VERMONT2016

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2016

Department of Mental Health
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Executive Summary: The Mental Health System of Care

The Department of Mental Health (DMH), with the Designated Hospitals (DHs) and the Vermont Designated Agencies (DAs), as well as other community and Agency of Human Services (AHS) partners, has continued to work throughout the past year to move the system of care forward within Vermont for people with mental health needs. The first Act 79 report addressed rebuilding a system of care in the time of crisis following Tropical Storm Irene. The second year focused on continuing to build capacity within the inpatient and outpatient systems, expansion of quality and evaluation activities, increased focus on the transitions of care, and internal changes and restructuring within the Department. As with the FY 2015 report, the FY 2016 report outlines the progress made to date in implementing the systems developed and outlined above.

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 an increase in the capacity of case management services for designated agency outpatient clients and emergency outreach services in every community, which has now been in place for approximately three years.

The array of peer support programs conceptualized in Act 79 continues to develop and expand their essential role in our system of care. These services include community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. Peers are also working within some designated agencies to provide supports to individuals awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services. Enhancement of these programs over the past year have included core training and mentoring for staff using the Intentional Peer Support Curriculum, which is used nation-wide for peer support providers, and expansion of service outcomes reporting using the Results-Based Accountability framework.

Emergency services provided by the Designated Agencies are the initial point of access for crisis beds, and to some extent, access to hospital beds for psychiatric care throughout the state. Working closely with law enforcement is essential to this process. A statewide inter-disciplinary training program known as “Team Two,” between law enforcement personnel and mobile crisis responders has grown and expanded to include further training opportunities this coming year, for dispatchers and 911 call center staff. This continues to be an area of need for further collaboration across many jurisdictions that are served by multiple law enforcement agencies. The Department has welcomed the support of the Department of Public Safety in achieving the goal of integration of these services in the interest of quality psychiatric care and public safety.

The departmental care management system facilitates the coordination of admissions and aftercare services across the involuntary inpatient psychiatric services at all Designated Hospitals and the Vermont Psychiatric Care Hospital. Care managers assist crisis services teams and providers to triage individuals into programs for admission, as well as facilitating the referral process for individuals to step-down programs, transitional housing programs, and supportive housing units when they are ready to return to the community. To accomplish this task, the team works closely with hospitals, holding weekly clinical

team meetings regarding inpatient status and supporting discharge and aftercare planning, creating a bridge to community programming, with technical assistance when 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. The UR Care Managers also review all Medicaid involuntary and Level 1 admissions, regardless of whether they are enrolled in any DA programs.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through the department's statewide conference, the DMH has partnered with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) and other community partners to support numerous training, technical assistance and practice improvement initiatives for the clinical system of care. VCPI is entering its second year of facilitating a statewide initiative to reduce seclusion and restraint in designated hospitals, using the "Six Core Strategies to Reduce the Use of Seclusion and Restraint ©"and is also providing trainings in the following clinical areas:

- Integrated Dual Disorder Treatment (IDDT) Initiative
- Promoting Recovery: Youth Adults First-Episode Psychosis (FEP) Initiative
- Core Competency for Direct Care Staff
- Dialectical Behavior Therapy
- Open Dialogue
- Treatment of Early Episode Psychosis

Current and future work continues to include stakeholder involvement. Over the past year, the Department has continued to host an Emergency Involuntary Procedures (EIP) Advisory Committee, which is comprised of a large cadre of stakeholders. Quarterly, this committee reviews data and receives updates from Designated Hospitals regarding their implementation of strategies to reduce seclusion and restraint. The committee also includes Disability Rights Vermont, who receives EIP Certificates of Need (CONs) for any involuntary patients in its capacity as Mental Health Ombudsman. The Department has also worked closely with the Designated Hospitals to further refine processes and to implement changes identified in the Act 192[1] legislation. These changes have included second certifications being completed while an individual is awaiting placement under an Emergency Examination order, seeking expedited hearings for non-emergency involuntary medications, and a notice of patient's rights being provided to patients while waiting in an Emergency Room.

Through its expanding focus on suicide prevention, the Department of Mental Health has partnered with the Center for Health and Learning and other AHS departments to begin implementation of the nationally-recognized Zero Suicide model, which has included training for clinicians in Chittenden and Franklin/Grand Isle counties on *Collaborative Assessment and Management of Suicidality* (CAMS). This process will make access to services for people better and provide training for clinicians to deliver state-of-the-art care to those seeking help.

[1] http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT192/ACT192%20As%20Enacted

The Department, in collaboration with the Vermont Suicide Prevention Coalition, is also working with the Vermont Federal of Sportsman's Clubs and the Gun Owners of Vermont to develop and disseminate public education and suicide awareness materials and contact information for crisis lines throughout Vermont for Gun Shop owners.

The Department continues to plan for the creation of a permanent Secure Residential Recovery (SRR) program to replace the 7-bed temporary facility in Middlesex. Recent activity has included a *Request for Information* posting to assess interest among community stakeholders to participate in the development and/or operation of a permanent secure recovery facility, and planning across multiple AHS departments to assess how the mental health needs of populations being served by other departments might be addressed by the future permanent facility.

The "Planning for the Future" section of this document outlines the path to move forward. The Department realizes that many of the new programs put into place over the past two years require continual monitoring as to the outcomes we are aiming to achieve. The Department of Mental Health looks to the legislature, stakeholders, and their colleagues in the Designated Hospitals and Designated Agencies to continue to work together towards improving care and the quality of life for persons with severe mental illness.

2015 Accomplishments

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness; Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions; Emergency Services for anyone, regardless of age, in a mental-health crisis; and child and adolescent mental health services including children who have a serious emotional disturbance and their families. The Department 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 Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

The Department has made significant progress since the emergency closing of the Vermont State Hospital in late August 2011 following Tropical Storm Irene. Inpatient care is being provided using a decentralized system which includes one state-run hospital and five Designated Hospitals located across the state. Community services have been enhanced and support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

The new Vermont Psychiatric Care Hospital which opened in July 2014 has been in operation for one year and has attained Centers for Medicare and Medicaid Services (CMS) certification and The Joint Commission (TJC) accreditation. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center are fully operational and have remained at capacity throughout the year.

Local hospital emergency departments in collaboration with the Designated Agencies throughout the state provide screening, stabilization, and limited treatment until admission to a psychiatric inpatient bed can be facilitated. As part of "decentralizing high intensity inpatient mental health care,"[2] the Department is also working to preserve the quality of treatment services afforded to patients who experience involuntary hospitalization in Vermont.

Under Act 79, the Department continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements by category include:

- Hospital Services
  - Operating a new 25 bed psychiatric hospital (July, 2014) that is both CMS certified and TJC accredited

[2] http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT079/ACT079%20As%20Enacted.pdf

    - Ongoing operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat
    - 45 Level 1 beds with a total of 188 adult psychiatric inpatient beds across the system of care
    - Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR)
- Community Services
    - Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
    - Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
    - Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
    - Increased and additional training for Team Two collaboration between law enforcement and mental health responders
    - Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations
    - Resources to assist individuals in finding and keeping stable housing
- Residential and Transitional Services
    - Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
    - Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals.
    - Continued planning for permanent replacement capacity for the Secure Residential Program

The Department is continuing to monitor the functioning of the 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" as written in Act 79. This system encompasses the following functions:

- Departmental Clinical Care Managers provide assistance to crisis services clinicians in the field, Designated Agency case managers, and Designated Hospital social workers to link individuals with the appropriate level of care and services as well as acting as a bridging team for aftercare and discharge planning from hospital inpatient care to community services
- Departmental Clinical Care Managers provide support to Designated Agencies and monitor care to individuals on Orders of Non-Hospitalization (ONH)
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis bed services
- Patient transport services that are least restrictive have been developed and are coordinated through Admissions and Central Office
- Supervision by law enforcement for individuals in Emergency Departments on Emergency Examination status who are awaiting admission to a Designated Hospital is coordinated through the Department
- Review and coordination 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 Mental Health System of Care with a focus on adult services. Measures with national rates are calculated from Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System Tables. A summary report is provided in the appendix.

Utilization of Services and Capacity

The Department of Mental Health, as part of the Agency of Human Services, has been working closely with the Legislative committees of jurisdiction, and multiple other stakeholders, to monitor and enhance the development of services to those requiring mental health care in Vermont as it works to improve the hospital and community based system. This process is reflected in monthly and annual reporting on utilization of these services and is described below.

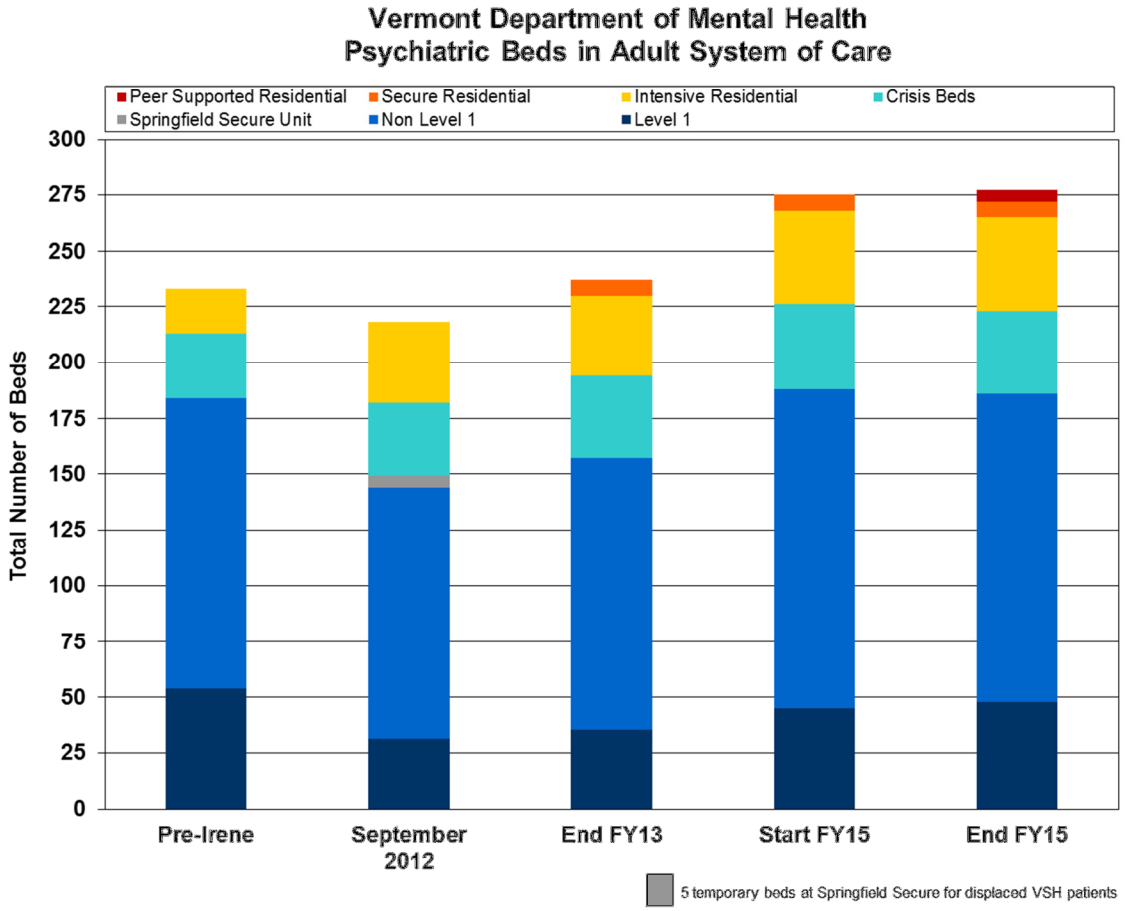
Inpatient Care

Vermont utilizes a decentralized system of inpatient care, where people in need of hospitalization are provided treatment at either the state-run inpatient facility or one of five Designated Hospitals throughout the state. Designated Hospitals provide treatment to both voluntary and involuntary inpatient stays. Involuntary hospitalization stays for people who are the most acutely distressed are defined as Level 1 and are served primarily at the Brattleboro Retreat, Vermont Psychiatric Care Hospital, and Rutland Regional Medical Center. Level 1 hospital stays are a subset of all involuntary hospitalizations in Vermont.

Hospital	Location	Total Adult Inpatient Beds
Brattleboro Retreat	Brattleboro, VT	89
Central Vermont Medical Center	Berlin, VT	14
University of Vermont Medical Center	Burlington, VT	27
Rutland Regional Medical Center	Rutland, VT	23
Windham Center at Springfield Hospital	Springfield, VT	10
Vermont Psychiatric Care Hospital	Berlin, VT	25

An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. Departmental leadership and care management staff work 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 to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care. With the additional services implemented in FY 2014, and with the opening of the Vermont Psychiatric Care Hospital in FY 2015, the numbers of patients waiting for admission and the lengths of time they spend in Emergency Departments or the Department of Corrections has decreased.

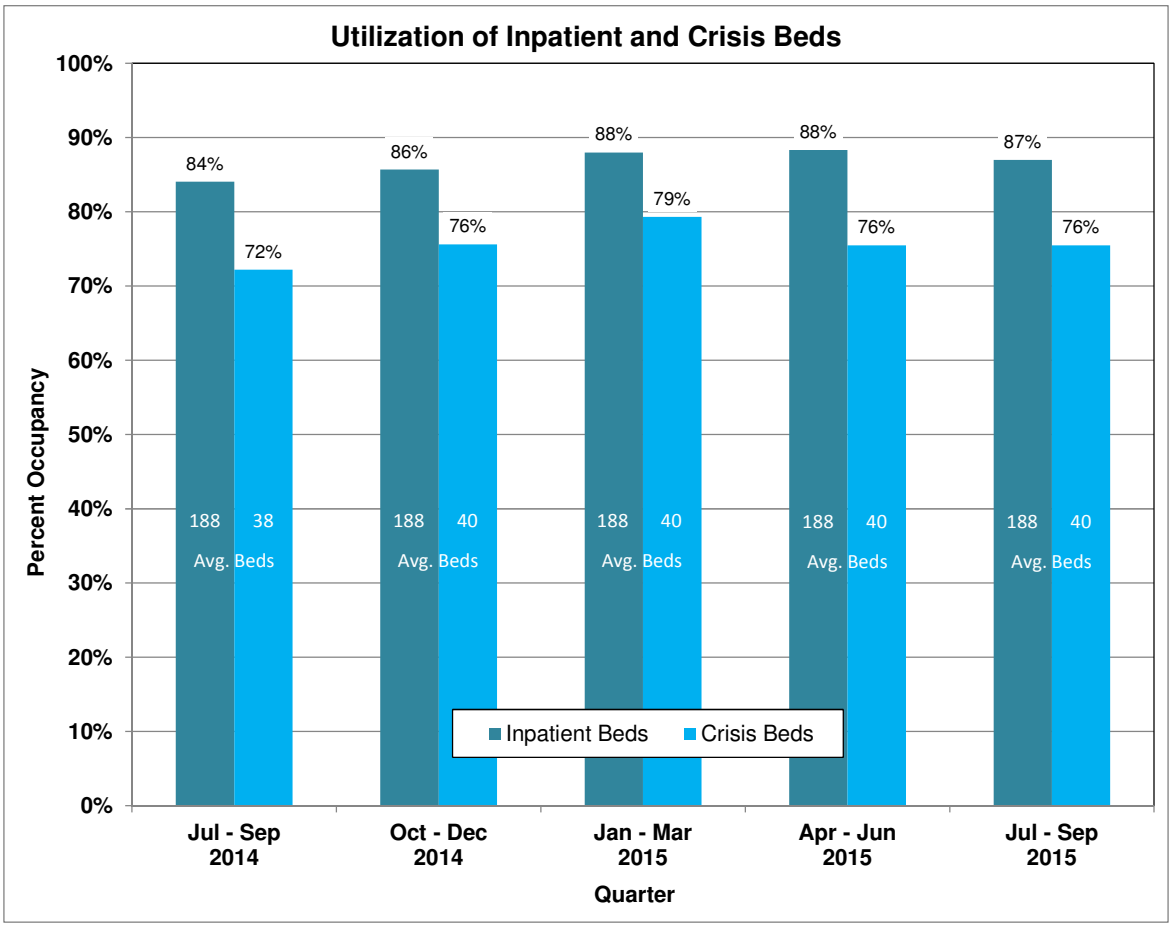
Chart 1: Psychiatric Beds in the System of Care



Vermont has increased its capacity for mental care substantially since August 2011 (Chart 1). Overall, the system capacity for psychiatric beds has increased by almost 50 beds since August 2011. Our current capacity for adult inpatient beds is 188, which includes 45 Level 1 beds. This capacity slightly exceeds pre-Irene numbers.

At the same time, crisis and intensive residential beds have increased from 49 (Pre-Irene) to 87. Additional funding supported expansion of crisis beds for those persons not in need of hospital level of care and for persons needing step-down care; these beds are now available at all ten Designated Agencies. A number of these beds also provide access to peer support services, and the number of peer-supported residential beds has increased with the opening of Soteria House in Chittenden County. Middlesex Therapeutic Care Residence (the Secure Recovery Residence) continues to operate as a secure therapeutic community residential program in which individuals can continue their individual course of recovery. The Department and other AHS agencies are working together to find and develop a permanent site for the Secure Recovery Residence.

Chart 2: Percent Utilization of Adult Inpatient and Adult Crisis Beds

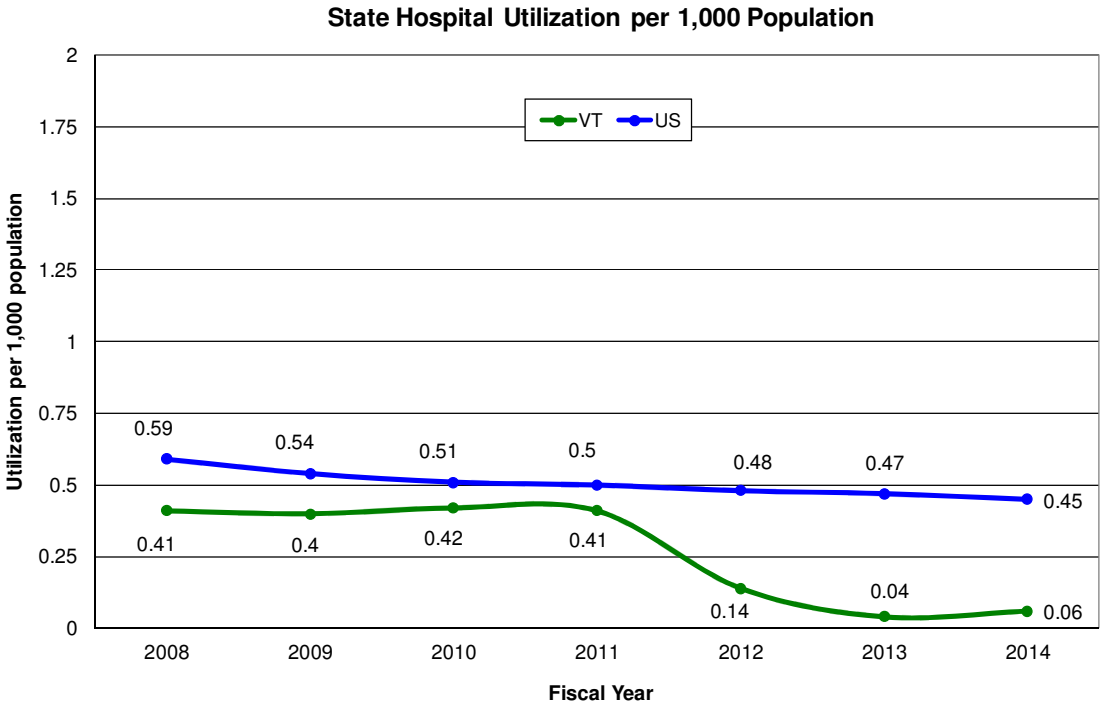


Occupancy of adult crisis beds has remained fairly consistent, though there has been a slight increase in utilization of crisis beds by 4%. The target occupancy rate is 80%, with crisis bed occupancy ranging from 72-79% and averaging 76% over the course of the period. While the target has been set at 80%, there are many factors that influence this data including the time to move people in and out of the facility, staffing, preparation for new admissions, and assuring clients' needs are met. There was a slight increase in the number of adult crisis beds during the time period, from 38 to 40.

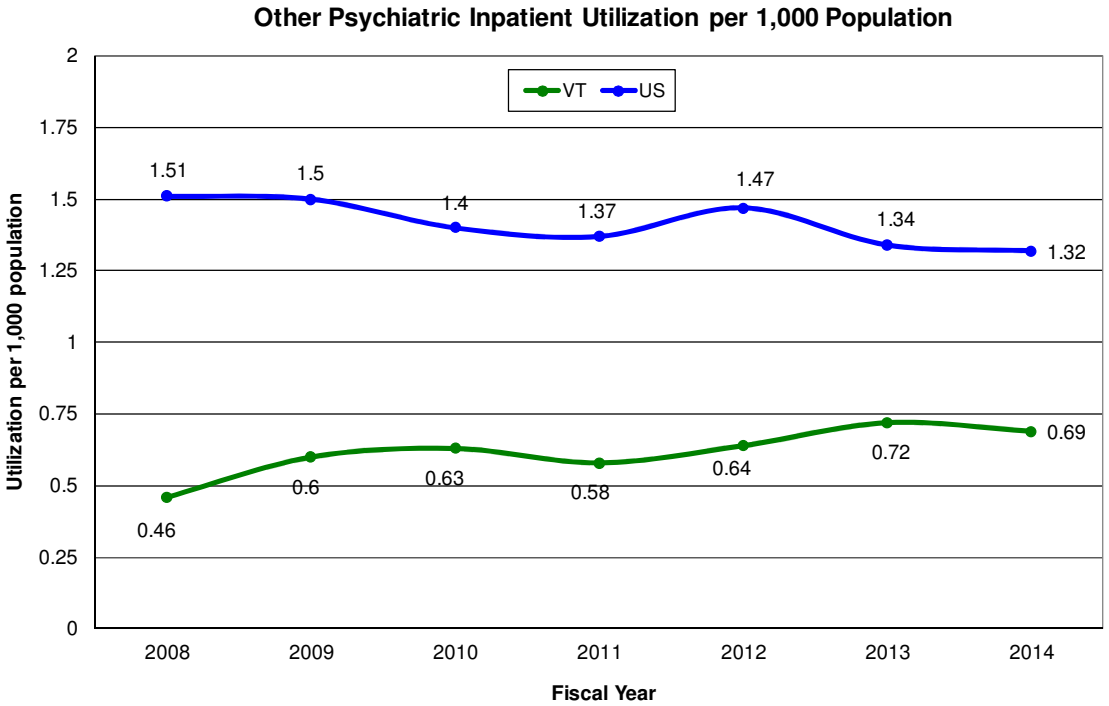
Adult inpatient bed occupancy has remained stable throughout the time period, with bed occupancy ranging from 84-88% and averaging 87% over the time period. There were no new adult inpatient beds added during this time, leaving the average number of adult inpatient beds system wide at 188.

The Department also compares the utilization of our system of care to national benchmarks. The following two charts provide information for state hospitals as well as other psychiatric inpatient hospitals and illustrate utilization compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2014 is the most recent data available.

Charts 3 and 4: State Hospital and Other Psychiatric Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2014.
US totals are calculated uniquely based on only those states who reported clients served.



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2014.
US totals are calculated uniquely based on only those states who reported clients served.

With the closure of the Vermont State Hospital, Vermont's rate of inpatient utilization continues to be lower than the national average in the United States (Chart 3). This number does not yet include operation of Vermont Psychiatric Care Hospital, which opened in FY 2015. Other psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in Chart 4. There was a slight increase in utilization of other psychiatric inpatient beds in FY 2013, but utilization continues to stay below the national averages while rates of community utilization continue to be markedly higher than national averages (Chart 25). National and State utilization rates both dropped slightly in FY 2014.

Chart 5: Adult Inpatient Utilization and Bed Closures

Adult Inpatient Utilization and Bed Closures
Nov 2014 - Oct 2015

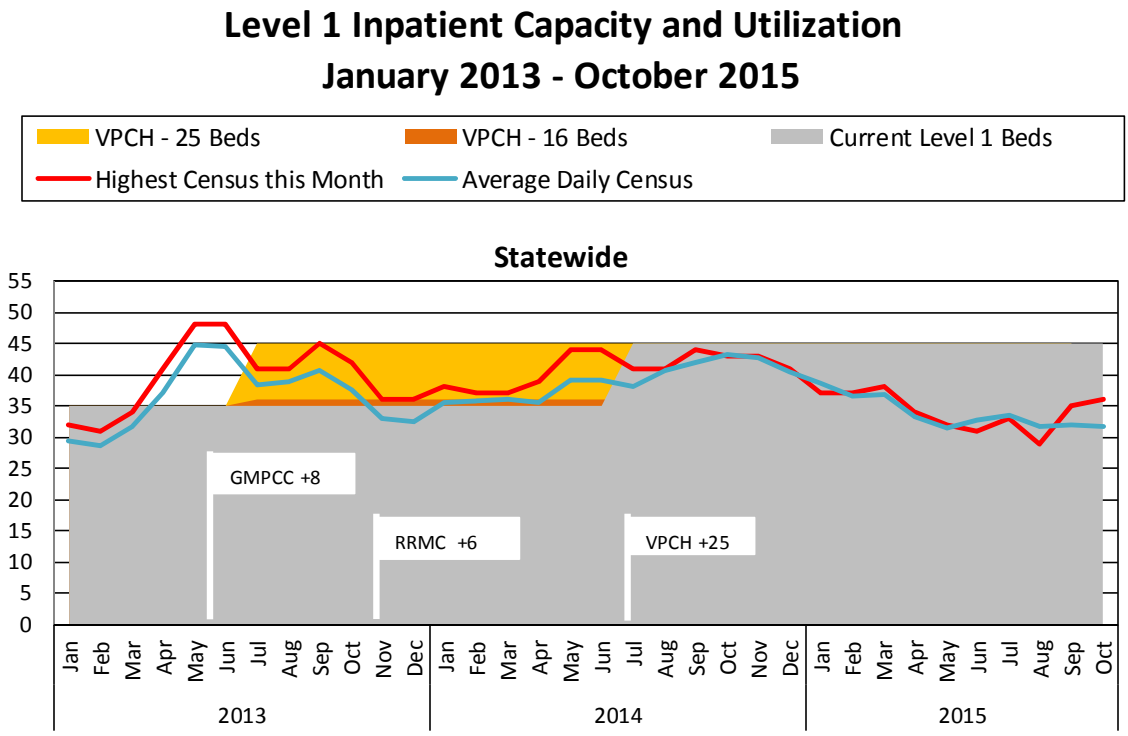
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ADULT INPATIENT UNITS												
Total Beds	188	188	188	188	188	188	188	188	188	188	188	188
Average Daily Census	164	153	164	164	174	170	165	163	163	161	165	160
Percent Occupancy	87%	83%	87%	87%	92%	90%	88%	87%	87%	85%	88%	85%
# Days at Occupancy	0	0	0	0	0	0	0	0	0	0	0	0
# Days with Closed Beds	30	31	31	28	31	23	30	29	31	31	30	31
Average # of Closed Beds	6	8	8	7	4	3	3	3	4	10	5	4

Based on data reported to the Vermont Department of Mental Health (DMH) by designated hospitals (DH) for adult inpatient care using the electronic bed boards system. Beds at inpatient settings can be closed based on the clinical decision of the director of each inpatient unit.

This chart depicts the total census capacity and average daily census across the Vermont Designated Hospital system for November 2014 to the end of October 2015. The range of average numbers of closed beds for this time period is 7, with a minimum of three and a maximum of 10, which is markedly less than the range reported last year (15). Bed closures throughout the system may be due to renovation, staffing, patient safety and care, or other causes. The Department, in concert with the Designated Hospitals, works to maintain the maximum compliment of beds and utilization of these beds through the bed board system.

Level 1

Chart 6: Level 1 Inpatient Capacity and Utilization



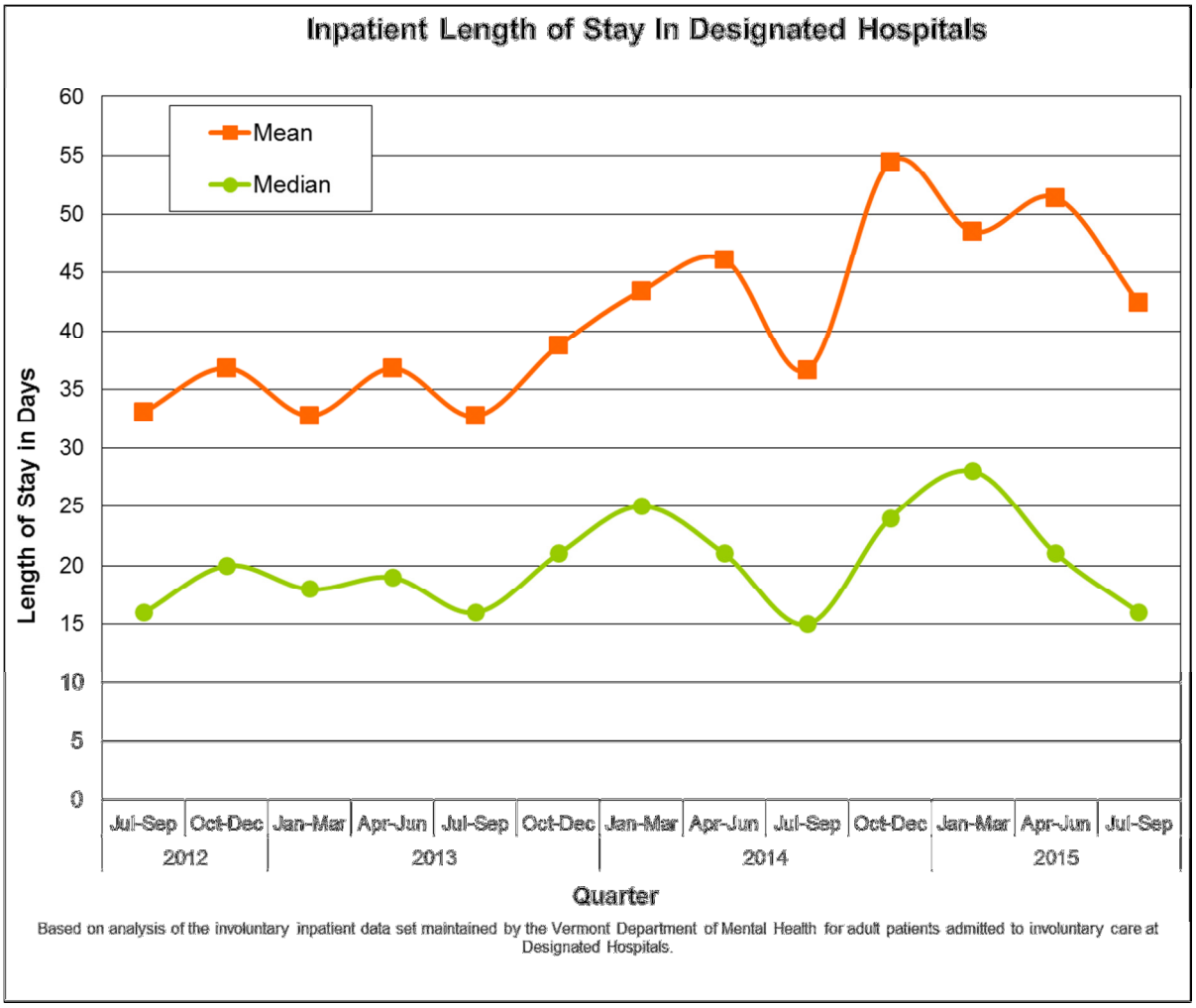
Level 1 patients require the highest level of care and services within the inpatient system. The chart above, represents the number of Level 1 patients receiving acute inpatient care in any hospital setting including those other than at the designated Level 1 units at Rutland Regional Medical Center (RRMC), Brattleboro Retreat (BR), and Vermont Psychiatric Care Hospital (VPCH), including the number of individuals treated in each setting and the single combined one-day highest number each month. The data depicted by this graph represent both the statewide and hospital specific census rates between January 2013 and October 2015.

The data for the year indicate that there has been a steady movement to place the majority of Level 1 patients in designated units when available. There are 45 beds currently designated for Level 1 patients throughout the state. The highest average daily census was 48 (May-June 2013), which is three more people than contracted Level 1 beds. The numbers indicate that we have not exceeded capacity since the opening of VPCH in July 2014. The system's capacity is predicated upon the need for balance in admissions and discharges across the Level 1 system. When the numbers are not equal, which is to say, when more admissions than discharges occur, over time this reduces the number of beds available in the system for new admissions.

While Vermont Psychiatric Care Hospital has 25 inpatient beds for Level 1 care, the hospital is also part of a no-refusal system, meaning that the hospital admits people requiring involuntary inpatient care who are not Level 1 if another placement cannot be arranged. The Department is continually evaluating the application of Level 1 admission criteria across the Level I hospitals to ensure that it is uniformly

applied to admissions at Vermont Psychiatric Care Hospital as well as other Level I hospital inpatient units.

Chart 7: Inpatient Length of Stay in Designated Hospitals

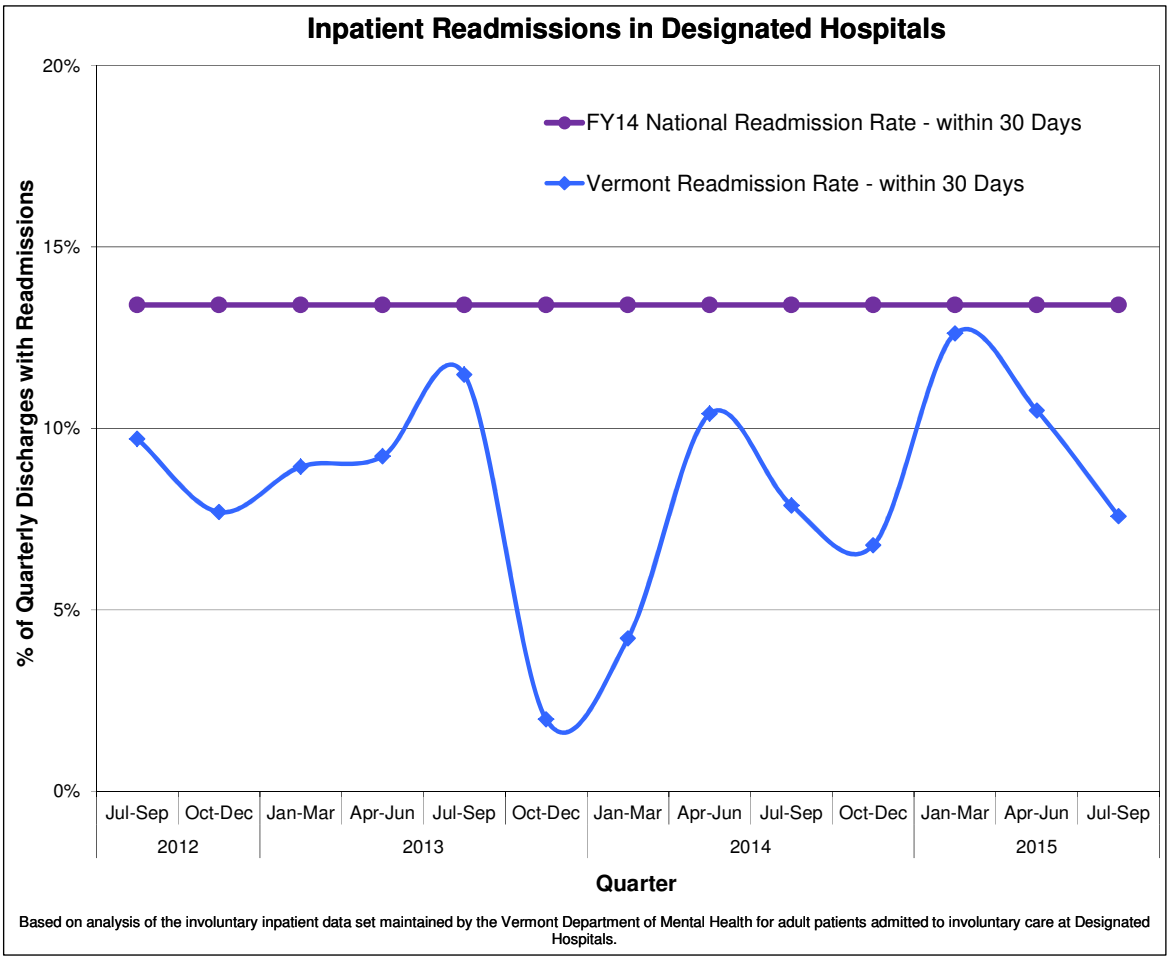


This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from July 2012 through September 2015. The trend indicates an increase in length of stay in hospital settings, from an average of 33 days to 42 days overall. The data suggests that patients with higher acuity are being treated on an inpatient basis, reflected in the longer lengths of stay. Those who can be are appropriately cared for in the community through alternatives such as crisis beds and/or enhanced wraparound services through the Designated Agency programs. This is suggested by the slight decrease in emergency admissions from FY2013 to FY 2014 (Chart 11) and the marked increase in non-categorical case management services to Adult Outpatient clients (Chart 29). Increases in mean length of stay towards the end of the time period are attributed to several long inpatient stays that were discharged.

Additionally, this time period also encompasses the introduction of the Level 1 system of care, which started in Designated Hospitals in July 2012. From this initial start date, the system has seen an increase from 25 Level 1 patients per day (on average) to 45 Level 1 clients per day. Level 1 patients also have

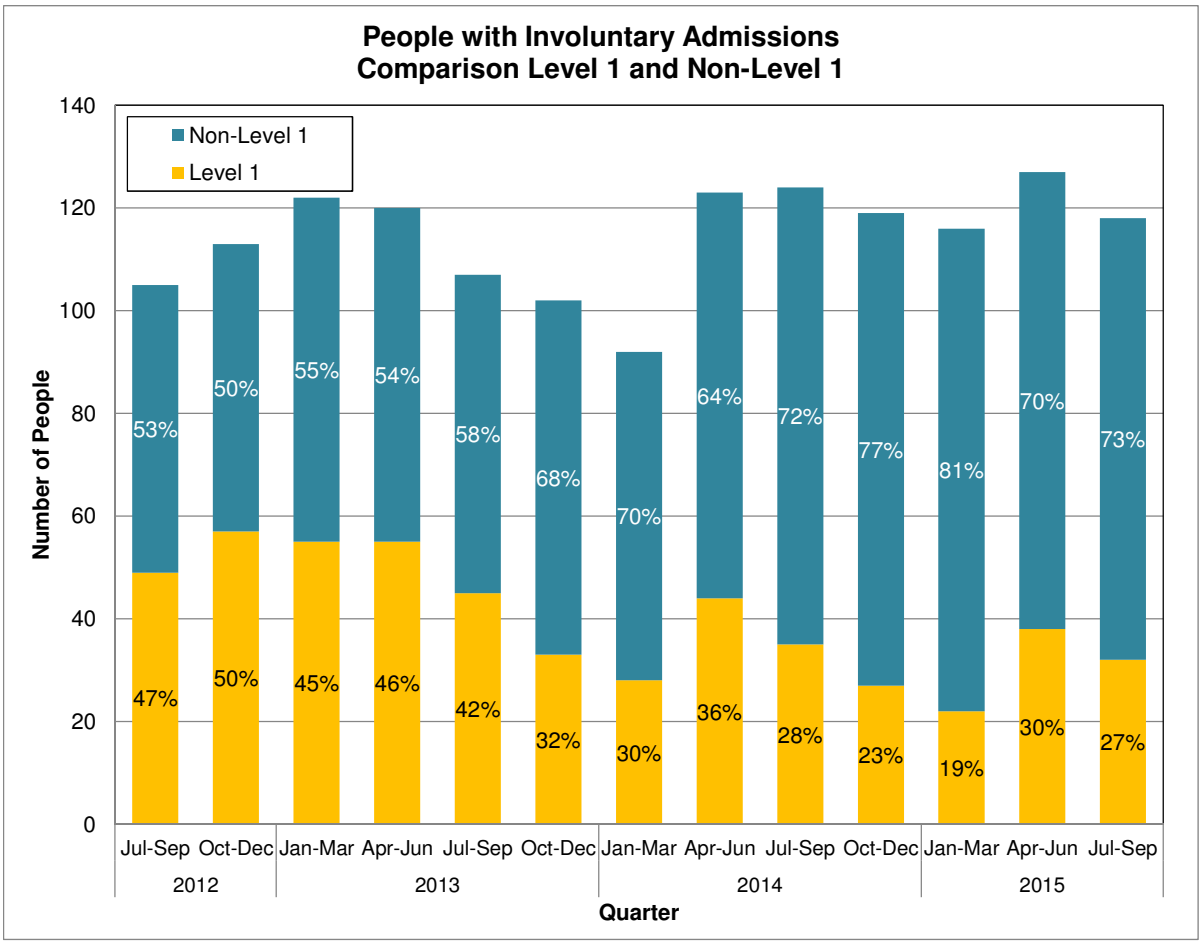
longer lengths of stay than non-Level 1 patients, which can also be a contributing factor to the overall increase in lengths of stay over the time period.

Chart 8: Inpatient Readmissions in Designated Hospitals



Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. This graph shows a steep downward trend for July through December 2013, April through December 2014, and January through September 2015. While less stable than prior time periods, this data continues to show that Vermont's rates at their highest were two percent lower than the average national rate—presented in the National Outcome Measures (NOMS)—and as much as ten percent lower at the lowest rate.

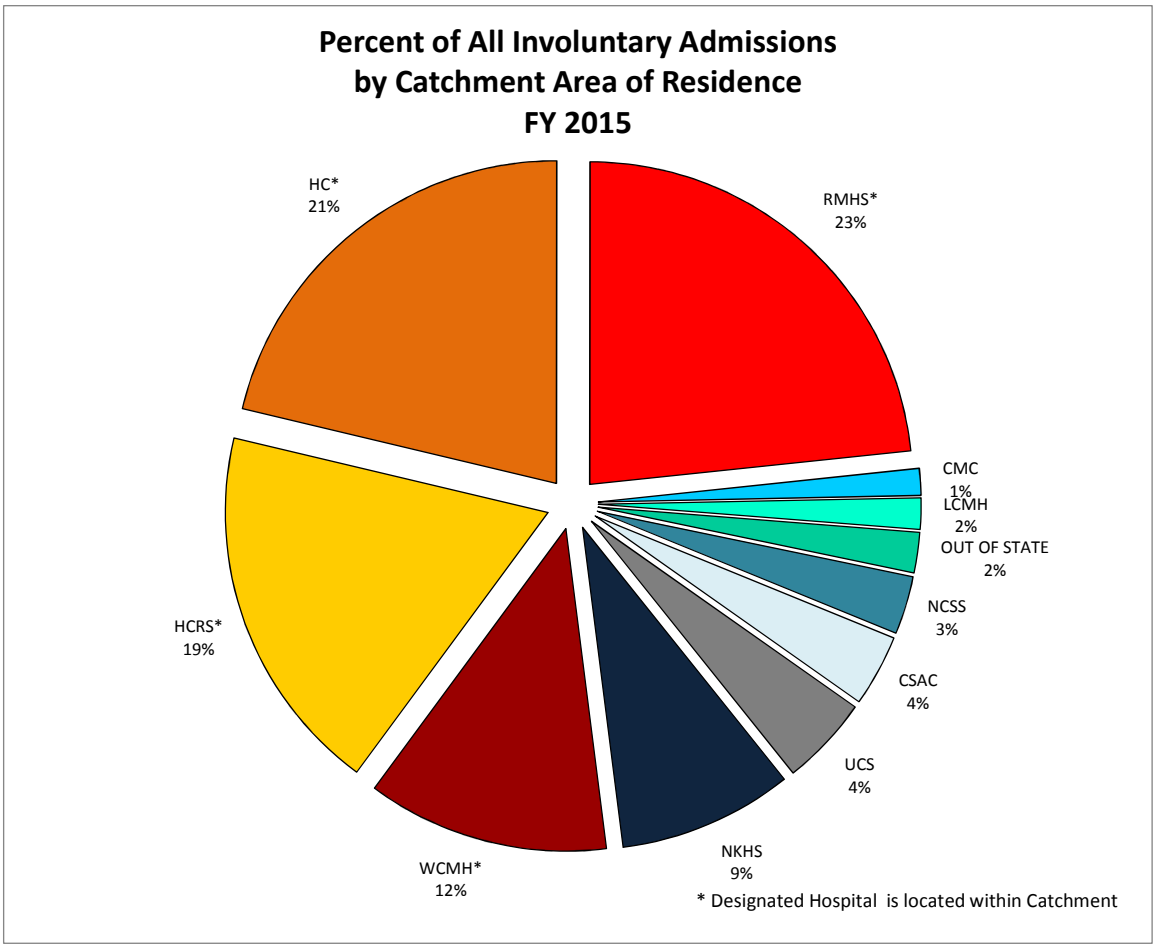
Chart 9: Involuntary Admissions – Comparison of Total Number and Level 1 patients



The number of people involuntarily admitted to inpatient care was at its highest during April-June 2015 (127); 38 of these admissions were for Level 1 stays. 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.

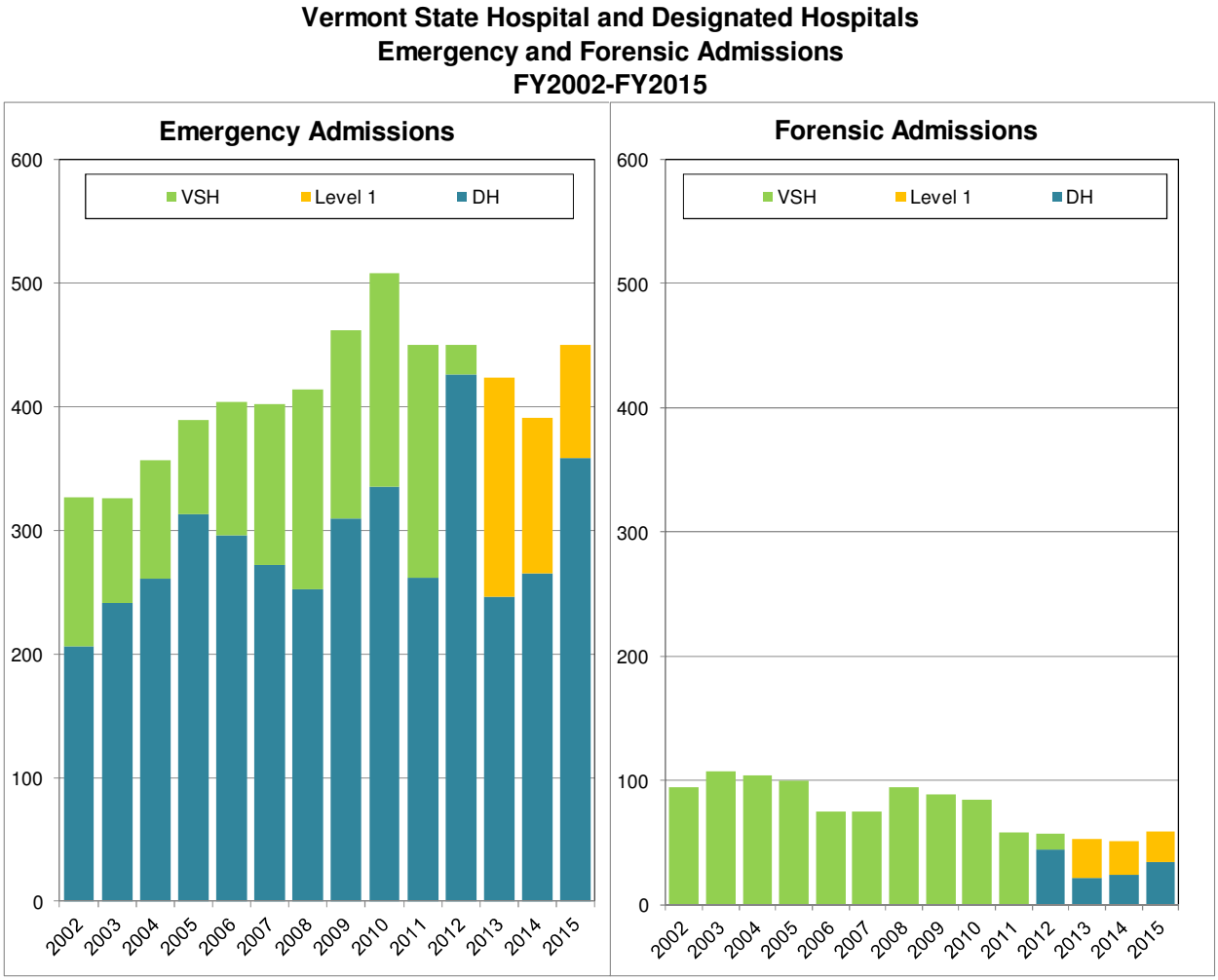
As can be seen on this graph, the numbers of Level 1 patients admitted to psychiatric care has continued to decrease, while the actual numbers of overall admissions held relatively stable through FY 2015 onward. As noted previously, July 2012 represents the starting period of the Level 1 system and admission numbers for the time period through June 2013 represent the gradual increase of Level 1 patients in the system of care. It is an expected result to see fewer people with the Level 1 designation since lengths of stay are longer than the non-Level 1 cohort. In other words, the capacity of the Level 1 system is limited by longer lengths of stay for the population, while the capacity of the non-Level 1 system experiences more people moving through the system with shorter lengths of stay.

Chart 10: Involuntary Admissions by Catchment Area of Residence



This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are treating more individuals. This chart also suggests that the placement of hospitals in the decentralized system of care is appropriate to the population needs of adult Vermonters. A majority of admissions (80% of all admissions and 82% of Vermonter admissions) come from catchment areas which contain a Designated Hospital.

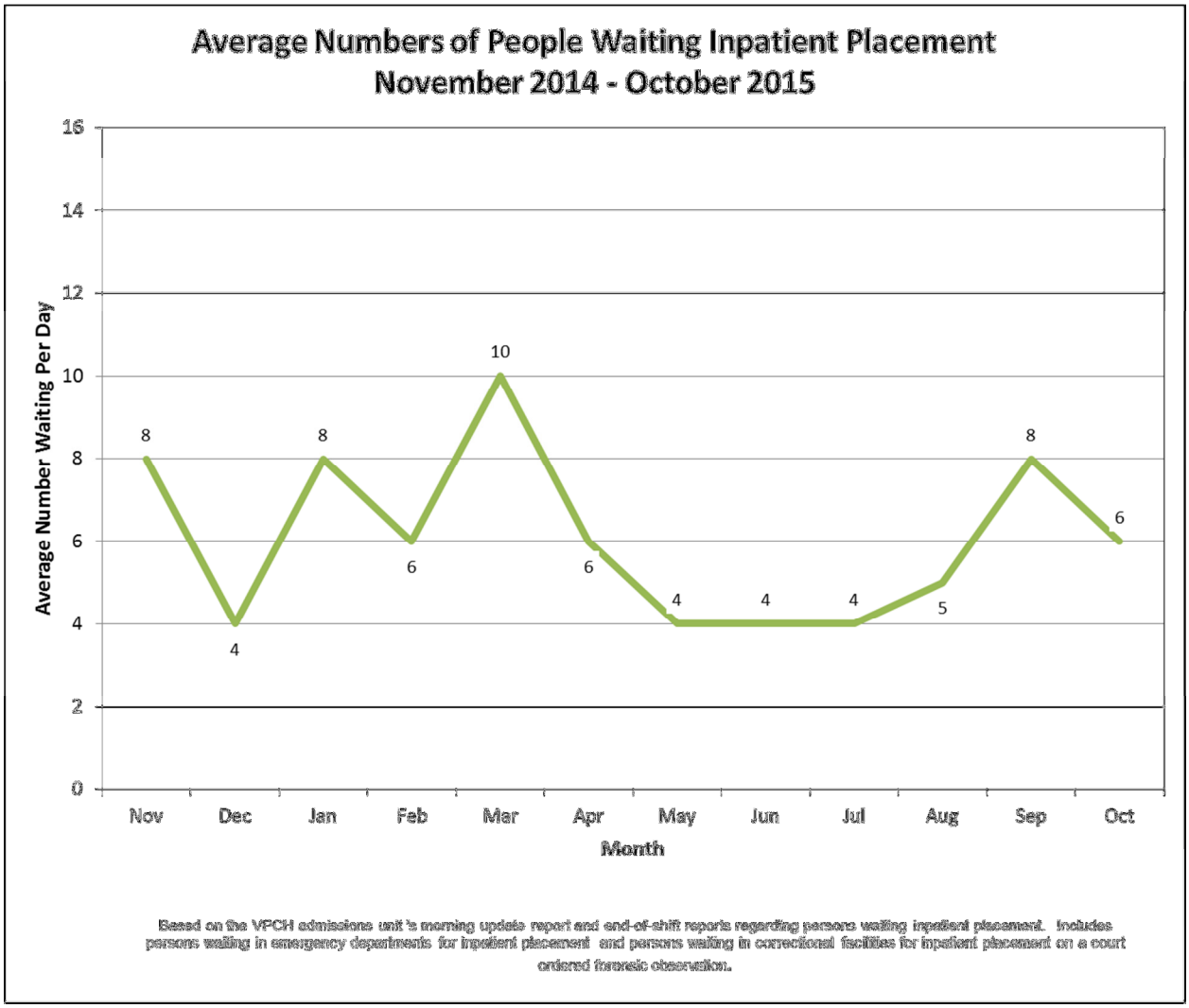
Chart 11: Emergency and Forensic Admissions



Analysis based on the Vermont State Hospital (VSH) Treatment Episode Database. Includes all admissions during FY2002 - FY2014 with a forensic legal status or emergency legal status at admission.

The number of emergency (civil) and forensic admissions increased in FY2015, with the addition of 25 beds with the opening of Vermont Psychiatric Care Hospital. Overall, the numbers of emergency admissions has increased by almost 60 admissions, while forensic admissions increased by less than 10 additional admissions. While not all Level 1 patients are admitted for forensic reasons—and not all forensic patients are Level 1—Level 1 admissions do represent a greater percentage of total forensic admissions than total emergency exam admissions.

Chart 12: Average Number of People Waiting Inpatient Placement

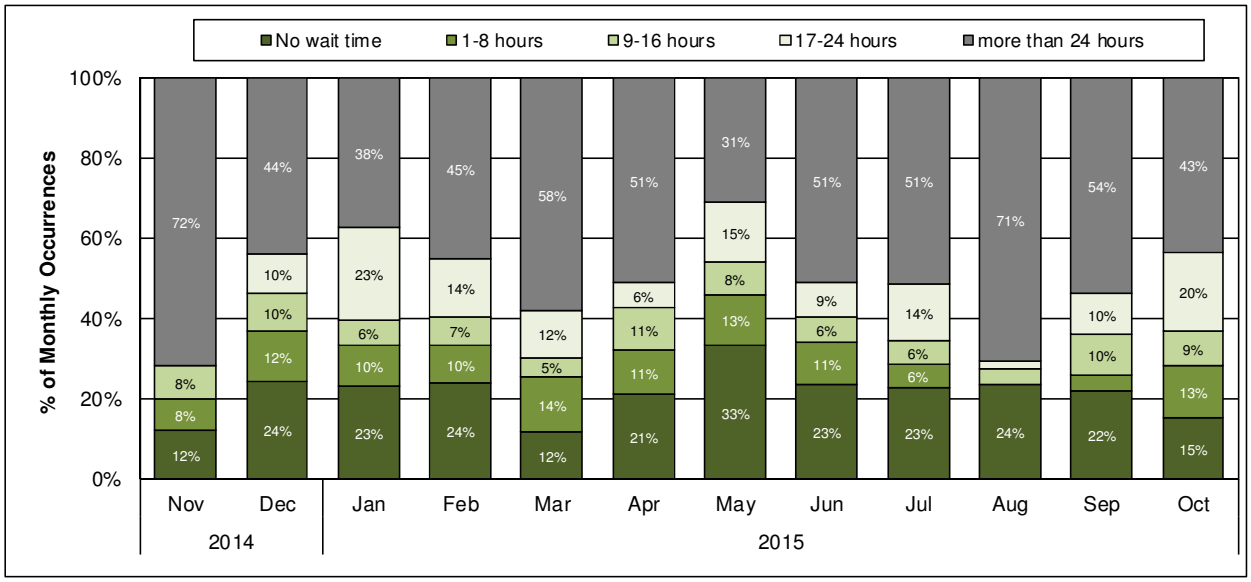


The point in time average number of individuals per day waiting for admission to a psychiatric treatment bed continues to fluctuate over the time period. Timely transition of people to inpatient care requires active management on a daily basis for individuals of all statuses in need of hospital care.

Chart 13: Emergency Department Times to Involuntary Admission

Emergency Exams and Warrants, Court Ordered Forensic Observations, and Youth

Wait Times in Hours for Involuntary Inpatient Admission
November 2014 - October 2015



		2014					2015						
Wait time		**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
No wait time		6	10	11	10	5	10	16	11	9	12	11	12
1-8 hours		4	5	5	4	6	5	6	5	2	0	3	5
9-16 hours		4	4	3	3	2	5	4	3	2	2	5	0
17-24 hours		0	4	11	6	5	3	7	4	5	1	6	4
more than 24 hours		36	18	18	19	25	24	15	24	18	38	27	23
Total		50	41	48	42	43	47	48	47	36	53	52	44
Wait Time in Hours													
Youth	**Mean**	54	29	30	22	60	36	11	0	19	61	31	53
	Median	53	24	25	14	60	26	5	0	26	61	25	21
EEs/Wrts	**Mean**	62	41	47	40	46	31	27	33	47	47	46	36
	Median	45	9	18	18	25	18	17	24	23	32	22	28
OBS	**Mean**	199	158	442	102	155	35	20	75	123	194	122	36
	Median	187	14	442	100	167	33	5	75	123	196	96	2
Total	**Mean**	74	56	61	51	54	32	24	34	47	64	53	38
	Median	53	22	20	22	27	25	10	25	25	41	25	28

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Analysis based on data maintained by the VPCH admissions department from paperwork submitted by crisis, designated agency, and hospital screeners. Wait times are defined from determination of need to admission to disposition, less time for medical clearance, for persons on warrant for immediate examination, applications for emergency exam, court ordered forensic observations, and youth waiting for inpatient admission. Wait times are point in time and are categorized based on month of service, not month of disposition, for clients who had a disposition to a psychiatric inpatient unit.

Chart 13 contains information across a twelve month period, between November 2014 to October 2015, presenting the means and median wait times for Youth, Emergency Exams and Warrants, and those individuals who are ordered by the Court to be in a psychiatric hospital. As illustrated in the table above, for 5 of the 12 months during the time period, the majority of individuals were placed in 24 hours or less. Reviewed as a whole, the total mean wait time for the 12 months measured is 49 hours or approximately 2 days and a median wait time of 27 hours. This a decrease of an entire day as compared

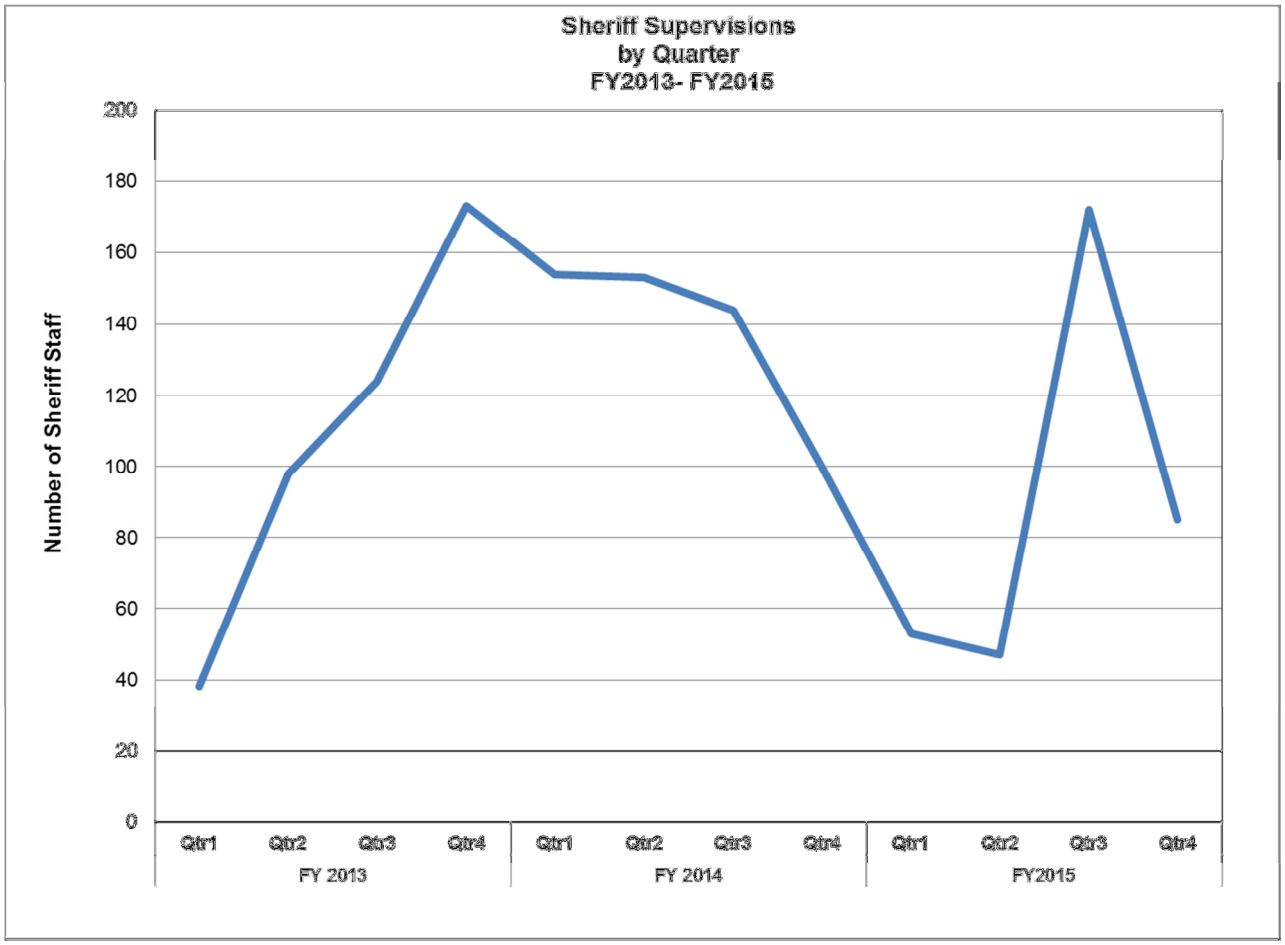
to the average reported in last year's report. This number is greatly affected by the discrepancy between the average wait times for those on Emergency Examination (EE) or Warrant status and those on Court Orders, who are waiting in Corrections. Those waiting in Corrections have significantly longer wait times for admission to hospital beds. Youth also have substantially lower wait times than adults.

The difference between age cohorts, legal status cohorts, and percentiles are due to a variety of circumstances such as bed closures due to unit acuity, no bed being readily available, or due to the acuity of the person waiting. The department's goal is to continue to place individuals in appropriate beds as soon as they are available.

The Department of Mental Health has a cadre of experienced care managers (Care Management Team) who work with each of the Designated Hospitals, the Designated Agencies emergency services teams, and the hospital emergency departments statewide. Their function is to work with individual cases and the relevant action systems to move people needing care through the system. The system is comprised of several points along a continuum which represent appropriate levels of care. Since our acute mental health treatment system became decentralized, placement considerations have become more complex. The care management Team also works on longer term planning for these individuals, monitoring availability of placements in various levels of community care across the state.

When patients are awaiting placement for treatment in a psychiatric hospital setting, supervision assistance by Sheriff Deputies is sometimes required. This is a service which is funded through the department and the chart below illustrates utilization of sheriff supervision.

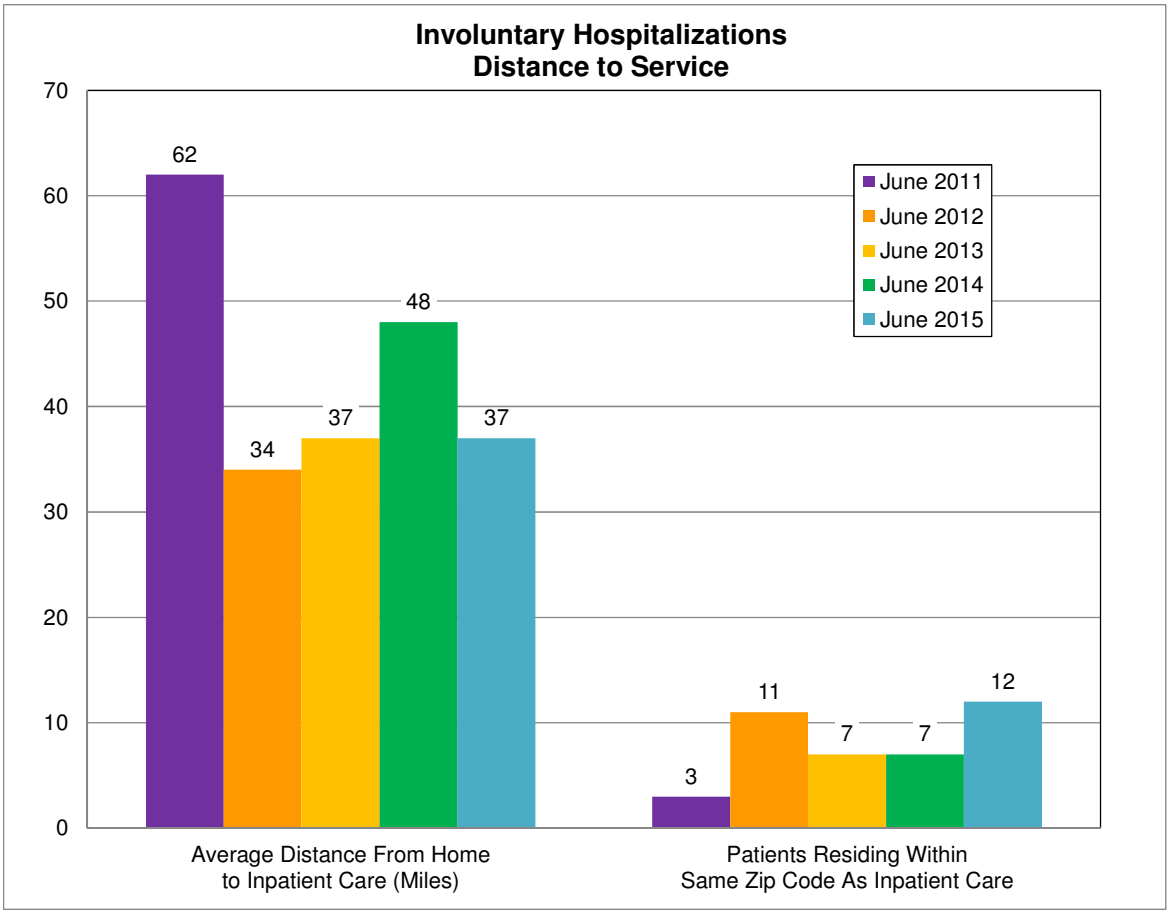
Chart 14: Sheriff Supervision in Hospital



A hospital's ability to manage the dysregulated behavior of a patient who is waiting for an inpatient psychiatric bed varies greatly. This may be due to the high need for addressing behaviors displayed by the patient in order to maintain a safe surrounding, the lack of available support resources, or the lack of security services at the hospital. While total Sheriff staff involved in supervisions was greater in FY2014, utilization is decreasing with each quarter following the high point in the last quarter of FY 2013 (April-June).

The number of total sheriff staff being used for supervisions of patients waiting for an inpatient psychiatric bed continued to decrease during FY 2015. There was an increase in use of Sheriffs during the third quarter of FY 2015 and this is seen as a spike as the previous and subsequent quarters were both lower than any quarter in FY 2014. The overall decrease may be due to how some hospitals have responded to this issue of people waiting for inpatient psychiatric beds, such as hiring staff to perform supervision or restructuring and reorganization of their Emergency Department layout.

Chart 15: Distance to Service for Involuntary Inpatient Admission



The closing of the Vermont State Hospital resulted in an increased use of beds in Designated Hospitals 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 Designated Hospitals. This is also reflected in Chart 10.

Involuntary Medications

The ability to care for those most acutely ill individuals may require the need for the Designated Hospital to seek the ability to provide medication to a patient against their wishes. This is an issue which has garnered state-wide attention by multiple stakeholder groups, the Administration, and the Legislature.

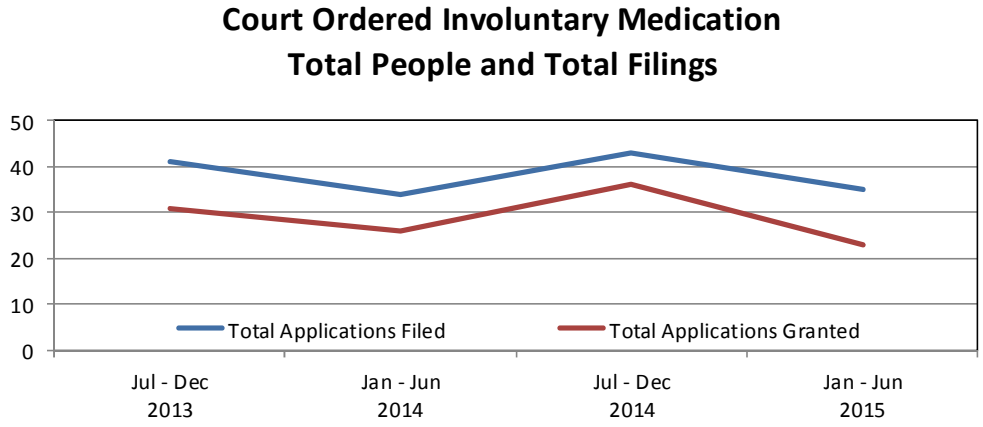
Act 192, an act relating to involuntary treatment and medication, was passed during the 2014 Legislative session, making significant changes to the laws governing petition and hearing processes for the determination of the need and Court order for involuntary medications.

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.

Chart 16: Outcomes and Other Legal Data pertaining to Court Ordered Involuntary Medications

Measure	Methodology
Percentage of Filings Resulting in Granted Order	Number of granted orders over the total number of petitions filed
Length of Stay for Discharged Patients	Total length of stay in days from admission to discharge, overall and by total number of court ordered involuntary medication filings
30-Day Readmission Rate	Rate of readmissions within 30 days of discharge.
Rate of Emergency Involuntary Procedures (EIPs) Per 1,000 Patient Hours	Rate of EIP pre- and post-granted orders *This measure has been tabled until DMH can find a systematic method for compiling this data.*

Chart 16-A: Court Ordered Involuntary Medication, Total People and Total Filings



	Time Period			
Court Ordered Medication	Jul - Dec 2013	Jan - Jun 2014	Jul - Dec 2014	Jan - Jun 2015
Number of people	**36**	**28**	**41**	**29**
Total Applications Filed	41	34	43	35
Total Applications Granted	31	26	36	23
% Granted	76%	76%	84%	66%

Chart 16-A represents the total number of court ordered involuntary medication orders filed, the total granted, and the total number of people with filings. The percent of filings granted varies from 66%-84%. Measurement of future time periods will indicate whether there is a trend regarding court ordered involuntary medication filings.

Chart 16-B: Court Ordered Involuntary Medication, Mean Length of Stay

Court Ordered Involuntary Medication
Length of Stay for Discharged Patients

		FY 2015
Total Discharges	Overall	55
	Inp. Stays with One Filing	44
	Inp. Stays with Multiple Filings	11
Mean LOS (days)	Overall	191
	Inp. Stays with One Filing	155
	Inp. Stays with Multiple Filings	334

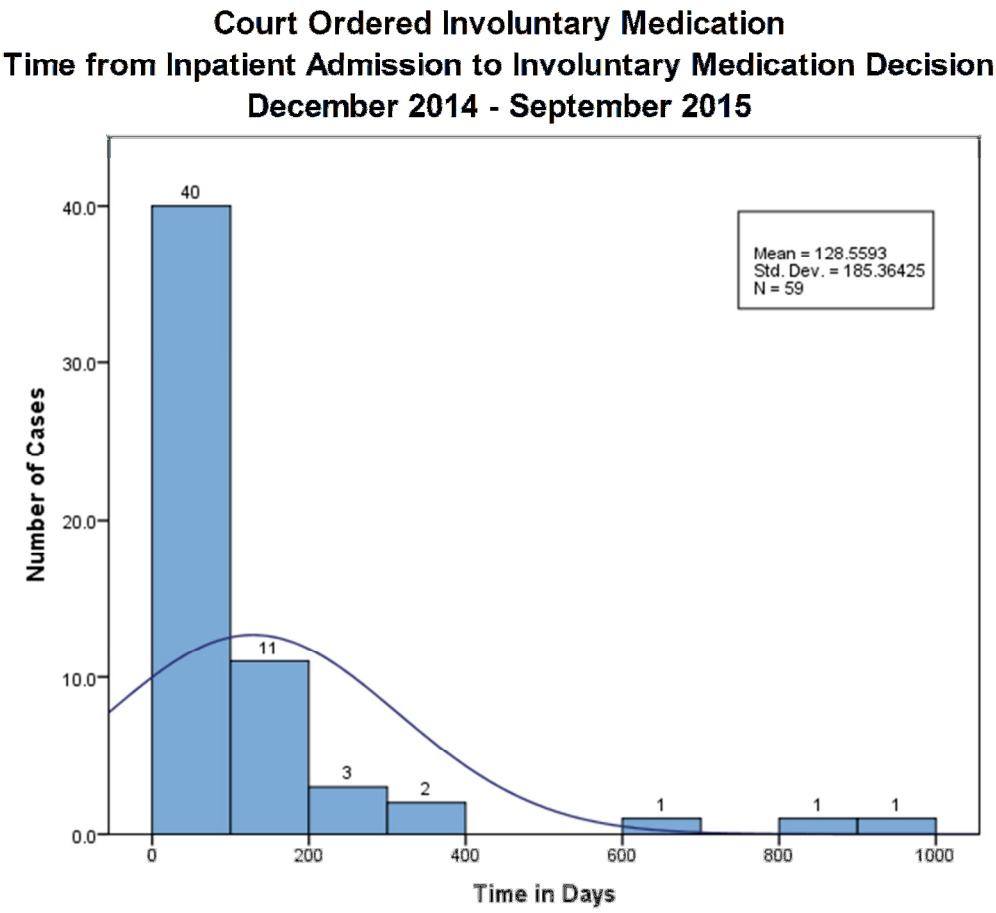
Chart 16-C: Court Ordered Involuntary Medication, 30 Day Readmission Rate

Court Ordered Involuntary Medication
30 Day Readmission Rate for Discharged Patients

		FY 2015
Total Discharges	Overall	55
	Inp. Stays with One Filing	44
	Inp. Stays with Multiple Filings	11
30 Day Readmission Rate	Overall	5%
	Inp. Stays with One Filing	7%
	Inp. Stays with Multiple Filings	0%

The Department has worked to provide lengths of stay and 30-day readmission rates for people that had a court-ordered involuntary medication filing at any time during their hospital stay and were discharged in FY 2015. A total of 55 people met these criteria. Of those, 20% had multiple medication filings during their course of hospitalization. Multiple filings can occur for a variety of circumstances: the court order has expired but the patient was not willing to continue medications; the patient agrees to take medications between hospital filing and the court date but is not willing to continue once the court process has been discontinued; or the medication ordered by the court is not effective and a new order has to be pursued for different medication. When comparing these two groups of people, those with multiple filings had—on average—lengths of stays that were twice as long as those with one filing. When examining involuntary readmission rates, there were no individuals with multiple filings that were readmitted involuntarily within 30 days of discharge. The Department will continue to monitor this information going forward to identify trends.

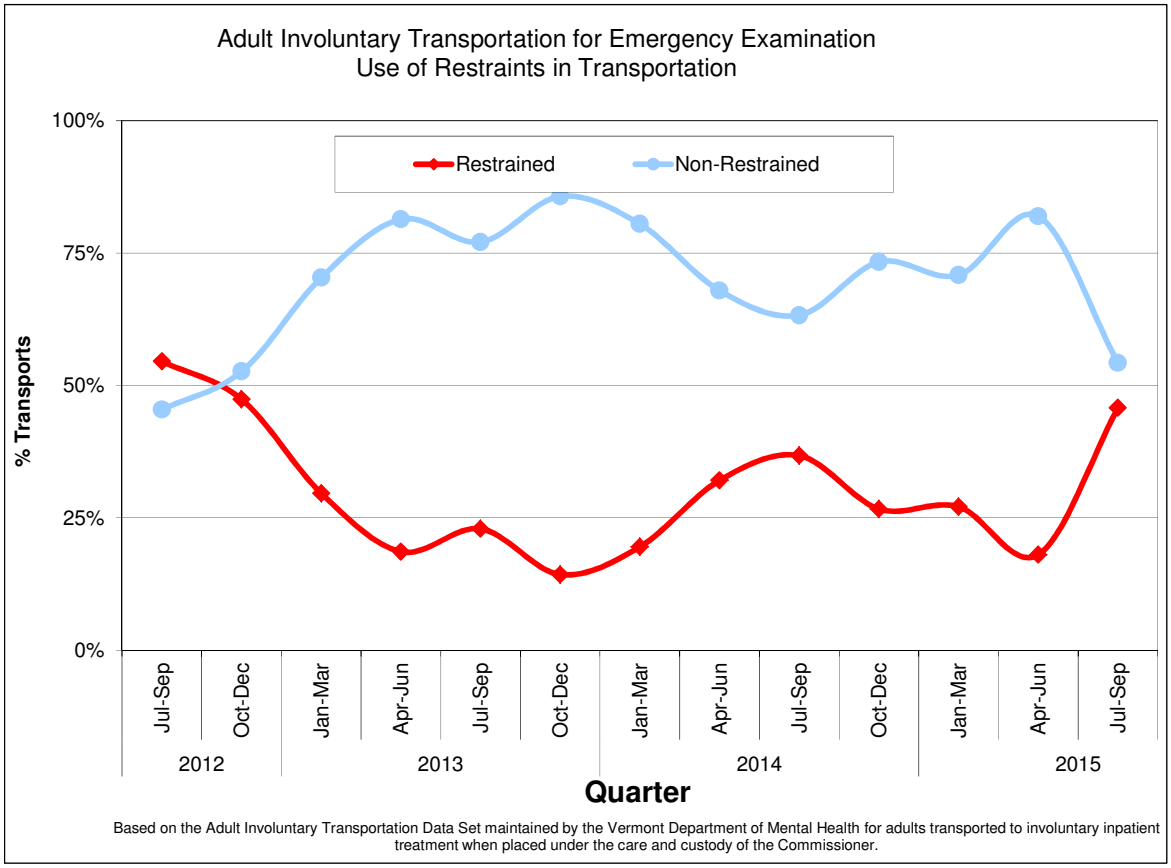
Chart 17: Time in Days from Admission to Court Ordered Medication



This graph illustrates all of those (59) who have had applications filed for involuntary medication between December 2014 and September 2015. The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 128 days, with a small number of outliers on the longer end of the curve. This illustrates the variability in this measure across time and jurisdictions, with approximately 68% resolved in less than 100 days.

Transportation

Chart 18: Use of Restraints in Adult Involuntary Transport



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 19: Use of Restraints in Youth Involuntary Transport

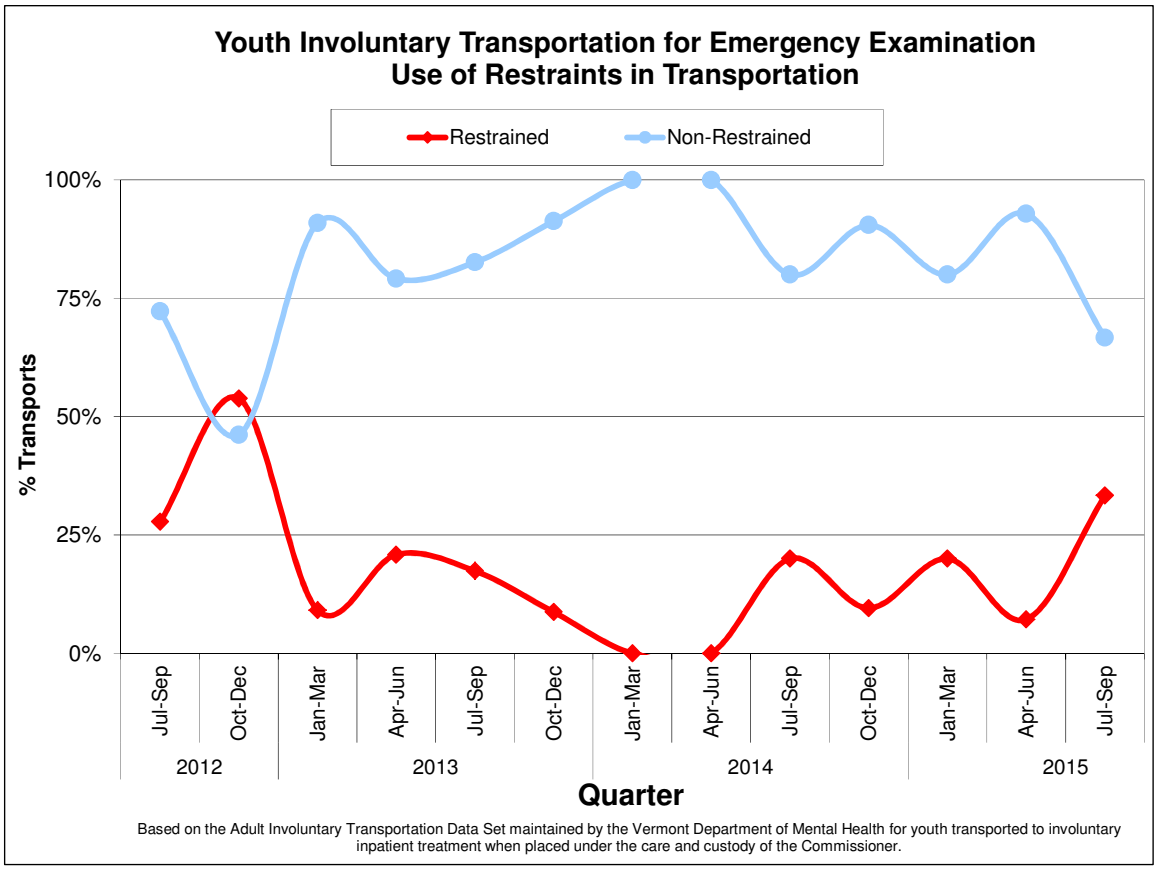


Chart 20: Use of Metal Restraints in Adult Involuntary Transport

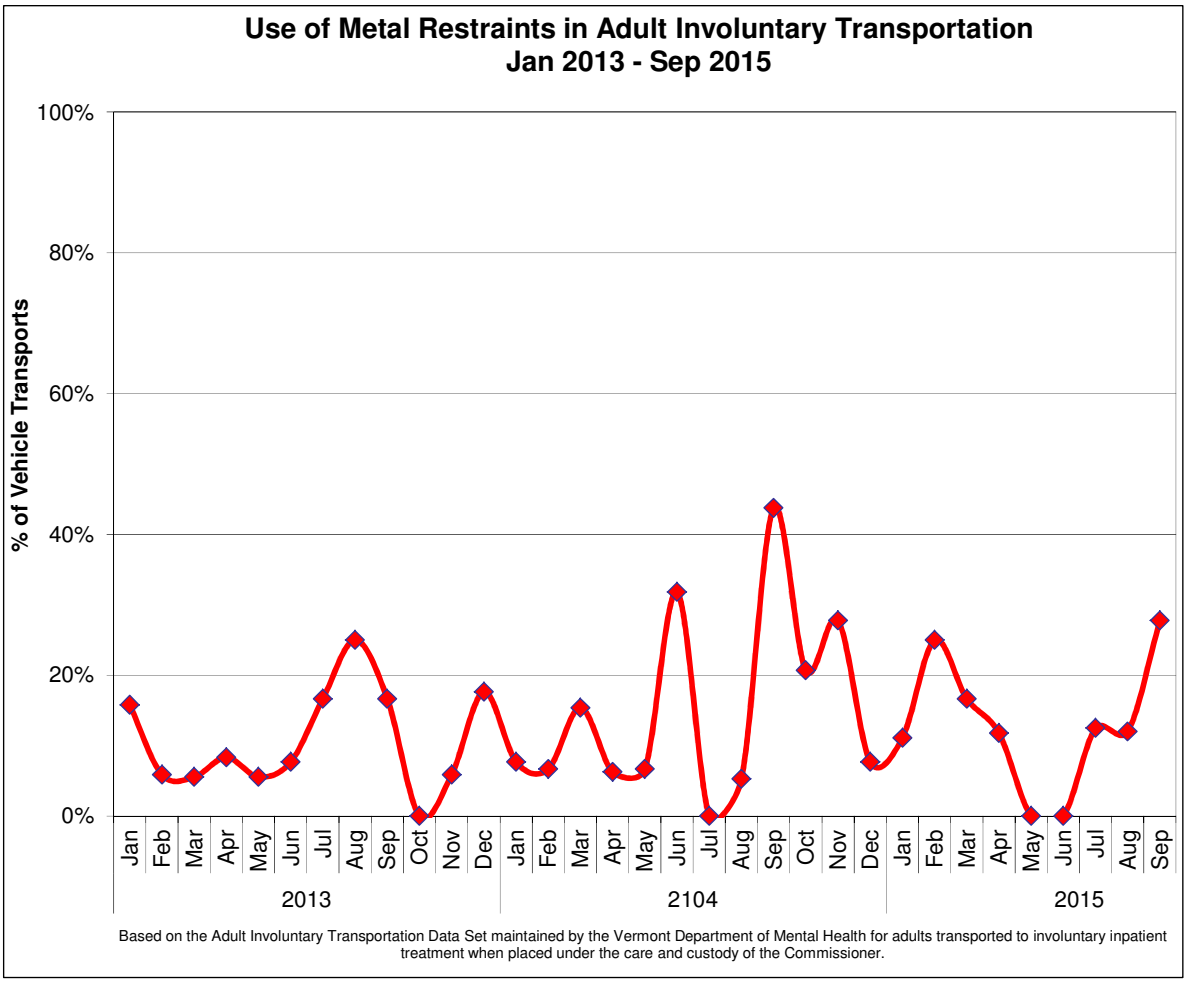
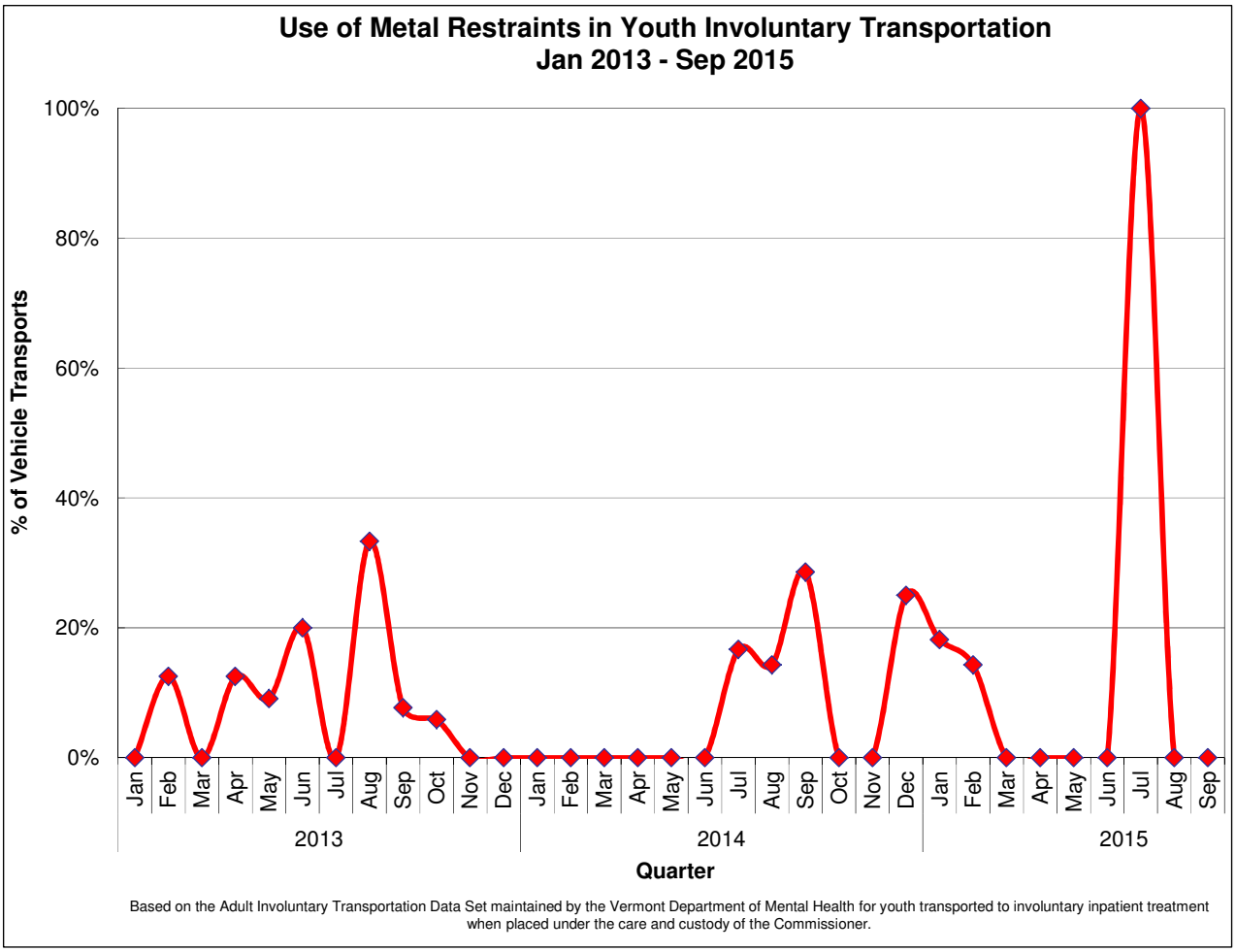


Chart 21: Use of Metal Restraints in Youth Involuntary Transport



Since April 2012, the Department 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. Act 180, Title 18 §7511, recognizes the need to take steps to reduce trauma for people who are found to need sheriff transport for involuntary psychiatric hospitalization. For many years, secure transport was defined as a transport by sheriffs. The current definition of secure transport is defined as the application of mechanical restraints, either soft or metal. This change in terms evolved out the success of the involuntary transportation workgroup.

Grants to support a pilot program with sheriffs in Lamoille and Windham Counties using a least-restrictive approach by deputies in plain clothes with an unmarked van have been continued. Progression to some type of restraint is utilized only when a no-restraint approach fails.

Review of the data provided in Charts 18-21 shows that there has been a fluctuation with periods of increased use of restraints for transport for both adults and children. When examining the use of metal restraints by month there are periods with significantly higher uses of metal. In general, the use of metal restraints for both adults and youth is lower, with the majority of transports being unrestrained,

reflecting the ongoing effort of the department to ensure transportations use restraints as an option only when other means have been exhausted.

The Department is aware of differing practices that exist across law enforcement agencies, as a result of a review process conducted by the Quality Unit. These differences are due in part to the need for more frequent training and monitoring of expectations from those who work in law enforcement. The Department continues to have specific contracts for use of soft or no restraints during transports; however some law enforcement agencies may not utilize the same policy and procedures. The Department is continually working to create a consistent law enforcement response to the need for least restrictive transportation protocols.

Chart 22: One year overview of Adult Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
Fiscal Year 2015

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	4	4	10	6	8	2	3	4	6	4	1	6	**58**
Non-Restrained	10	15	6	23	10	11	15	8	11	13	19	18	**159**
Missing	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Restraints Used in Transport													
None	10	15	6	23	10	11	15	8	11	13	19	18	**159**
Metal	0	1	7	6	5	1	2	3	3	2	0	0	**30**
Soft	4	3	3	0	3	1	1	1	3	2	1	6	**28**
Missing	0	0	0	0	0	0	0	0	1	0	0	0	**1**
% All vehicle transports that use Metal	0%	5%	44%	21%	28%	8%	11%	25%	17%	12%	0%	0%	**14%**
Vehicle Used in Transport													
Ambulance	6	6	0	6	2	4	2	1	4	2	1	0	**34**
MH Van Alternative	0	0	0	1	0	1	0	0	0	0	2	0	**4**
Private Transport	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	3	3	3	7	4	3	4	4	0	5	8	11	**55**
Sheriff Cruiser	5	10	13	15	12	5	12	7	13	10	9	13	**124**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance	43%	32%		21%	11%	31%	11%	8%	24%	12%	5%	0%	**16%**
%Vehicle Transports that use MH Van Alternative				3%		8%					10%		**2%**
%Vehicle Transports that use Sheriff's Alternative	21%	16%	19%	24%	22%	23%	22%	33%		29%	40%	46%	**25%**
%Vehicle Transports that use Sheriff's Cruiser	36%	53%	81%	52%	67%	38%	67%	58%	76%	59%	45%	54%	**57%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	8	13	16	22	16	8	16	11	13	15	17	24	**179**
TOTAL EE Transports	14	19	16	29	18	13	18	12	17	17	20	24	**217**

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Adult 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.

Date of Report: 11/09/2015

Chart 23: One year overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
Fiscal Year 2015

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Transportation Type													
Restrained	1	1	2	0	0	2	3	1	0	0	1	0	**11**
Non-Restrained	5	6	5	3	10	6	8	6	2	8	5	0	**64**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport													
None	5	6	5	3	10	6	8	6	2	8	5	0	**59**
Metal	1	1	2	0	0	2	2	1	0	0	0	0	**9**
Soft	0	0	0	0	0	0	1	0	0	0	1	0	**1**
Missing	0	0	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	17%	14%	29%	0%	0%	25%	18%	14%	0%	0%	0%	0%	**12%**
Vehicle Used in Transport													
Ambulance	5	6	3	3	9	3	4	5	0	6	1	0	**45**
MH Van Alternative	0	0	0	0	0	0	1	0	1	0	2	0	**4**
Private Transport	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	1	0	3	0	1	1	1	0	1	2	0	0	**10**
Sheriff Cruiser	0	1	1	0	0	4	5	2	0	0	3	0	**16**
Other	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	**0**
No Data	0	0	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance	83%	86%	43%	100%	90%	38%	36%	71%		75%	17%		**60%**
%Vehicle Transports that use MH Van Alternative							9%		50%		33%		**5%**
%Vehicle Transports that use Sheriff's Alternative	17%		43%		10%	13%	9%		50%	25%			**13%**
%Vehicle Transports that use Sheriff's Cruiser		14%	14%			50%	45%	29%			50%		**21%**

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
EE's with Sheriff Involvement	1	1	4	0	1	5	6	2	1	2	3	0	**26**
TOTAL EE Transports	6	7	7	3	10	8	11	7	2	8	6	0	**75**

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Youth 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.

Date of Report: 11/09/2015

Adult Outpatient Care and Utilization

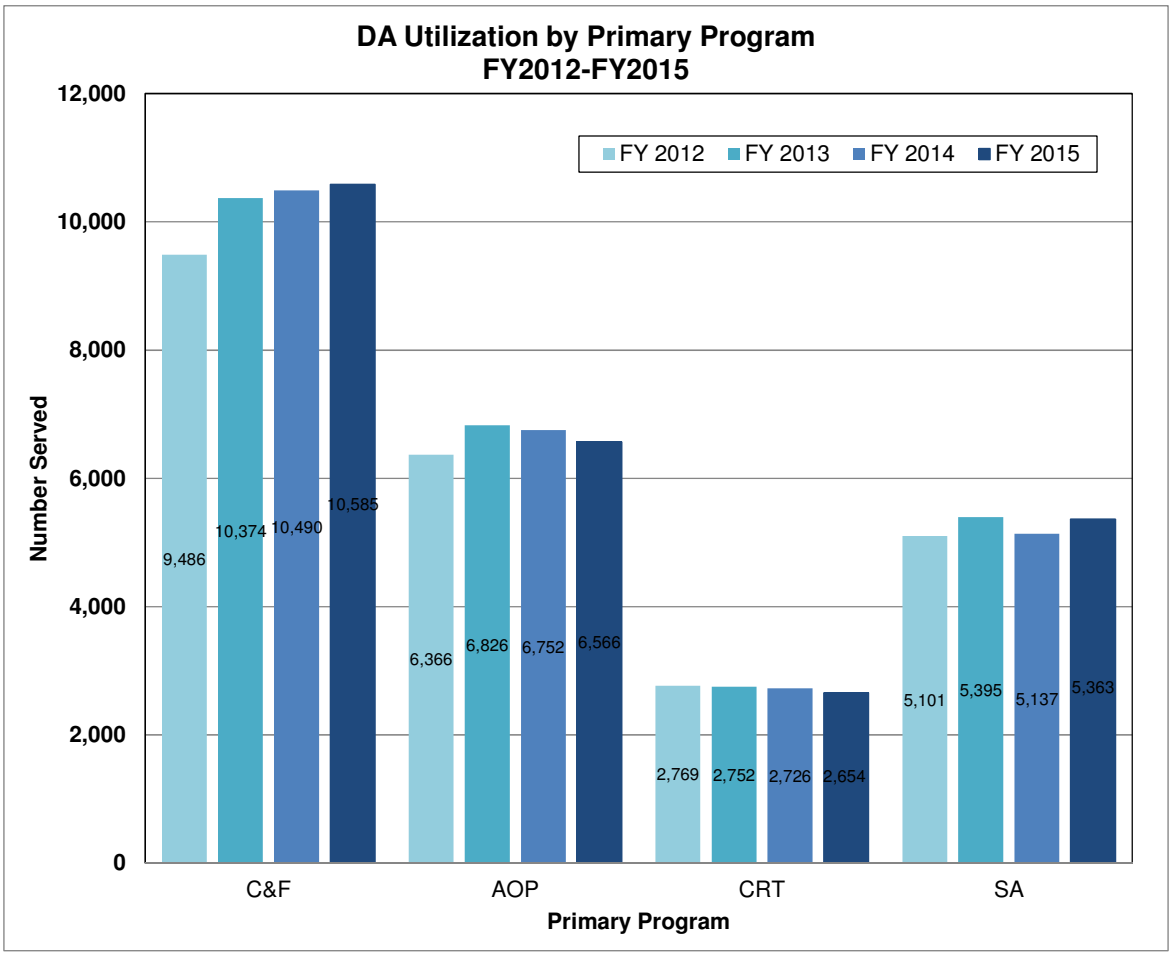
Outpatient services are provided through a system of care that includes the Designated Agencies in addition to private practitioners and other state and local social services agencies. The Designated Agencies provide comprehensive services to individuals with severe mental illness through the Community Rehabilitation and Treatment 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, Designated Agency 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 and by local resources.

In order to maximize utilization of limited treatment resources in both the community and hospitals, the Department developed a care management system that employs clinicians as key contacts and liaisons between Designated Agencies and Designated Hospitals, ensuring that people in need of treatment receive the appropriate levels of care.

Community Rehabilitation and Treatment program staff within the Designated Agencies work with hospital staff to ensure a smooth transition to the community with a range of services in place as indicated by discharge and treatment plans for those clients being discharged from the inpatient setting as soon as possible. This period of time ranges from one hour to within one week of discharge. The Department expects that individuals are seen in the Designated Agency 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 follow-up visit. A multi-departmental Performance Improvement Project is underway, led by the Department and the Department of Vermont Health Access (DVHA), to assess the rates of timely follow up visits after discharge from a psychiatric hospital stay.

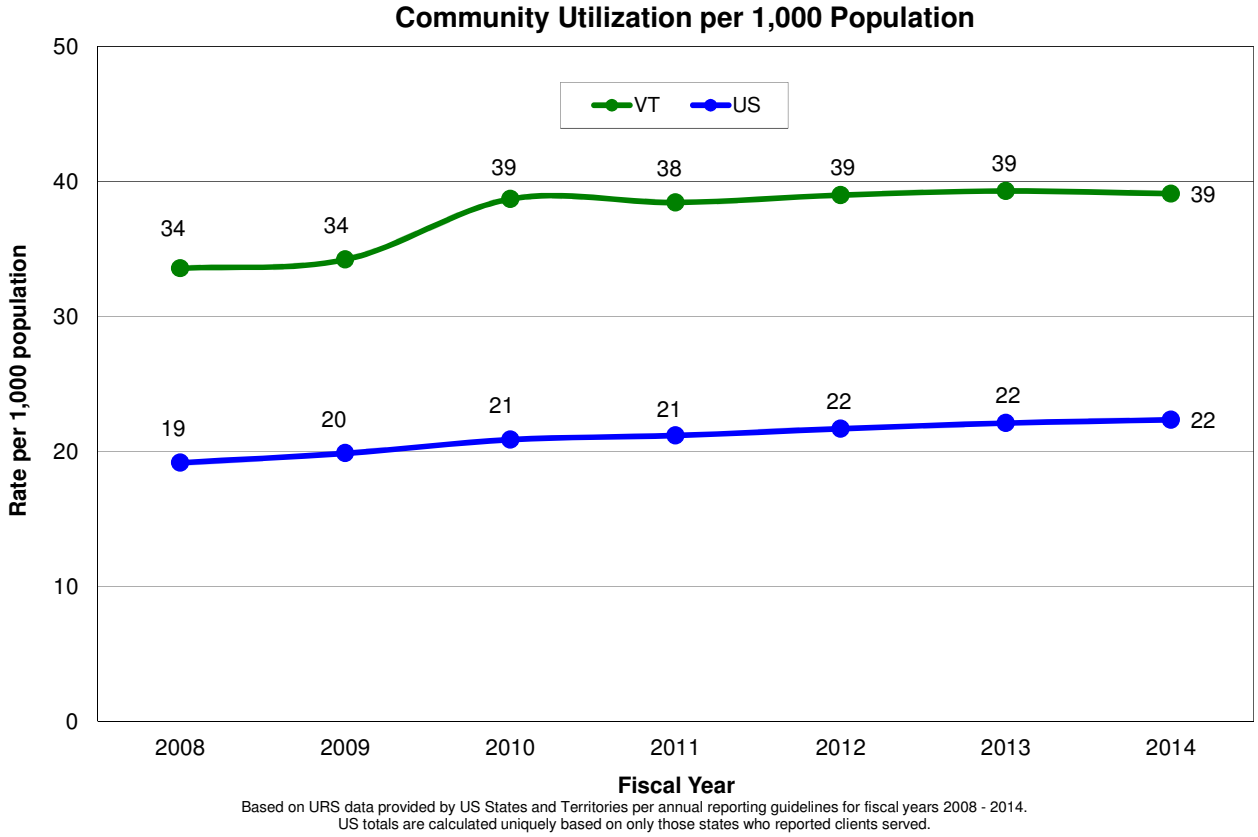
Although the Department provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY 2013 and FY 2014, staff recruitment to ramp up these service levels has continued to be a struggle. Information provided by the Designated Agencies 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 FY 2015 remained relatively stable and do not reflect any upward trend in persons served.

Chart 24: Designated Agency Volume by Program



The highest number of persons served by a program offered by the Designated Agencies (DAs) continues to be in services for children and families, while the lowest numbers of persons served by a Designated Agency program are those in the Community Rehabilitation and Treatment (CRT) programs. The volume of clients served in all of the program areas has been fairly stable over time. There is a significant increase in case management services to outpatient clients as discussed later in this report.

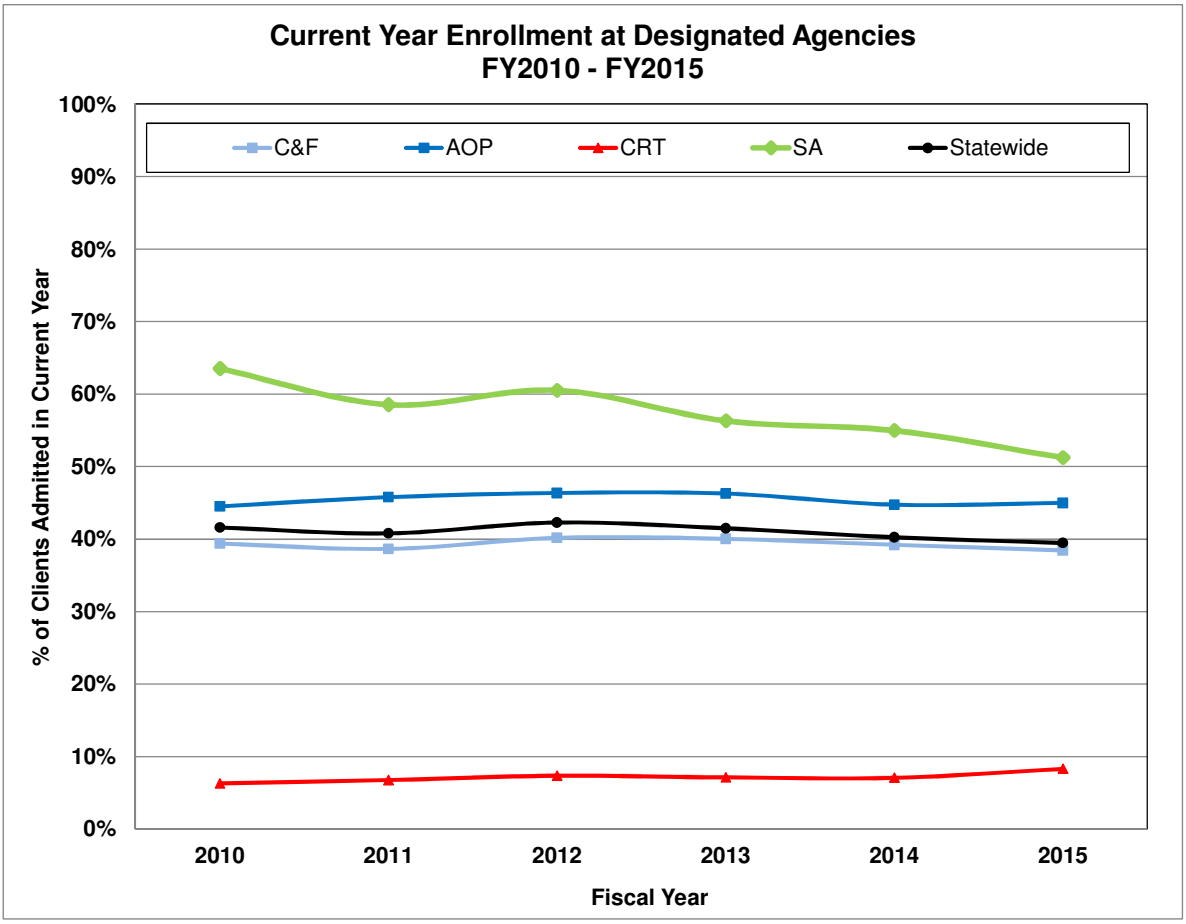
Chart 25: Community Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2014.
US totals are calculated uniquely based on only those states who reported clients served.

Vermont community mental health system serves 38 out of every 1,000 Vermonters, which is 75% higher than the national figure. This data show that Vermont is achieving success in moving care from the highest levels of hospitalization to least restrictive settings in the community. While the progress appears to be static, other data shown in Chart 29, indicate that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care.

Chart 26: Enrollment at Designated Agencies by Program



The system of care is established on the recognition that people move through a continuum of needs for care. Ideally, individuals would receive community-based treatment appropriate to their needs, and move to higher or lower levels of care only as needed to support them. For many who have a chronic illness, this is more challenging, requiring continued higher level of 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.

Consistent with historical data (Chart 26), the most static and lowest rates of new enrollments are within the Community Rehabilitation and Treatment programs, while Substance Abuse treatment is significantly higher. The overall new enrollment rate statewide for all programs is steady at around 40%.

Chart 27: Intensive Residential Bed Utilization

Legislative Report to Mental Health Oversight Committee
and Health Care Oversight Committee
Intensive Residential Census Report
January - September 2015

Adult Intensive Residential Facilities

	Hilltop	Meadowview	Second Spring Williamstown	Second Spring Westford	RMHS MapleWood	Soteria House*	Middlesex	State Avg	State Avg Excluding Middlesex
January									
Total Beds	8	6	14	8	4	0	7	47	40
Monthly Avg.	8.00	6.00	11.84	6.61	3.74	0.00	7.00	43.19	36.17
Monthly % Occupancy	100.0%	100.0%	84.6%	82.6%	93.5%	0.0%	100.0%	91.9%	90.4%
February									
Total Beds	8	6	14	8	4	0	7	47	40
Monthly Avg.	7.82	6.00	12.14	7.61	3.82	0.00	6.82	44.21	37.39
Monthly % Occupancy	97.8%	100.0%	86.7%	95.1%	95.5%	0.0%	97.4%	94.1%	93.5%
March									
Total Beds	8	6	14	8	4	0	7	47	40
Monthly Avg.	7.65	6.00	13.00	7.77	3.52	0.00	6.00	43.94	38.03
Monthly % Occupancy	95.6%	100.0%	92.9%	97.1%	88.0%	0.0%	85.7%	93.5%	95.1%
April									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	6.70	6.00	11.57	7.43	3.00	1.17	5.33	40.73	35.40
Monthly % Occupancy	83.8%	100.0%	82.6%	92.9%	75.0%	23.4%	76.1%	81.5%	82.3%
May									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	7.90	6.00	12.19	6.71	3.77	2.19	6.26	45.03	38.77
Monthly % Occupancy	98.8%	100.0%	87.1%	83.9%	94.3%	43.8%	89.4%	86.6%	86.2%
June									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	7.53	5.93	12.47	7.00	3.93	2.60	7.00	46.47	39.47
Monthly % Occupancy	94.1%	98.8%	89.1%	87.5%	98.3%	52.0%	100.0%	89.4%	87.7%
July									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	7.61	5.87	12.97	7.00	4.00	2.71	6.84	47.00	40.16
Monthly % Occupancy	95.1%	97.8%	92.6%	87.5%	100.0%	54.2%	97.7%	90.4%	89.2%
August									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	6.68	5.87	11.42	5.29	4.00	4.00	6.58	43.45	36.87
Monthly % Occupancy	83.5%	97.8%	81.6%	66.1%	100.0%	80.0%	94.0%	84.2%	82.6%
September									
Total Beds	8	6	14	8	4	5	7	52	45
Monthly Avg.	7.30	6.00	11.83	6.50	4.00	5.00	5.93	46.57	41.57
Monthly % Occupancy	91.3%	100.0%	84.5%	81.3%	100.0%	100.0%	84.8%	89.6%	88.4%

* Soteria House began accepting referals Aptil 2015

Based on data reported to the Vermont Department of Mental Health (DMH) by intensive recovery residence beds for adult care using the electronic bed boards system. Programs are expected to report to electronic bed boards a minimum of once per day to update their residential census. State averages for November 2013 and subsequent months have been adjusted to exclude programs on days where there were no updates submitted to the bed board.Middlesex Therapeutic Community Residence began accepting placements on June 20th, 2013 and began reporting to electronic bed boards system on June 21, 2013. Before the opening of Second Spring -Westford on August 19, 2013, Second Spring Williamstown had 2 crisis beds that could be reallocated to intesive residential as needed, bringing their total capacity to 22 during some days in each month. This is reflected in months where percent occupancy exceeds 100%.

The Intensive Residential Recovery Programs (IRRs) are continuing to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward more independent living. Chart 27 illustrates the utilization of beds in the IRRs. There are now seven programs in operation. Soteria House opened in spring 2015, adding 5 beds. Maplewood opened in spring 2014, adding 4 beds for those needing a higher level of community care. Second Spring Westford and Middlesex Therapeutic Community Residence (MTCR) opened in February 2013. The programs provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-18 month time frame for residents.

In accordance with creating movement within the system of care, the Department worked to develop increased crisis bed capacity during 2013 and has continued to work closely with the Designated Agencies and Peer Agencies to support this capacity. Table 28 below depicts Crisis Bed occupancy for 2014. Utilization has been within expected rates, with an average statewide of 76% during the period between January and September of 2015. This is slightly below target rate established for crisis bed utilization (80%). In looking at the utilization, it can be seen that there is some unused capacity for clients who may need step-down from hospitalization, however it may also be inferred that there is a need for an increased number of Intensive Residential beds.

Chart 28: Crisis Bed Census Report

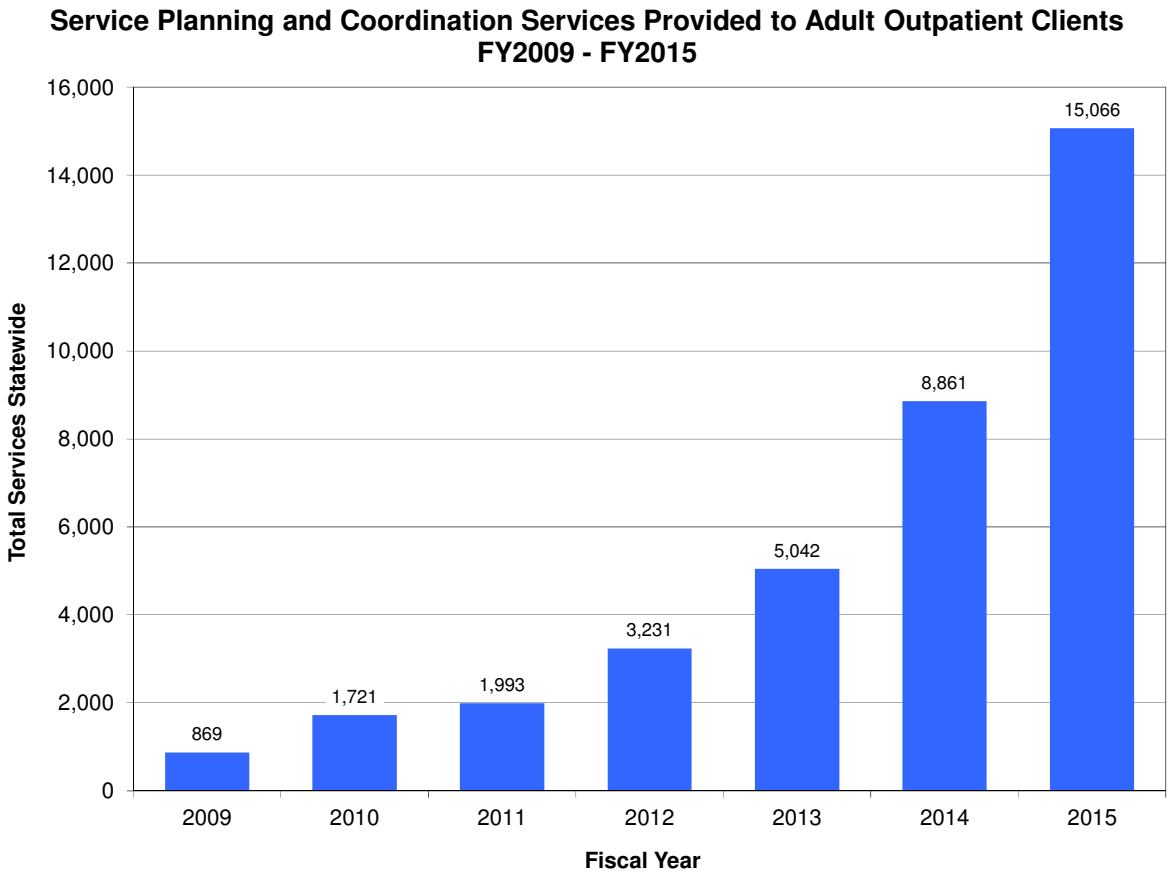
Legislative Report to Mental Health Oversight Committee
and Health Care Oversight Committee
Crisis Bed Census Report
2015

Adult Crisis Bed Units

	Alyssum	CMC Chris' Place	CSAC Hill House	HC Assist	HCRS Alternatives	LCMH Oasis House	WCMH Maple House	NCSS Bayview	NKHS Care Bed	RMHS CSID	Second Spring Williamstown	UCS Battelle House	WCMH Home Intervention	State Avg
January														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.94	1.52	1	4.9	5.87	1.35	0.45	1.94	1.61	2.61	2	4.35	2.65	32.19
Monthly % Occupancy	96.80%	75.80%	100.00%	81.70%	97.80%	67.70%	45.20%	96.80%	80.60%	65.30%	100.00%	72.60%	66.10%	80.50%
February														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.64	1.29	1	4.68	5.89	1.71	0.21	1.86	1	2.25	1.89	4.04	3.54	30.43
Monthly % Occupancy	82.10%	64.30%	100.00%	78.00%	98.20%	85.70%	21.40%	92.90%	50.00%	56.30%	94.60%	67.40%	88.40%	76.10%
March														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.68	0.94	1	5.19	6	1.26	0.93	1.87	1.52	3.94	1.07	3.76	3.71	32.52
Monthly % Occupancy	83.90%	46.80%	100.00%	86.60%	100.00%	62.90%	93.10%	93.50%	75.80%	98.40%	53.30%	62.60%	92.70%	81.30%
April														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	2	1.37	0.9	3.97	6	1.57	0.33	1.93	1.7	3.93	1.17	4.23	3.4	32.5
Monthly % Occupancy	100.00%	68.30%	90.00%	66.10%	100.00%	78.30%	33.30%	96.70%	85.00%	98.30%	58.30%	70.60%	85.00%	81.30%
May														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.74	0.94	0.68	4.1	6	1.45	1	1.61	1.58	3.58	0.97	3.68	2.19	29.52
Monthly % Occupancy	87.10%	46.80%	67.70%	68.30%	100.00%	72.60%	100.00%	80.60%	79.00%	89.50%	48.40%	61.30%	54.80%	73.80%
June														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.77	1.20	0.27	5.47	5.83	1.43	0.77	1.77	1.47	3.53	0.00	3.36	2.60	28.57
Monthly % Occupancy	88.3%	60.0%	26.7%	91.1%	97.2%	71.7%	76.7%	88.3%	73.3%	88.3%	0.0%	56.1%	65.0%	71.4%
July														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.9	1.19	0.97	4.97	5.97	0.94	0.71	1.94	0.9	3.58	1.39	3.16	2.23	29.84
Monthly % Occupancy	95.20%	59.70%	96.80%	82.80%	99.50%	46.80%	71.00%	96.80%	45.20%	89.50%	69.40%	52.70%	55.60%	74.60%
August														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.9	1.65	0.8	4.71	5.29	1.23	0.87	1.84	1	3.87	0.68	3.1	1.94	28.77
Monthly % Occupancy	95.00%	82.30%	80.00%	78.50%	88.20%	61.30%	87.10%	91.90%	50.00%	96.80%	33.90%	51.60%	48.40%	71.90%
September														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.43	1.90	1.00	4.90	5.57	1.10	0.80	1.93	1.13	3.87	1.23	3.43	3	31.30
Monthly % Occupancy	71.7%	95.0%	100.0%	81.7%	92.8%	55.0%	80.0%	96.7%	56.7%	96.7%	61.7%	57.2%	75.0%	78.3%

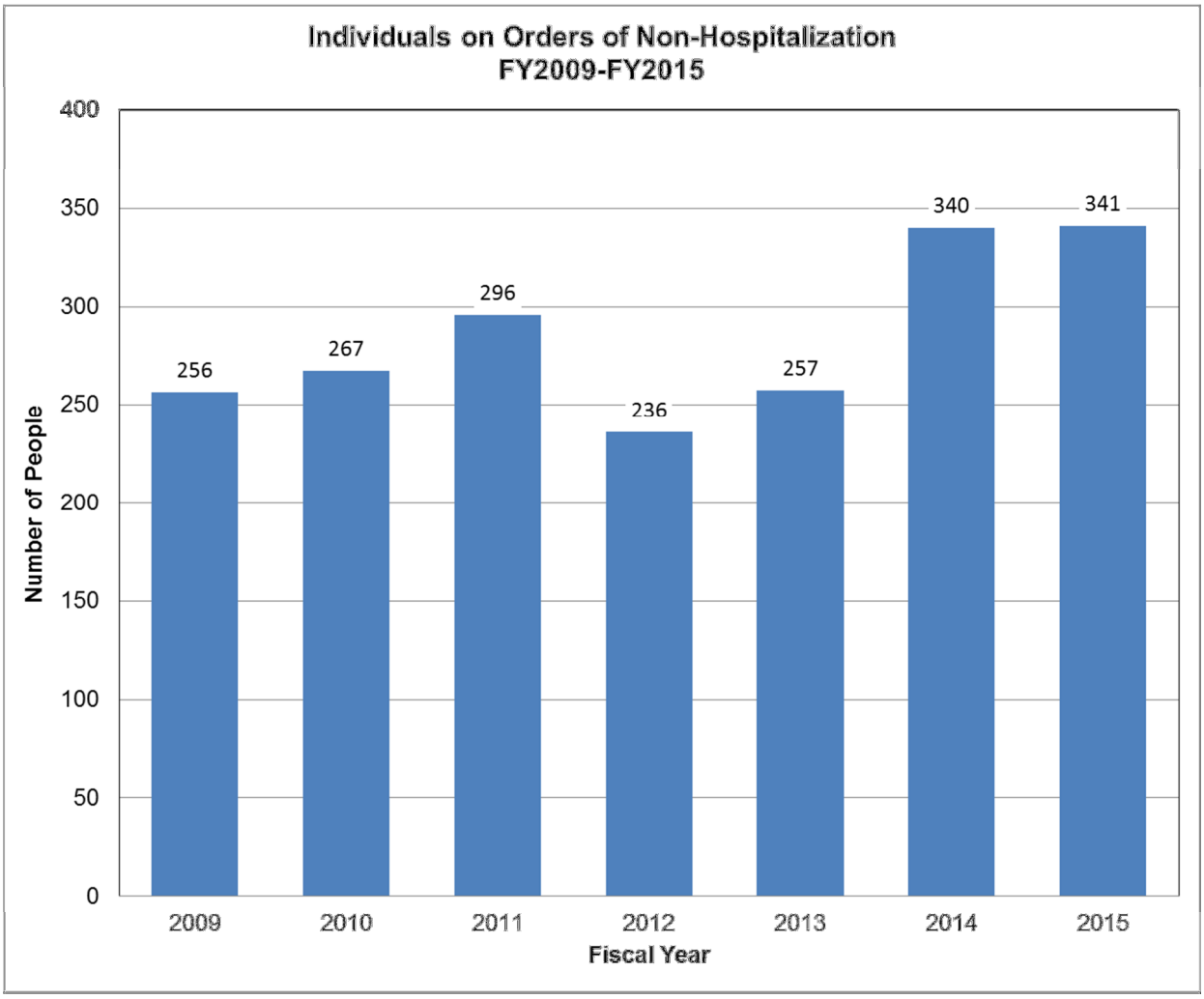
Based on data reported to the Vermont Department of Mental Health (DMH) by crisis bed programs for adult care using the electronic bed boards system. Programs are expected to report to electronic bed boards a minimum of once per day to update their census. State averages are adjusted to exclude programs on days where there were no updates submitted to the bed board.
The Second Spring -Williamstown program is based upon two beds that can be reallocated to intensive residential services as needed.

Chart 29: Non-Categorical Case Management



The support of non-categorical case management has led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services. It is worth noting here that the amount of services provided for service planning and coordination almost doubled in FY 2014, and again in FY 2015. This is a good indicator of the need for this level of case management to the adult outpatient population.

Chart 30: Orders for Non-Hospitalizations



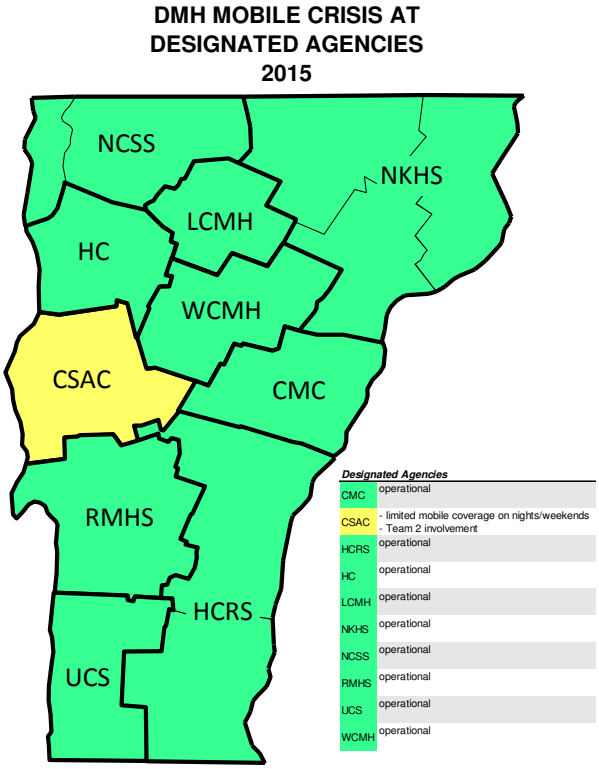
Department of Mental Health Orders of Non-Hospitalization (ONHs) were the highest in four years reaching 341 people during FY 2015. Departmental legal staff members work closely with clinical staff and Designated Agency clinicians to monitor treatment compliance and maintain communication with providers. The Care Management Team monitors community care through the Designated Agencies which provide direct services in the community. Through this process, community service providers are required to provide clinical justification of the ongoing need and their efforts to engage individuals in the treatment planning process and in understanding and complying with community conditions imposed by the Court. The Department plans to continue providing oversight through the care management team. The Department assigned a Care Manager in May 2015 to work solely with Designated Agencies to provide closer oversight and case consultation in regards to individuals being served who are on ONHs. Designated Agencies consult with this Care Manager prior to their requests to continue or discontinue Orders of Non-Hospitalization. The ONH Manual was finalized in November 2015 after significant input from the Designated Agencies.

Enhanced Outpatient and Emergency Services

The impact of the enhancements allocated by the legislature in Act 79 has been significant in retooling some of the ways in which mental health services are delivered at the community level. All of the designated agencies participated in developing additional services and enhancing those services that were already in place, in order to provide more timely access to and response for those in crisis.

The list of services covered by the changes was fairly broad, with common themes and best practices identified and implemented across all of the Designated Agencies. This year, the Department and Vermont Care Partners revisited the Act 79 reporting form and revised it using an RBA framework (Attachment D).

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, perform outreach through Department grant initiatives, providing support in the community at such places as individuals' homes and in emergency departments. Joint interventions between law enforcement and mobile crisis teams have the potential benefit for service recipients in modeling de-escalation techniques. This collaboration has been viewed as enhancing the successful interventions in the community.

Each Designated Agency has developed 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. In

addition, the Designated Agencies are providing increased services to patients waiting in emergency rooms for admission to psychiatric hospital care.

To continue these efforts successfully, standards and training for law enforcement personnel and crisis teams have been established. Law enforcement staff from local and statewide jurisdictions have participated in the trainings which will be continuing into 2016. Over the past three years, 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 the Department and Public Safety and has been delivered regionally through a collaborative effort between Vermont Care Partners, the Department of Public Safety and the Department of Mental health, using a train-the-trainers model referred to as "Team Two" Training. "Team Two" teams have been established in the 5 regions of the State:

- Central Team – Washington County, Orange County
- Southeast Team – Windham and Windsor Counties
- Southwest Team – Bennington, Rutland and Addison
- Northwest Team – Chittenden, Franklin Counties
- Northeast Team – Lamoille, Orleans and Caledonia Counties

The philosophy behind the Team Two training is one of collaboration, information sharing, and resource management for law enforcement and mental health crisis teams when responding to a situation from the legal, clinical, and safety perspectives. Training provides responders a clear understanding of the limitations and expectations of their fellow responders and evaluates the legal, clinical and safety aspects of the situation. "Train-the-Trainer" trainings have also been held to build capacity to maintain the learning and assure responders have the same interpretation of statutory issues. At this time, the Department of Public Safety is collaborating in funding additional trainings to adjunct emergency services staff, such as police dispatchers and statewide 911 call centers.

Peer Services

Through Act 79 and other prior initiatives that were underway, the Department of Mental Health has been working to expand and improve services provided by individuals with the lived experience of mental illness (peers). The Department recognizes the value of peer support in promoting an individual's recovery from mental illness, and has sought to expand both access to mental health peer services and improve the quality of those services. The focus has been twofold:

1. Increasing peer services for individuals with mental health and other co-occurring issues that are in need of and desiring additional recovery support from those with lived experience; and
2. Improving Vermont's infrastructure to ensure that individuals and organizations providing peer services are supported through training, continuing education, mentoring, co-supervision, technical assistance, administrative support, organizational consultation and development, and collaborative networking with peer and other providers.

The Importance of Peer Support in Vermont

The concept of "peer support" is not something that is unique to individuals with mental health and other co-occurring issues. In their 2004 article *Peer Support: What Makes It Unique?,* Shery Mead and Cheryl MacNeil write:

"Peer support for people with similar life experiences (e.g., people who've lost children, people with alcohol and substance abuse problems, etc.) has proven to be tremendously important towards helping many move through difficult situations (Reissman, 1989; Roberts & Rappaport, 1989). In general, peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not offer or even know about. Maintaining its non-professional vantage point is crucial in helping people rebuild their sense of community when they've had a disconnecting kind of experience."[3]

While there is great diversity in the ways in which peer support is provided for individuals with mental health and other co-occurring issues, Mead and MacNeil (2004) have identified core elements of mental health peer support that make it unique and an alternative form of support for individuals who have not been able to achieve recovery through traditional, professional services. These include:

- being free from coercion (e.g. voluntary),
- consumer run and directed (both governmentally and programmatically),
- an informal setting with flexibility, and a non-hierarchical, and non-medical approach (e.g. not diagnosing, etc),
- the peer principle (finding affiliation with someone with similar life experience and having an equal relationship),
- the helper principle (the notion that being helpful to someone else is also self-healing),
- empowerment (finding hope and believing that recovery is possible; taking personal responsibility for making it happen),
- advocacy (self and system advocacy skills),
- choice and decision-making opportunities,
- skill development,
- positive risk taking,
- reciprocity,
- support,
- sense of community,
- self-help,
- developing awareness.[4]

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[3] http://mentalhealthpeers.com/pdfs/PeerSupportUnique.pdf

[4] http://mentalhealthpeers.com/pdfs/PeerSupportUnique.pdf

Peer support can take many different forms (e.g. self-help and mutual support groups, peer crisis respite, warm lines, inpatient peer services, wellness planning and skill development, peer-driven housing supports, peer drop-in and community centers) and has been shown to be effective in supporting recovery. As stated by the Substance Abuse and Mental Health Services Administration (SAMHSA), "Evidence shows that consumer-operated services are supporting people in their wellness and recovery while also contributing to the entire mental health service system."[5] For these reasons, it is the goal of the Department of Mental Health to make a variety of peer supports available to anyone in the state struggling with mental health and other co-occurring issues. The implementation of the programs described below is helping the Department move closer to this goal.

Implementation of Peer Services

Over the past year, the Department has focused primarily on improving and refining Vermont's expanded array of peer services, many of which were developed or enhanced following the passage of Act 79. This expanded array of services includes community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. A full listing of peer programming supported by the Department of Mental Health is listed below in Chart 31.

Chart 31: Vermont Peer Services Organizations

Organization	Services Provided
Alyssum	Operates two-bed program providing crisis respite and hospital diversion and step-down.
Another Way	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving individuals who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups for individuals with mental health conditions and their families.
Northeast Kingdom Human Services Peer Cadre	Provides respite and peer support for individuals waiting in hospital emergency departments for inpatient psychiatric care.
Pathways – Vermont Support Line	Statewide telephone peer support to prevent crisis and provide wellness coaching.

[5] http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf

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.
Vermont Vet-to-Vet	Community outreach, support groups and crisis intervention for veterans at risk of hospitalization due to mental health and substance use challenges.
Wellness Cooperative	Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services.
Wellness Workforce Coalition	Provides infrastructure and workforce development for organizations that provide peer support. Activities include: o Coordinating core training (e.g Intentional Peer Support) o Workforce development (e.g. recruitment, retention, career development) o Mentoring o Quality improvement o Coordination of peer services o Communication and networking o Systems advocacy.

During FY 2015, each of the programs has worked closely with the Wellness Workforce Coalition (WWC) to participate in core training and mentoring for staff using the Intentional Peer Support Curriculum, which is used nation-wide for peer support providers. These peer organizations have also worked with the WWC to improve their infrastructure (e.g. financial management, board development) and expand their capacity for collecting and reporting service outcomes using the Results-Based Accountability framework.

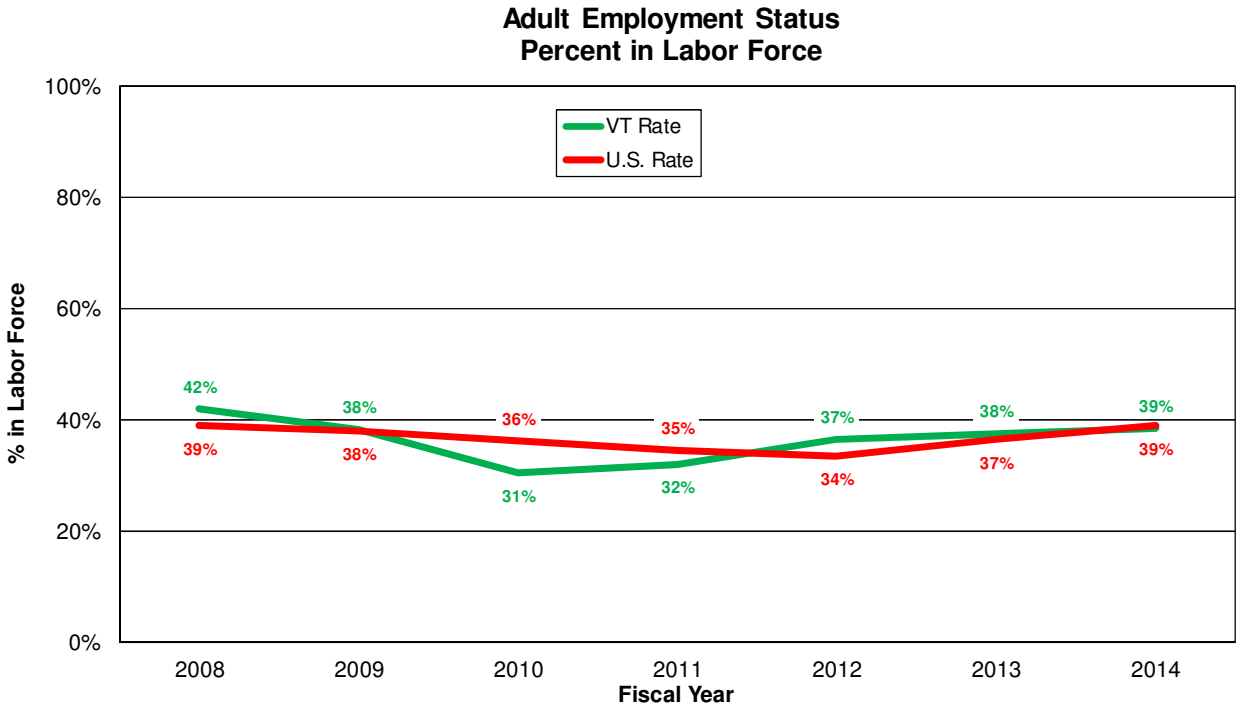
The Vermont Support Line is one of the programs developed subsequent to the implementation of Act 79. It provides statewide telephone peer support to prevent crisis and provide wellness coaching; currently operating 365 days a year. The line is operated by full time and part time peer staff who have been trained using the Intentional Peer Support model which uses a specialized curriculum developed expressly for support line workers.

The Vermont Support Line took its first call on March 18, 2013 and has provided 14,890 individual instances of completed support through November of this year, with 2015 already surpassing the call volume of 2014 by over 1,400 calls. Through November 2015, the Vermont Support Line has diverted 755 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). In 2015 the support line has been able to increase the amount of incoming calls answered from 8.42% in 2014 to 22.13% (through November) of total incoming calls. In 2015, 98% of callers who answered the survey questions reported that the call was helpful.

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. Employment reduces a person's dependence on Social Security and has the potential to create significant savings to the system of care over time.

Chart 32: Percentage of All Adults with Mental Illness Employed in U.S. and VT

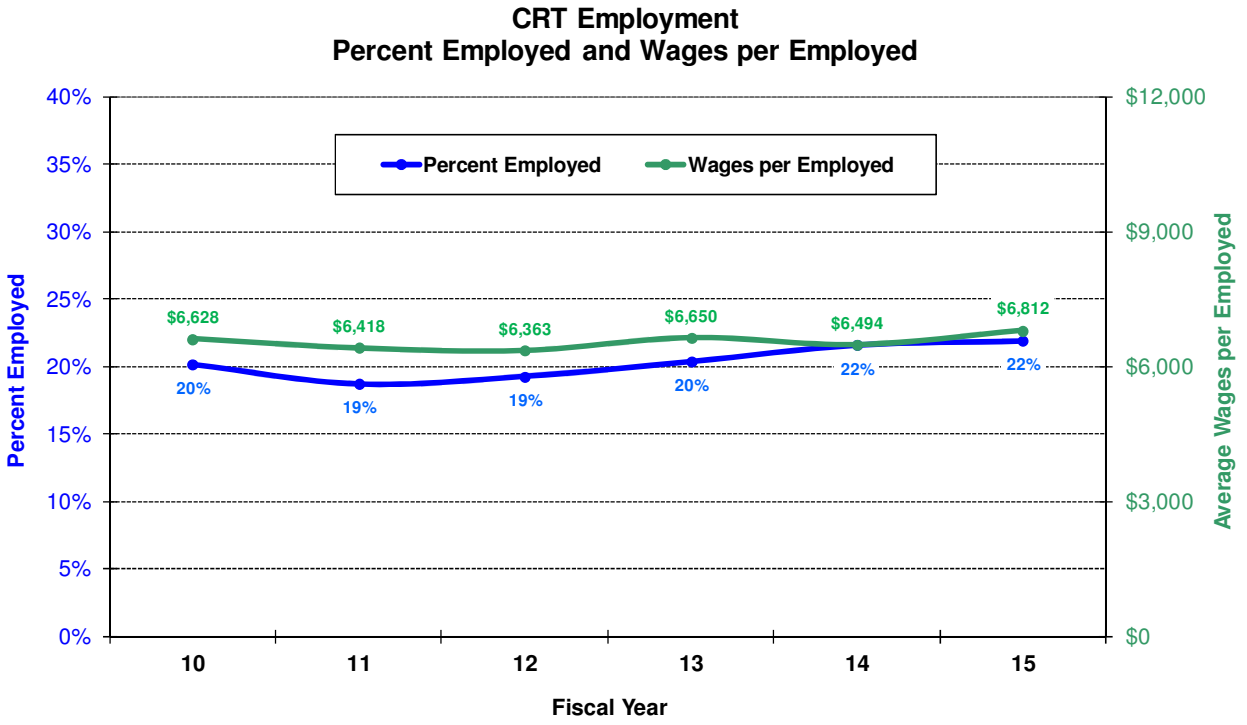


Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2014. Employment status for other mental health clients is based on case manager monthly service reports.
Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2014.
US totals are calculated uniquely based on those states who reported. Percentage in Labor Force includes all eligible adult mental health clients with SMI and is calculated as the percentage of those employed divided by the total number of adult clients (unemployed plus competively employeed). 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 32 shows the employment rate for all adults with mental illness in Designated Agencies—Adult Outpatient and Community Rehabilitation and Treatment combined—which increased by 1% and matches the national rate. Reasons for the continued increase may include:

- Sustained efforts of peer employment staff in two peer-run programs
- Increased focus on employment as key component of wellness and recovery at DAs
- Consistent evidence-based supported employment training and technical assistance at DAs
- Creative Workforce Solutions
- Collaborative efforts between Vocational Rehabilitation and the Department.

Chart 33: CRT Annual Employment Rates and Average Earnings



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 33 indicates a 1% increase in Community Rehabilitation and Treatment employment outcomes between FY 2012 and FY 2013 and an additional 2% increase by end of FY 2014 that has held steady through FY 2015. Wages dipped slightly for the period but have increased in FY 2015. Community Rehabilitation and Treatment programs continued to support individuals with their employment goals despite continued challenges within the system of care. Individuals, on average, earned $6,812 per year (*16 hours per week for full year at minimum wage*). Total wages earned in FY 2015 were $3.6 million, an increase of 1% from FY 2014.

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 Department 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 in Charts 34 and 35.

Person centered care is focused upon the individual needs and movement towards stabilization and recovery. The individual needs of clients are the focal point at all of the levels of care in the system. The Department of Mental Health 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.

In addition to supporting people to obtain employment, which is one of the most effective interventions for improving recovery and reducing stigma, the Department currently supports and continues to expand a number of other non-medical interventions for the management of and recovery from distressing symptoms associated with mental illness. Interventions such as *Wellness Recovery Action Planning, Illness Management and Recovery, Cognitive Behavioral Therapy for Schizophrenia*, *Open Dialogue,* and the *Hearing Voices* curriculum module support individuals to develop non-medical methods for reducing or eliminating the negative effects of their psychiatric symptoms. These approaches may, in some cases, give the individual an opportunity to work with their physician to reduce the medications that are being taken to manage those same symptoms. These types of interventions are available to a varying degree at the designated agencies and are an essential component of the peer service program described above. Currently, across the state, there are a number of initiatives underway to expand the availability of several of these interventions.

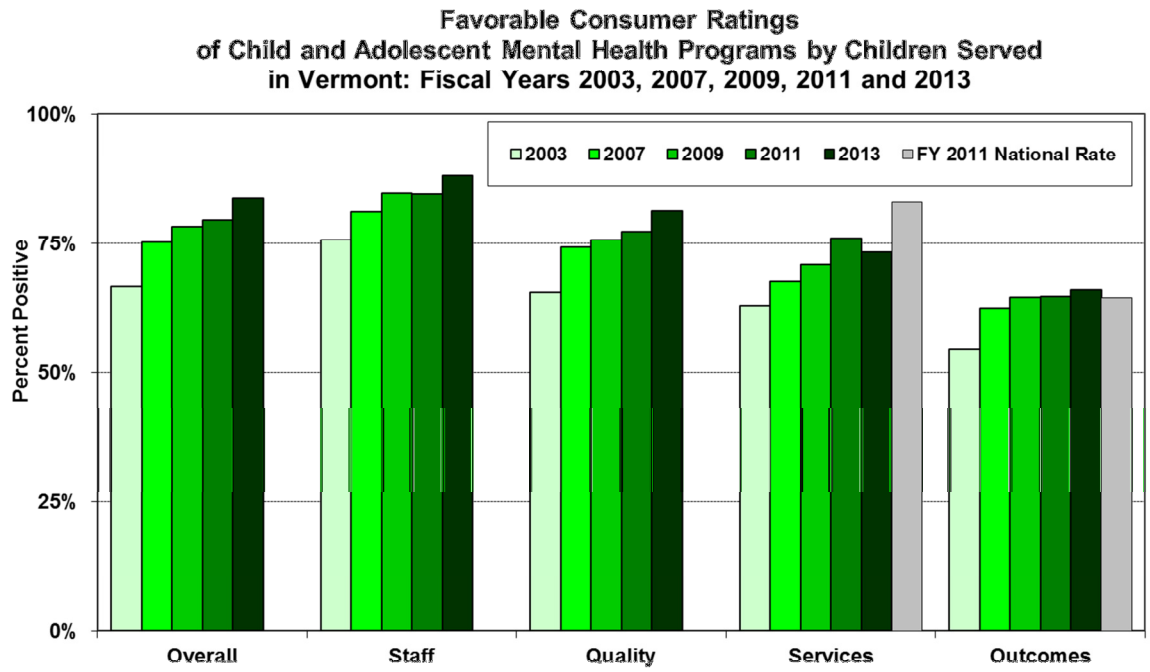
Over the past year, the Department has also worked to expand options for individuals seeking to avoid or reduce reliance on medications through the development of the residential program *Soteria – Vermont*, which provides specialized treatment and support for individuals experiencing first break psychosis who are seeking to avoid or reduce their reliance on medications. This program, which opened in the spring 2015, includes care from a psychiatrist to support withdrawal from medications. The intensive residential program *Hilltop,* which has been in operation since 2012, also provides treatment and support using the *Soteria* model.

Lastly, Vermont was recently informed of an increase in their Federal Mental Health Block Grant to support the expansion of targeted services for individuals experiencing early episodes of psychosis. Current research indicates that early intervention and treatment of individuals who are first experiencing psychosis has the ability to prevent or reduce long-term disability, and, in some cases, reduce long-term reliance on psychotropic medication. In 2015, the Department began working with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) to identify and promulgate specific evidence-based practices for this population and is supporting an ethnographic study on this area.

Perception of Care Surveys

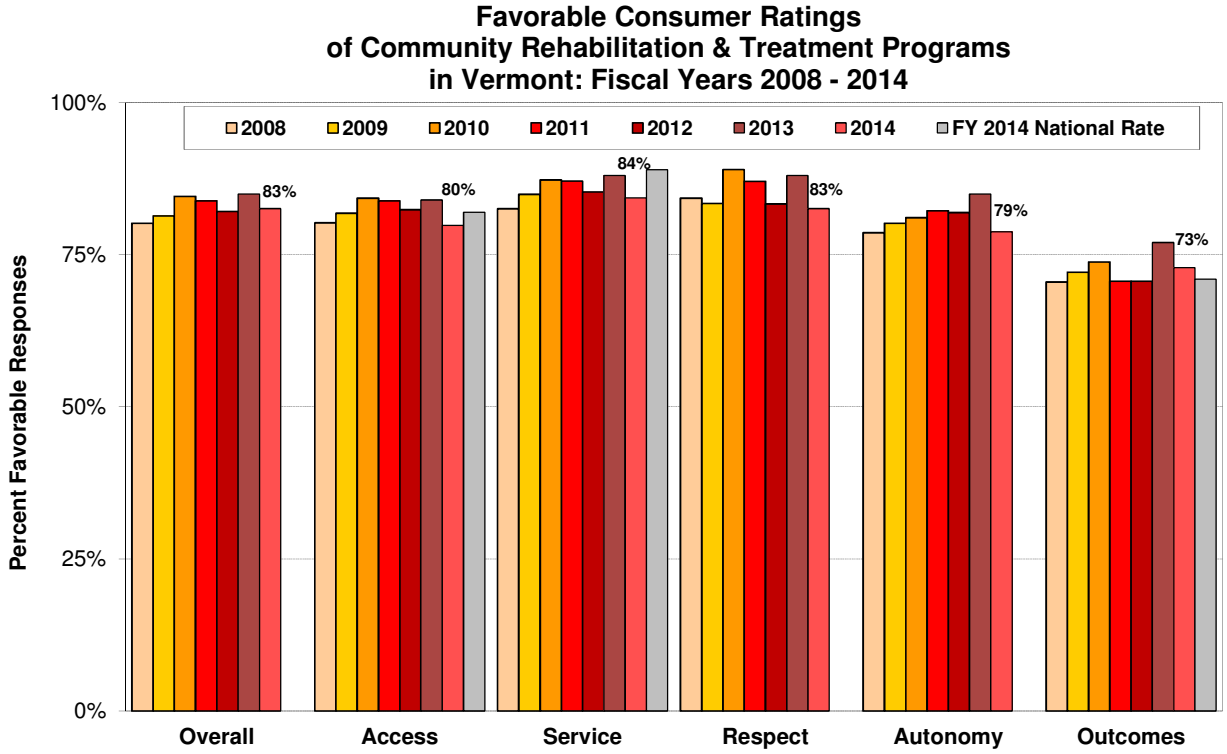
The Department conducts consumer surveys to evaluate Community Rehabilitation and Treatment Services and Children and Family Services provided by the ten designated agencies in Vermont. (The survey for children and families includes parents of children and adolescents with a severe emotional disturbance as well as youth in services.) The full survey reports can be found online at: http://mentalhealth.vermnt.gov/report/survey. The surveys focus on five areas with a resulting overall score constructed from responses to the 44 survey questions. These are represented in Charts 34 and 35.

Chart 34: Favorable Outcomes Percentage of Child & Family (C&F)



Overall satisfaction in Child and Adolescent Mental Health Programs has increased over the years, along with satisfaction surrounding staff and quality of services. The 2015 survey is in process and will have results by spring 2016.

Chart 35: Favorable Outcomes Percentage for CRT

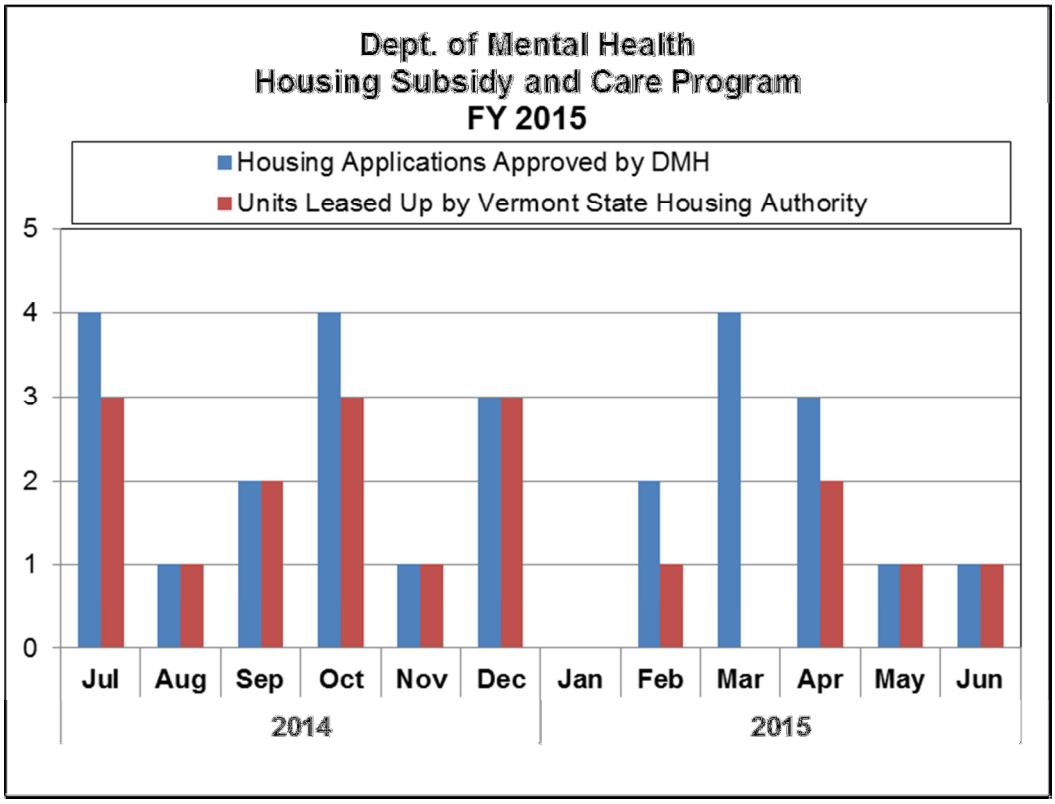


Analysis is based on responses to surveys of Consumer Evaluation of Community Rehabilitation and Treatment Programs. Responses of "agree" or "strongly agree" are considered positive, compared to "no opinion", "disagree", and "strongly disagree".

Satisfaction with Community Rehabilitation and Treatment programs has shown less improvement, but remains in the eightieth percentile for all domains, with the exception of autonomy and outcomes. Survey results vary widely by Designated Agency. Information from surveys is used in the designation process and when working with Designated Agencies to improve care.

Housing

Chart 36: Housing Subsidy and Care Program



During the reporting period July 2014 to June 2015, a total of 144 persons who were homeless, mentally ill and needing an acute care bed have been allocated a subsidy and have subsequently been housed with community supportive services by the Department's Housing Subsidy & Care Program. The Vermont State Housing Authority remains the Department's collaborating partner verifying income, setting rent payments, and working with landlords.

The performance indicator the department seeks to achieve is a one year housing retention. The lengths of stay in housing since the program began range from 29 to 1,114 days, with over 76% having lengths of stay greater than one year. An equal number of male and female were also served. Of the 144 served during, more than 74% were literally homeless, meaning on the streets, in a shelter, or in a hospital. Less than 18% of those assisted came from psychiatric hospitalization. Of the 169 housed since December 2011, 51 persons have exited. Thirty five percent of those have positive outcomes.

Chart 37: People Housed Through End FY15

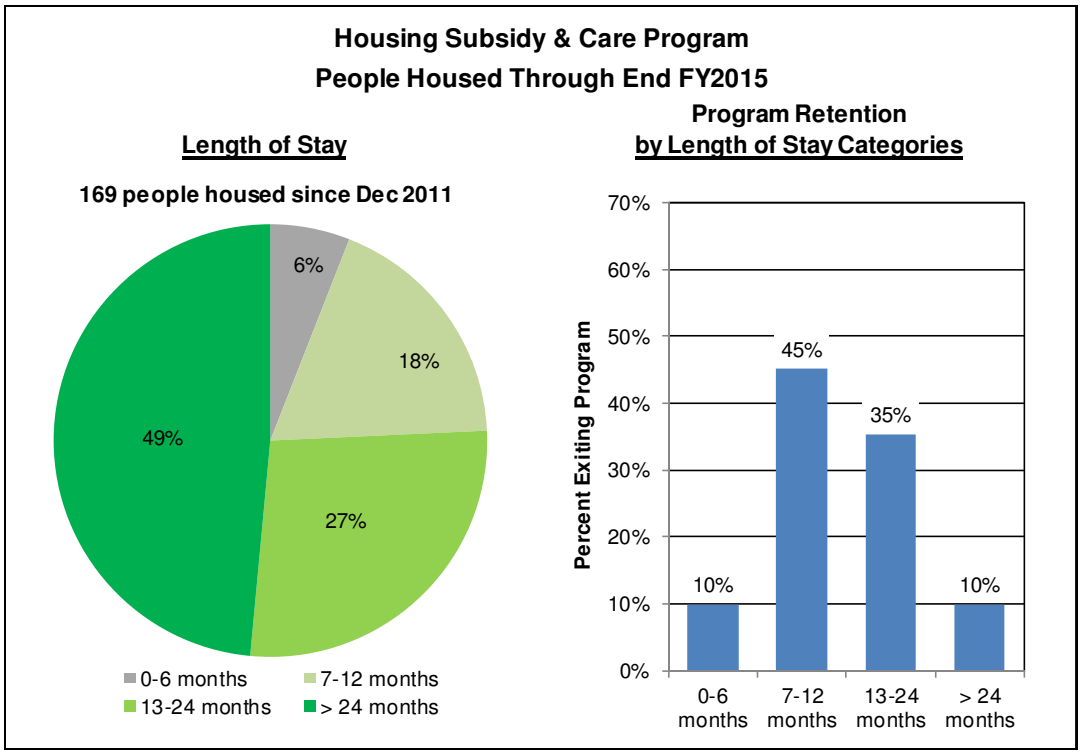
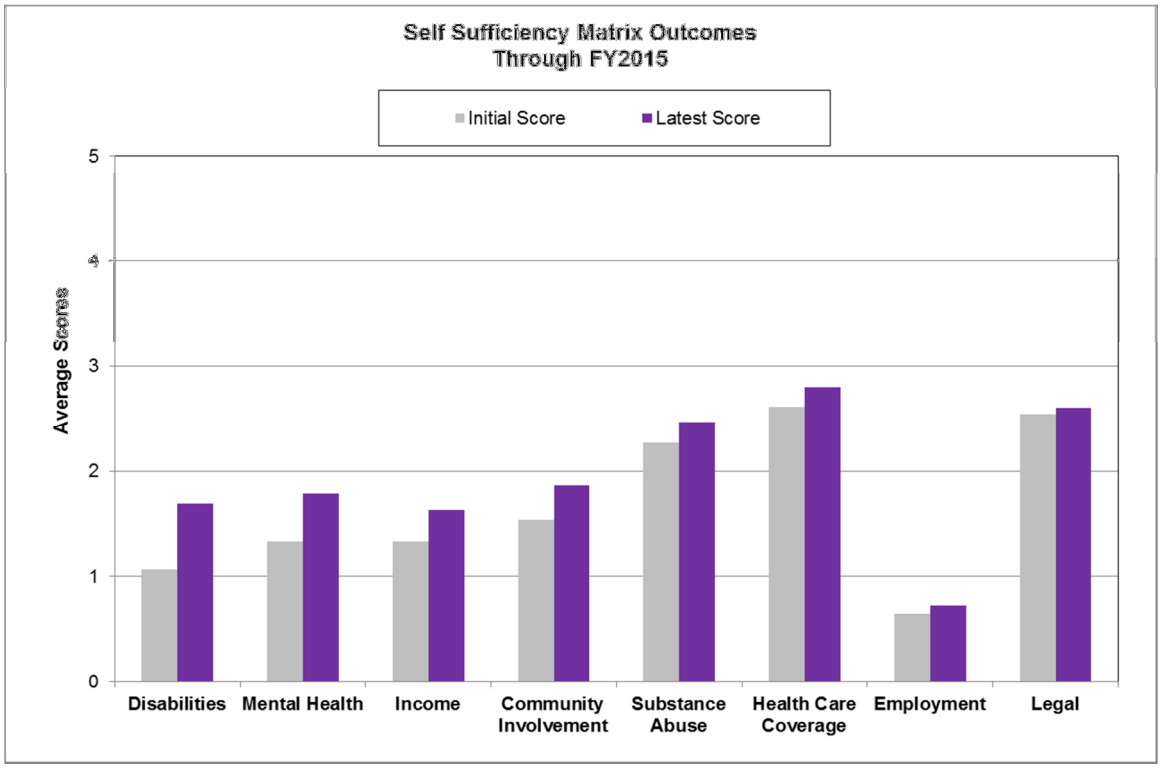


Chart 38: Self Sufficiency Matrix Outcomes Through FY2014



All 9 self-sufficiency outcome measures recorded demonstrate improvement for the individuals participating in the Housing Subsidy & Care program. Most notable was the improvement in disability, income, housing, mental health, and community involvement.

All 10 Designated Agencies and the Department's adult Specialized Service Agency (Pathways) are service providers for housing subsidy and care, as well as several additional providers listed below:

- Another Way
- Brattleboro Area Drop In Center
- Community Health Center of Burlington
- Helping Overcome Poverty's Effects
- Northeast Kingdom Community Action
- Homeless Prevention Center

Conducting Quality Management

The Vermont Department of Mental Health endorses principles of recovery, integrated evidence based health, mental health and substance abuse care through flexible, person-centered care offered in the least restrictive environment. The Department is committed to the following Quality Domain Measures: Access, Practice Patterns, Outcomes/Results of Treatment, and Administration of fully functional agencies providing care.

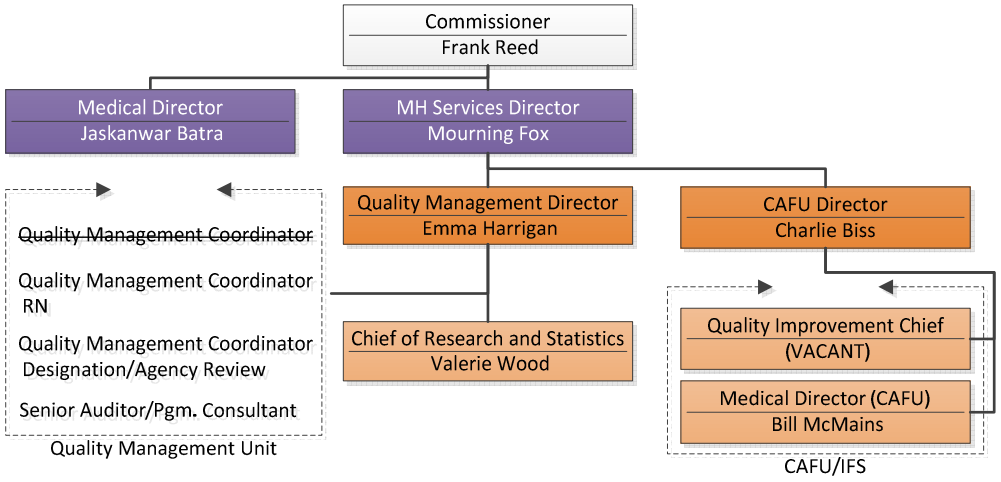
Quality Unit Structure

The Department Quality Management Unit was reconstituted in September 2012, with the hiring of a Quality Management Director. Two additional quality management coordinator positions were added to the unit; however, one position was lost in the 2015 rescissions. In response to the 2014 State Auditors Report, the Department has added a senior auditor/program consultant position to the quality unit.

The unit has made significant progress in the development of a system of quality assurance, monitoring, and quality improvement. Quality Assurance and Quality Improvement are often used interchangeably. In order to clarify the use of these terms, see below for definitions.

Quality Assurance:	Oversight of the services provided within our system of care, identifying deficiencies and/or weaknesses, while ensuring that services meet minimum standards
Quality Monitoring:	Collection and review of data, analysis and aggregate reporting
Quality Improvement:	Working with system partners to improve and enhance the quality of care. Providing assistance in the achievement of desired outcomes and goals, utilizing best practices. Supporting and improving the internal quality processes, service delivery, and performance management within our partner agencies.

The Quality Management Unit encompasses the both members of central office and members of the Children, Family and Adolescent Quality Team. Both DMH Medical Directors interface with staff, and although not directly part of the quality team, research and statistics are also included because data and measurement are central to good quality work.



Philosophy of Quality Management

The Department utilizes a collaborative approach in working with our partners and those who provide services for which the Department of Mental Health is the Mental Health Authority.

- We begin with the belief that the designated providers are working hard to improve lives.
- We want our designated partners to succeed.
- We develop quality projects around mutually identified areas of concern between the Department and our partners.
- Our purpose is to provide resources and oversight to assure delivery of quality mental health services.

Summary of Significant Quality Unit Activities

Despite losses in staff, the Quality Unit continues to review grievance and appeals, critical incidents, and certificates of need for emergency involuntary procedures. The Quality Unit continues to conduct agency re-designation, oversee plans of corrective action for designation deficiencies, and designate new agencies. A significant amount of work has been conducted to create a Departmental RBA scorecard, which is posted on the DMH website.

The unit has continued development and implementation of a comprehensive DMH Snapshot of significant measures, which is used by Leadership to monitor progress of the system of care and made available on a monthly basis to the committees of jurisdiction and posted online.

The unit also participates in several AHS quality initiatives and performance initiatives:

- Performance Accountability Committee
- Performance Accountability Liaison workgroup
- RBA Scorecard Champions workgroup
- Department of Vermont Health Access (DVHA) Quality Committee
- AHS STAT related to the AHS Strategic Plan
- The Agency Improvement Model program (AIM)

- DVHA Performance Improvement Project (PIP) related to Medicaid improvement on Healthcare Effectiveness Data and Information Set (HEDIS) measures

The unit has worked with Department of Vermont Health Access (DVHA) in its capacity as a Managed Care Entity (MCE) under Intergovernmental Agreements (IGA). The unit has also developed a Quality Plan for performance accountability, titled *The Quality Plan (2/14/14).* This document provides guidance for the purpose and scope of work that comprises both quality assurance and quality improvement activities. It is also required by DVHA to implement and ensure the delivery of quality mental health care to Medicaid beneficiaries.

Quality Management Unit Goals

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 Quality Management Unit contributes to policy development through the ongoing processes to gather accurate, valid and reliable data and continuous quality improvement activities including the development and real time adjustments of departmental dashboards and reporting, for the leadership team and stakeholders.

The following list represents the top-priority goals identified by departmental 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;
- Continue to develop the role of the Quality Council and the culture of a Results Based Accountability;
- Determine performance measures for the Care Management Team functions to assess efficacy of the interventions the Department is using to facilitate transitions across elements of the system of care; and
- Work closely with the Vermont Cooperative for Practice Improvement and Innovation (VCPII) to support the implementation of promising, evidence-based, and recovery-oriented practices within the state's treatment and support system.

The Department, through its Quality Management and Research and Statistics Units, 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 and policy making process.

Challenges

Maintenance of the balance of quality improvement with oversight is a challenge to the Quality Unit. The oversight that is conducted by the Department is based on state regulations, federal regulations, and on contractual deliverables. Ultimate accountability to those regulations that affect licensing is the purview of other state entities. For example, regulations that affect licensing are the preview of Department of Aging and Independent Living Division of Licensing and Protection under contract with Centers for Medicare and Medicaid Services (CMS), the purview of Department for Children and Families for its licensure of residential services for children and adolescents, and the purview of Department of Vermont Health Access as the Medicaid authority and insurer.

Oversight of Regulatory Requirements for Designated Hospitals and Designated Agencies Receiving Funding

Departmental quality staff collaborates formally with Designated Hospital administration and Quality Managers on a monthly basis, and as needed, to facilitate policies and procedures pertaining to quality assurance and improvement and to implement changes as they are identified through and for the system of care that is evolving. In this forum, the group has reviewed and revised critical incident reporting, core measures of performance, patients' experience of care, use of seclusion and restraint, and to interface with the Department, law enforcement and to address legal issues. Other Joint Commission quality measures including Hospital-Based Inpatient Psychiatric Services (HBIPS) are also a subject of quality review by the Department.

In 2013, the Department established a grant to the VCPII for a quality improvement initiative around reduction of seclusion and restraint and provided a two day training for staff from all of the Designated Hospitals, Vermont Psychiatric Care Hospital and Departmental leadership, to provide all institutions which can use seclusion and restraint practices, with in depth training on safe, ethical and appropriate methods. Consistent with previous years, the Department will continues to engage with Dr. Huckshorn via the grant with VCPII throughout the coming year, during which she will be working with each of the hospitals around implementing and ensuring best practices.

Quality coordinators are involved with and manage the re-designation processes for both the Designated Hospitals and the Designated Agencies. During the summer and fall of this year, the Department began to review and revise the policy for hospital designation and is in the process of final draft. The Designated Agencies are in a continuous cycle of re-designation that involves a four-year process. The Minimum Standards elements have been revised and are now being utilized in quality assurance activities, in concert with a comprehensive revision of the 2004 Community Rehabilitation and Treatment Manual. This revision is in final draft as the Department works closely with the Designated Agencies to finalize it.

Planning for the Future

The landscape of the Mental Health System of Care has been changing and evolving during the past three years as new system resources come on line and are deployed to community-based care or inpatient care settings. Since last year's report, and while resources were still in development, we have seen an ongoing demand for the limited number of inpatient beds to serve individuals with acute mental health needs. The increase in intensive residential recovery, secure residential, and crisis beds have continued to support a system in recovery as new inpatient hospital beds came on line. At all times, the Department's daily work continues to be one of assuring that individuals are cared for in the least restrictive setting, that wait times for admissions continue to be actively managed, and that services throughout the system are of high quality.

The Department of Mental Health continues to work diligently with the Designated Hospitals and Designated Agencies to develop the capacity to care for this vulnerable population of Vermonters, implement process and outcome measures to assure value to the system of care in terms of quality and cost, and collaborate with partners including the Designated Hospitals, Designated Agencies, Courts, Law Enforcement, Disability Rights Vermont, Department of Correction, Department of Vermont Health Access, and the Blueprint for Health. The Department will continue with these efforts in the coming year and beyond.

Building and Maintaining Capacity

The Department of Mental Health's top priority for the past year has been improving access to the right level of care through a more reliable "system flow" as both inpatient bed and various community residential capacities have come on line. The entirety of the Level I inpatient bed capacity has ebbed and flowed this past year given new hospital start-up and staffing challenges to this new bed capacity. With the full complement of Level I or high acuity beds to the existing system capacity, the state's psychiatric inpatient hospital units will be better positioned to serve voluntary individuals with mental health needs as well. In combination with enhanced community-based treatment and support programs a fundamentally essential underpinning of our public mental health system of care is fully maturing as a continuum of care and better resourced for the complexity of needs present in our local communities. The Department's task ahead is the active monitoring and evaluation of the adequacy of the system that has been built over the past three years.

Lastly, the array of system treatment capacities achieved to date will only be complete when there is both access across care and service settings and full integration of care delivery environments. Over the coming year, the Department will continue to prioritize mental health as an integral component of overall health. In order to realize this broader mission of integrated care for all Vermonters, DMH will be seeking opportunities to further embed and develop this expectation in current health reform efforts.

Appendices

Appendix A: DMH Snapshot

Appendix B: NOMS (National Outcome Measures) Data Sheet

Appendix C: Act 79 Quarterly Reporting Form

APPENDIX A: DMH MONTHLY SNAPSHOT

This is a sample report of the DMH monthly snapshot. Monthly versions are available online at http://mentalhealth.vermont.gov/reports_Data/SysSnapshot.

VERMONT

Vermont Department of Mental Health
System Snapshot (November 17, 2014)

*data forthcoming

	2014											
	FY14 Q3			FY14 Q4			FY15 Q1			FY15 Q2		
Reporting Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Adult Inpatient Hospital												
% Occupancy	87%	88%	89%	91%	93%	89%	82%	85%	86%	89%		
Avg. Daily Census	146	147	151	153	157	150	153	159	162	167		
% Occupancy at No Refusal Units	98%	98%	100%	100%	99%	100%	63%	75%	84%	90%		
Avg. Daily Census	28	27	28	28	28	28	29	34	38	41		
Adult Crisis Beds							* VPCH gradual opening of 25 beds					
% Occupancy	83%	79%	77%	77%	77%	76%	76%	66%	75%	80%		
Avg. Daily Census	32	30	29	29	29	29	29	25	28	32		
Applications for Involuntary Hospitalizations (EE)												
Youth (0-17)	5	4	7	5	9	10	4	3	8	5		
Adults	38	32	35	46	42	46	45	52	49	54		
Total adults admitted with CRT	9	11	8	9	9	14	15	10	16	12		
Designation (% of Total applications)	24%	34%	23%	20%	21%	30%	33%	19%	33%	22%		
Total Level 1 Admissions	14	8	10	11	18	16	9	14	9	7		
Instances when Placement Unavailable & Adult Client Held in ED	19	19	27	27	30	33	28	29	32	26		
Adult Involuntary Medications												
# Applications	6	8	7	4	4	5	8	6	5	12		
# Granted Orders	5	4	6	4	4	4	7	4	4	5		
Mean time from filing date to decision date (days)	14	17	18	10	14	9	13	12	10	11		
Court Ordered Forensic Observation Screenings												
# Requested	6	11	12	14	8	10	11	10	5	7		
# Inpatient Ordered	2	7	3	5	5	4	3	4	2	4		
VT Resident Suicides												
Youth (0-17)												
Total	2	0	0	0	0	1	0	3	1	*		
# with DA contact within previous year	2	0	0	0	0	1	0	1	0	*		
Adults (18+)												
Total	11	5	6	6	6	7	8	10	14	*		
# with DA contact within previous year	1	1	0	2	2	3	1	2	3	*		
Housing												
# Clients permanently housed as a result of new Act79 housing funding	1	2	3	3	4	1	1	1	2	1		
Total # enrolled to date	124	122	124	131	131	131	132	133	129	121		
Involuntary Transportation												
Adults (total transports)												
# of Transports	13	15	13	16	15	22	14	19	16	*		
% Non-Restrained	85%	87%	69%	81%	67%	59%	71%	79%	38%	*		
% Restrained	15%	13%	31%	19%	33%	41%	29%	21%	63%	*		
% all transports using metal restraints	8%	7%	15%	6%	7%	32%	0%	5%	44%	*		
% all transports using soft restraints	8%	7%	15%	13%	27%	9%	29%	16%	19%	*		
Youth Under 18 (total transports)												
# of Transports	4	5	7	4	3	5	6	7	7	*		
% Non-Restrained	100%	100%	100%	100%	100%	100%	83%	86%	71%	*		
% Restrained	0%	0%	0%	0%	0%	0%	17%	14%	29%	*		
% all transports using metal restraints	0%	0%	0%	0%	0%	0%	17%	14%	29%	*		
% all transports using soft restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	*		
CRT Employment												
% Employed	16%			18%			*					
Wages per employed client	$2,301			$2,375								

Vermont Department of Mental Health
System Snapshot (November 17, 2014)

Definitions

Inpatient Hospital	The hospitals designated by the Commissioner of Mental Health for involuntary psychiatric treatment: Brattleboro Retreat (BR), Central Vermont Medical Center (CVMC), Fletcher Allen Health Care (FAHC), Rutland Regional Medical Center (RRMC), Windham Center at Springfield Hospital (WC), and Vermont Psychiatric Care Hospital (VPCH). Adult Inpatient Units at VPCH, RRMC - South Wing, and Brattleboro Retreat - Tyler 4.The units designated as no refusal units: BR - Tyler 4, RRMC - South Wing, VPCH.
Designated Agency Crisis Bed	Emergency Services beds intended to provide crisis intervention, respite, or hospital diversion that are staffed by and under the supervision of a designated community mental health agency (DA). Statewide averages are adjusted to exclude programs on days where there were no updates submitted to the bed board.
Court-ordered Forensic Observations	Forensic patients are designated when there is criminal justice involvement and when there are questions concerning competency/sanity of an individual being arraigned. A screening is requested by a community mental health agency pursuant to §4815 13 VSA. Numbers represent a point in time count mid-month.
Emergency Examination (EE)	An application for emergency examination has been completed for involuntarily admission (§7508 of 18 VSA) to a designated hospital for psychiatric treatment (danger to self or others) subsequent to an evaluation by community mental health agency screener & medical doctor.
Restrained Transport (formerly called Secure)	Transport via law enforcement utilizing either metal or soft restraints.
Non-Restrained Transport (formerly called Non-Secure)	Transport not utilizing restraints; this can include plain clothed law enforcement, Designated Agency transport teams, or other means of transport such as family members.
VT Resident Suicides	Based on PRELIMINARY data from the Vital Statistics System maintained by Vermont Department of Health and Monthly Service Report (MSR) data provided by the Department of Mental Health (DMH). Cross-sector data analysis was conducted using LinkPlus, a probabilistic statistical linkage software developed by the CDC for linking records across databases. MSR data includes services provided by community designated agencies for clients served by DAs within the year prior to death. Primary Program is defined as the primary program assignment on the client's last service with DMH. Monthly counts are subject to change as more information is made available.
Housing	Based on the number of applications approved, in the months the program has been operating and the total approved to date. Enrollment to date numbers do not necessarily sum to total numbers housed. Data cleaning is on-going.

APPENDIX B: National Outcome Measures

Vermont 2014 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per1,000 population	7,296,842	39.14	22.78	59
Community Utilization per 1,000 population	7,148,971	39.08	22.33	58
State Hospital Utilization per 1,000 population	144,695	0.06	0.45	53
Other Psychiatric Inpatient Utilization per 1,000 population	349,528	0.69	1.32	39

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	617,174	38.6%	39.0%	57
Employed (percent with Employment Data)**	617,174	26.3%	17.9%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	73.2%	71.3%	51

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	61.1%	67.3%	48

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	8,203	7.4%	8.2%	51
State Hospital Readmissions: 180 Days	18,762	7.4%	18.8%	53
State Hospital Readmissions: 30 Days: Adults	7,648	7.4%	8.4%	50
State Hospital Readmissions: 180 Days: Adults	17,385	7.4%	19.1%	52
State Hospital Readmissions: 30 Days: Children	498	0.0%	6.3%	17
State Hospital Readmissions: 180 Days: Children	1,286	0.0%	16.3%	22

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,292,455	84.3%	78.8%	58
Homeless/Shelter	176,675	3.2%	3.2%	55
Jail/Correctional Facility	86,078	0.2%	1.6%	54

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	81,422	-	2.9%	36
Supported Employment	61,511	32.8%	2.0%	41
Assertive Community Treatment	61,445	-	2.0%	38
Family Psychoeducation	23,228	-	1.4%	16
Dual Diagnosis Treatment	205,709	-	10.9%	25
Illness Self Management	242,621	-	15.8%	20
Medications Management	369,008	77.3%	24.5%	19

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	8,859	-	1.1%	24
Multisystemic Therapy	17,988	-	2.6%	16
Functional Family Therapy	20,996	-	3.7%	13

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	69.4%	72.8%	51
Child/Family Improved Social Connectedness	-	83.9%	46

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

SAMHSA Uniform Reporting System - 2014 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,500	39.14	7,296,842	22.78	59
Community Utilization per 1,000 population	24,464	39.08	7,148,971	22.33	58
State Hospital Utilization per 1,000 population	36	0.06	144,695	0.45	53
Medicaid Funding Status	15,213	69%	4,453,600	64%	57
Employment Status (percent employed)	2,541	26%	617,174	18%	57
State Hospital Adult Admissions	31	0.86	110,845	0.83	53
Community Adult Admissions	6,629	0.46	11,138,443	2.32	55
Percent Adults with SMI and Children with SED	7,412	30%	5,048,543	69%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	53 Days	68 Days	51
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	40 Days	67 Days	50
Percent of Client who meet Federal SMI definition	18%	71%	56
Adults with Co-occurring MH/SA Disorders	14%	22%	51
Children with Co-occurring MH/SA Disorders	2%	5%	48

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	81%	82%	50
Quality/Appropriateness of Services	87%	89%	50
Outcome from Services	73%	71%	51
Participation in Treatment Planning	80%	82%	50
General Satisfaction with Care	87%	89%	50

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	85%	83%	47
General Satisfaction with Care	74%	88%	48
Outcome from Services	61%	67%	48
Participation in Treatment Planning	83%	87%	48
Cultural Sensitivity of Providers	89%	93%	47

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,137	84.3%	4,292,455	78.8%	58
Jail/Correctional Facility	33	0.2%	86,078	1.6%	54
Homeless or Shelter	654	3.2%	176,675	3.2%	55

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	2	7.4%	8,203	8.2%	51
State Hospital Readmissions: 180 Days	2	7.4%	18,762	18.8%	53
Readmission to any psychiatric hospital: 30 Days	-	-	27,706	13.4%	24

State Mental Health Finance (FY2013)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$165,000,000	90.4%	$28,397,464,444	74.5%	50
SMHA Revenues from State Sources **	$3,500,000	2.0%	$14,435,904,841	38.7%	50
Total SMHA Expenditures	$182,600,000	-	$38,098,637,217	-	50

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	61,445	2.0%	38
Supported Housing	-	-	81,422	2.9%	36
Supported Employment	851	32.8%	61,511	2.0%	41
Family Psychoeducation	-	-	23,228	1.4%	16
Integrated Dual Diagnosis Treatment	-	-	205,709	10.9%	25
Illness Self-Management and Recovery	-	-	242,621	15.8%	20
Medications Management	2,003	77.3%	369,008	24.5%	19

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	8,859	1.1%	24
Multisystemic Therapy	-	-	17,988	2.6%	16
Functional Family Therapy	-	-	20,996	3.7%	13

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	22,817	4.4%	36
Juvenile Justice Contacts	410	3.1%	5,834	3.6%	38
School Attendance (Improved)	-	-	12,072	36.5%	25

* Includes Other 24 -Hour expenditures for state hospitals.
** Revenues for state hospitals and community MH

APPENDIX C: Act 79 Quarterly Reporting Form

Act 79 Quarterly Reporting

Goals of Act 79:

Community Services Identified within No. 79 – an Act relating to reforming Vermont's mental health system:

- Peer services
- Programs that improve emergency responses to include mobile support teams, non-categorical case management, adult outpatient services, and alternative residential
- Collaborative work with law enforcement, corrections, local hospitals, DAIL and peers to integrate and expand treatment options
- The provision of housing subsidies to individuals living with or recovering from mental illness

Outcomes collected at the STATE level: Information about population indicators will be collected at the State level on an annual basis.

1. **Adult** Involuntary Hospitalization rates:
    a. Number of admissions at state and/or Designated Hospitals
    b. Total number of days in State and/or Designated Hospitals
    c. By Program Group (CRT vs Non-CRT)
2. Time from discharge from a mental health hospitalization to a follow up service within
    a. 7 days and 30 days
    b. For all adults and children served via Medicaid

Performance Measures collected at the STATE and DA Level: Information about performance measures will be collected from the MSR quarterly.

How Much?

1. The number of emergency/crisis assessment, support and referral services **provided to all in crisis (adults and children).**
    a. Overall
    b. By program
    c. By location

2. The unduplicated number of people receiving emergency/crisis assessment, support and referral services
    a. Overall
    b. By program
    c. By location

How Well? (address the effectiveness of services provided to increase timely access to continued supports following a mental health crisis)

3. The percent of clients receiving non-emergency services within 7 days of emergency services
    a. Emergency services operationally defined as emergency/crisis assessment, support and referral under any program of service or assignment
    b. Non-emergency services are operationally defined as:
        - services other than emergency/crisis assessment, support and referral
        - crisis bed services for any program of service or assignment

Performance Measures collected at the AGENCY level regarding the strategies chosen to meet the goals of Act 79:

The following information will be collected quarterly using the attached data collection form. The questions on the form address the following questions:

1. The types of programs provided sorted by Act 79 category addressed (see collection sheet)
2. The status of the programs
3. Qualitative data regarding the effectiveness of the programs supported through Act 79 at the community level.
4. Any quantitative data regarding the effectiveness of the program that is not reportable via DMH's data systems (no more than 3 measures)

Directions: List the program name that receives the funding down the left column. Check off the goals addressed by that program.

Program Name	Act 79 Goal								Status of Program			
	Peer Services	Expansion of Crisis Beds	Programs/Initiatives with Law Enforcement	Expansion of Mobile Crisis Capacity	Non-categorical Case Management	Evidenced-based and/or innovative clinical practices and/or treatment programs	Increased housing options for people at risk of hospitalization	Other (please describe how it fits into Act 79 Priorities on separate sheet)	Implemented? (F - Fully, P- Partially, Planning only)	Full coverage across catchment area? (yes/no)	Team 2 involvement (e.g., Law enforcement, emergency responders, etc.) (yes/no)	Comments on Status
1.												
2.												

Please describe 3 accomplishments of note from this past quarter:

Please describe 3 goals for the upcoming quarter: