirty-One: Clients entering Housing Subsidy and Care Program



An analysis of the Housing Subsidy and Care data thus far finds that:

- Ninety-four persons who were homeless, mentally ill and at risk of needing an acute care bed have been housed and supported in the community by DMH HS&C program. The Vermont State Housing Authority is a collaborating partner.
- Twelve of our community partner agencies have provided essential services and have documented the work they do to support housing retention.
- Of the 94 persons housed since the program began, two have exited for a legal matter or a substance-abuse issue.
- The lengths of stay in housing since the program began range from 75 days to over 250 days. The performance indicator we seek to achieve is a one-year housing retention.
- Persons served were mostly female, and three children were also assisted with their mothers.
- Of 94 served, more than 80 were literally homeless with less than 10% of those assisted at serious risk of losing housing.

Chart Thirty-Two: Self Sufficiency Outcome Matrix for those in Housing Subsidy and Care



Eight of the 9 self-sufficiency outcome measures recorded here demonstrated improvement for the individuals participating in the Housing Subsidy & Care program. Most notable was the improvement in community involvement, improvement in disability, income, housing, mental health, and substance-abuse outcome measures.

Peer measures

DMH is also 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.

4. Conducting Quality Management

Development of a Quality Management Unit

DMH endorses principles of recovery and integrated evidence-based health, mental health and substance abuse services through flexible, person-centered care offered in the least-restrictive environment. DMH is committed to the following quality domain measures: Access, Practice Patterns, Outcomes/Results of Treatment, and Administration of fully functional agencies providing care, as delineated in the *DMH System of Care 3-Year Plan FY2012-2014*.

During a reorganization of the Agency of Human Services (AHS), the quality functions of DMH were centralized within the AHS and key staff positions were eliminated. Required reporting tasks and functions were reassigned to remaining employees in various units of the Department, thus affecting systemic coordination and contributing to fragmentation of these activities.

A Director of Quality Management (QMD) was hired in late August 2012. Unit needs were evaluated and there are currently three coordinator positions to carry out the activities of the Quality Management Unit. The scope of responsibility of the QM Director has expanded with the recent changes to the leadership team within DMH. The primary responsibilities of DMH Quality Management Unit are to:

1. Create and monitor systems to assess, evaluate and report on clinical services provided by DMH
2. Address gaps in reporting that require immediate attention and to serve as an Intergovernmental Agency (IGA) of Department of Vermont Health Access (DVHA) for the Managed Care Entity (MCE) as described below
3. Designate both Hospitals and Community Mental Health Agencies through systematic assessment and evaluation activities
 - a. These include updates to the *Administrative Rules for Agency Designation* and *Minimum Standards* as well as other manuals for standardization of care.
 - b. Revise Statewide System of Care Plans

DMH Quality Management Unit staff participates in Quality Assurance/Performance Improvement (QAPI) activities as part of the Agency of Human Services, participates in the AIM Steering Committee to support continuous quality improvement across the AHS and within DMH, and works closely with other quality management staff engaged in performance improvement in both DHs and DAs.

The goal of the Quality Management Unit is to assure that all programs and services funded by the state are in compliance with state and federal laws and regulations while achieving desired outcomes through the provision of high-quality services and supports. In addition, the QM Unit contributes to policy development through the generation of accurate, valid and reliable data and ongoing continuous quality improvement activities including the development and ongoing modification of DMH dashboards for the leadership team and stakeholders.

DMH utilizes an Executive Dashboard to monitor point-in-time utilization of resources and to track movement of individuals on a monthly basis across the continuum of care. The Executive Dashboard is also provided to the Legislative Mental Health Oversight Committee on a periodic and as-requested basis. Leadership at DMH, in concert with stakeholders, began to identify and gather data in the second Quarter of FY2012 that provide information vital to the ongoing assessment and enhancement of mental health care in our State, following Tropical Storm Irene. DMH, through its Quality Management Unit, will continue to analyze and report on measures of our system of care on an annual basis, as this information is a cornerstone to our ongoing quality improvement process.

In July 2012, DMH assumed delegated responsibility from the DVHA to conduct authorization for admission and continued treatment for inpatient psychiatric hospitalization of patients with Medicaid (beneficiaries) receiving care through the DAs and DHs. The following functions are components of the Quality management Unit.

Clinical Care Management

The Clinical Care Management Team was convened following enactment of Act 79 and has been in operation for approximately one year. The team is comprised of DMH social workers,

psychiatrists and psychologists who meet weekly with staff from BR, FAHC, and RRMC and also with CVMC and Windham Center staff when psychiatric patients are admitted to those inpatient units. The team works with hospital and community DA staff to support and provide resources to assist in transitioning patients to lower levels of care and to facilitate placement when needed, within a system of limited capacity. Individuals served are primarily those who are involuntarily hospitalized and/or on Orders of Non-Hospitalization (ONH).

The Care Management Team and staff of the Commissioner's Office also work directly with DHs, DAs, Alyssum, hospital emergency departments, Pathways to Housing, AHS Field Directors and others to ensure access to services for individuals needing them. An electronic bed board system has been in place for approximately 6 months. This new web-based tool provides current information on a daily basis as to where crisis, residential and hospital placements are located and available, providing access to least-restrictive environments when needed. Oversight is provided on a daily basis during the work week and through 24/7 on-call staff, for all patients who need involuntary hospitalization and/or are in the process of moving through that level to a less-restrictive level of care.

DMH is also moving towards further development of the clinical management resource tools and personnel to support a more effective care management system. The care management and utilization review managers will monitor the flow in and out of acute-care inpatient services. Care management staff are also working closely with DVHA care managers to provide oversight to all Medicaid inpatient psychiatric hospitalization. These review processes closely align between the two departments for consistency with inpatient providers as well. Equally important to DMH is a Technical Assistance team comprised of psychology and nursing personnel who are available to consult with hospitals and DAs on individuals needing more intensive case management and support services when being discharged from acute hospitalization or as active deterrents to unnecessary inpatient hospitalization. A workgroup has been convened to further development in meeting the 24/7 the clinical care management resource system.

Oversight of Regulatory Requirements for DHs and DAs Receiving Funding Through the State:

Under Act 79, DMH will be forming a workgroup with the Vermont Association for Hospitals and Health Systems (VAHHS), Vermont Program on Quality in Health Care (VPQ), and the DHs to identify and reduce overlapping or redundant federal and state reporting requirements for hospitals. Possible requirements to be reviewed include: 1) reporting of serious adverse events required by the Vermont Department of Health (VDH) and DMH, and 2) the collection and reporting of aggregate seclusion and restraint events according to the requirements of the Joint Commission, the Centers for Medicare and Medicaid Services (CMS) and DMH.

DMH will also be working with the Vermont Council for Developmental and Mental Health Services to identify and reduce overlapping or redundant requirements for the DAs. Possible requirements to be reviewed include:

- Critical incident reports by required by DMH, VDH's Division of Alcohol and Drug Abuse (ADAP) and the Department of Children and Families (DCF)
- Bed board census data
- Forms for client plans of care and CRT client reassessments every two years
- Fidelity reviews prepared by DAs' Supported Employment programs for Vocational Rehabilitation

- Improved information technology functionality and interoperability among the Vermont Health Information Exchange (VHIE), the National Committee for Quality Assurance (NCQA), hospitals, primary care providers, DAs, DMH, DCF, the Department of Disabilities Aging and Independent Living (DAIL), and ADAP
- Housing subsidy reporting for DMH and the Department of Housing and Urban Development (HUD) for service point tracking
- The “One Plan” through Children’s Integrated Services (CIS) for DMH and DCF
- Substance Abuse Treatment Information System (SATIS) data for ADAP and DMH

Quality Management Unit Processes for DMH

Formation of a new DMH Quality Council was approved by the former Commissioner Patrick Flood and will soon be convened by Acting Commissioner, Mary D. Moulton. Membership of the Council is comprised of the Director of Quality Management (lead), DMH Medical Director, the Directors of services for adult mental health and for children, adolescents and their families, the Director of Mental Health Services, the Deputy Commissioner, and the Executive Director of the GMPCC. Others may be invited to participate when discussion of specific issues requires their attendance.

The Quality Management Unit will provide oversight and facilitate development of standardized definitions and standards of practice to be implemented by the DAs and DHs providing care. The work will include the following:

Data reporting and analysis in collaboration with partners at both AHS and the community providers to measure engagement and retention in care, utilization review, integration with health care services, and involvement of peers and other stakeholders in policy development.

DMH has contracted with the Vermont Center for Independent Living (VCIL) to coordinate and support the development of a Vermont Peer Network (VPN) for organizations offering peer-based services and supports to individuals with mental health and other co-occurring challenges. This network will support the expansion, coordination, and quality improvement of peer services in the state, including:

- Coordinating core training
- Workforce development (e.g. recruitment, retention, career development)
- Mentoring
- Quality improvement
- Coordination of peer services
- Communication and networking
- Systems advocacy

DMH has contracted with Southern New Hampshire University to work with provider, peers, and family organizations as well as other stakeholders to coordinate the establishment of an independent, cooperative organization focused on mental health practice improvement and workforce development in the state of Vermont. This new organization, referred to as the Educational and Practice Improvement Cooperative (EPIC), will work with mental health providers of all types - including community-based providers, residential providers, hospital-based providers, peer providers, consumers, family members, and other types of health, mental health, substance abuse and human service organizations - to support the implementation of

consumer/family centered workforce competencies based on best practices in behavioral health and to promote promising, evidence-based, and recovery-oriented practices within the state’s treatment and support system. These efforts will improve the quality-of-life outcomes for individuals receiving services from Vermont’s public mental health system. EPIC will also focus on establishing and supporting core-competency training in mental health and substance abuse for Vermont’s health, human services, mental health and substance abuse providers to ensure that the workforce has the core values, skills and knowledge to meet the needs of the consumers and families receiving service.

Financial Review

Chart Thirty-Three: Per Capita Cost for Services

Statewide Overview
Adult Outpatient Programs, CRT Clinical & Support Services, and Emergency Clinical & Support Services
Fiscal Years 2010, 2011, and 2012

	Adult Services			CRT Services			Emergency Services		
	Outpatient			Clinical & Support Svcs.			Clinical & Support Svcs.		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
Cost per Unit	\$ 84.75	\$ 93.82	\$ 111.64	\$ 68.08	\$ 71.83	\$ 77.61	\$ 222.79	\$ 195.31	\$ 245.95
Expenditures/Capita	\$ 15.61	\$ 16.23	\$ 18.19	\$ 50.49	\$ 49.24	\$ 48.65	\$ 6.47	\$ 6.28	\$ 9.00

Analysis is based on information provided by Department of Mental Health Business Office and Monthly Service Report (MSR) data submitted to the Vermont Department of Mental Health by the designated agencies for FY2010 - FY2012.

DMH spends the most public funding for individuals identified as having severe mental health needs. The roughly 3,000 individuals served annually and accounting for these expenditures are enrolled in CRT Programs throughout the state. The per capita spending for these individuals has decreased from \$50.49 to \$48.65 over the most recent three-year period. In sharp contrast to the CRT Programs, individuals served in the Adult Outpatient program’s offered by the DAs have received 37% more funding per capita: \$18.19 up from \$15.61. This spending actually represented a 16% increase for this program during this time period. Crisis Services programs, which operate 24/7 and are available to anyone in a mental health crisis are currently funded at a modest rate of only \$9.00 per capita across the state. This is also up 39% in the most recent three fiscal years. Even with these discrepancies across programs, Vermont is currently ranked sixth in the nation for overall community mental health services expenditures.

Quality Management Unit Goals

As noted above, the Quality Management Unit is newly reconstituted. It is working with both internal and external stakeholders to determine priorities and time lines for its goals and objectives for the next one to three years and beyond. The following list presents top-priority goals identified by DMH leadership.

- Update of major documents to include *Administrative Rules* pertaining to agency designation, mission/vision statements and coordination with other mission/vision statements within AHS
- Establish the Quality Council to begin its work in January of 2013
- Complete recruitment and hiring process to achieve full complement of QM staff
- Fully implement the utilization review process for inpatient psychiatric hospitalization of Level I patients
- Develop and implement reporting processes:
 - Establish data points pertaining to patient care and safety to be tracked and analyzed across all DHs
 - Add key variables to DMH Dashboard for monthly tracking
 - Train and certify staff conducting in the LOCUS tool (level of care utilization of services, for psychiatric and addiction services) to determine appropriate level of care (two central office staff have now attained their certifications)
 - Determine performance measures for the Care Management Team functions to assess efficacy of the interventions DMH is using to facilitate transitions across elements of the system of care
 - Perception of Care Surveys will be reviewed and revised as determined necessary; to include an expanded population of consumers
 - Work closely with the Evidence-Based Practice Consortium to identify EBPs being utilized across state-funded programs and work with the DAs to establish performance measures
 - Tie performance measures in with AHS Master Grant goals

5. Planning for the Future

This section lists the top priorities for the department based on current system stresses identified by other providers, considers DMH evaluation of current system of care data within this report, and emphasizes the recommendations in the DMH consultant's report through the Behavioral Health Policy Collaborative. Identified issues and recommendations for future planning are as follows:

- High utilizers of hospital
 - DMH will initiate a process to review readmission trends in order to identify specific factors and develop a plan to reverse the increase in readmission rates
 - All cases readmitted three times to a hospital are referred to the technical support team for review
 - The care management and technical support team will work together to identify the best living environment match to assist a person in gaining stability within the community
 - DMH anticipates a need for more wraparound programs; 1-2 bed supported apartments and wrap-around services are highly successful investments in the recovery of the individual. Among the individuals supported in this manner, hospitalization rates are negligible
 - A few individuals move from hospital to high-cost community-based wraparound programs and require significant supervisory resources, and yet they accept little in the way of treatment and present ongoing safety concerns. Evaluation of the numbers in this category, as well as a public-policy discussion regarding the cost

of individualized programming versus congregate housing, is planned for the coming year

- Individuals with higher acuity being treated in the community, placing high demand for services/staff in outpatient arena.
 - Funding needs to be maintained and increased needs evaluated for outpatient management programming
 - Over time, the CRT and AOP programs could blend, thus addressing the consultants' recommendation that there be an expansion in the CRT program. DMH believes it is less important what we name the program than to have sufficient service provision with appropriate funding resources

- Flow of individuals within the system of care
 - When the hospital and crisis bed inpatient system has no beds, there is a backup in emergency rooms statewide (see Chart 20)
 - The clinical care management system needs to continue its working partnership with hospitals, bridging from hospital to communities around placement options. DMH is developing training and consultation, both legal and clinical, to emergency rooms regarding the care and treatment of a person in mental health crisis.
 - Outpatient community-based services need to be available to a person seeking services immediately upon discharge from the hospital. While the system of care now has a standard, assuring that a person seen by crisis services will receive outpatient follow-up services within 48 hours, persons discharged as outpatient clients from the hospital may still experience a delay in services.

- Concerns around staff capacity in the outpatient arena
 - Staff capacity is an issue, with approximately 75 open positions statewide within designated agencies that are trying to hire for the programs which support our system of care
 - Designated agencies have identified a need to increase the rate of pay as an issue in hiring

- Collaboration with Corrections
 - Bridging from Corrections to community services, particularly for clients who are categorized as seriously functionally impaired (SFI), continues to require more resources than are available within communities, particularly in the outpatient setting. Public policy discussion is being led by AHS
 - A state mental health liaison assists in planning, assessment, and implementation within designated agencies
 - Training opportunities regarding working with the SFI population have been jointly sponsored over the past two years by DMH and DOC. A DOC/DMH work group will begin meeting to discuss on-going training for correctional officers and clinicians regarding the SFI population. The goals of the work group will include identification of DOC needs for augmentation of its current contract for provision of mental health services, consultation, and clear protocols with DMH for inmates needing in-patient hospital treatment

- Treatment of individuals with co-occurring issues (mental health and substance abuse)
 - Designated agencies throughout the state are working towards co-occurring treatment capability
 - Although funding streams are still separate for mental health and substance abuse services, program integration efforts are outlined below

- Needs of Refugee Resettlement programs
 - The population of refugees making their homes in Vermont is growing. Mental health needs are growing exponentially for these diverse groups
 - DMH will participate in focus groups throughout the year to discern need, assist area providers with supports, and develop a report with recommendations to meet needs of these groups by September 2013

- Complete implementation of Act 79 activities and evaluate effectiveness
 - Evaluation of the effectiveness of enhanced community supports, no-refusal hospital beds, crisis bed programs, intensive residential recovery beds, and the care management/technical support system shall take place over the next year to formulate proposals for new programming

- DMH is working toward implementing a robust Information Systems program.
 - At the time of closing, the Vermont State Hospital was utilizing portions of the PsychConsult electronic health record (EHR) and had plans to expand its use to make it a fully integrated EHR. At this time DMH has contracted with Askesis, Inc., the makers of PsychConsult, to modify our current EHR package to support the business and clinical functions of the new facility. The PsychConsult package will be a web-based system hosted and supported 24/7 by Askesis, Inc.
 - PsychConsult follows all state and federal standards and is in compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Joint Commission, the Centers for Medicare and Medicaid Services (CMS). PsychConsult is certified for meaningful use, the Medicare and Medicaid EHR Incentive Programs provide financial incentives for the “meaningful use” of certified EHR technology. DMH is working with Vermont Information Technology Leaders, Inc., (VITL) to ensure compliance with the health information technology plan established under 18 V.S.A. § 9351. The goal at DMH is to fulfill the strategic mission through implementation of a state-of-the-art EHR that maintains interoperable connectivity to the Health Information Exchange (HIE) network to coordinate care

- Integration of health, mental health, and substance use care

DMH, in collaboration with the Departments of Health and Vermont Health Access, continues to support the coordination and integration of mental health, substance abuse, and physical health services within all parts of the health care delivery system. In the coming months and years, DMH will need to expand and enhance its work to support the following:

- 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).

Appendices

Appendix A – Comments from Key Stakeholders

Mr. Michael Sabourin, Patient Representative

Mr. Jack McCullough III, Vermont Legal Aid – Requested but not received.

Mr. Edward Paquin, Disability Rights Vermont – Requested but not received.

Appendix B – DMH Progress Towards the Implementation of Act 79

Appendix C – Act 79 Consultant report crosswalk to document

Appendix D - NOMS (National Outcome Measures) data sheet

APPENDIX A: Comments from DMH's hospital patient representative; Michael Sabourin, 12/17/12

(a) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committees on human services and on judiciary on issues and protections relating to decentralizing high intensity inpatient mental health care. The commissioner of mental health shall:

(1) Recommend whether any statutory changes are needed to preserve the rights afforded to patients in the Vermont State Hospital . In so doing, the commissioner shall consider 18 V.S.A. §§ 7705 and 7707, the Vermont Hospital Patient Bill of Rights as provided in 18 V.S.A. § 1852, the settlement order in Doe, et al. v. Miller, et al., docket number S-142-82-Wnc dated May 1984, and other state and federal regulatory and accreditation requirements related to patient rights.

Should consider 42 CFR §482.13, Condition of participation: Patient's rights, Such as: §482.13 (a)(2)(i)-(iii) regarding grievances; (b)(3) The patient has the right to formulate advance directives; (b)(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital; (d)(2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame.; e) Standard: Restraint or seclusion.; (g) Standard: Death reporting requirements:

As well as rights previously available to patients at the former Vermont State Hospital through the VSH Notice of Patient Rights: (12) If you are an involuntary patient, you have a right to a judicial review; (15) You have a right to ... habeas corpus; (16) you have the right to request the opinion of a consultant at your expense; (24) you have the right to exercise your rights without reprisal and (32) you have the right to receive services without regard to race, religion, etc..

There was language at VSH, which I have not been able to locate, that enabled a patient to call their legal representative, clergy, etc. at any time. I think this should still be considered as well as adding the DMH/VPS patient representative. I am not getting some phone calls from the Retreat because they come out of a patients' allotted two phone calls per shift.

18 V.S.A. §§ 7705

(1) to communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital;

(2) to receive visitors and to make and receive telephone calls; and

Above language antiquated; should be updated to consider language regarding electronic communications, computers, cell phones, portable phones, etc.

(b) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committee on human services regarding the department's efforts to date to plan for implementation, quality improvement, and innovation of Vermont's mental health system and how the department recommends that it proceed in its efforts to improve the system. The recommendation shall be based on an assessment of outcome and financial measures focused on at least the following criteria for individuals with a mental health condition:

(1) the development of sufficient capacity for inpatient and community psychiatric services :

Still a work in progress. There is an obvious demand for stepdown beds that are hopefully forthcoming; however there is also a concern that we are developing a reliance on stepdown facilities. A number of individuals have gone to stepdown facilities whom have known resources in the community; i.e there own residences, family support, etc. Question the philosophy of stepdown services instead of wrap around services.

and peer supports across the continuum of care;

There has been a marked increase in peer services with the advent of the Wellness Center, Alyssum, DMH Patient Rep., Another Way hirings, NAMI Peer connections, etc. Could still use support in expanding the patient representative role and providing peer field workers in the Northeast Kingdom and Bennington areas.

And though hiring Mental Health Recovery Specialist at the Green Mountain Psychiatric Center was a nice direction; there wasn't enough emphasis put on "peer" as there could have been.

(2) the support of individuals in accessing the services nearest to their home:

Certainly room for improvement in this area. Psychiatric inpatient care close to home was not an option for individuals residing in the Northeast Kingdom and residents from Chittenden and Franklin Counties were on a regular basis finding themselves at the Brattleboro Retreat. Also there appears to be little if no effort to get someone in a bed closer to home once they have landed in a remote location.

(3) the reduction in emergency department usage and law enforcement intervention;

An area where the department appears to be lacking inroads. It is reported that there is still a demand on emergency departments. We could do a more efficient job on the front end of triaging the urgency of the need for an individual to be taking up a bed at that point in time; particularly in situations of an ONH violation. We could also as a practice have mental health workers accompany law enforcement on welfare checks. I probably heard half a dozen times this fall of welfare checks equaling being carted off to the emergency room by law enforcement. We could be more diligent/ proactive in the use of mental health and drug courts.

(4) the reduction in hospital admissions and length of inpatient stays, including any impact on readmissions; -

Continues to be a demand on psychiatric inpatient services. The lack of psycho-social skill building and psychological services prolongs the stay of some individuals; particular those with cognitive impairments. These individuals could be better or as well served in other settings such as outpatient, dbt residences, rehab, etc.

(5) the implementation of quality assessment tools for evaluation of services at all levels, including those needed to measure the effectiveness of the care management system;

Unaware of any outside the bedboard

(7) individuals' satisfaction with provided services.

For the most part individuals remain satisfied with services however there is no or little recourse for those individuals that are unsatisfied. The opportunity to change treating physicians or facilities is for the most part lacking.

APPENDIX B: Progress Towards Implementation of Act 79

Act 79: Core Requirements and Status Updates

Requirement	Status:
<p>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:</p> <ul style="list-style-type: none"> -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. 	<p>In progress:</p> <ul style="list-style-type: none"> -Care Management team meets weekly with hospitals to review all patients involuntarily hospitalized and monitor transitions between levels of care. -DMH tracks individuals who are hospitalized and on Orders of Non-hospitalization. -DMH is contracting with Vermont Psychiatric Survivors for an additional .5 FTE patient representative. -Electronic web-based system up and running since August 2013. -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 have developed and begun implementing approaches to providing least restrictive transportation options for those needing involuntary hospitalization.
<p>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.</p>	<p>In progress:</p> <ul style="list-style-type: none"> -Statewide Warmline to begin operations in Spring 2013. -New peer outreach services funded in St. Johnsbury and Rutland. -Capacity and infrastructure grants to peer organizations complete. -Peer workforce development program through Vermont Center of Independent Living established; core training events have already occurred.

Improve DA Emergency Response, Non-categorical Case management, Mobile Support Teams, Adult Outpatient services, and Alternative residential opportunities.	In progress: See pages 24-31
Develop at least four Short-term Crisis Beds in designated agencies to prevent or divert individuals from hospitalization when clinically appropriate,	Complete: -4-bed crisis program in Rutland county, 2 bed crisis program in Orange county, and 2 bed crisis program in Lamoille county are operating.
Develop voluntary five-bed residence (Soteria House) for individuals experiencing an initial episode of psychosis or seeking to avoid or reduce reliance on medication.	In progress: -Contract with Pathways Vermont to develop program in Chittenden county.
Develop Housing Subsidies for individuals living with or recovering from mental illness.	Complete: -94 persons who were homeless, mentally ill and at risk of needing an acute care bed have been housed and supported in the community by housing subsidies and care.
Develop 15 Intensive Residential Recovery (IRR) Beds in northwestern Vermont	In Progress: -Planning for 8-bed IRR beds in Westford underway. -Additional 7 IRR beds on hold.
Develop 8 Intensive Residential Recovery Beds (IRR) in southeastern Vermont	Complete: -Hilltop 8-bed residential program in Westminster up and running.
Develop 8 Intensive Residential Recovery Beds (IRR) in either central or southwestern Vermont.	In progress: -4-bed IRR in Rutland being planned. -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)	In progress: -Brattleboro Retreat has been providing an average of 26 Level I beds to date. This will be reduced to 14 Level I beds as part of the no-refusal system when the 25-bed state-run facility opens.
Establish 6-Bed Inpatient Unit in southwestern Vermont (RRMC)	In Progress: 6-bed acute inpatient psychiatric unit at RRMC is under construction.

Construct and operate a 25-bed Acute Inpatient Hospital in central Vermont (Berlin)	In Progress: -Application for site development and construction approved by the town of Berlin. -Certification of Need (CON) granted by DFR. -Architectural and program planning in progress. -Scheduled to open in 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.	Complete: -DMH has a contract for beds at FAHC.
Develop 8-bed Temporary Acute Inpatient Hospital in Morrisville , which will be discontinued when the state-owned and -operated hospital is operational.	Complete: -8 bed Green Mountain Psychiatric Care Center now accepting patients.
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.	In progress: -Construction of facility in Middlesex to be completed by end of January 2013 with the expected opening in March 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.	Complete: -Critical Incidents Protocol developed in collaboration with DAs and the Vermont Council of Development and Mental Health Services.
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.	In progress: -Draft rules created; to be reviewed by ICAR and LCAR in the coming months.
Reports	
Report annually on utilization of services within the system, the adequacy of the system's capacity, individual experience, and the performance of the system as compared to national standards.	Complete: See pages 10-43

<p>Report regarding the decentralization of inpatient mental health care, including any statutory changes needed to preserve rights afforded to patients at the former state hospital, the development of a process to ensure public involvement with policy matters, the development of consistent definitions of seclusion and restraint, and the efficacy of housing subsidy programs.</p>	<p>Complete: See pages 8-10, 43-49</p>
<p>Report on DMH efforts to plan for implementation of and its recommendations to improve the new mental health system, based on an assessment of outcome and financial measures.</p>	<p>Complete: See pages 48-51</p>
<p>Report on plan to streamline overlapping state and federal reporting requirements for providers in the mental health care system.</p>	<p>In progress: See page 45</p>
<p>Report regarding fiscal review determination as to whether the department's hospital cost reimbursement methodology reflects reasonable actual costs.</p>	<p>Complete: See page 47</p>
<p>Independent consultant report to evaluate the structure, services, and financial implications of Vermont's mental health care system, including:</p> <ol style="list-style-type: none"> 1) Whether the proposed mental health system serves the needs of Vermonters, and if there are any needs unmet by the system, how they should be addressed. 2) Recommendations for data and evaluation mechanisms necessary to manage and improve the quality of care and outcomes for individuals with a mental health condition. 	<p>Complete: See Appendix C</p>

APPENDIX C: Act 79 Consultant report crosswalk to document

RECOMMENDATIONS: (<i>Priority noted in bold.</i>)	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. 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.
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.	Complete. This is the responsibility of the Medical Director.
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 is gathering this data.
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.

<p>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.</p>	<p>In process.</p> <p>The Care Management Unit is undergoing a review of activities and responsibilities. Recommendations from this review will include a comprehensive staff plan.</p>
<p>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.</p>	<p>In process.</p> <p><i>See 9 above.</i></p>
<p>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.</p>	<p>In process.</p> <p>Plans to expand the scope of the Blueprint are underway. The development of the “Hub and Spoke” model for substance abuse treatment has started.</p>
<p>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.</p>	<p>In process.</p> <p>Work with the DHs and DAs to define expectations continue.</p>
<p>13. The Department of Mental Health should establish comparative performance targets and measures (e.g., admission, discharge, and readmission) 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.</p>	<p>In process.</p> <p>Dashboard development is underway. Incentive payments have been and will continue to be added to the Master Grant for DAs and contract with the DHs.</p>
<p>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.</p>	<p>In process.</p> <p>The new hospital is designed to meet all standards.</p>

<p>15. The Department of Mental Health should immediately develop a workgroup led by its medical director to develop appropriate policies, 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.</p>	<p>In process.</p> <p>Workgroup meets regularly.</p>
<p>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.</p>	
<p>17. Evaluate the clinical eligibility criteria and raise the cap on Community Rehabilitation and Treatment (CRT) to accommodate increased need for CRT services.</p>	<p>In process.</p>
<p>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.</p>	<p>In process.</p>
<p>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.</p>	<p>Complete.</p> <p>Included in DH contracts and enhanced funding for DAs.</p>
<p>20. The Department of Mental Health should expand jail diversion and crisis intervention teams available to work with local and state police.</p>	<p>Complete.</p> <p>Mobile crisis units have been established across the state.</p>
<p>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.</p>	<p>In process.</p>

<p>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.</p>	<p>In process.</p>
<p>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.</p>	<p>Complete Quality Management Unit Director was hired in September 2012.</p>
<p>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.</p>	<p>Under consideration.</p>

APPENDIX D: NOMS



Vermont 2011 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System



Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	6,879,637	38.83	22.10	56
Community Utilization per 1,000 population	6,587,988	38.43	21.17	55
State Hospital Utilization per 1,000 population	156,387	0.41	0.50	53
Other Psychiatric Inpatient Utilization per 1,000 population	364,926	0.58	1.37	41

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	578,225	32.2%	34.7%	54
Employed (percent with Employment Data)**	578,225	22.0%	18.1%	54

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	69.3%	70.5%	51

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	61.2%	64.6%	51

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	11,213	11.7%	9.0%	50
State Hospital Readmissions: 180 Days	25,438	19.0%	20.5%	52
State Hospital Readmissions: 30 Days: Adults	10,105	11.8%	9.3%	50
State Hospital Readmissions: 180 Days: Adults	22,812	19.1%	21.0%	52
State Hospital Readmissions: 30 Days: Children	1,108	0.0%	7.3%	24
State Hospital Readmissions: 180 Days: Children	2,620	0.0%	17.2%	27

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,031,681	84.7%	82.0%	55
Homeless/Shelter	151,011	2.1%	3.1%	53
Jail/Correctional Facility	89,663	0.2%	1.8%	50

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	68,498	-	2.5%	38
Supported Employment	50,394	30.5%	1.7%	40
Assertive Community Treatment	65,311	-	2.1%	41
Family Psychoeducation	17,644	-	1.2%	16
Dual Diagnosis Treatment	58,876	-	3.6%	24
Illness Self Management	159,167	-	11.6%	21
Medications Management	296,177	83.1%	22.6%	18

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	18,392	-	1.7%	28
Multisystemic Therapy	8,448	-	1.1%	20
Functional Family Therapy	10,989	-	1.8%	14

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	68.9%	70.0%	51
Child/Family Improved Social Connectedness	73.2%	85.3%	49

*Denominator is the sum of consumers employed and unemployed.

**Denominator is the sum of consumers employed, unemployed, and not in labor force.

CMHS Uniform Reporting System - 2011 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,116	38.83	6,879,637	22.10	56
Community Utilization per 1,000 population	23,862	38.43	6,587,988	21.17	55
State Hospital Utilization per 1,000 population	254	0.41	156,387	0.50	53
Medicaid Funding Status	15,855	67%	4,232,274	64%	54
Employment Status (percent employed)	2,208	22%	578,225	18%	54
State Hospital Adult Admissions	260	1.03	131,934	0.91	52
Community Adult Admissions	5,909	0.42	10,568,018	2.42	52
State Hospital LOS Discharged Adult patients (Median)	-	29 Days	-	57 Days	50
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	-	66 Days	-	63 Days	48
Percent Adults with SMI and Children with SED	9,014	37%	4,782,147	70%	55
Percent of Client who meet Federal SMI definition	-	22%	-	71%	54
Adults with Co-occurring MH/SA Disorders	-	20%	-	21%	51
Children with Co-occurring MH/SA Disorders	-	3%	-	5%	49
Adult Consumer Survey Measures					
	State Rate		U.S. Rate		States
Access to Services	82.2%		85.2%		51
Quality/Appropriateness of Services	84.6%		88.4%		51
Outcome from Services	69.3%		70.5%		51
Participation in Treatment Planning	76.9%		80.4%		51
General Satisfaction with Care	84.4%		88.4%		51
Child/Family Consumer Survey Measures					
	State Rate		U.S. Rate		States
Access to Services	84.3%		83.8%		50
General Satisfaction with Care	76.8%		83.8%		51
Outcome from Services	61.2%		64.6%		51
Participation in Treatment Planning	84.1%		86.8%		51
Cultural Sensitivity of Providers	87.3%		92.5%		50
Consumer Living Situations					
	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,552	84.7%	4,031,681	82.0%	55
Jail/Correctional Facility	38	0.2%	89,663	1.8%	50
Homeless or Shelter	425	2.1%	151,011	3.1%	53
Hospital Readmissions					
	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	24	11.7%	11,213	9.0%	50
State Hospital Readmissions: 180 Days	39	19.0%	25,438	20.5%	52
Readmission to any psychiatric hospital: 30 Days	0	0.0%	40,509	12.0%	32
State Mental Health Finance (FY2009)					
	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	\$118,100,000	81.7%	\$26,971,286,468	71.7%	51
SMHA Revenues from State Sources **	\$22,500,000	16.1%	\$15,306,676,059	40.9%	51
Total SMHA Expenditures	\$144,500,000	-	\$37,611,390,427	-	51
Adult Evidence-Based Practices					
	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	65,311	2.1%	41
Supported Housing	-	-	68,498	2.5%	38
Supported Employment	899	30.5%	50,394	1.7%	40
Family Psychoeducation	-	-	17,644	1.2%	16
Integrated Dual Diagnosis Treatment	-	-	58,876	3.6%	24
Illness Self-Management and Recovery	-	-	159,167	11.6%	21
Medications Management	2,451	83.1%	296,177	22.6%	18
Child Evidence Based Practices					
	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	18,392	1.7%	28
Multisystemic Therapy	-	-	8,448	1.1%	20
Functional Family Therapy	-	-	10,989	1.8%	14
New Generation Medication					
	State Number	State Rate	U.S.	U.S. Rate	States
New Generation Meds: State Hospitals	120	90.91%	5,855	54.03%	13
New Generation Meds: Community MH	425	31.72%	39,605	33.81%	11
New Generation Meds: Total System	519	37.23%	22,070	26.64%	9
Outcome					
	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	32,607	7.1%	44
Juvenile Justice Contacts	569	5.5%	5,506	6.6%	42
School Attendance (Improved)	126	34.5%	9,105	38.4%	37

* Includes Other 24 -Hour expenditures for state hospitals.

** Revenues for state hospitals and community MH