State of Vermont
Agency of Human Services
Office of the Secretary
208 Hurricane Lane, Suite 103
Williston, VT 05495
www.humanservices.vermont.gov

[phone] 802-871-3009
[fax] 802-871-3001

Harry L. Chen, M.D., Acting Secretary
Dixie Henry, Deputy Secretary

December 18, 2014

Robert Bliss
Chairman, Rutland Mental Health Services
P.O. Box 222
78 South Main Street
Rutland, VT 05701

Re: RMHS Designated Agency Master Grant Agreement #DA-14-005

Dear Mr. Bliss and Members of the Board:

Please be advised that Rutland Mental Health Services, Inc. (RMHS) is out of compliance with the terms of Master Grant Agreement #DA-14-005 (Agreement), Grant Term July 1, 2013 to June 30, 2014, as described in detail below. Therefore, the Vermont Agency of Human Services (AHS) will only extend the term of the current Agreement until March 1, 2015, and delay the designation process and signing of the new FY2015 Master Grant Agreement until RMHS comes into compliance. The goal of AHS is to ensure that consumers served by Designated Agencies (DAs) have access to high quality care and RMHS has not met its obligation to do so.

Under the terms of the Agreement, RMHS, as a DA, is responsible for providing developmental, mental health, substance abuse and vocational rehabilitation services for AHS consumers in its designated area for the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). The violations outlined below include the specific areas in which RMHS is in material non-compliance with the Agreement.

For care related to DMH consumers, the following issues have been raised:

1. Clinical Care
    a. Failure to follow clinically-indicated, budgeted 2:1 staffing protocol for safety leading to near-death suicide attempt (even 1:1 care was questionable at time of event)
    b. Failure to comply with mandated reporting guidelines
    c. Failure to report critical incident accurately or convey seriousness of event
    d. Use of prohibited practice (physical restraints)
    e. Failure to report routine physical restraints as critical incidents (prohibited practices)
    f. Failure to document residential care
    g. Failure to perform mandated reporting obligation to Adult Protective Services (APS)

2. Environment of Care
    a. Lack of monitoring of contracted provider

b. Lack of adequate hygiene in some residential facilities
c. Failure to secure medication
d. Failure to maintain clinically indicated level of supervision
e. Failure to secure sharps and other means of harm
f. Failure to provide adequate therapeutic activity for consumer

3. Treatment Planning
    a. Failure to review Individualized Plan of Care or to have treatment plan reviews when necessary at regular interval (or prompted by events)
    b. Failure to develop client-centered, clinically appropriate plans
    c. Failure to follow treatment plans
    d. Failure to document residential care
    e. Failure to provide crisis intervention and planning
    f. Failure to provide clinically indicated ancillary services despite available funding

4. Clinical, Administrative and Financial Oversight Failures
    a. Failure to maintain oversight of shared living provider
    b. Inadequate oversight of contracted providers
    c. Failure to delegate specific responsibilities (in contract)
    d. Concerns regarding staffing levels/ability to provide adequate care
        i. Staff ratio at CRT (approximately 50:1 at time of review)
    e. Failure to train direct service staff
    f. Failure to enter into valid, complete contracts with subcontractors

5. Medication Security
    a. Failure to consistently secure medication

6. Quality Review/Process Improvement
    a. Failure to follow internal policies and procedures
    b. Failure to follow DMH Critical Incident Reporting requirements
    c. Failure to conduct and report an adequate internal quality review process
    d. Failure to recognize suicide attempt, requiring ICU care, as serious
    e. Inadequate plan of correction in response to DMH concerns

7. Insufficient Training, Clinical Oversight and Supervision
    a. New employee and contracted provider training and oversight deficiencies. No documented competencies for regular staff or oversight for contracted providers in the following areas including but not limited to:
        i. RMHS and DMH policies and procedures on:
            1. Mandated reporting
            2. Seclusion and Restraint
            3. Methods of Seclusion and Restraint- CPI (with refreshers)

4. Critical Incident Reporting
5. Grievance and Appeals
6. Treatment Planning
7. Medication Handling (medication designation procedures, training refreshers and supervision of staff and contracted providers)
8. Medication Error reporting
9. Documentation
10. Clinical Supervision and support to licensure

DMH has addressed the above issues with RMHS and requested corrective action, as required by the Agreement. RMHS, however, has failed to fulfill its obligations under the Agreement. The following is a list of the major communications between DMH and RMHS:

- July 24th: Daniel Quinn, David Long and Karen Cartier went to DMH to discuss these concerns.
- July 28th: a formal letter of deficiencies was sent to RMHS.
- August 19th: RMHS submitted its first plan of correction.
- September 5th: RMHS was notified DMH staff deemed the plan of correction inadequate.
- September 15th: a revised plan of correction was submitted to DMH.

Similarly, over the past several months, the Department of Disabilities, Aging and Independent Living (DAIL) has identified significant issues relative to the care of DAIL consumers:

1. Clinical Care
    a. Failure to complete and/or timely file Critical Incident Reports
    b. Inappropriate use of restraints and/or use of chemical restraints
    c. Insufficient training
        i. pre-service
        ii. Individual Service Agreements (ISA)
        iii. medication management
        iv. restraints and therapeutic alternatives
        v. authorization for services: Medicaid billing for services prior to ISA completion.
    d. Failure in medication management
        i. administration errors (day and night medications reversed)
        ii. off-label use
        iii. insufficient physician oversight
    e. Failure to accurately document Behavior Support Plans
    f. Failure to report to APS in accordance with mandated reporting obligation

2. Environment of Care
    a. Insufficient oversight of providers
    b. Inadequate person-centered planning process
    c. Failure to complete required home inspection(s)

3. Treatment planning
    a. Inadequate person-centered planning process
    b. Failure to request a review of a comprehensive behavior support plan by the Human Rights Commission at designated intervals
    c. Failure to accurately document Behavior Support Plans
    d. Unnecessary use of non-Medicaid providers, in conflict with the Vermont State System of Care Plan

4. Administrative Failures
    a. Failure to document role and/or terms of payment for provider in a written contract
    b. Failure to require a Business Associate Agreement resulting in potential HIPAA violations
    c. Failure to establish and document a medication administration protocol
    d. Failure to establish and document a medication monitoring protocol
    e. Failure to establish and document a provider oversight protocol

The Commissioner of DAIL, the Director of the Developmental Disabilities Services Division (DDSD) and the DDSD Quality team have communicated directly with RMHS, regarding the issues outlined above, in telephone calls, letters, investigation summaries, emails and meetings. The on-going dialogue, between DAIL and RMHS, regarding deficiencies and concerns over the past year, has included, but is not limited to:

- March 7, 2014: Letter from Chris O'Neill, DAIL's DDSD Quality Management Team Leader to Ellen Malone, RCMH's Vice President for Developmental Services regarding multiple, significant deficiencies and grave concerns regarding the care of a consumer.
- April 23, 2014: Letter of response to March 7th letter, from Ellen Malone to Chris O'Neill enclosing a plan of correction.
- June 30, 2014: Meeting between DDSD Quality team and RMHS regarding the plan of correction. The issues, to which the plan of correction was responding, to date, have not been fully resolved.
- August 18 – 28, 2014: On-site quality review at RCMH by DDSD Quality team
- October 6, 2014: Letter from Jackie Rogers, Director of Office of Public Guardian (OPG) and Becky Guyett, OPG Regional Supervisor, to Ellen Malone requesting increased on-site supervision of a consumer, in response to concerns raised about the consumer's care.
- October 16, 2014: Meeting between Camille George, DAIL's DDSD Director, Chris O'Neill and other members of the DDSD Quality team and Ellen Malone and staff to discuss the quality review.
- October 23, 2014: Conference call conducted by Commissioner Wehry and Camille George with Dan Quinn to object to home placements of consumers, due to risk of harm concerns.
- November 4, 2014: Email exchange regarding a Critical Incident Report concerning an untimely death of a DAIL consumer.
- November 25, 2014: Unannounced visit to consumer's home by DDSD Quality team following reported concerns.

Lastly, Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) has noted the following areas of concern:

a. Inconsistencies found between the SATIS data, Medicaid paid claims data, and the clinical notes
b. Adolescent programs inconsistent in LADC supervisory co-signature as needed
c. Discharge summaries not completed or provided late
d. Treatment plans have been found to be generic rather than individualized.
e. Treatment plans missing required elements and signatures
f. Lack of utilization review process
g. Treatment plan not consistently reflecting the services provided

The above-listed issues have been communicated via a variety of means, including:

- April 15, 2014: Following a February 24, 2014 site visit, Evan Smith sent an email to David Long with a report of the findings which detailed a number of "significant areas of concern" which required a plan of correction.
- May 15, 2014: Dan Quinn sent an email to Evan Smith containing a plan of correction. On May 21, 2014, Evan Smith sent a response to Dan Quinn to notify him the plan of correction was received and reviewed by Evan Smith, but the plan was denied approval because it did not contain documentation needed to support their findings.
- July 7th, 2014: ADAP sent a follow-up email to Dan Quinn because the requested documentation had not been received.
- July 31st, 2014: Plan of correction received with requested documentation, reviewed and approved by ADAP's Evan Smith. Presently plans for a follow-up site visit to ensure effective implementation of the plan of correction has not been scheduled because RMHS has not submitted the SATIS data necessary to conduct the review.

The above constitutes material non-compliance with the Agreement in that it reflects a pattern of deficiencies resulting from a failure to comply with laws, procedures, standards, guidelines, and policies provided for in the Agreement to ensure the health, safety, and welfare of the AHS consumers under your agency's care. Moreover, these actions or inactions by your agency, or your contracted providers, under the current leadership, have compromised the quality of care and the integrity of the delivery of services to vulnerable Vermonters as provided for in the Vermont System of Care Plan.

RMHS has addressed some of the specific violations of the Agreement set forth above. The second plan of correction, submitted on September 15, 2014 to DMH, and the plan of correction submitted by your agency on April 23, 2014 to DAIL, represent steps toward addressing these significant violations. However, while uncorrected, the violations place AHS consumers at risk and a pattern of deficiencies remains.

Critically, the leadership of RMHS has not demonstrated an ability to meet its legal obligations under the Agreement, nor meaningfully respond when deficiencies are brought to its attention. Under the leadership of the current CEO and other members of RMHS management, AHS consumers have been negatively impacted by the care they have received, including, but not limited to, critical incidents which have jeopardized consumers' lives as described above. Indeed, there is an active criminal investigation related to the death of a DAIL consumer.

These deficiencies must be addressed without delay. RMHS must immediately provide a comprehensive and thorough agency-wide acceptable plan of correction, to include written assurances, verifications, and timelines to AHS. **The plan of correction must be received by AHS within 15**

days of the date of this letter. The plan of correction must specifically explain how the Board will address AHS concerns regarding leadership and quality oversight. If, between now and the contract end date, March 1, 2015, AHS determines that RMHS has demonstrated the ability and intention to comply with the terms of the Agreement and progress is made based upon an accepted plan of correction, the parties will then discuss entering into a new Probationary Agreement for FY2016.

At this time, AHS is looking to the Board to provide the guidance and leadership that RMHS requires. The Board has the authority and the ability to address AHS's concerns regarding the current leadership and matters that have resulted in material breaches of the Agreement as discussed above.

I have designated Monica Light, Director of Health Care Operations, Compliance, & Improvement State of Vermont Agency of Human Services, as the AHS point person for your agency to work with to determine RMHS' compliance with these expectations. You may reach her at Monica.Light@state.vt.us or (802) 871-3254.

Thank you in advance for your prompt attention to remediation of these serious issues.

Sincerely,

Harry L. Chen, MD
Acting Secretary, Agency of Human Services

Cc. Susan Wehry, Commissioner, Department of Disabilities, Aging and Independent Living
Paul Dupre, Commissioner, Department of Mental Health
Barbara Cimaglio, Deputy Commissioner, Department of Health
Monica Light, Director of Health Care Operations, Compliance, & Improvement State of Vermont Agency of Human Services