VERMONT2015

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79

January 15, 2015

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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. The FY2014 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 two years.

Peer support programs have expanded to include the development of a peer supported warm line and other support and emergency outreach services. Peers are also working within some designated agencies to provide supports to patients awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services. These service enhancements have coalesced and we expect to place more emphasis on assessing outcomes within the coming year.

Emergency services provided by the Designated Agencies perform the function of gatekeeper for crisis beds, and to some extent, 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 crisis line responders. 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 enlisted 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 evolving departmental care management system provides for coordination of admissions and discharges across the inpatient psychiatric services at two 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 directing 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 patient status and supporting discharge planning, creating a bridge to community programming, with referral to additional technical supports, if necessary. Acting as a managed care organization in partnership with the Department of Vermont Health Access (DVHA), a segment of the team performs utilization review for Community Rehabilitation and Treatment (CRT) clients and Designated Agency Adult Outpatient (AOP) clients receiving Medicaid benefits who are hospitalized.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through the department at one statewide conference, the Cooperative for Workforce Development and Practice Improvement (Coop) is bringing several trainings and technical assistance to the clinical system of care. The Coop is facilitating a statewide initiative to reduce seclusion and restraint in its 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

Current and future work includes stakeholder involvement. Throughout this past year, the Department has initiated the Emergency Involuntary Procedures Advisory Committee, which meets quarterly and is comprised of a large cadre of stakeholders. The Department has also worked closely with the Designated Hospitals to further refine processes and to implement changes brought about by the Act 192[1] legislation. These changes have included the need for second certifications to be administered while an individual is awaiting placement under an Emergency Examination order, expedited hearings for non-emergency involuntary medications, and a notice of patient's rights being provided to patients while waiting in an Emergency Room.

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.

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

2014 Accomplishments

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with severe emotional disturbances and adults with severe mental illnesses. Funding is provided through the Vermont Agency of Human Services Master Grants to ten Designated Agencies and two Specialized Service Agencies. Pathway to Housing was provisionally designated as a Specialized Service Agency in July, 2014. These agencies are located across the state of Vermont for the provision of Community Rehabilitation and Treatment 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 Children Adolescent and Family Services for children and adolescents with severe emotional disturbances 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 DA in their catchment area.

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 patients' homes.

Green Mountain Psychiatric Care Center, which opened an eight-bed hospital in January 2013, was transitioned to the new Vermont Psychiatric Care Hospital which opened in July, 2014. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center are in full operation and have been 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 rights afforded to patients who would have been involuntarily hospitalized at the Vermont State Hospital.

With regard to the expectation that the Department by law encourages and sanctions reduction in coercion, the Emergency Involuntary Procedures Advisory Committee was formed and the Department now receives Certificates of Need (CONs) for all emergency involuntary procedures for any involuntary patient. Reports are compiled quarterly and reviewed by the Advisory Committee, and shared with the Disability Rights Vermont in its capacity as Mental Health Ombudsman for these patients.

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:

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

- Hospital beds
    - Planning, development, and opening of a new 25 bed psychiatric hospital (July, 2014)
    - Closure of Level 1 beds at Fletcher Allen Health Care
    - Net gain of 10 Level 1 beds
- Community Services
    - Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
    - Development of and 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 supports to assist individuals in finding and keeping stable housing
    - Pathways to Housing became provisionally designated as a Specialized Services Agency for the Department
- Residential and Transitional Services
    - One crisis bed was moved to a peer supported program in Washington County in order to create more alternative crisis intervention access
    - Development of additional intensive residential and crisis beds for hospital diversion and step-down
        - Maplewood Intensive Residential Program opened in Rutland
    - Development of a universal referral form to be used by Designated Hospitals in assisting individuals transitioning to the community
- Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals.

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 discharge planning from hospital inpatient care to community care

- Departmental Clinical Care Managers provide support 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 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 ongoing and coordinated through the Department
- Review and approval of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress

The remainder of this report will provide more in-depth information about utilization, capacity, and outcomes of these programs within the 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 has been working closely with the Agency of Human Services, 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, while it works to rebuild a hospital and community based system following the closure of Vermont State Hospital. This process is reflected in monthly and annual reporting on utilization of these services and is described in detail below.

Inpatient Care

Many changes have been implemented in the last 12 months in adherence to the intent of Act 79. Designated Hospitals serve as our decentralized system of inpatient psychiatric care. Designated Hospitals have accepted the most acutely distressed and involuntary individuals who had been previously treated primarily at the Vermont State Hospital. These individuals are currently identified as Level 1 and are served primarily at the Brattleboro Retreat, Vermont Psychiatric Care Hospital, Rutland Regional Medical Center, and to a lesser extent, Fletcher Allen Health Care. Green Mountain Psychiatric Care Center transitioned to the Vermont State Psychiatric Hospital in July, 2014 and the Middlesex Therapeutic Care Residence will continue to operate as a secure therapeutic community residential program in which individuals can continue their individual course of recovery.

Demand for inpatient care frequently exceeds current capacity. An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. Departmental leadership and its 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. During this year the number of inpatient beds was increased by 10, with the opening of the Vermont Psychiatric Care Hospital. In addition, a new Intensive Residential Recovery program in Rutland was opened, adding four beds for those needing to step down from hospital levels of care. With new services coming on line, the Department expects that pressure will be alleviated in the numbers of patients waiting for admission and the lengths of time they may spend in Emergency Departments or the Department of Corrections. The following section describes the expansions. The following set of figures illustrates utilization of inpatient care services.

Chart One: Psychiatric Beds in the System of Care

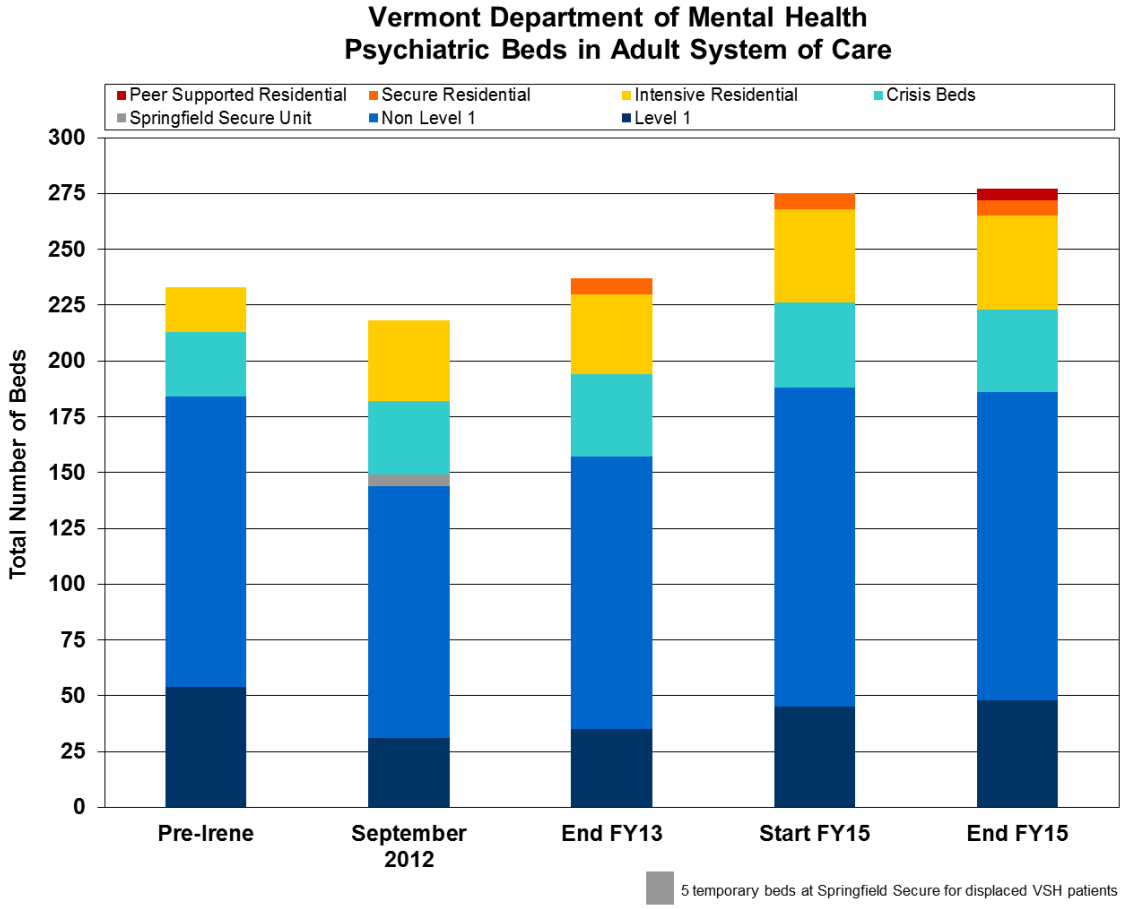
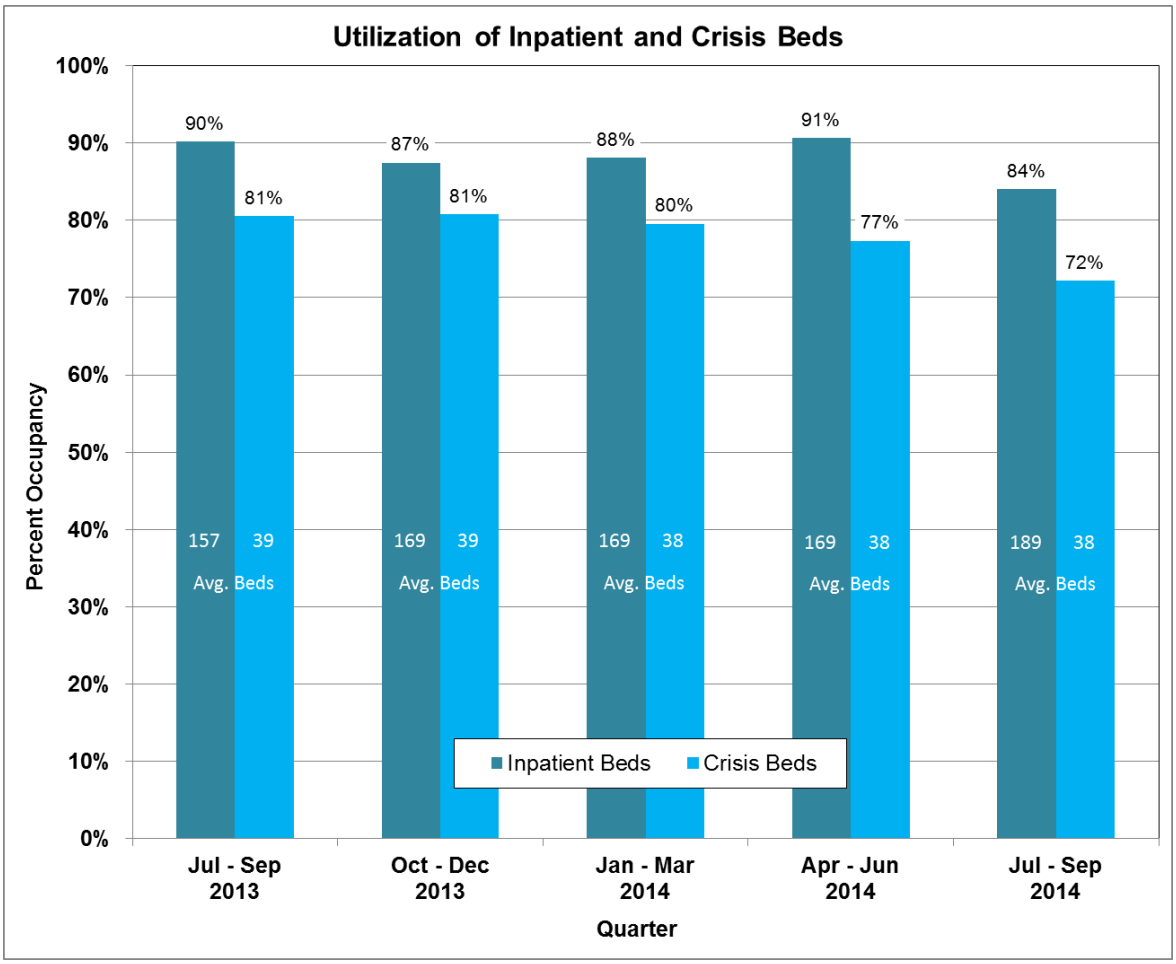


Chart 1 shows the changes in available psychiatric placements since August 2011. The total number of inpatient beds in the system at the start of FY2015 was 275. These include inpatient psychiatric treatment beds, residential treatment programs, crisis beds and peer – supported placements for transition.

Crisis and intensive residential beds have increased from 49 (Pre-Irene) to 87 (Start FY15), with an addition of 6 beds in the past year. A new program of four intensive residential beds opened in June, 2014 in Rutland County and Second Spring opened their Westford intensive residential setting for a net gain of two intensive residential beds. 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 10 Designated Agencies. The Chart also depicts projected bed capacity through the end of FY 2015.

A number of these beds provide access to peer support services, and the number of peer-supported residential beds included the projected opening of Soteria-Vermont during FY15. This program was delayed in its opening due to funding and is planning to open early in CY15. This five-bed facility in Chittenden County will serve individuals experiencing first-break psychosis. Residents will be encouraged to follow recommended treatment plans, and will have the option of choosing to work on recovery using alternatives to medication.

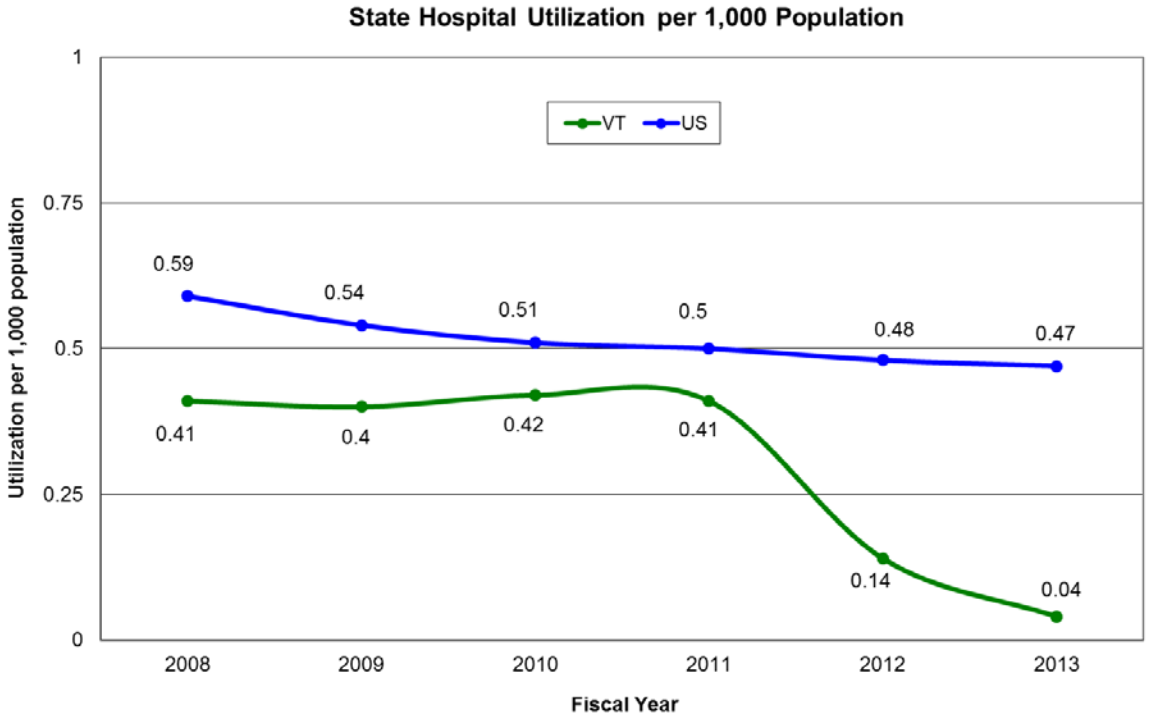
Chart Two: Percent Utilization of Inpatient and Crisis Beds

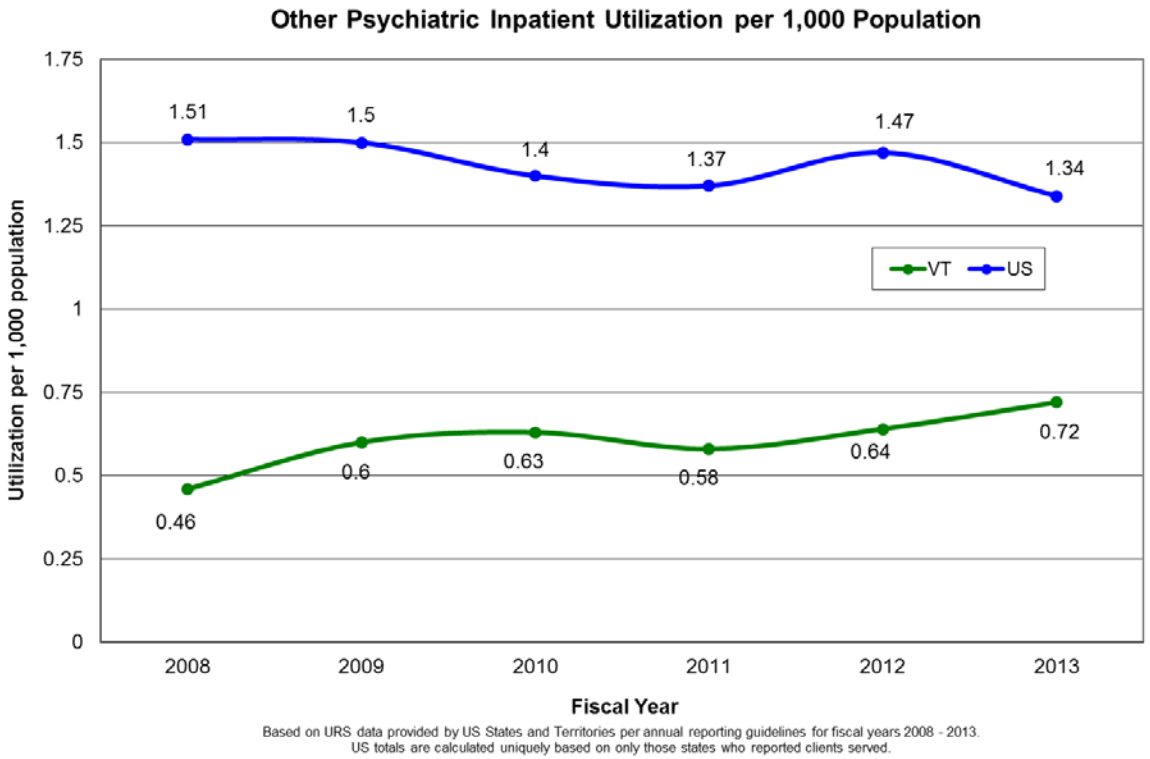


Occupancy of crisis beds has remained fairly consistent, though there has been a slight dip in utilization of crisis beds by 9 percentage points. The target occupancy rate is 80% with crisis bed occupancy ranging from 72-81%, averaging close to the target of 80% occupancy over the course of the period. 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.

It is important that as we build inpatient capacity, we compare our utilization 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.

Charts Three and Four: State Hospital and Other Psychiatric Utilization per 1,000 Populations





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). Other psychiatric hospital unit admissions are included in Chart 4. There was a slight increase in utilization of other psychiatric inpatient beds in FY13, but utilization continues to stay below the national averages while rates of community utilization continue to be markedly higher than national averages (Chart 25).

Chart Five: Adult Inpatient Utilization and Bed Closures

Adult Inpatient Utilization and Bed Closures
Nov 2013 - Oct 2014

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
ADULT INPATIENT UNITS												
Total Beds	169	169	169	169	169	169	169	169	188	188	188	188
Average Daily Census	149	137	137	147	151	153	155	148	154	159	163	167
Percent Occupancy	90%	83%	83%	87%	89%	91%	92%	88%	82%	85%	87%	89%
# Days at Occupancy	0	0	0	0	0	0	0	0	0	0	0	0
# Days with Closed Beds	30	31	31	28	31	30	31	19	30	31	30	31
Average # of Closed Beds	10	6	6	10	7	3	4	3	18	14	10	6

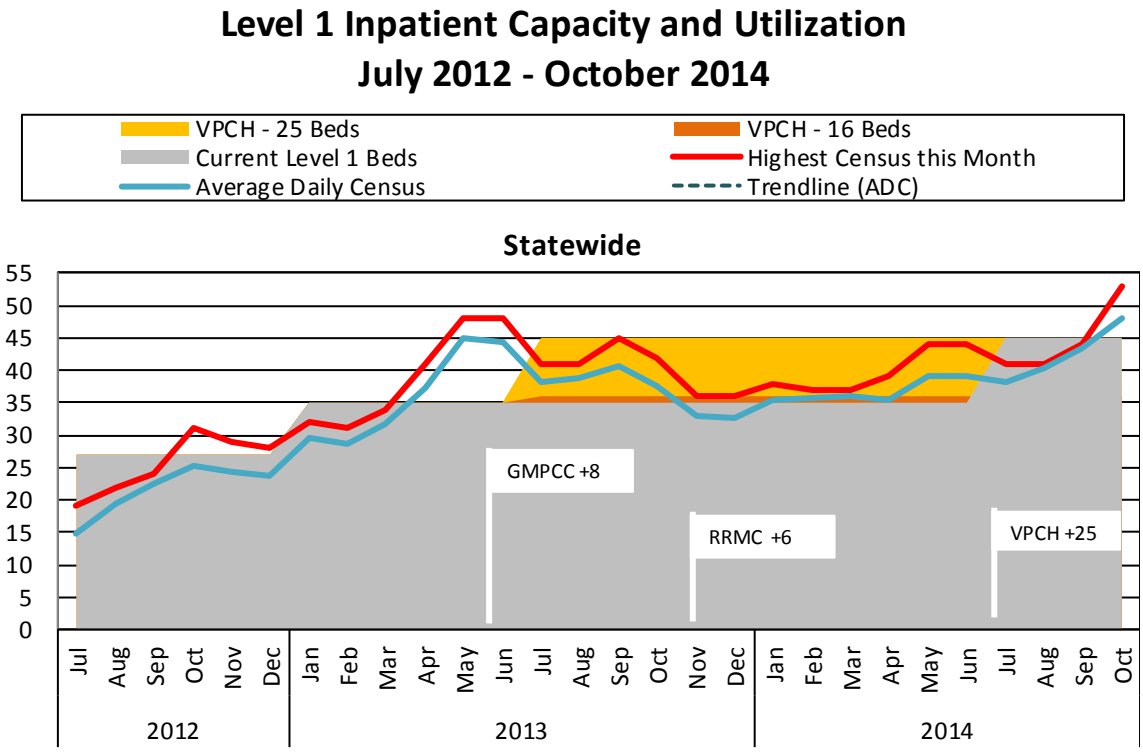
Based on data reported to the Vermont Department of Mental Health (DMH) by designated hospitals (DH) for adult inpatient care using the electronic bed boards system. Beds at inpatient settings can be closed based on the clinical decision of the director of each inpatient unit.

This chart depicts the total census capacity and average daily census across the Vermont Designated Hospital system for November 2013 to the end of October 2014. The range of average numbers of closed beds for this time period is 15, with a minimum of three and a maximum of 18. The increase in bed closures from July to September 2014 was due to the newly opened Vermont Psychiatric Care Hospital. The process of admissions to the new hospital has taken a few months due to managing clinically appropriate patients to the available hospital beds. 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

Level 1 patients require the highest level of care and services within the inpatient system. Maintaining the bed capacity to meet the need has been difficult since the closing of the state hospital and has required collaboration and cooperation between the designated hospitals, community services and the department.

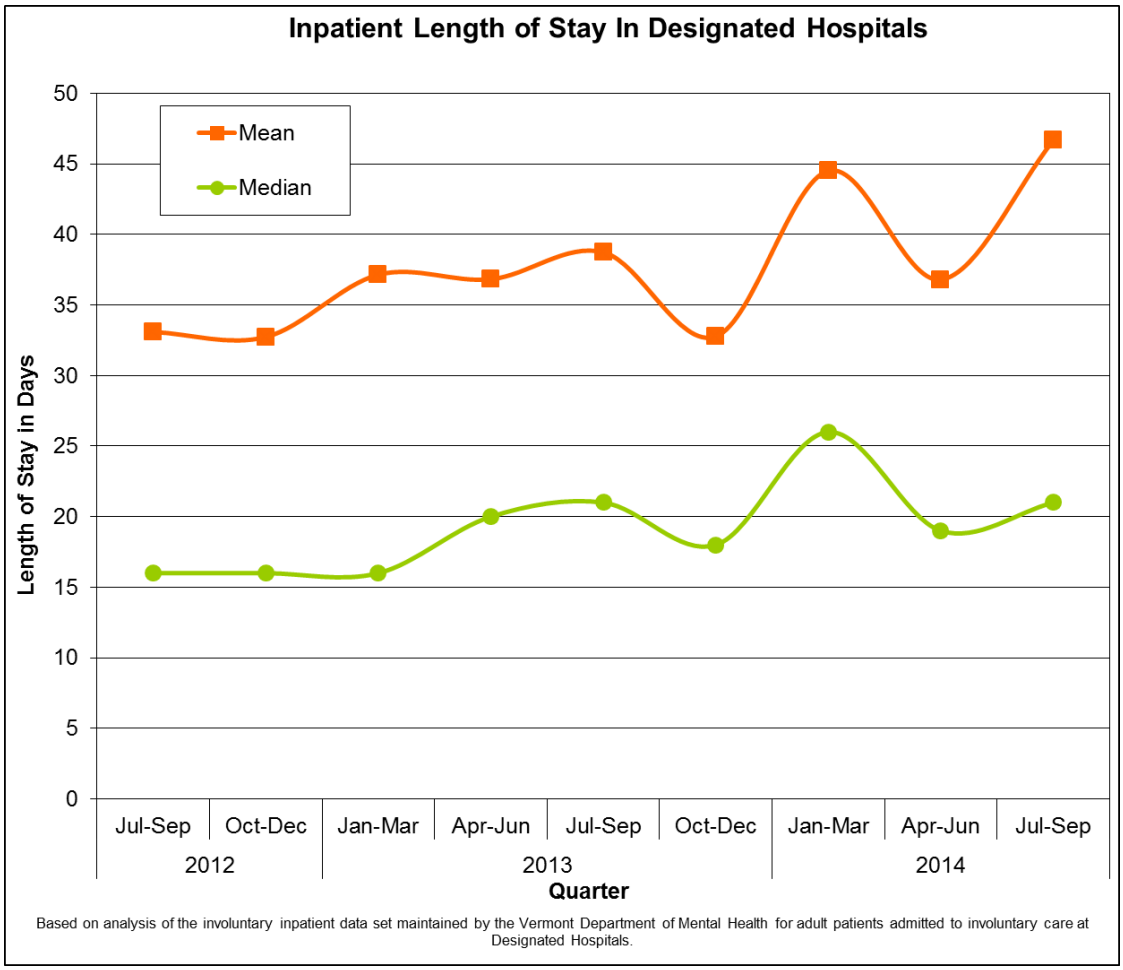
Chart Six: Level 1 Inpatient Capacity and Utilization



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 July 2012 and October 2014.

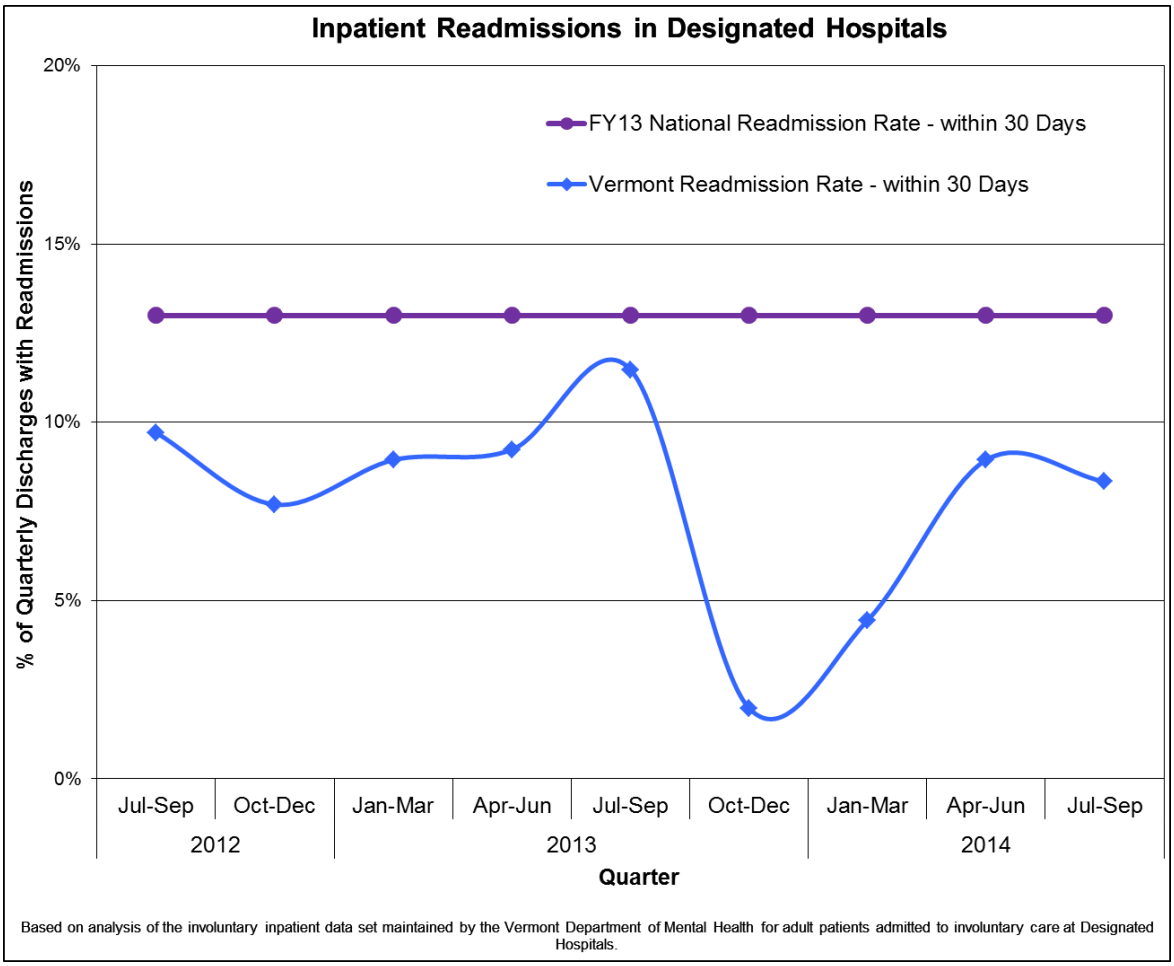
The data for the year indicate that there has been a steady movement to place the majority of Level 1 patients in designated units when available. There are 45 beds currently designated for Level 1 patients throughout the state. The highest average daily census was 48, which is three more people than contracted Level 1 beds. The numbers indicate that we exceeded capacity during the month of October by an average of three, which includes a one day highest daily census of 53 people per day. 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. It should also be noted that the average daily census of 48 in October 2014 is the first time average daily census exceeded the planned capacity of designated beds (45). The department is currently reviewing this increase to identify the factors that contribute to a rise in census.

Chart Seven: Inpatient Length of Stay in Designated Hospitals



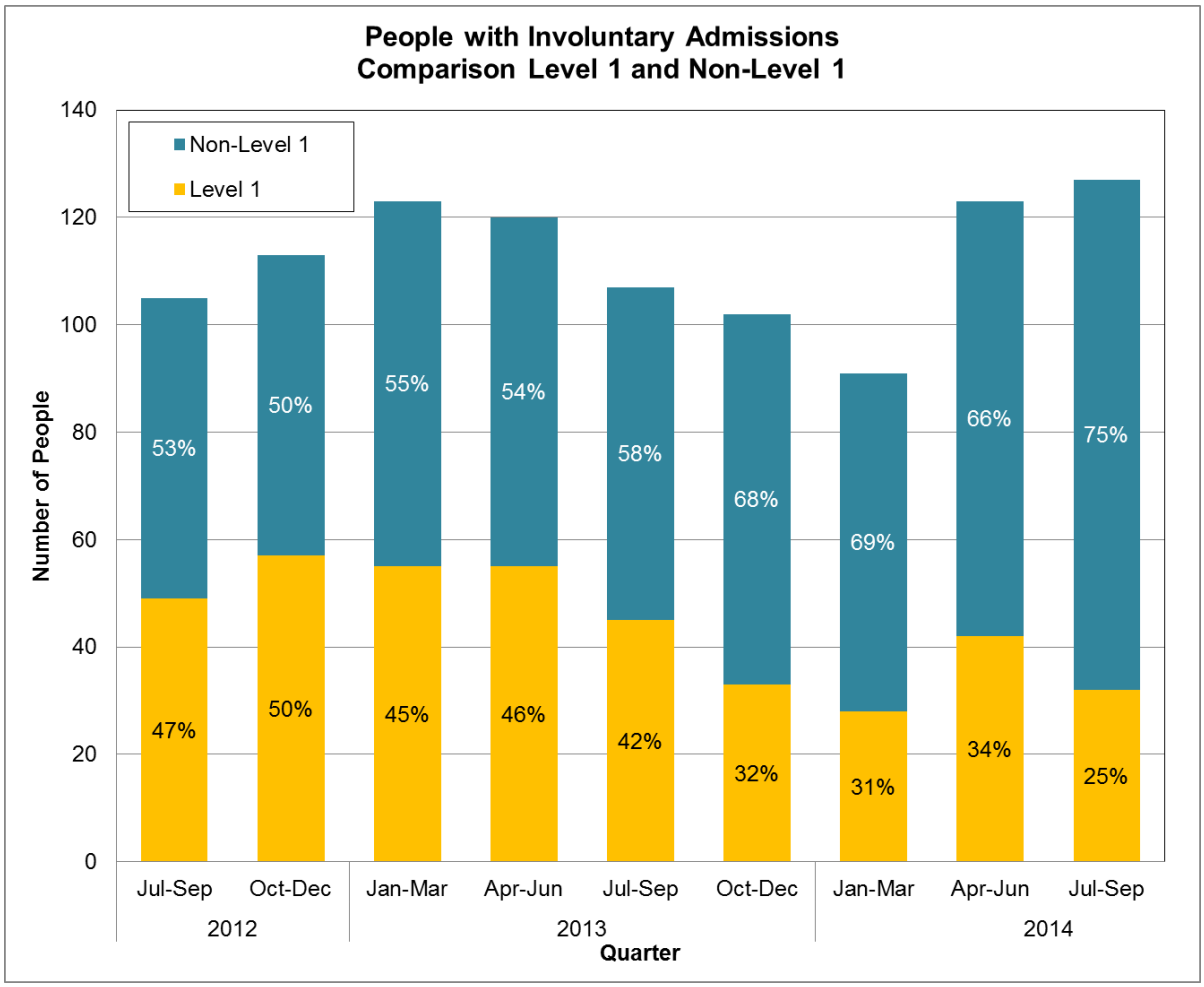
This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients from July 2012 through September 2015. The trend indicates an increase in length of stay in hospital settings, from an average of 33 days to 48 days overall. The data suggests that patients with higher acuity are being treated on an inpatient basis, reflected in the longer lengths of stay. Those who can be are appropriately cared for in the community through continuum-of-care 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 12) and the marked increase in non-categorical case management services to Adult Outpatient clients (Chart 29). 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 Eight: Inpatient Readmissions in Designated Hospitals



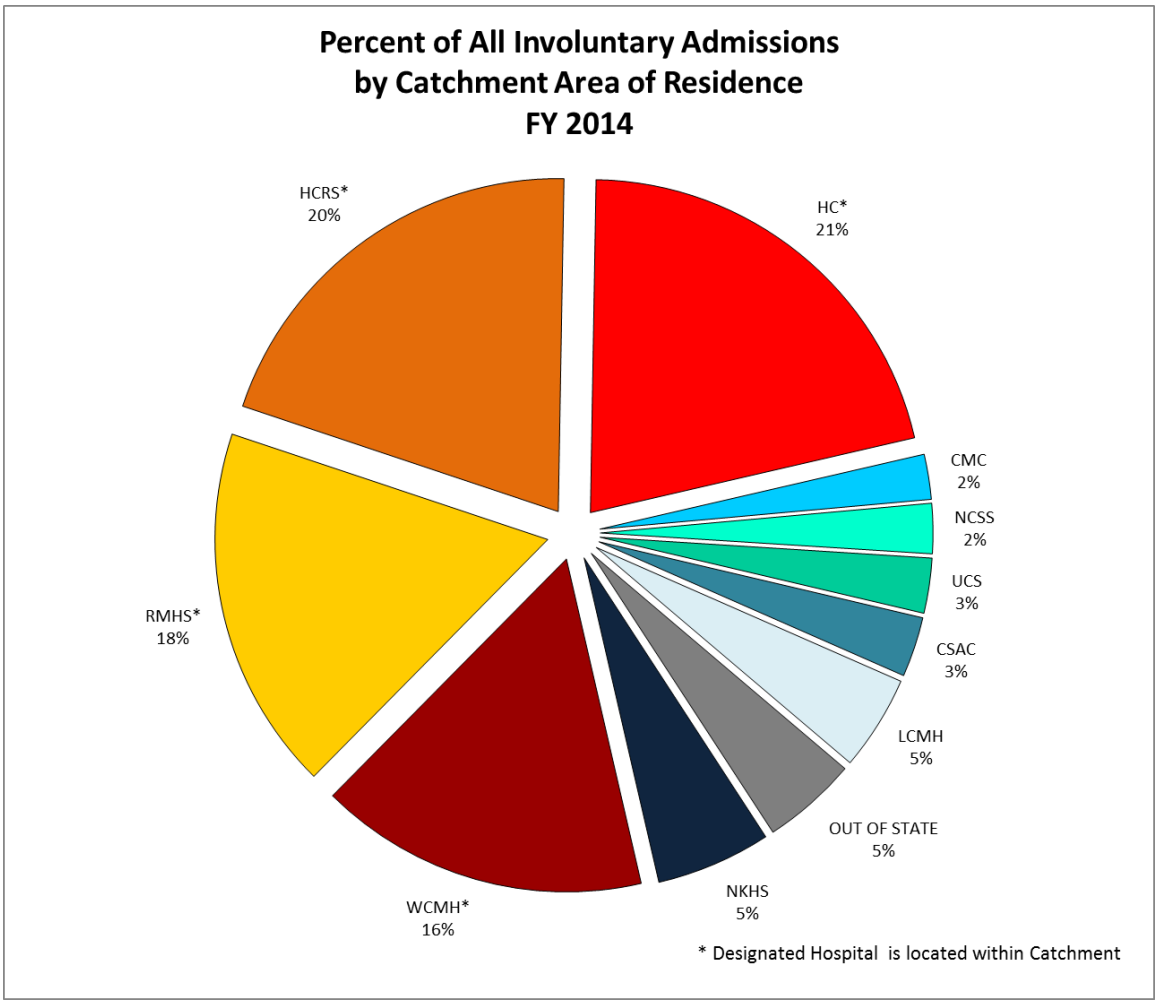
Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. This graph shows a steep downward trend for July through December 2013. There can be multiple contributing factors to explain this trend, and the readmission rates for the other periods reported have held steady, with less than 10% of those discharged being readmitted within 30 days. This 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 rates.

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



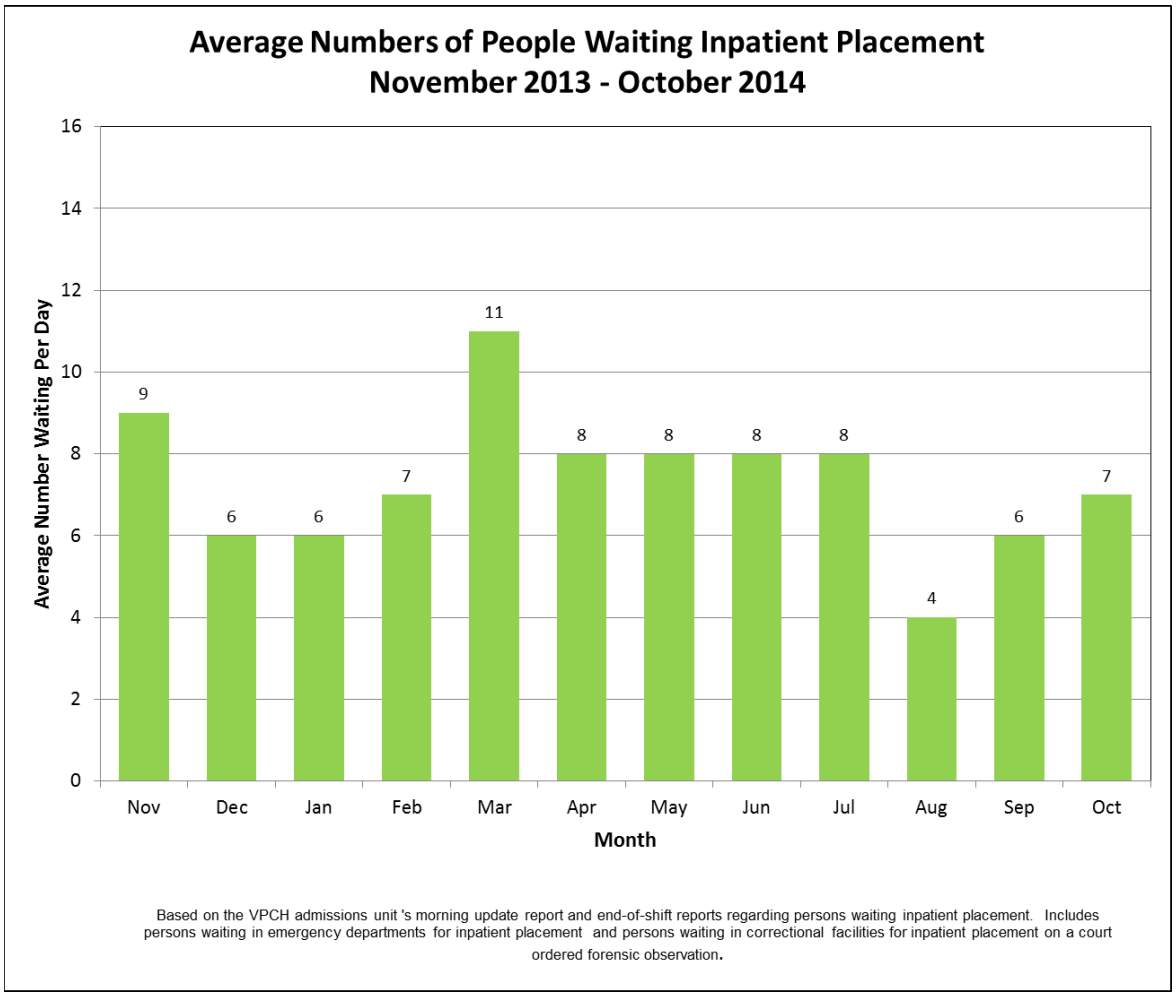
The number of people involuntarily admitted to inpatient care was at its highest during July-September 2014, at 127, 32 of which were Level 1. Given the reduction in capacity of inpatient psychiatric beds and their geographic placements in different parts of the state, the system of care continues to 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 decreased from the previous year, while the actual numbers of overall admissions increased slightly. As noted previously, July 2012 represents the starting period of the Level 1 system and admission numbers for the time period through June 2013represent 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. Of the total number of admissions for April-June of 2014, the percentage of patients who were designated Level 1 was 34%, and 25% for July-September; about one quarter of all involuntary hospitalizations for that time period.

Chart Ten: 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 (75% of all admissions and 78% of Vermonter admissions) come from catchment areas which contain a Designated Hospital.

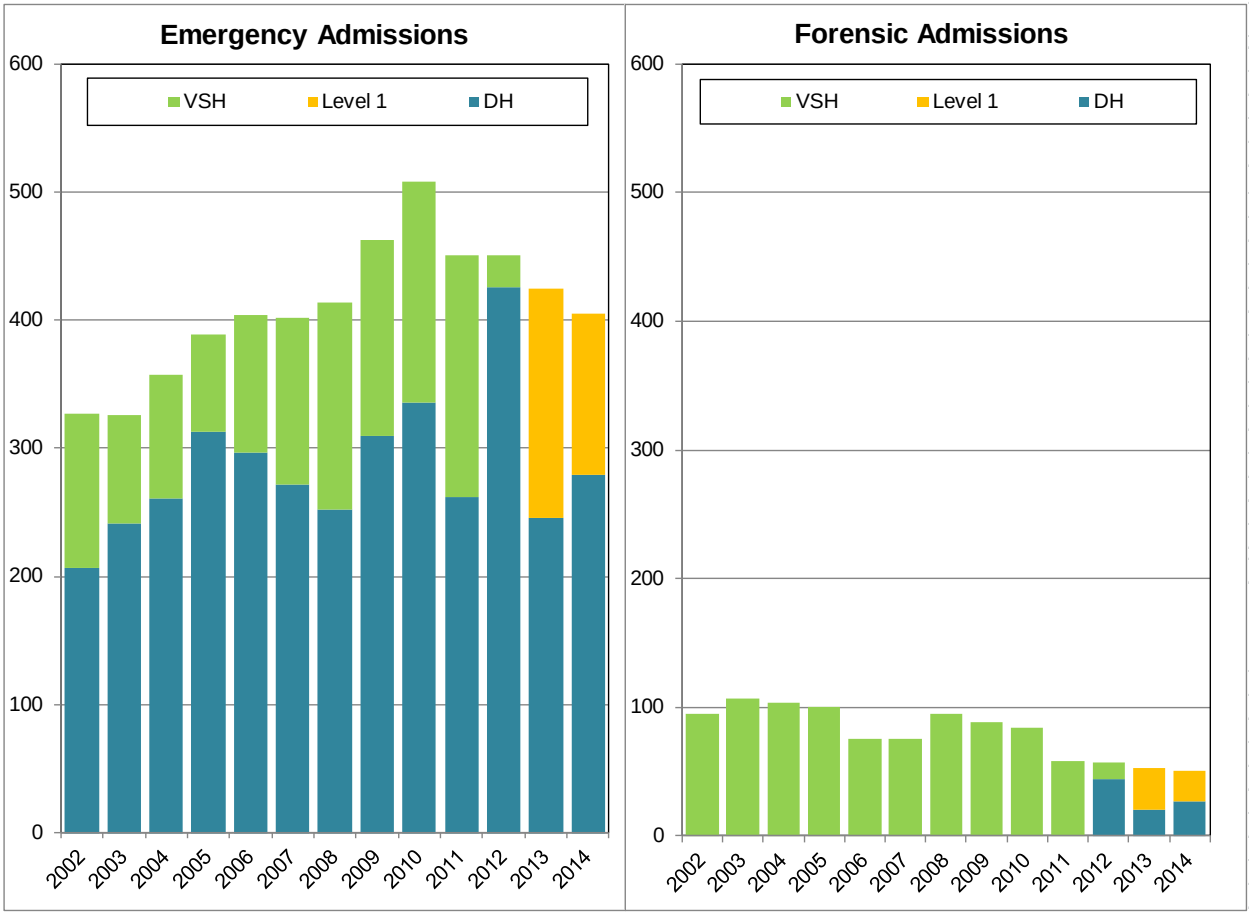
Chart Eleven: Average Number of People Waiting Inpatient Placement



The point in time average number of individuals per day waiting for admission to a psychiatric treatment bed has fluctuated over the time period; however it is showing a relatively stable trend. It is notable that the number of people waiting for inpatient admission was lower in August while the average for the time period was 7 people waiting. The median rate of 7 indicates that 50% of the time there were less than 7 waiting and 50% of the time there were more than 7 people waiting to be admitted. Timely flow of these inpatient resources requires active management on a daily basis for individuals of all statuses in need of hospital care.

Chart Twelve: Emergency and Forensic Admissions

Vermont State Hospital and Designated Hospitals
Emergency and Forensic Admissions
FY2002-FY2014

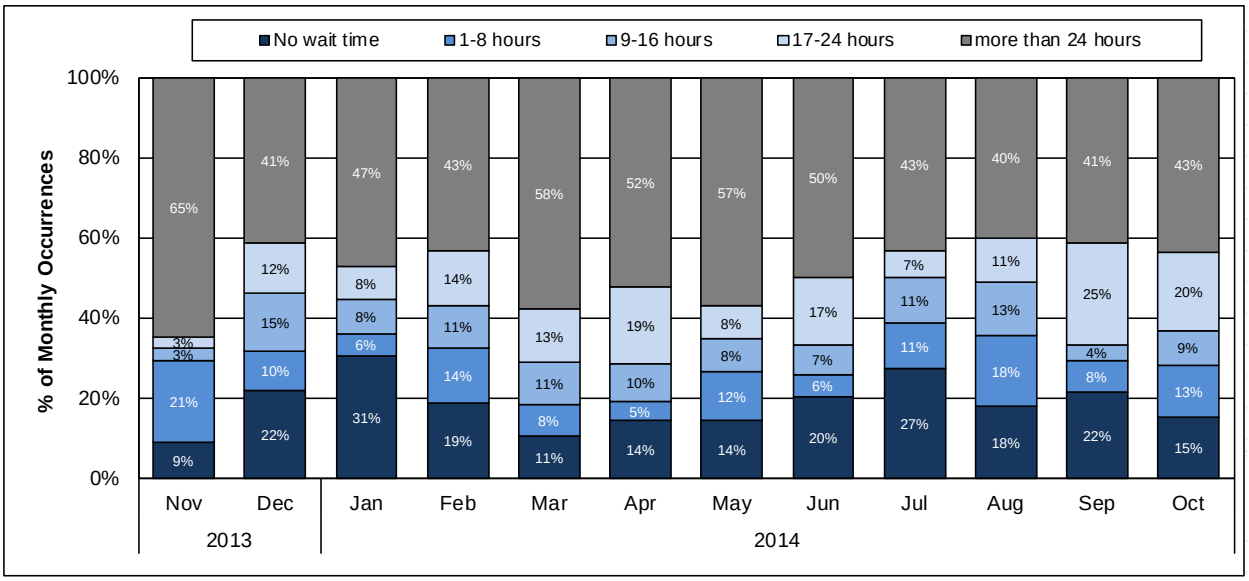


Analysis based on the Vermont State Hospital (VSH) Treatment Episode Database. Includes all admissions during FY2002 - FY2014 with a forensic legal status or emergency legal status at admission.

The number of Emergency and Forensic admissions has decreased slightly in the past year. As the chart indicates, we see a decrease in the number of Level 1 admissions, however length of stay has increased. Overall, the numbers of emergency and forensic admissions has slightly decreased. 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 Thirteen: 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 2013 - October 2014



		2013		2014									
Wait time		**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
No wait time		3	9	11	7	4	6	7	11	12	8	11	7
1-8 hours		7	4	2	5	3	2	6	3	5	8	4	6
9-16 hours		1	6	3	4	4	4	4	4	5	6	2	4
17-24 hours		1	5	3	5	5	8	4	9	3	5	13	9
more than 24 hours		22	17	17	16	22	22	28	27	19	18	21	20
Total		34	41	36	37	38	42	49	54	44	45	51	46
Wait Time in Hours													
Youth	**Mean**	32	8	19	17	39	30	45	49	18	28	24	23
	Median	26	8	17	14	28	28	28	38	17	35	21	24
EEs/Wrts	**Mean**	60	33	40	56	80	39	48	56	56	39	55	44
	Median	39	14	17	17	39	21	27	20	16	16	19	21
OBS	**Mean**	525	325	580	652	641	753	288	447	24	55	412	93
	Median	495	281	580	532	641	613	311	219	0	74	412	93
Total	**Mean**	111	67	68	132	102	106	67	84	51	40	64	44
	Median	46	17	19	19	39	26	28	26	14	16	20	22

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 2013 to October 2014, 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 7 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 76 hours or approximately 3 days and a median wait time of 22 hours. These longer wait times do not reflect a

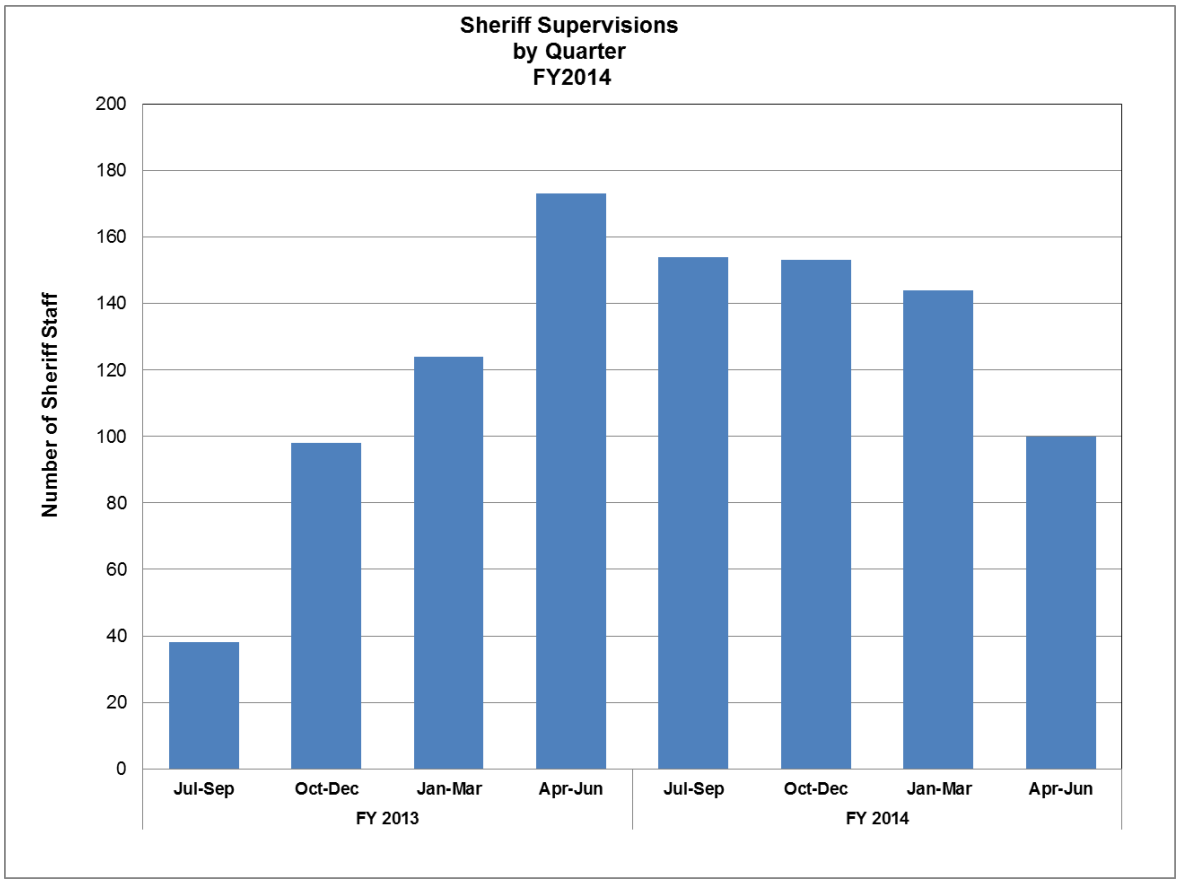
system-wide experience; it is heavily skewed by a small number of individuals who wait much longer than others in their cohort. During the same time period, the lowest 75% of people waited an average of 19 hours, while the greatest 25% waited an average of 246 hours. This number is greatly affected by 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. In another example, the month of October saw 41 clients awaiting placements under an EE/Warrant for an average wait time of 44 hours. Included in this figure are two individuals with a combined average wait time of 260 hours. When we remove these two individuals, the remaining group had an average wait time of 24 hours – approximating a 50% reduction in time. Again considering data through October 2014, approximately 75% of individuals were placed within 46 hours or less with an average wait time of 12 hours. A similar pattern is observed when looking at the entire first quarter of FY15. Excluding two individuals in August, wait times decreased from 39 hours to 24 hours and not including the three individuals from September decreased wait times from 55 hours to 36. 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.

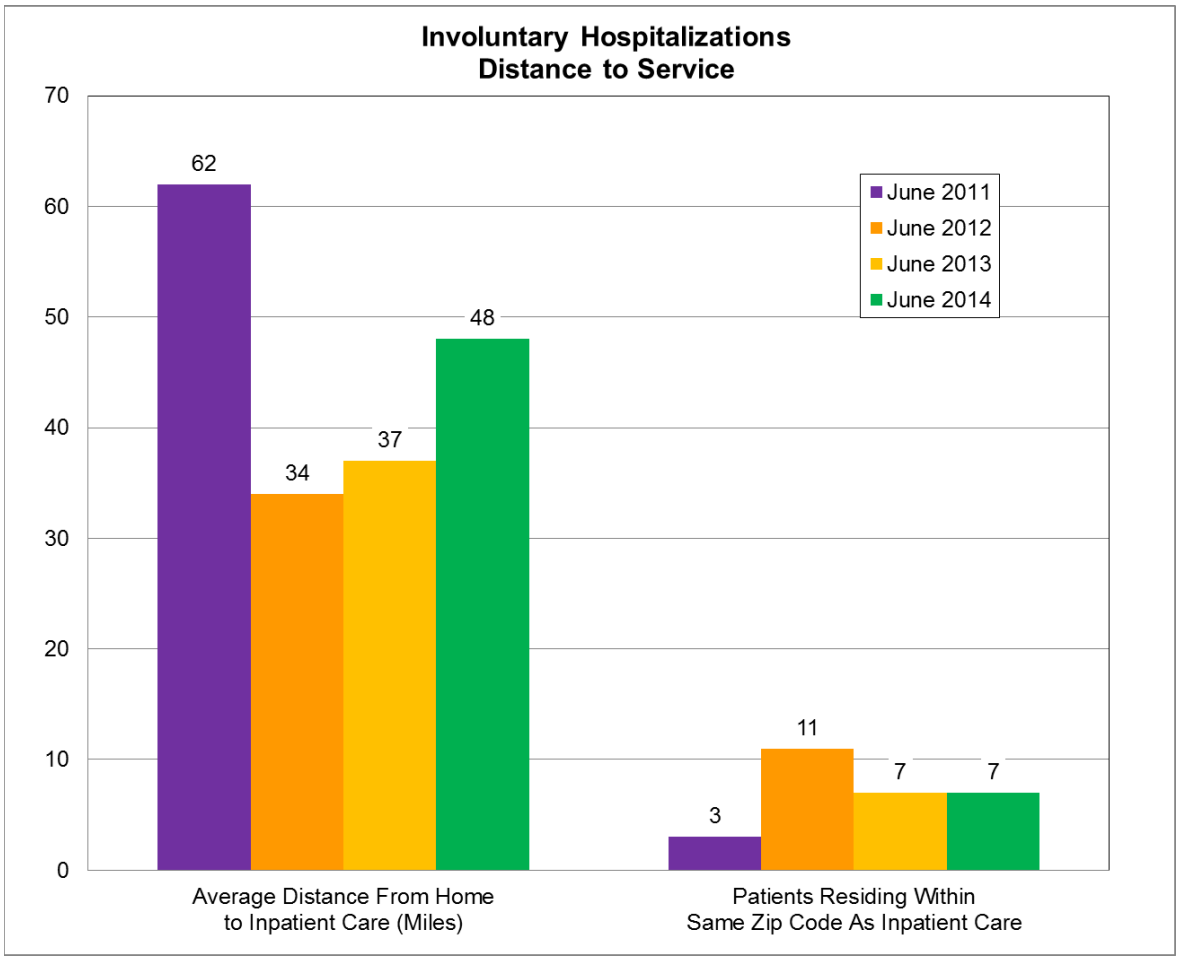
When patients are awaiting placement for treatment in a psychiatric hospital setting, supervision assistance by Sheriff Deputies is sometimes required. This is a service which is funded through the department and the chart below illustrates utilization of sheriff supervision

Chart Fourteen: 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).

Chart Fifteen: 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.

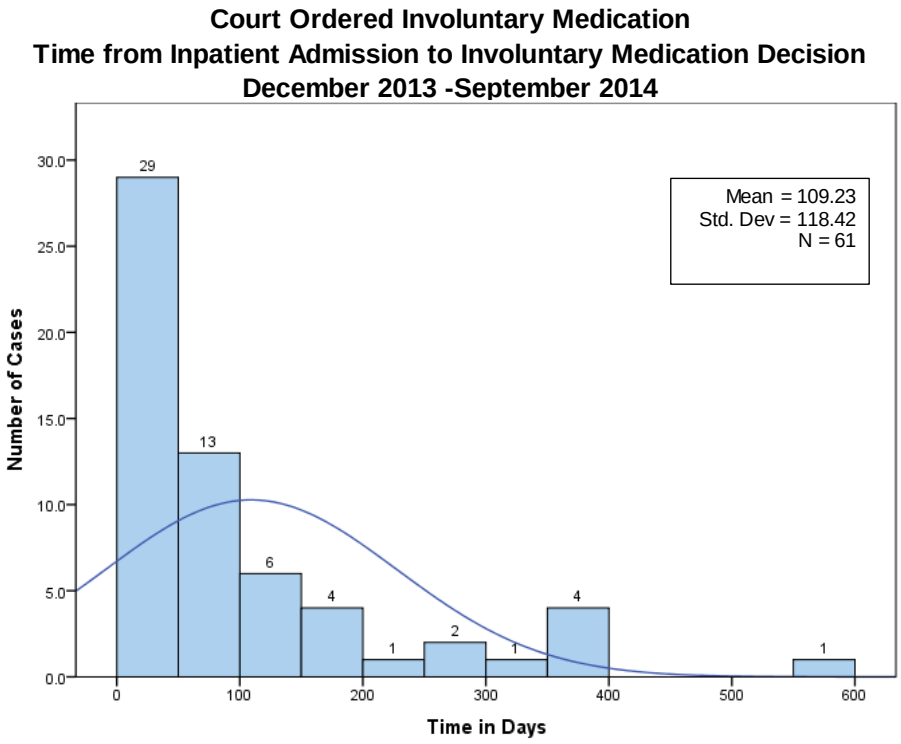
During the summer and fall of 2013, the Department convened a Mental Health Judicial Proceedings / Involuntary Treatment Laws Work Group to examine current Vermont statutes pertaining to judicial proceedings and involuntary treatment in Title 18, Part 8 and develop recommendations for a summary or report that would inform possible legislation in January 2014. 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 FY2015 report will discuss outcomes pertaining to these legislative changes.

Chart Sixteen: Outcomes and Other Legal Data pertaining to 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	Total length of stay in days overall, from admission to petition decision, and from petition decision to psychiatric discharge
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

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 Seventeen: Time in Days from Admission to Court Ordered Medication



This graph illustrates all of those (61) who have had applications filed for involuntary medication between December 2013 and September 2014. One third of all cases for involuntary medication

originate at the Brattleboro Retreat, which also has the highest average number days between admission to court decision.

The average (mean) length of time between an admission to the hospital and to the medication decision is approximately 109 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 50% resolved in less than 50 days.

The time from filing to hearing and to the court decision was variable among patients for whom petitions were filed. The average was ten days to hearing and two days to decision. The longest period was admission to commitment, followed by commitment to hospital petition date. This time period should be significantly impacted by the changes enacted by Act 192, which allows for consolidation of the commitment and involuntary medication hearings.

Transportation

Chart Eighteen: Use of Restraints in Adult Involuntary Transport

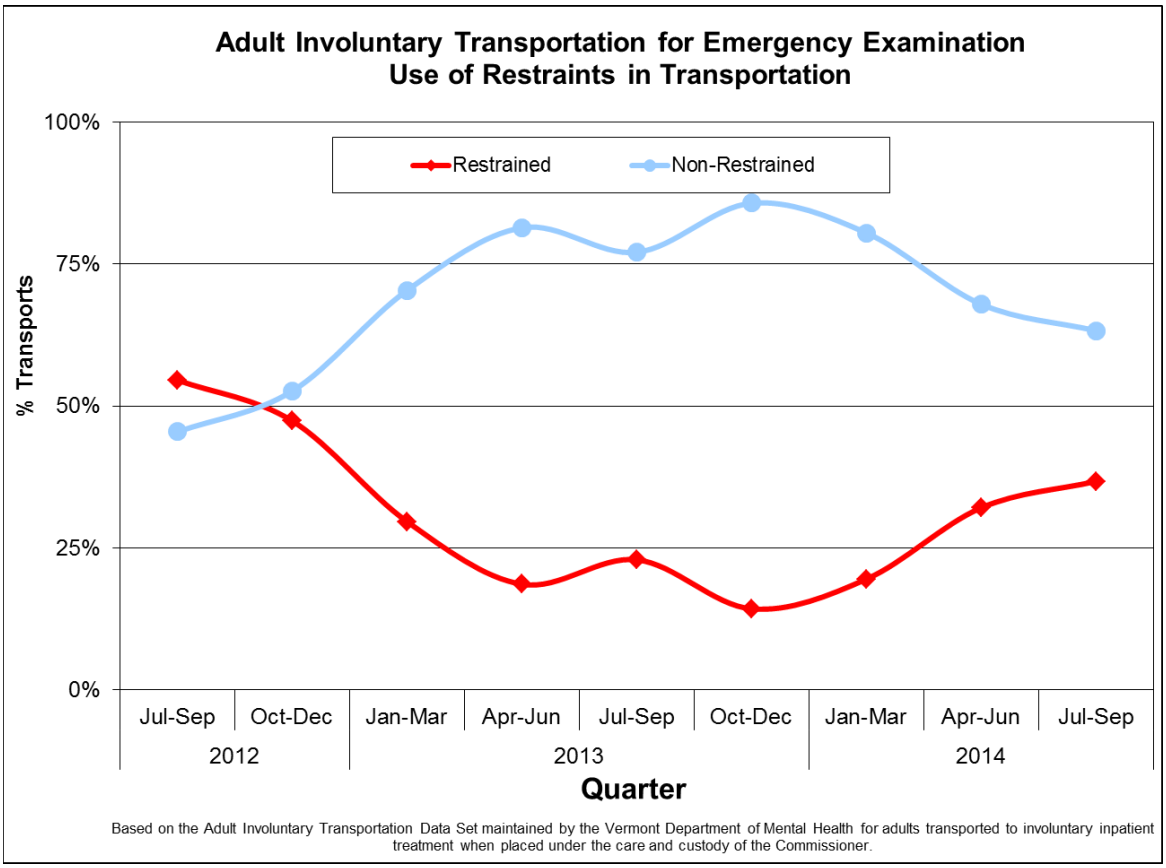
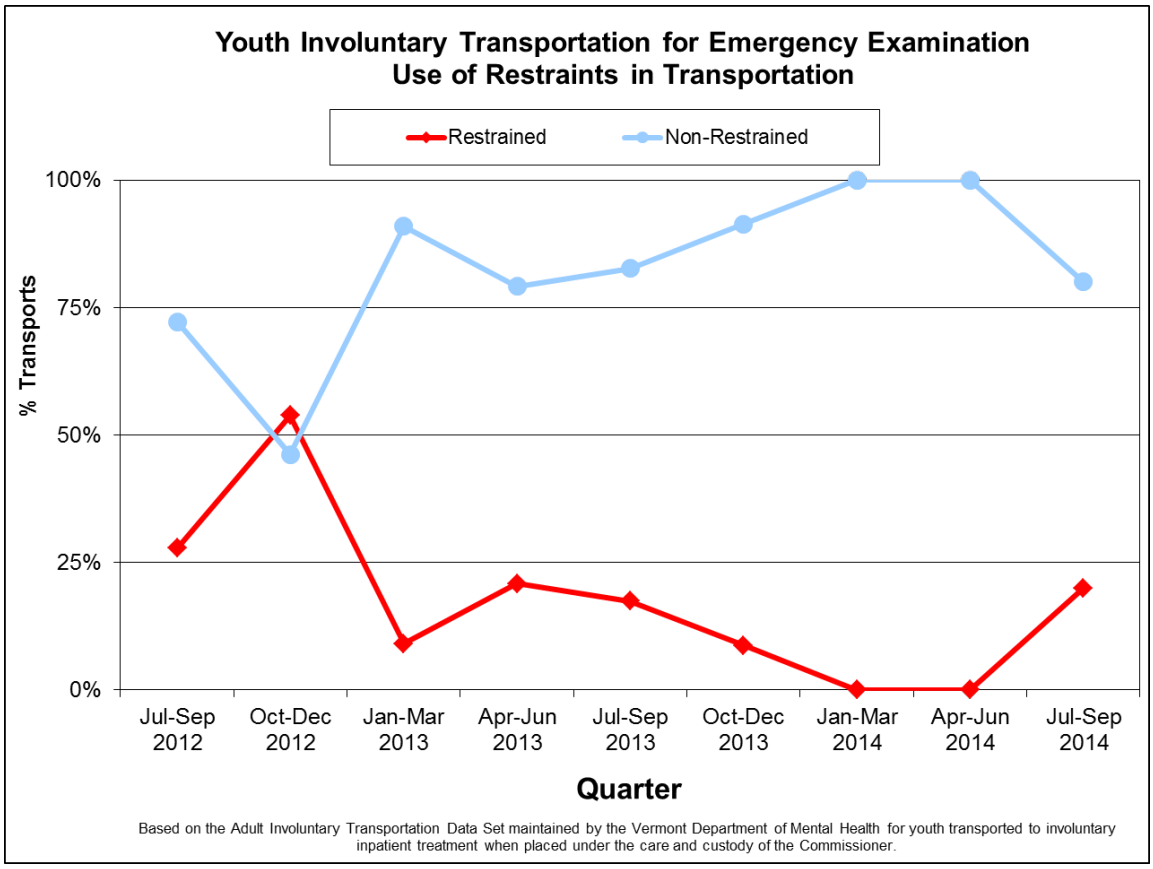


Chart Nineteen: Use of Restraints in Youth Involuntary Transport



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 19-21, shows that there has been a fluctuation with periods of increased use of restraints for transport, for both adults and children. 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. June through September showed an increase of about 25% for youth and restraints were used with adults during transports between none in July, to about 43% in September. These periods of increased use of restraints are seen as spikes in the trend, since the

average percentage of transports in restraints is 31% for adults from December 2013-September 2014 (Chart 22).

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 has developed 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 currently working to create a consistent law enforcement response to the need for least restrictive transportation protocols.

Chart Twenty: Use of Metal Restraints in Adult Involuntary Transport

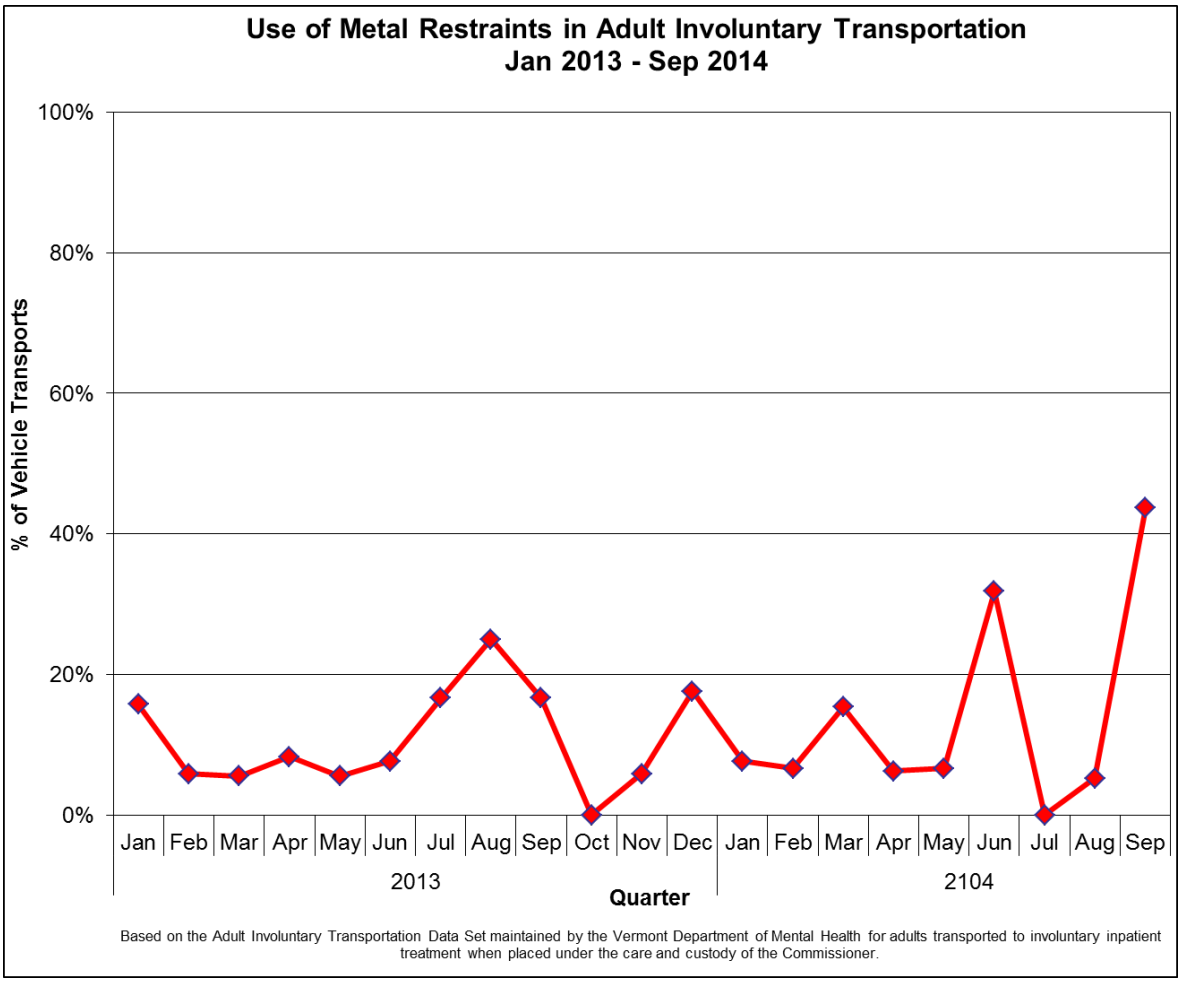


Chart Twenty-One: Use of Metal Restraints in Youth Involuntary Transport

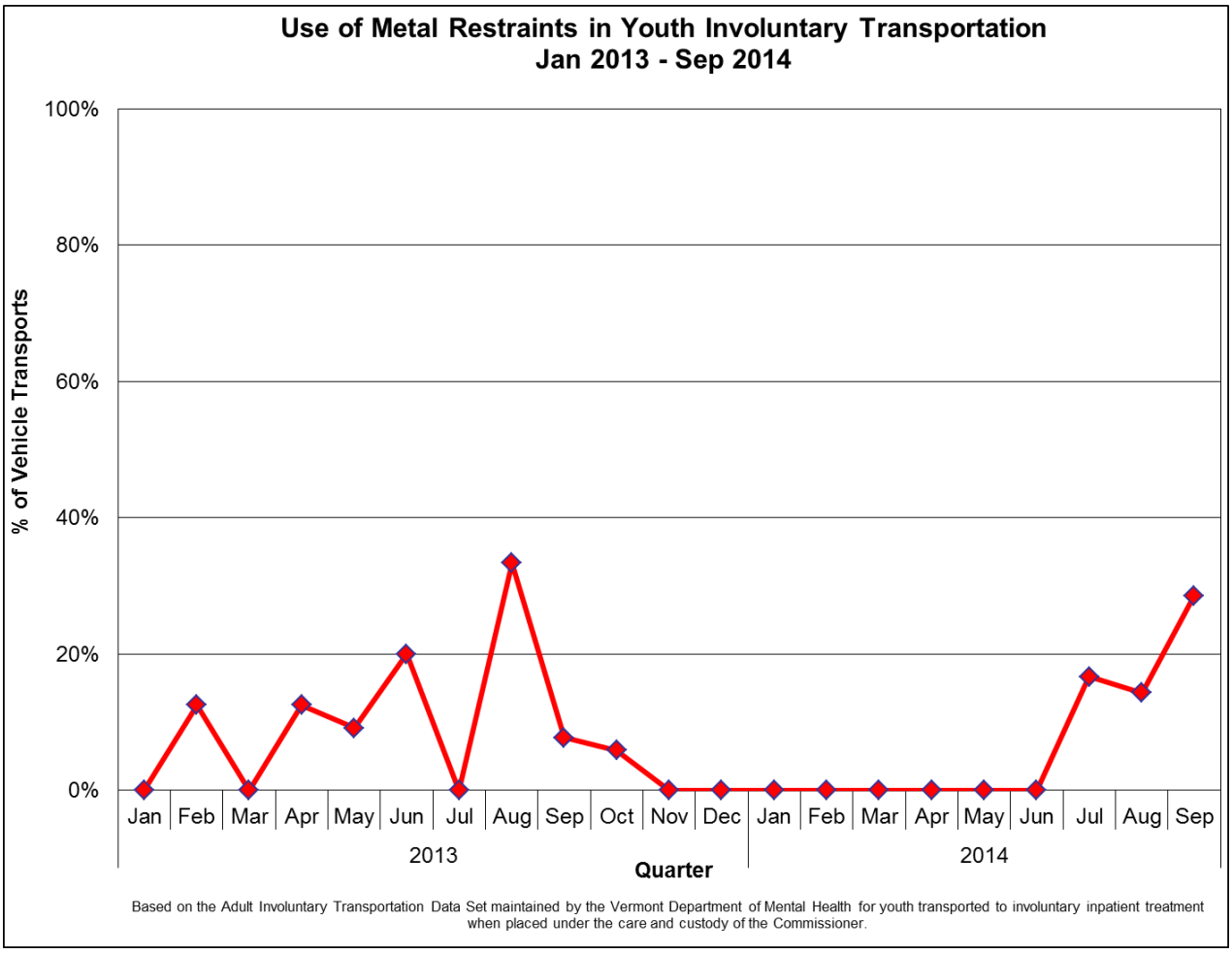


Chart Twenty-Two: One year overview of Adult Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
(December 2013-September 2014)

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Annual
Transportation Type											
Restrained	6	2	2	4	3	5	9	4	4	10	**49**
Non-Restrained	11	11	13	9	13	10	13	10	15	6	**111**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport											
None	11	11	13	9	13	10	13	10	15	6	**111**
Metal	3	1	1	2	1	1	7	0	1	7	**24**
Soft	3	1	1	2	2	4	2	4	3	3	**25**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	18%	8%	7%	15%	6%	7%	32%	0%	5%	44%	**15%**
Vehicle Used in Transport											
Ambulance	1	2	8	5	5	2	2	6	6	0	**37**
MH Van Alternative	2	0	0	0	0	0	2	0	0	0	**4**
Private Transport	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	8	6	1	3	3	1	4	3	3	3	**35**
Sheriff Cruiser	6	5	6	5	8	12	13	5	10	13	**83**
Other	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**
No Data	0	0	0	0	0	0	1	0	0	0	**1**
%Vehicle Transports that use Ambulance	6%	15%	53%	38%	31%	13%	9%	43%	32%		**23%**
%Vehicle Transports that use MH Van Alternative	12%						9%				**3%**
%Vehicle Transports that use Sheriff's Alternative	47%	46%	7%	23%	19%	7%	18%	21%	16%	19%	**22%**
%Vehicle Transports that use Sheriff's Cruiser	35%	38%	40%	38%	50%	80%	59%	36%	53%	81%	**52%**

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Annual
EE's with Sheriff Involvement	14	11	7	8	11	13	17	8	13	16	**118**
TOTAL EE Transports	**17**	**13**	**15**	**13**	**16**	**15**	**22**	**14**	**19**	**16**	**160**

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: 11/12/2014

Chart Twenty-Three: One year overview of Youth Involuntary Transport

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
(December 2013-September 2014)

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Annual
Transportation Type											
Restrained	1	0	0	0	0	0	0	1	1	2	**5**
Non-Restrained	1	4	5	7	4	3	5	5	6	5	**45**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
Restraints Used in Transport											
None	1	4	5	7	4	3	5	5	6	5	**45**
Metal	0	0	0	0	0	0	0	1	1	2	**4**
Soft	1	0	0	0	0	0	0	0	0	0	**1**
Missing	0	0	0	0	0	0	0	0	0	0	**0**
% All vehicle transports that use Metal	0%	0%	0%	0%	0%	0%	0%	17%	14%	29%	**8%**
Vehicle Used in Transport											
Ambulance	1	3	5	4	4	1	3	5	6	3	**35**
MH Van Alternative	0	0	0	0	0	0	1	0	0	0	**1**
Private Transport	0	0	0	0	0	0	0	0	0	0	**0**
Sheriff Alternative	1	0	0	1	0	1	0	1	0	3	**7**
Sheriff Cruiser	0	1	0	2	0	1	1	0	1	1	**7**
Other	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**
No Data	0	0	0	0	0	0	0	0	0	0	**0**
%Vehicle Transports that use Ambulance	50%	75%	100%	57%	100%	33%	60%	83%	86%	43%	**70%**
%Vehicle Transports that use MH Van Alternative							20%				**2%**
%Vehicle Transports that use Private Transport											
%Vehicle Transports that use Sheriff's Alternative	50%			14%		33%		17%		43%	**14%**
%Vehicle Transports that use Sheriff's Cruiser		25%		29%		33%	20%		14%	14%	**14%**

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Annual
EE's with Sheriff Involvement	1	1	0	3	0	2	1	1	1	4	**14**
TOTAL EE Transports	**2**	**4**	**5**	**7**	**4**	**3**	**5**	**6**	**7**	**7**	**50**

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: 11/12/2014

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.

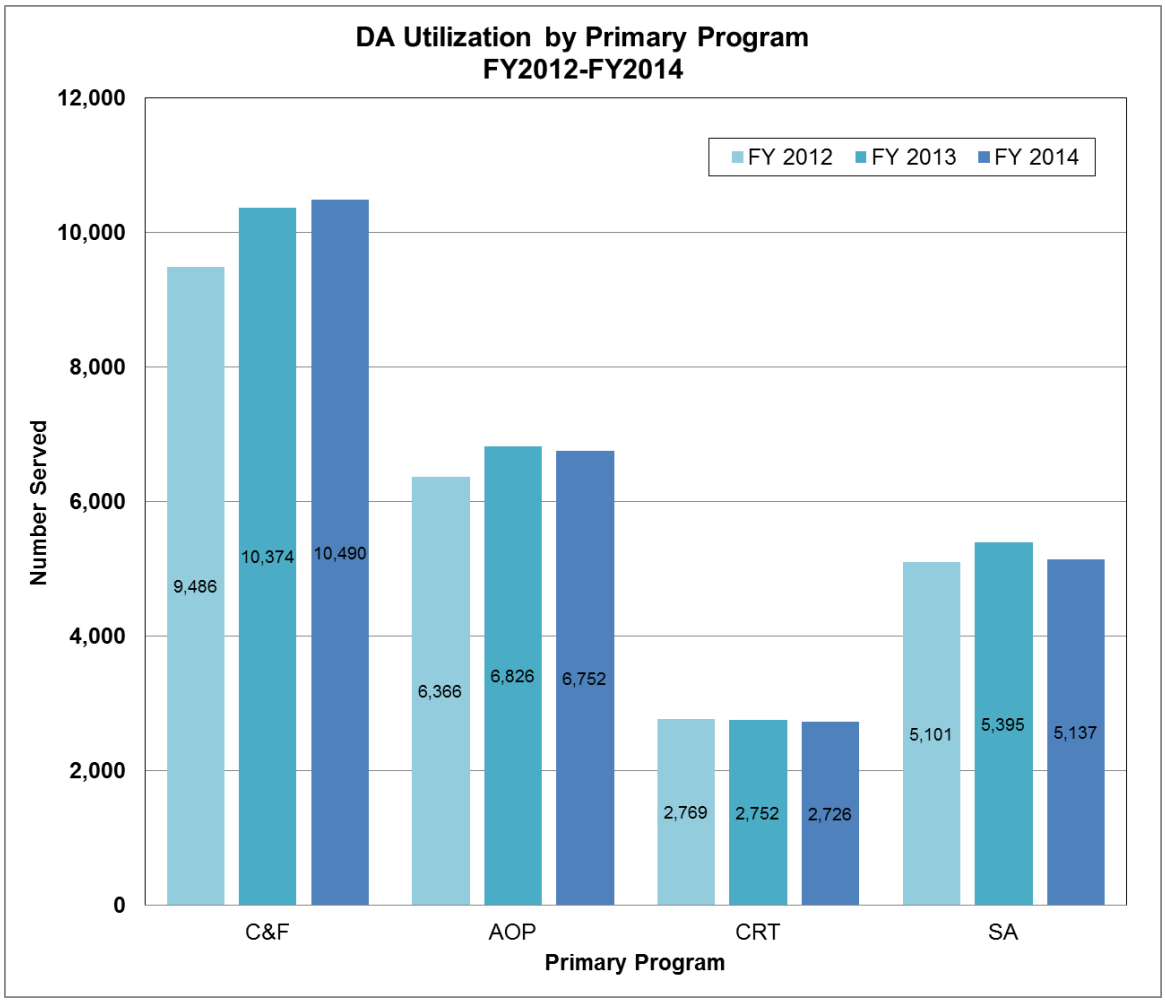
In order to maximize utilization of limited treatment resources in both the community and hospitals, the Department developed a care management system that employs clinicians as key contacts and liaisons between Designated Agencies and Designated Hospitals, ensuring that people in need of treatment receive 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 FY13 and FY14, 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 FY14 remained relatively stable and do not yet reflect any statistically significant upward trend in persons served.

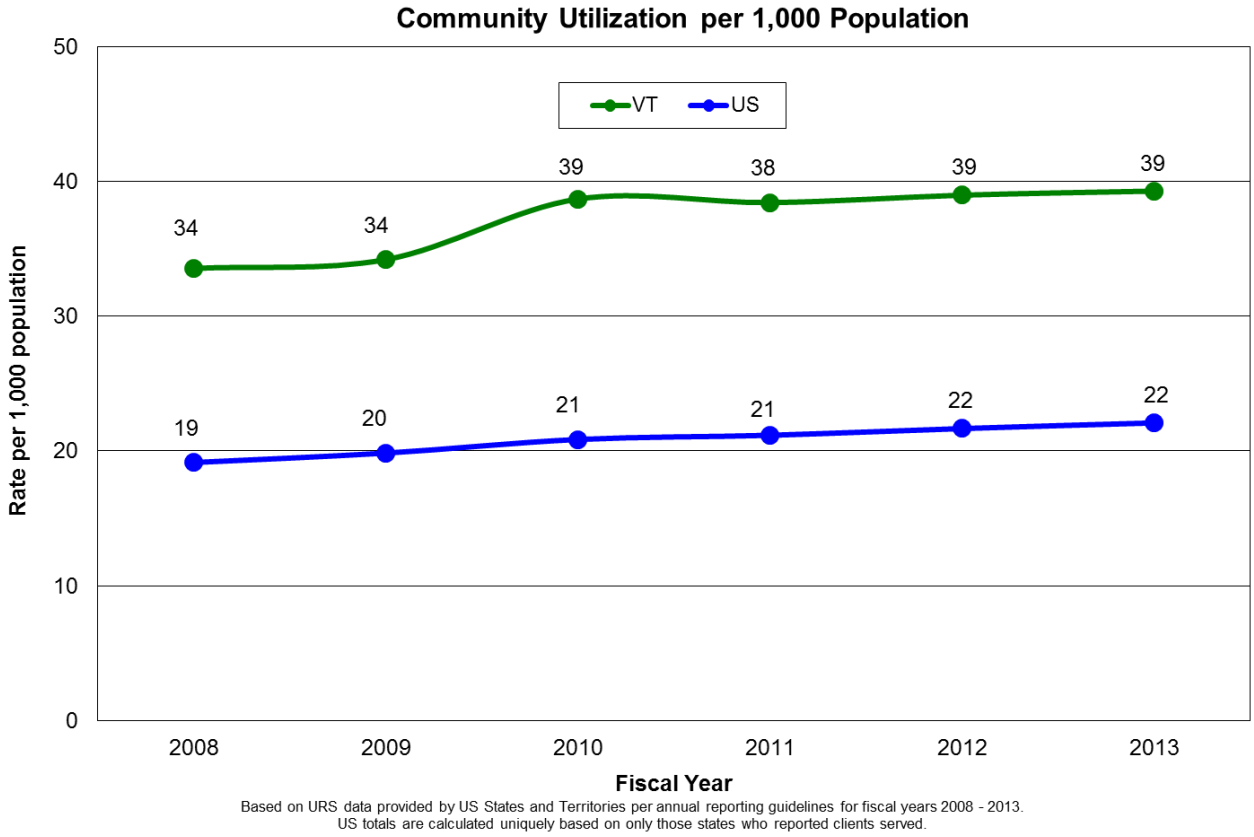
In FY13 and early in FY14 the Department received regular reports from Designated Agencies regarding service initiatives and the numbers of people served through these new capacities. Cumulative service data reported to the Department during this time period show the impact of increased program funding and the increase in numbers served.

Chart Twenty-Four: Designated Agency Volume by Program



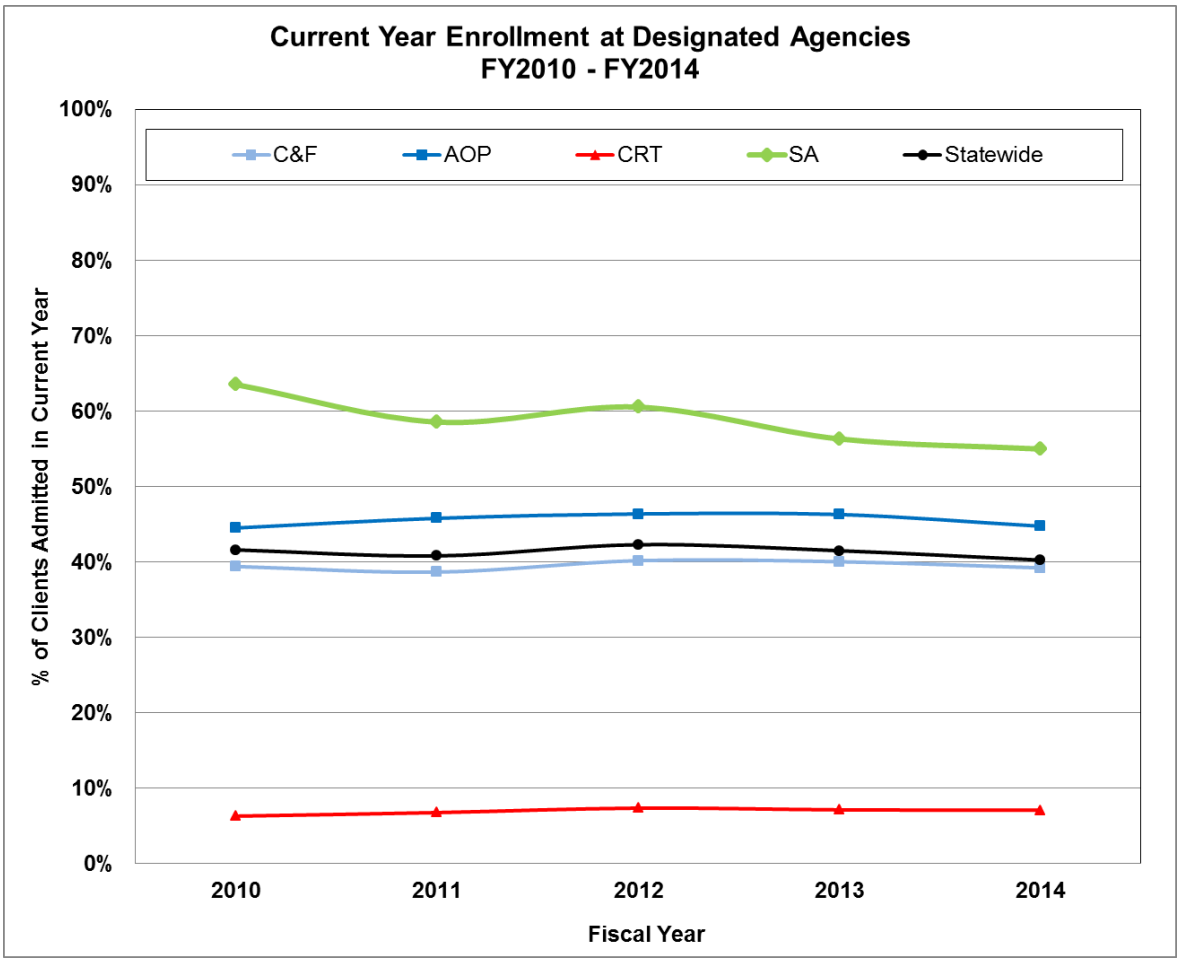
The highest number of persons served by a program offered by the Designated Agencies (DAs) continues to be in services for children and families, while the lowest numbers of persons served by a Designated Agency program are those in the Community Rehabilitation and Treatment (CRT) programs. The volume 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 Twenty-Five: Community Utilization per 1,000 Populations



The number of individuals served in the community per 1,000 populations in Vermont is 38, or 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 Twenty-Six: Enrollment at Designated Agencies by Program



The system of care is predicated 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 return to baseline or above. 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.

Chart 26 tells the story of enrollment across the programs provided in the Designated Agencies across the state over the past five year period. 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%.

The most significant finding across the five years studied for this report is that over 41% of the Community Rehabilitation and Treatment client population has been engaged and retained in treatment for 11 or more years. This percentage increased by 1% in FY14. The next highest length of stay is three to ten years. This indicates that approximately half of the seriously mentally ill population may be significantly older at this time and that the number of clients new to the system (enrolled within the last

one to two years) has continued to decrease. The clients served by the Community Rehabilitation and Treatment programs are chronically ill and require ongoing care. The numbers of clients in the age ranges of 35-64 have increased over the past 4 years, while the numbers of clients between 20 and 34 years of age have decreased. The largest percentage of clients are in the 50-64 age range. The Department is working with other stakeholders to determine the needs of the changing recipients of Community Rehabilitation and Treatment services and specifically, those making the transition from child and family services to adult services.

Chart Twenty-Seven: Intensive Residential Bed Utilization

Legislative Report to Mental Health Oversight Committee and Health Care Oversight Committee
Intensive Residential Census Report
January - October 2014

Adult Intensive Residential Facilities

	Hilltop	Meadowview	Second Spring Williamstown	Second Spring Westford	RMHS MapleWood	Middlesex	State Avg	State Avg Excluding Middlesex
January								
Total Beds	8	6	21	8	-	7	50	43
Monthly Avg.	7.35	5.73	21.13	7.74	-	6.87	47.97	41.10
Monthly % Occupancy	91.9%	95.5%	100.6%	96.8%	-	98.1%	95.9%	97.6%
February								
Total Beds	8	6	22	8	-	7	51	44
Monthly Avg.	7.54	4.64	21.64	7.71	-	7.00	48.54	41.54
Monthly % Occupancy	94.3%	77.3%	98.4%	96.4%	-	100.0%	95.2%	95.2%
March								
Total Beds	8	6	22	8	-	7	51	44
Monthly Avg.	8.00	6.00	20.32	7.58	-	7.00	48.90	41.90
Monthly % Occupancy	100.0%	100.0%	92.4%	94.8%	-	100.0%	95.9%	95.9%
April								
Total Beds	8	6	22	8	-	7	51	44
Monthly Avg.	8.00	6.00	21.27	7.80	-	7.00	50.07	43.07
Monthly % Occupancy	100.0%	100.0%	96.7%	97.5%	-	100.0%	98.2%	98.2%
May								
Total Beds	8	6	22	8	-	7	51	44
Monthly Avg.	8.00	5.71	20.84	7.52	-	6.71	48.77	42.06
Monthly % Occupancy	100.0%	95.2%	94.7%	94.0%	-	95.9%	95.6%	95.6%
June								
Total Beds	8	6	22	8	4	7	55	48
Monthly Avg.	7.90	5.70	19.67	7.69	2.26	7.00	49.43	42.43
Monthly % Occupancy	98.8%	95.0%	89.4%	96.1%	56.5%	100.0%	91.9%	90.7%
July								
Total Beds	8	6	16	8	4	7	49	42
Monthly Avg.	7.94	6.00	16.00	781.0%	4.00	7.00	48.73	41.73
Monthly % Occupancy	99.3%	100.0%	100.0%	97.6%	100.0%	100.0%	99.5%	99.4%
August								
Total Beds	8	6	16	8	4	7	49	42
Monthly Avg.	7.87	6.00	16.00	8.00	4.00	6.65	48.53	41.87
Monthly % Occupancy	98.4%	100.0%	100.0%	100.0%	100.0%	95.0%	99.0%	99.7%
September								
Total Beds	8	6	16	8	4	7	49	42
Monthly Avg.	7.97	6.00	15.47	7.30	4.00	6.33	47.07	40.73
Monthly % Occupancy	99.6%	100.0%	96.7%	91.3%	100.0%	90.4%	96.1%	97.0%
October								
Total Beds	8	6	16	8	4	7	49	42
Monthly Avg.	8.00	6.00	13.77	7.03	4.00	6.77	45.58	40.73
Monthly % Occupancy	100.0%	100.0%	86.1%	87.9%	100.0%	96.7%	96.1%	97.0%

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 w here 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 Williamstow n 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 w here 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 the hospital level 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 six programs in operation; Maplewood was opened in the spring of 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 to support this capacity. Table 28 below depicts Crisis Bed occupancy for 2014. Utilization has been within expected rates, with an average statewide of 80.2% during the period between January and October of 2014. This is the *target rate* established for crisis bed utilization. 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 conjectured that there is a need for an increased number of Intensive Residential beds.

Chart Twenty-Eight: Crisis Bed Census Report

Legislative Report to Mental Health Oversight Committee
and Health Care Oversight Committee
Crisis Bed Census Report
2014

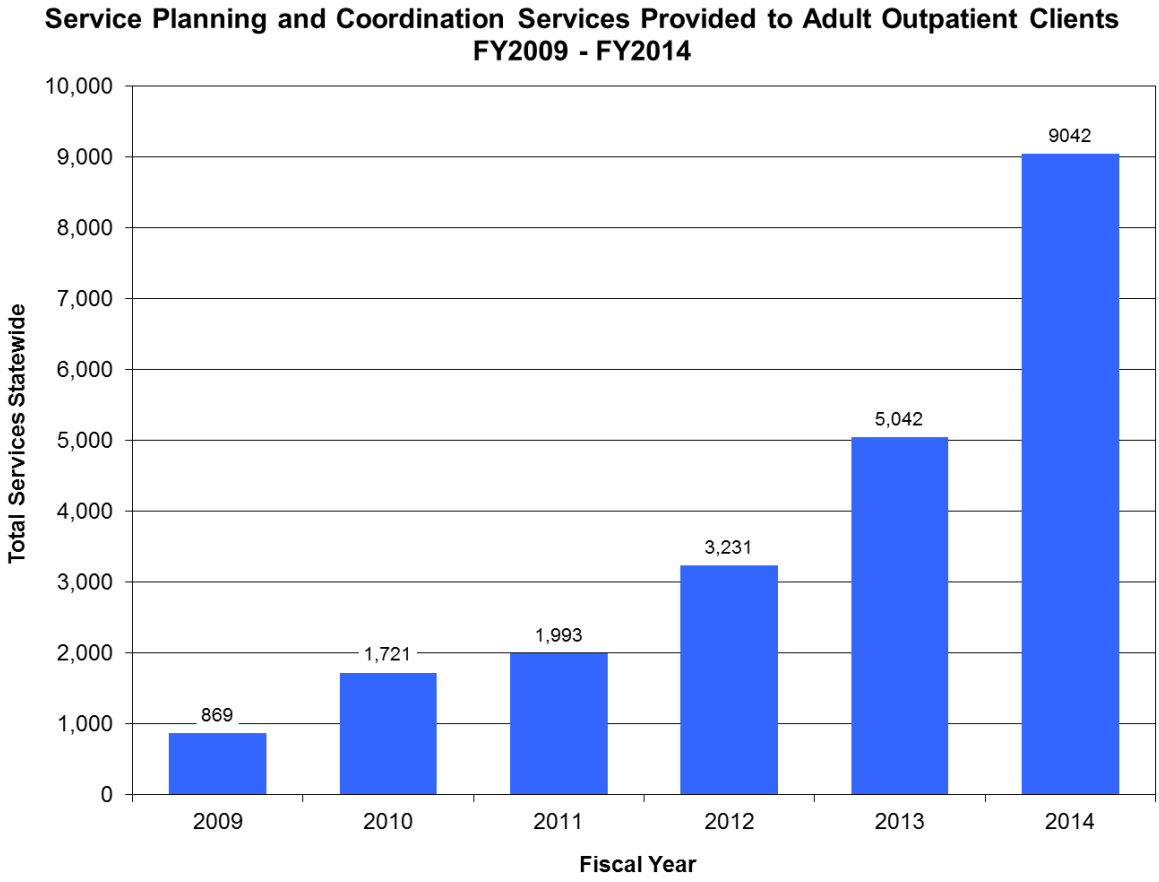
Adult Crisis Bed Units

	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		2	2	4	1	6	5	39
Monthly Avg.	1.90	1.52	1.00	4.94	5.94	1.61		2.00	1.00	2.32	0.30	5.77	3.97	31.94
Monthly % Occupancy	95.2%	75.8%	100.0%	82.3%	98.9%	80.6%		100.0%	50.0%	58.1%	30.0%	96.1%	79.4%	82.8%
February														
Total Beds	2	2	1	6	6	2		2	2	4	-	6	5	38
Monthly Avg.	1.86	0.93	1.00	4.79	6.00	1.96		2.00	0.78	2.32	-	4.96	3.48	29.71
Monthly % Occupancy	92.9%	46.4%	100.0%	79.8%	100.0%	98.2%		100.0%	38.9%	58.0%	-	82.7%	69.6%	79.2%
March														
Total Beds	2	2	1	6	6	2		2	2	4	-	6	5	38
Monthly Avg.	1.81	1.26	1.00	4.81	5.81	1.71		1.84	0.94	2.35	-	4.16	3.45	29.13
Monthly % Occupancy	90.3%	62.9%	100.0%	80.1%	96.8%	85.5%		91.9%	46.8%	58.9%	-	69.4%	69.0%	76.7%
April														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	1.93	1.67	1.00	4.57	6.00	1.90	0.87	1.90	0.70	1.83	-	4.63	3.07	30.07
Monthly % Occupancy	96.7%	83.3%	100.0%	76.1%	100.0%	95.0%	86.7%	95.0%	35.0%	45.8%	-	77.2%	76.7%	79.1%
May														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	1.47	1.45	1.00	4.13	6.00	1.84	0.90	1.77	0.65	2.16	-	4.23	3.87	29.42
Monthly % Occupancy	73.3%	72.6%	100.0%	68.8%	100.0%	91.9%	90.3%	88.7%	32.3%	54.0%	-	70.4%	96.8%	77.4%
June														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	2.00	1.43	1.00	4.53	5.97	1.90	0.60	1.80	1.67	1.87	-	3.87	2.10	28.73
Monthly % Occupancy	100.0%	71.7%	100.0%	75.6%	99.4%	95.0%	60.0%	90.0%	83.3%	46.7%	-	64.4%	52.5%	75.6%
July														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	1.84	1.45	1.00	4.06	5.97	1.48	1.00	1.94	0.48	1.9	-	4.65	3.19	28.81
Monthly % Occupancy	91.9%	72.6%	100.0%	67.7%	99.5%	74.2%	100.0%	96.8%	24.2%	47.6%	-	77.4%	79.8%	75.8%
August														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	1.45	0.45	1.00	4.00	5.84	1.39	0.55	1.68	1.29	1.61	-	2.19	3.65	25.1
Monthly % Occupancy	72.6%	22.6%	100.0%	66.7%	97.3%	69.4%	54.8%	83.9%	64.5%	40.3%	-	36.6%	91.1%	66.0%
September														
Total Beds	2	2	1	6	6	2	1	2	2	4	-	6	4	38
Monthly Avg.	1.80	1.17	1.00	5.00	5.97	1.67	0.80	1.80	0.90	1.90	-	2.67	3.77	28.43
Monthly % Occupancy	90.0%	58.3%	100.0%	83.3%	99.4%	83.3%	80.0%	90.0%	45.0%	47.5%	-	44.4%	94.2%	74.8%
October														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.84	1.19	1.00	4.68	5.90	1.55	1.00	1.68	1.10	2.03	1.87	4.90	3.55	32.06
Monthly % Occupancy	91.9%	59.7%	100.0%	78.0%	98.4%	77.4%	100.0%	83.9%	55.2%	50.8%	93.5%	81.7%	88.7%	80.2%
November														
Total Beds	2	2	1	6	6	2	1	2	2	4	2	6	4	40
Monthly Avg.	1.97	1.10	0.90	5.31	5.37	1.63	0.83	1.67	1.57	2.00	0.97	3.70	2.67	29.13
Monthly % Occupancy	98.3%	55.0%	90.0%	88.5%	89.4%	81.7%	83.3%	83.3%	78.3%	50.0%	48.3%	61.7%	66.7%	72.8%

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.

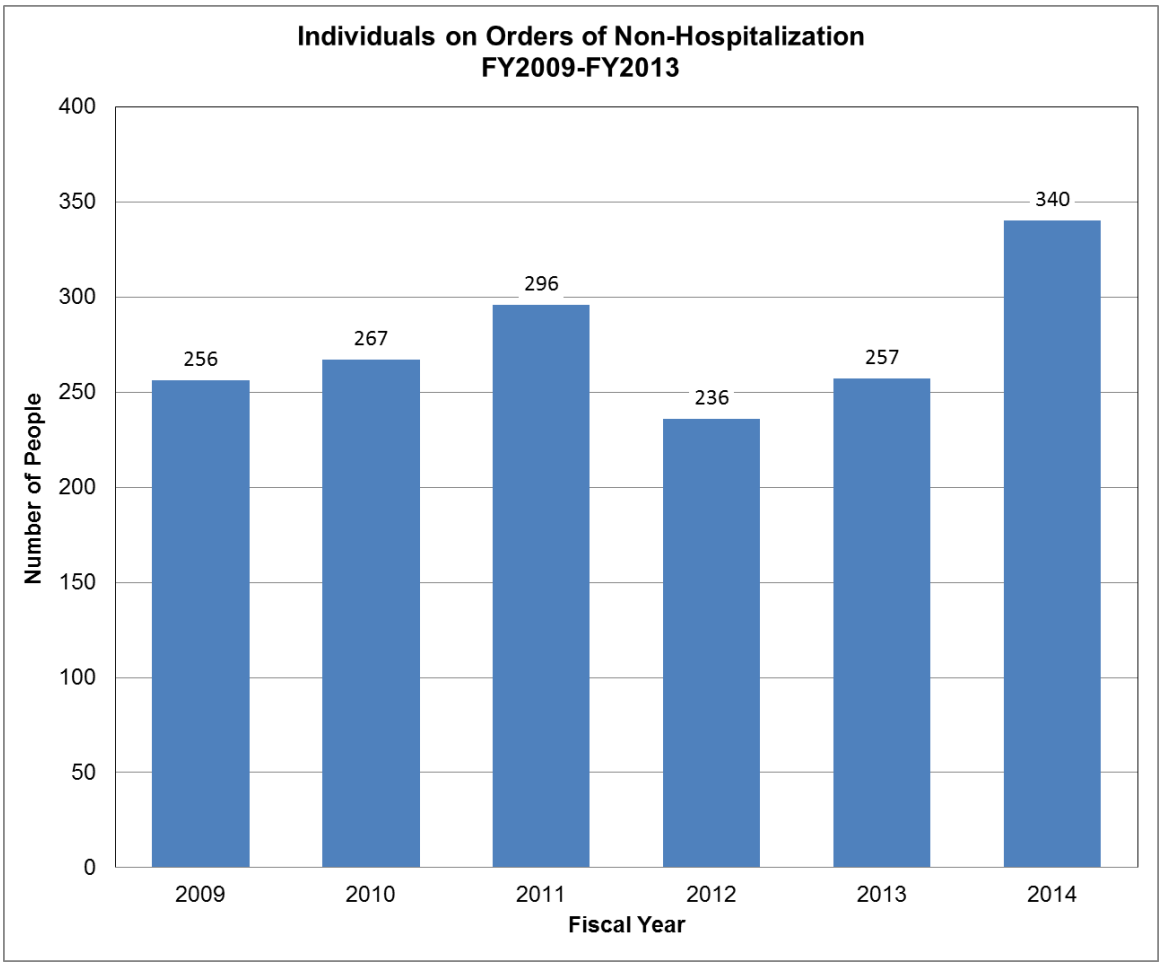
Chart Twenty-Nine: Non-Categorical Case Management



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 FY2014. This is a good indicator of the need for this level of case management to the adult outpatient population.

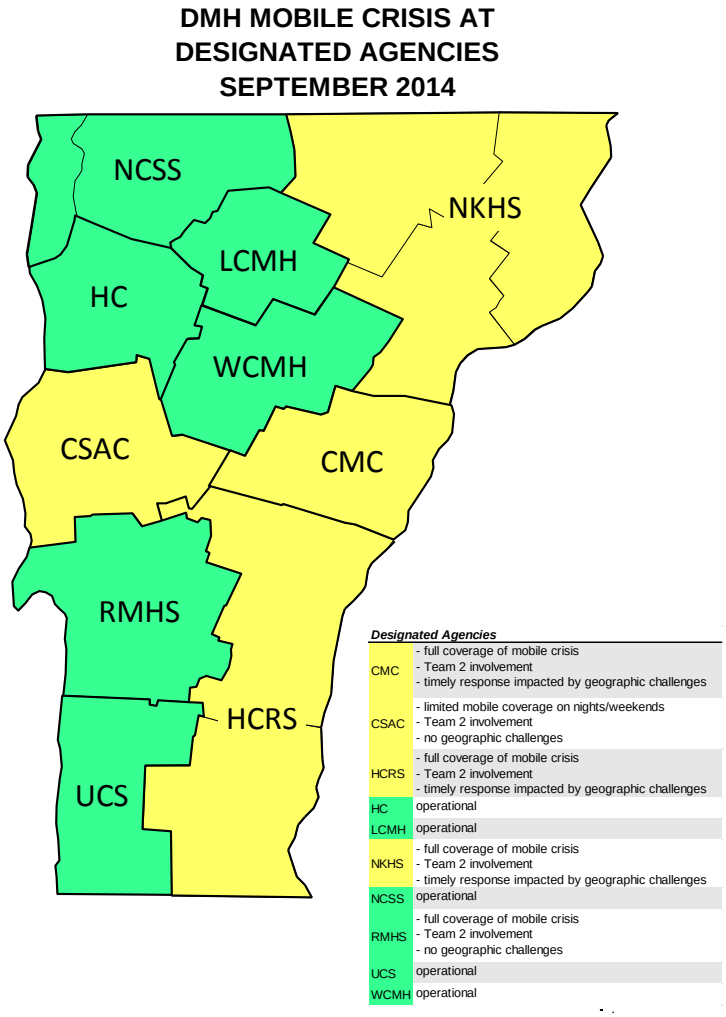
Each Designated Agency has developed mobile crisis teams to better respond to individuals experiencing psychiatric crisis and the majority of programs have begun to perform crisis assessments and interventions in the community, as well as providing law-enforcement related crisis response. In addition, the Designated Agencies are providing increased services to patients waiting in emergency rooms for admission to psychiatric hospital care. While the Department is still in the process of refining and standardizing data collection regarding the expansion of mobile crisis response, Designated Agencies have reported providing over 8,800 crisis assessments in the community during the state fiscal year 2014. This is a 75% increase in the number of assessments conducted. Enhanced outpatient services are described more fully in a later section of this report.

Chart Thirty: Orders for Non-Hospitalizations



Department of Mental Health Orders of Non-Hospitalization (ONH's) were the highest in four years reaching 340 people on Orders of Non Hospitalization during FY2014. 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 and plans to engage in further review by the departmental Quality Unit to analyze the reasons for this increase and the effectiveness of the model in maintaining eligible individuals in treatment to reduce hospitalization and risk to self and/or others. The ONH Manual is under revision and will be finalized early in 2015.

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.

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 2015. Over the past 2 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),

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

- 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]

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.

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

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

Chart Thirty-One: 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.
Northeast Kingdom Youth Services	Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization.
Pathways – Peer Support	Statewide telephone peer support to prevent crisis and provide wellness coaching.
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 FY14, 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.

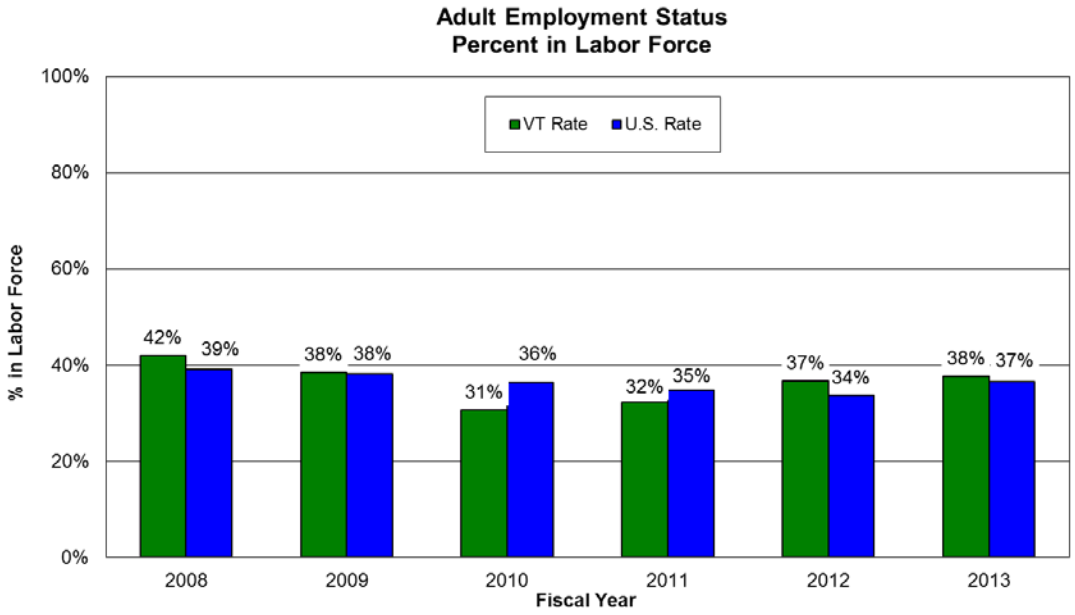
The Vermont Support Line is one of the programs developed subsequent to the implementation of Act 79. It provides statewide telephone peer support to prevent crisis and provide wellness coaching; currently operating 365 days a year. The line is operated by full time and part time peer staff who have 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 8,030 individual instances of completed support through mid-December 2014, with almost a 2,000 call increase in 2014. Through mid-December 2014, the Vermont Support Line has diverted 245 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). Due to the increasing number of calls, in 2014 the support line has been able to answer only 8.42% of the total incoming calls. 80% of support line connections are made by returning messages left, but only 50% of missed callers leave a message.

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 Thirty-Two: Percentage of All Adults with Mental Illness Employed in U.S. and VT

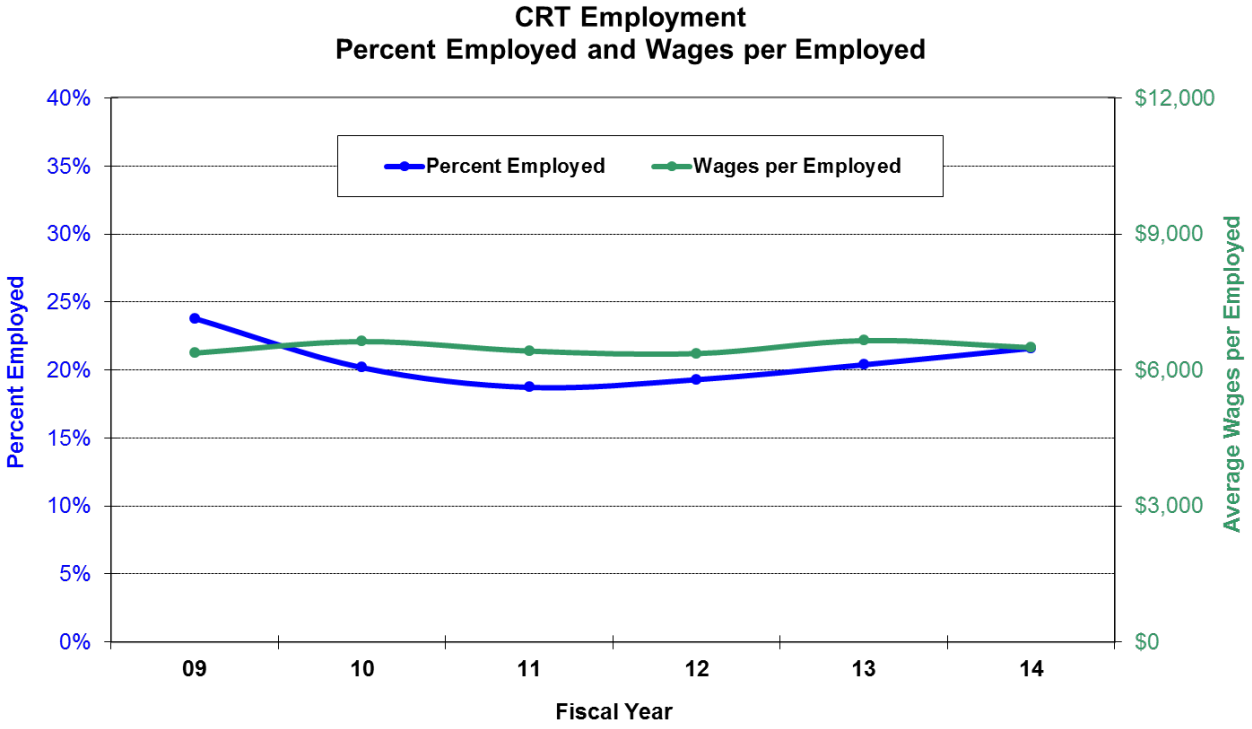


Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2013. Employment status for other mental health clients is based on case manager monthly service reports.
Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2013.
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—continues to be higher than the national rate. Reason for these rates may include:

- Addition of peer employment staff to two peer-run programs
- Increased focus on employment in non-categorical case management services
- Creative Workforce Solutions
- Collaborative efforts between Vocational Rehabilitation and the Department.

Chart Thirty-Three: CRT Annual Employment Rates and Average Earnings (2009-2013)



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 FY12 and FY13 and an additional 2% increase by end of FY 2014. Wages dipped slightly for the period. 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 $6,494 per year (*16 hours per week for full year at minimum wage*). Total wages earned in FY 14 were $3,565,183, an increase of 2% from FY13.

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.

Changes to Vermont's law via 2014 Act 192 require "progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications."

The Department currently supports and continues to expand a number of 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 will provide specialized treatment and support for individuals experiencing first break psychosis who are seeking to avoid or reduce their reliance on medications. This program, which is scheduled to open in early 2015, will include 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 will be working with the Vermont Cooperative for Practice Improvement and Innovation (VCPII) to identify and promulgate specific evidence-based practices for this population.

Perception of Care Surveys

The Department conducts consumer surveys to evaluate Community Rehabilitation and Treatment Services and Children and Family Services provided by the 10 designated agencies in Vermont. (The survey for children and families includes parents of children and adolescents with a severe emotional disturbance as well as youth in services.) The full survey reports can be found online at: http://mentalhealth.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.

Overall satisfaction in Child and Adolescent Mental Health Programs has increased over the years, along with satisfaction surrounding staff and quality of services. Satisfaction with Community Rehabilitation and Treatment programs has shown less improvement, but remains in the eightieth percentile for all domains, with the exception of 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.

Chart Thirty-Four: Favorable Outcomes Percentage of Child & Family (C&F)

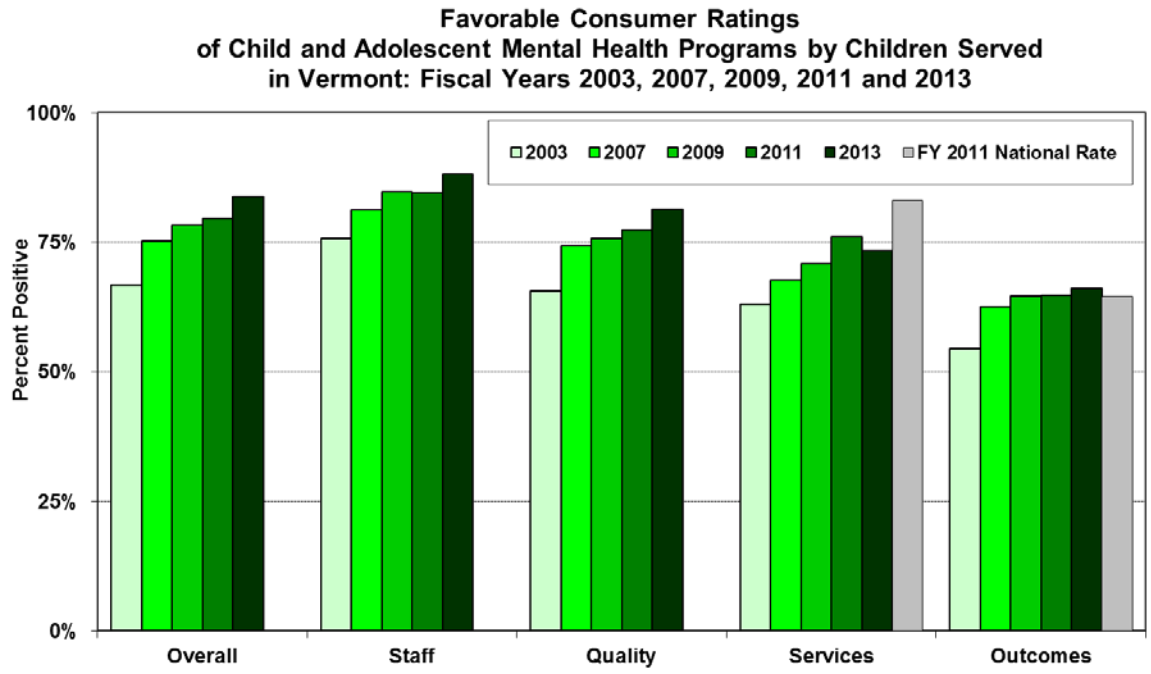
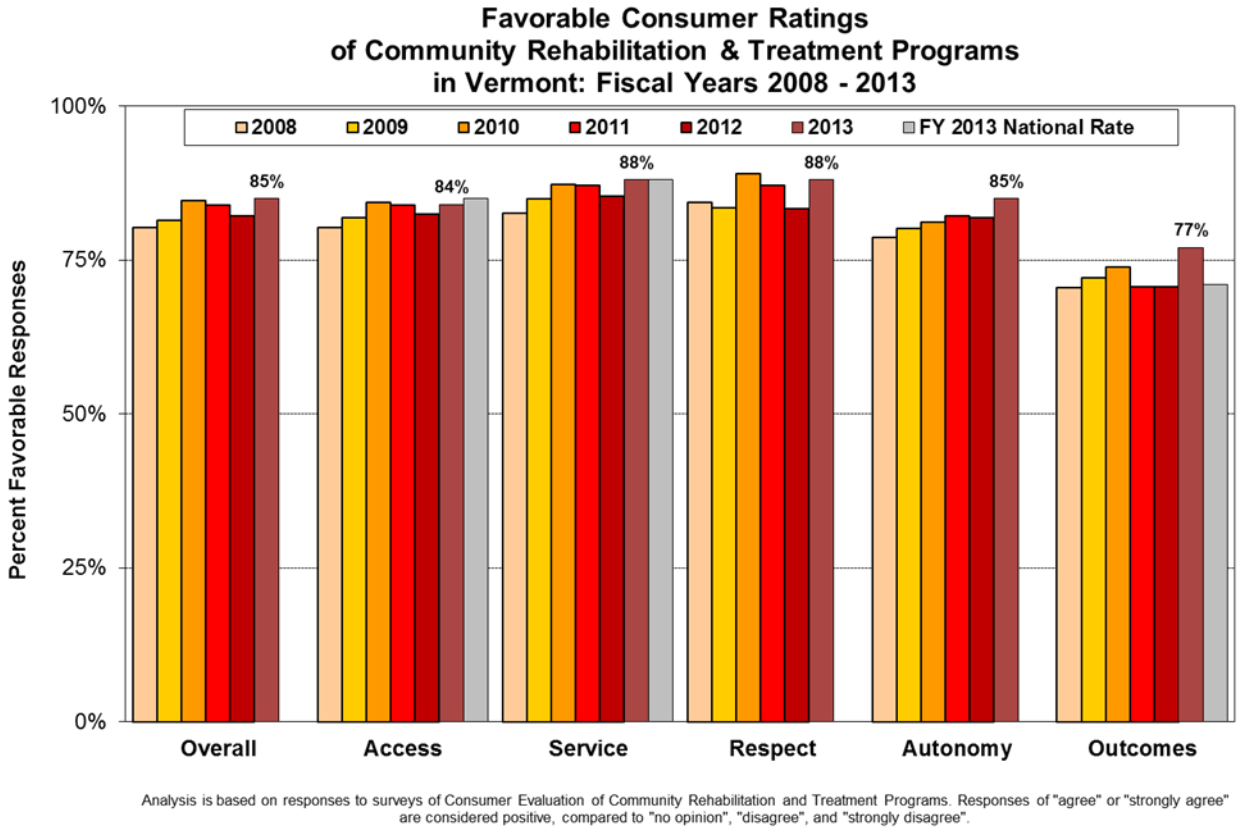
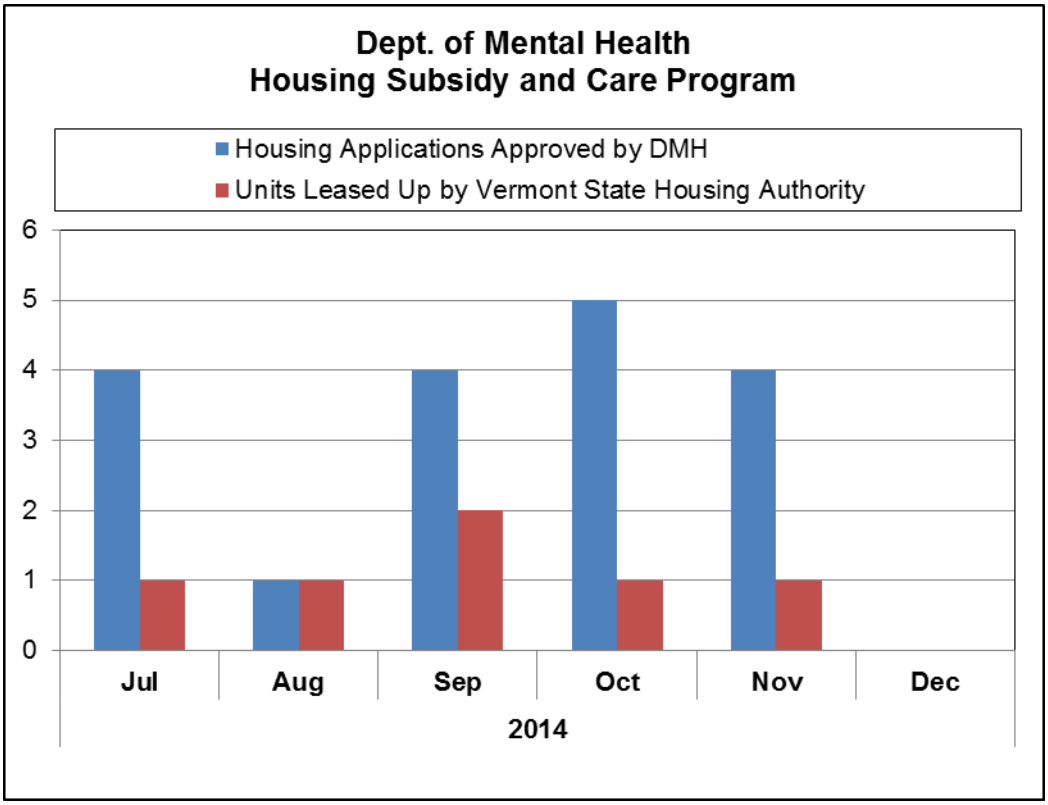


Chart Thirty-Five: Favorable Outcomes Percentage for CRT



Housing

Chart Thirty-Six: Housing Subsidy and Care Program



During the last half of 2014, a total of 135 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 30 to 713 days, with over 80% having lengths of stay greater than one year. An equal number of male and female were also served. Of the 135 served during the last half of 2014, more than 84% were literally homeless, meaning on the streets, in a shelter, or in a hospital. Less than 9% of those assisted were at serious risk of losing housing and going to an acute care bed. Of the 162 housed since December 2011, 41 persons have exited. Thirty three percent of those have positive outcomes.

Chart Thirty-Seven: People Housed Through End FY14

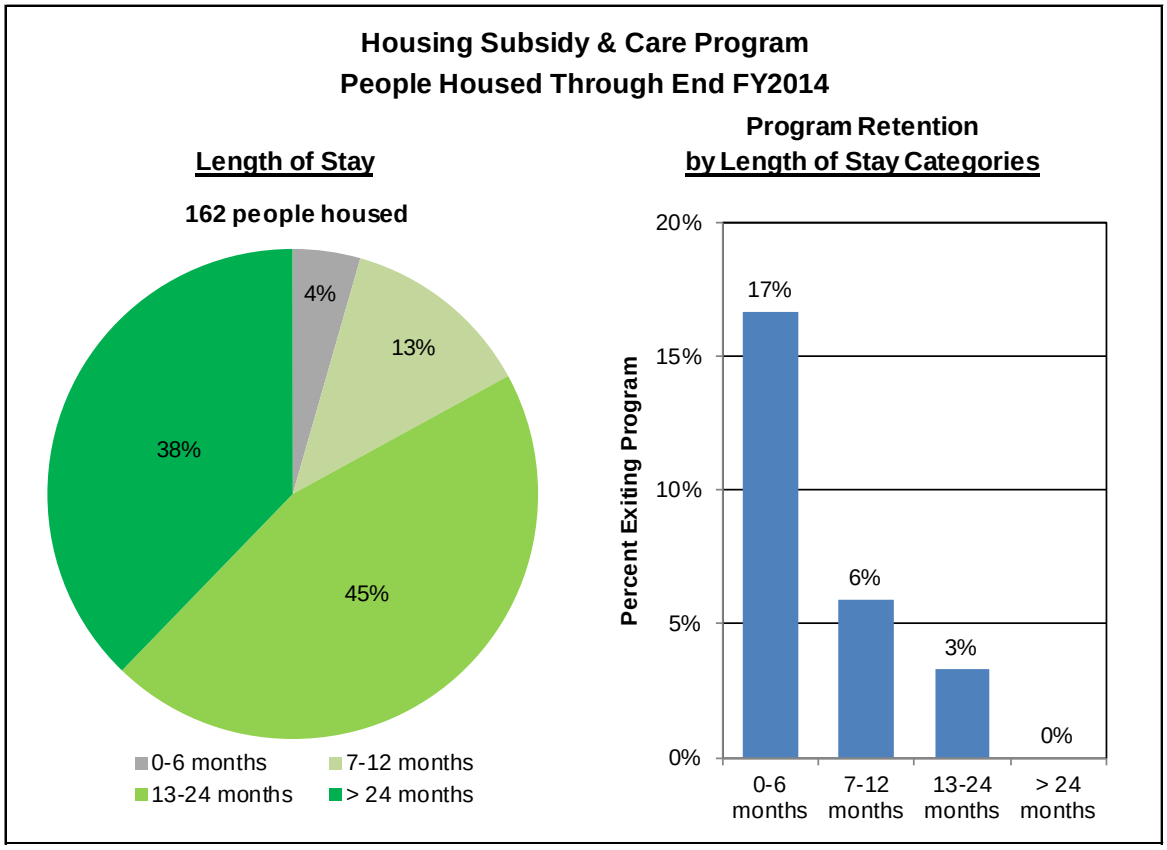
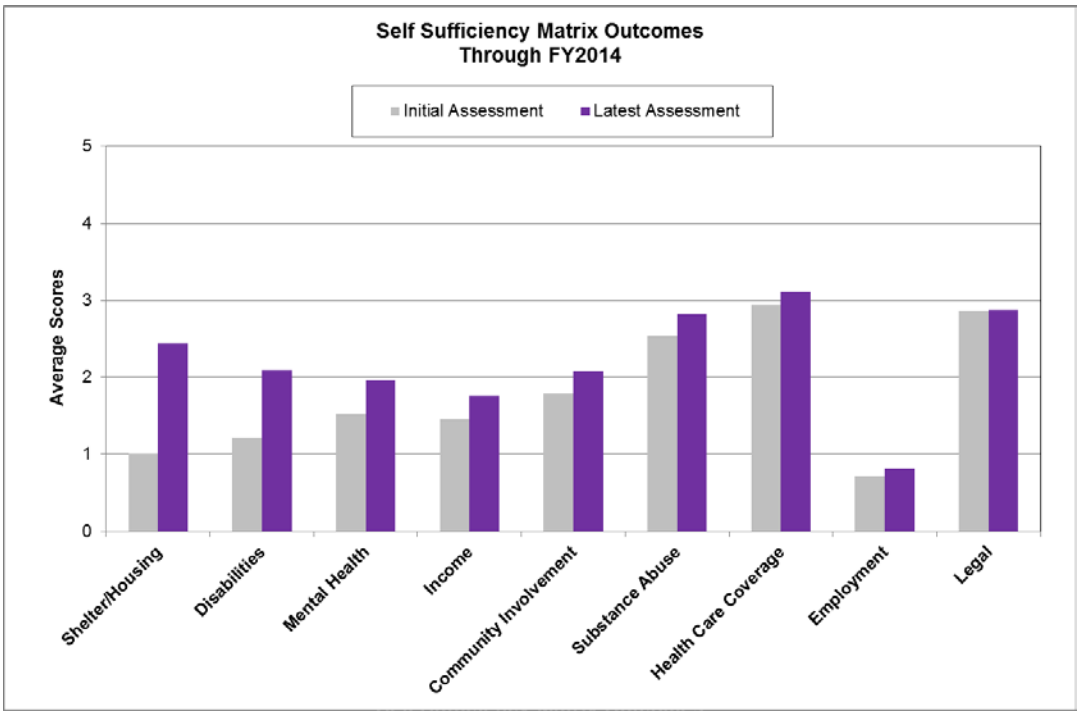


Chart Thirty-Eight: Self Sufficiency Matrix Outcomes Through FY2014



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, as delineated in the *DMH System of Care 3-Year Plan FY2012-2014,* currently being updated for the period from FY2015-FY2018.

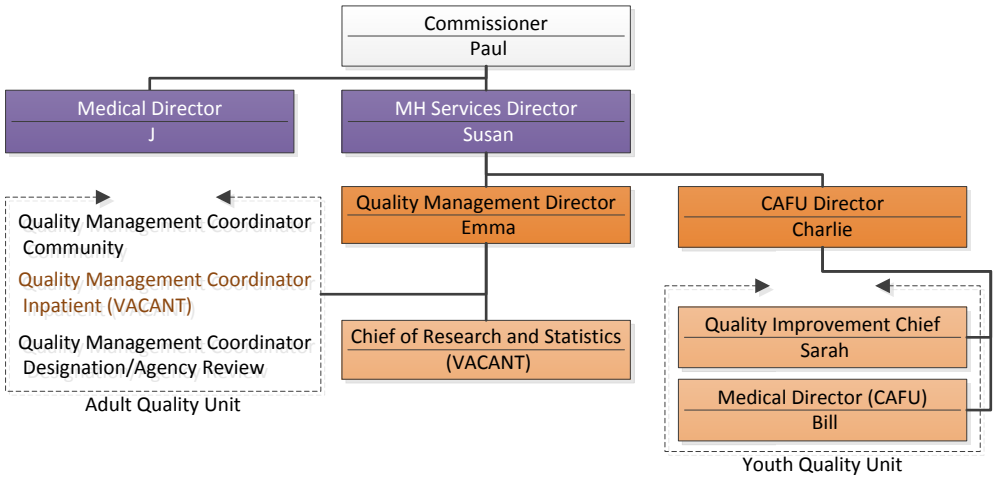
Quality Unit Structure

The Department Quality Management Unit was reconstituted in September, 2012, with the hiring of a Quality Management Director. Since that time, there have been two additional quality management coordinator positions added to the unit. In response to the guidance provided by the implementation of Act 79 (2012), 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 Unit encompasses the Children, Family and Adolescent Quality Team and the Adult Quality Team. The adult quality unit is located in Montpelier and is comprised of three quality management coordinators who directly report to the quality management director, also located in Montpelier. The Children and Adolescent Family Quality Unit (CAFU) is located in Williston with Integrated Family

Services (IFS). Each quality unit collaborates with their respective medical directors, which are noted on the chart below. 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

The Quality Unit has conducted a review and revision of the Grievance and Appeals process in concert with Department of Aging and Independent Living. Critical Incident reporting requirements and commensurate data collection have been reviewed and revised and continue to be improved upon as our new system evolves. The unit has worked to reduce involuntary transportation without restraint and works hard to maintain turning the curve on use of restraints in transporting patients to hospitals.

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 work with Department of Vermont Health Access (DVHA) in its capacity as a Managed Care Entity (MCE) under Intergovernmental Agreements (IGA). The specifics of this work are currently under revision with DVHA.

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 twofold; 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 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
- Monitor the results of data provided through the utilization review process for inpatient psychiatric hospitalization of Level 1 patients and the impact of the opening of Vermont Psychiatric Care Hospital
- 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
- Work closely with the newly established workforce development and practice-improvement cooperative (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 and 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. In particular, hospitals are required to maintain CMS and Joint Commission: Accreditation, Health Care, Certification (JCAHO) accreditation. Other Joint Commission quality measures including Hospital-Based Inpatient Psychiatric Services (HBIPS) are also a subject of quality review by the Department.

This year, the Department has established a grant to the VCPII for a quality improvement initiative around reduction of seclusion and restraint. Dr. Kevin Huckshorn, a subject matter expert and her team from Rhode Island, provided a 2 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. The Department will be engaging 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. 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 currently still in draft form, while the Department works closely with the Designated Agencies and the Vermont Council for Developmental and Mental Health Services to finalize it.

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. This report comprises information gathered from the Designated Agencies for the period between July 2012 and September 2014 in Year to Date format.

The list of services covered by the changes is fairly broad, with common themes and best practices identified and implemented across all of the Designated Agencies. Due to the fact that all of the agencies implemented their programs to meet the individual needs of their catchment areas, and to differences in how outcomes and delivery of services were measured, the quantitative data is gleaned from a representative sample and is not intended to be conclusive. The data does present a snapshot of what the services are accomplishing across the catchment areas reporting. A baseline of relevant themes reported by each of the agencies and a sample of numbers of persons served in several categories are presented.

The program services that were implemented by all of the Designated Agencies included:

- Enhancements to Emergency Services through hiring additional staff and implementing mobile/community crisis and assessment capacity.
- Adding Peer supports in either crisis settings, or in some areas, hospital emergency rooms.
- Diversion from Emergency Departments
- Collaboration with Law enforcement and participation with law enforcement training
- Development of Emergency respite and crisis beds
- Non-categorical case management
- Special services such as new programs developed to manage more complex clients in the community, extending services to those not previously covered through Community Rehabilitation and Treatment and/or AOP, and additional psychiatrist/Nurse Practitioner time for medication evaluation and administration.

The Designated Agencies receiving enhancement funding reported numbers of persons and/or services provided, where data was available. Due to differences in definitions and in services provided, it is difficult to capture quantitative outcomes. The primary outcome measures to be reported were descriptive:

# Assessed in Emergency Department	7,303
# Assessed in the Community	4,182
# Total Assessments	11,341
# Diverted from ED	6,243
# Diverted from Hospitalization	7,393
# Diverted to a Crisis Bed	846
# Total unique individuals assessed by Emergency Services	8,800

This representative sample of data from the majority of the Designated Agencies depicts a significant number of services and persons served in the community, at levels of care below hospitalization. While the numbers are important and tell a part of the story, the qualitative data really provides the information about the impact that this work has had in communities and among stakeholders. The funding provided for a host of services that were either not in existence or were not adequate prior to

the allocation. There are a number of themes that have been prominent since the implementation of Act 79 and the requisite changes it brought to the mental health system. Two years into the implementation of the clinical resources development, these are considered core components of emergency services in communities across the State.

Planning for the Future

As reported in the FY2013 Report, the landscape of the Mental Health System of Care continues to change and evolve as new system resources come on line and are deployed to community based care or inpatient care settings. Since last year's report and as we predicted, 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, and crisis beds have continued to buoy a system treading water while new hospital bed construction was underway. The Vermont Psychiatric Care Hospital opened on July 2, 2014 and is approaching its capacity for 25 patients. At all times, the Department's daily work continues to be one of assuring that patients 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 was the completion and opening of the Vermont Psychiatric Care Hospital suitable for both CMS certification and JCAHO accreditation. The addition of this twenty-five bed state-operated hospital added additional acute care bed capacity to our system of involuntary Level 1 inpatient capacity. With the addition of high acuity beds to the existing system capacity , the state's psychiatric inpatient hospitals are better equipped and have an added ability to serve voluntary individuals with mental health needs who must also compete for inpatient treatment beds. In combination with enhanced community-based treatment and support programs a fundamentally essential underpinning of our public mental health system of care has now been completed, in the new state-run hospital. First envisioned as part of the Future's initiative, the array of system treatment capacities undertaken and achieved to date will only be completed with additional underpinnings marked by both access across care and service settings and fully integrated care delivery environments. Much work remains to ensure a broader mission continues to assure mental health services for all Vermonters regardless of setting and as an integral component to overall health needs.

In moving this ideal forward, the Department's continuing priority is the ongoing evolution of the clinical care management system outlined in Act 79. The 45 bed inpatient capacity for Level 1 patients has been attained and the task for this year is to monitor and evaluate the adequacy of the system that has been built.

Lastly, the Department continues to prioritize mental health as an integral component of overall health and opportunities to further embed and develop this expectation in current health reform efforts. A dedicated departmental staff person, is now involved in a number of steering committee activities across State government, bringing the voice of mental health care needs to the conversations.

Evaluation of Services

Timely movement of a patient across the transition of care settings is an ongoing focus. There are a number of process and outcome measures that have been put in place and will continue to be monitored by the Quality Management Unit. As many of the measures are new, there are few data elements since the closing of the Vermont State Hospital and do not allow for review of the systems that have been put into place over time. Measurements are becoming more meaningful and review over time will be possible in several areas assuring the value of services in both terms of quality and cost.

Specific focus will also be given to evaluation of enhanced services. A more detailed review of enhanced funding will allow for comparisons across service areas and identification of best practices.

In order to accomplish the work required in a timely and cost effective manner, the Department requires a robust information system. Departmental staff is actively engaged in the Medicaid Management Information System development efforts underway at Vermont's Department of Vermont Health Access. The core components needed for an information system include the flexibility to meet the data reporting and services analysis demands of a multi-faceted health care system.

Collaboration

The need for strong collaboration with Designated Hospitals, Designated Agencies, other State Departments, and community organizations will continue to be of high importance to the department to assure coordination of services and funding are used to meet the needs of individuals.

- The integration of mental health services and primary care has taken on precedence at the national and state level. Work will continue with the Vermont Blueprint for Health to assure that the mental health needs of individuals are included in planning, implementation, and evaluation of services through that program.
- Work continues with the Department of Corrections to identify and plan for the transition of high need clients from Correction to community services and to reduce the number of clients who reoffend and return to the correction system. The Department has also planned for continued training of local sheriff and police departments to support their interactions with people with mental illness.
- Developing capacity within specialty substance abuse and mental health settings to provide coordinated health care services for individuals who are receiving significant treatment services through a designated/preferred community provider.
- Working with community mental health and substance abuse providers to support the inclusion of mental health and substance abuse health information into Vermont's development of a comprehensive Health Information Exchange.
- Providing leadership within Vermont's health care reform efforts to ensure that mental health and substance abuse care is accessible and integrated within the unified health system that is being developed (this includes current efforts to integrate public mental health and substance abuse services into Vermont's unified health system).

Appendices

Appendix A: DMH Snapshot

Appendix B: NOMS (National Outcome Measures) Data Sheet

Appendix C: Clinical Resource Management System Work Group FY13 Report

Appendix D: Pictures of Enhanced Funding

APPENDIX A: DMH MONTHLY SNAPSHOT

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

*data forthcoming

2014

Reporting Category	FY14 Q3 Jan	FY14 Q3 Feb	FY14 Q3 Mar	FY14 Q4 Apr	FY14 Q4 May	FY14 Q4 Jun	FY15 Q1 Jul	FY15 Q1 Aug	FY15 Q1 Sep	FY15 Q2 Oct	FY15 Q2 Nov	FY15 Q2 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 Designation (% of Total applications)	9 / 24%	11 / 34%	8 / 23%	9 / 20%	9 / 21%	14 / 30%	15 / 33%	10 / 19%	16 / 33%	12 / 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	16	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 2013 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per1,000 population	7,242,764	39.32	22.77	58
Community Utilization per 1,000 population	7,024,249	39.28	22.09	58
State Hospital Utilization per 1,000 population	147,853	0.04	0.47	54
Other Psychiatric Inpatient Utilization per 1,000 population	368,266	0.72	1.34	42

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	559,640	37.7%	36.5%	57
Employed (percent with Employment Data)**	559,640	25.7%	17.0%	57

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	72.2%	70.6%	53

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	61.1%	67.6%	51

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	9,248	0.0%	8.6%	48
State Hospital Readmissions: 180 Days	21,397	0.0%	19.8%	49
State Hospital Readmissions: 30 Days: Adults	8,744	0.0%	8.8%	48
State Hospital Readmissions: 180 Days: Adults	20,186	0.0%	20.3%	49
State Hospital Readmissions: 30 Days: Children	499	0.0%	5.7%	21
State Hospital Readmissions: 180 Days: Children	1,197	0.0%	13.8%	25

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	4,130,253	85.8%	83.3%	57
Homeless/Shelter	162,654	2.9%	3.3%	53
Jail/Correctional Facility	102,191	0.1%	2.1%	53

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	75,873	-	2.8%	38
Supported Employment	54,190	31.7%	1.9%	42
Assertive Community Treatment	63,445	-	2.0%	40
Family Psychoeducation	21,794	-	1.3%	17
Dual Diagnosis Treatment	63,026	-	3.7%	24
Illness Self Management	235,902	-	15.2%	22
Medications Management	365,616	85.8%	25.4%	18

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	13,444	-	1.3%	28
Multisystemic Therapy	7,566	-	1.0%	18
Functional Family Therapy	10,452	-	1.7%	13

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	66.3%	69.5%	53
Child/Family Improved Social Connectedness	-	85.1%	49

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

CMHS Uniform Reporting System - 2013 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,614	39.32	7,242,764	22.77	58
Community Utilization per 1,000 population	24,588	39.28	7,024,249	22.09	58
State Hospital Utilization per 1,000 population	26	0.04	147,853	0.47	54
Medicaid Funding Status	15,907	66%	4,274,218	62%	56
Employment Status (percent employed)	2,524	26%	559,640	17%	57
State Hospital Adult Admissions	27	1.04	115,644	0.84	53
Community Adult Admissions	6,699	0.45	11,132,022	2.45	51
Percent Adults with SMI and Children with SED	8,000	33%	4,867,556	67%	57

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	31 Days	79 Days	51
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	44 Days	64 Days	49
Percent of Client who meet Federal SMI definition	18%	68%	55
Adults with Co-occurring MH/SA Disorders	19%	21%	51
Children with Co-occurring MH/SA Disorders	2%	5%	49

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	80%	85%	52
Quality/Appropriateness of Services	84%	88%	52
Outcome from Services	72%	71%	53
Participation in Treatment Planning	79%	81%	52
General Satisfaction with Care	84%	88%	52

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	85%	85%	50
General Satisfaction with Care	74%	86%	51
Outcome from Services	61%	68%	51
Participation in Treatment Planning	83%	88%	51
Cultural Sensitivity of Providers	89%	93%	50

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	17,713	85.8%	4,130,253	83.3%	57
Jail/Correctional Facility	28	0.1%	102,191	2.1%	53
Homeless or Shelter	606	2.9%	162,654	3.3%	53

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	0	0.0%	9,248	8.6%	48
State Hospital Readmissions: 180 Days	0	0.0%	21,397	19.8%	49
Readmission to any psychiatric hospital: 30 Days	-	-	28,305	13.0%	22

State Mental Health Finance (FY2012)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$122,900,000	80.9%	$28,781,463,713	73.9%	51
SMHA Revenues from State Sources **	$23,000,000	15.8%	$15,004,098,297	39.5%	51
Total SMHA Expenditures	$152,000,000	-	$38,921,776,673	-	51

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	63,445	2.0%	40
Supported Housing	-	-	75,873	2.8%	38
Supported Employment	832	31.7%	54,190	1.9%	42
Family Psychoeducation	-	-	21,794	1.3%	17
Integrated Dual Diagnosis Treatment	-	-	63,026	3.7%	24
Illness Self-Management and Recovery	-	-	235,902	15.2%	22
Medications Management	2,252	85.8%	365,616	25.4%	18

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	13,444	1.3%	28
Multisystemic Therapy	-	-	7,566	1.0%	18
Functional Family Therapy	-	-	10,452	1.7%	13

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	-	-	21,607	4.5%	38
Juvenile Justice Contacts	506	4.1%	5,147	4.6%	39
School Attendance (Improved)	-	-	9,657	34.8%	26

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

Appendix C: Clinical Resource Management System FY 13

Vermont Department of Mental Health

Clinical Resource Management System (CRMS) Work Group

FY 2013 Report

A work group was formed through the Department of Mental Health (DMH) to implement the direction provided by Act 79: "The Commissioner of Mental Health in consultation with health care providers, designated hospitals, designated agencies, individuals with mental health conditions and other stakeholders, shall design and implement a clinical resource management system that ensures the highest quality of care and facilitates long-term sustained recovery for individuals in the custody of the commissioner." (Act No. 79 (H.630), Section 7253, P.7)

The CRMS work group, comprised of representatives from consumers groups, DMH, designated agencies (DAs) and designated hospitals (DHs), met approximately once per month during FY 2012-13. The group identified eleven goals, taken directly from the language in Act 79, to name and define the function and purpose of a Clinical Resource Management System for Vermonters in need of mental health services. The purpose of this report is to delineate the goals and objectives achieved and the progress towards implementation of those in process. Many of the goals are interwoven with others and therefore, the specific goals are listed below and are presented in an integrated way in the narrative section. The Summary section identifies next steps for the DMH and its multiple partners in continuing this work.

The goals are:

1. Ensure all individuals in the care and custody of the commissioner receive the highest quality and least restrictive care necessary.

2. Develop a process for receiving direct patient input on treatment opportunities and location of services.

3. Work collaboratively with community partners, including DAs, DHs, and individuals with mental health conditions, and peer groups to ensure access to services for individuals as needed.

4. Use an electronic, web-based bed board to track in real time the availability of bed resources across the continuum of care.

5. Use specific level-of-care descriptions, including admission, continuing stay and discharge criteria and mechanisms for ongoing assessment of service needs at all levels of care.

6. Specify protocols for medical clearance, bed location, transportation, information sharing, census management, and discharge or transition planning.

7. Coordinate transportation resources so that individuals may access the least restrictive mode of transport consistent with safety needs.

8. Ensure that to the extent patient's protected health information pertaining to any identifiable person that is otherwise confidential by state or federal law is used within the clinical resource management system, the health information exchange privacy standards and protocols as described in subsection 9351(e) of this title shall be followed.

9. Ensure that individuals under the custody of the commissioner being served in designated hospitals, intensive residential recovery facilities, and the secure residential recovery facility shall have access to a mental health patient representative.

10. Maintain the integrity and effectiveness of the clinical resource management system. Require a designated team of clinical staff to review the treatment received and clinical progress made by individuals within the commissioner's custody.

11. Coordinate care across the mental and physical health care systems as well as ensure coordination within the Agency of Human Services, particularly the Department of Corrections, the Department of Health's Alcohol and Drug Abuse Programs, and the Department of Disabilities, Aging, and Independent Living. Coordinate service delivery with Vermont's Blueprint for Health and health care reform initiatives, including the health information exchange.

There has been significant progress both within the DMH and in collaboration with stakeholders over the FY 2013, and into the FY 2014.

Coordination and Care Management

The DMH Clinical Care Management Team was convened following the enactment of Act 79 and has been in operation for approximately two years. The team is comprised of five DMH clinical care managers, and a Director who is a licensed clinician providing supervision and team leadership. The Clinical Care Management Team coordinates services with a psychological support team, comprised of a consulting psychiatrist, a nurse care manager, and three licensed psychologists. All or parts of the teams meet weekly with staff from the Designated Hospitals (DHs) which include: Brattleboro Retreat (BR), Fletcher Allen Health Care (FAHC), Rutland Regional Medical Center (RRMC), Green Mountain Psychiatric Care Center (GMPCC) and also with Central Vermont Medical Center (CVMC) and Windham Center (WC) staff when psychiatric patients are admitted to those inpatient units. An additional team of two Utilization Review (UR) care managers, work to authorize and monitor inpatient psychiatric hospitalization for Medicaid recipients, Level 1 patients and Community Rehabilitation and Treatment participants. The UR team is supervised by a psychiatrist who conducts a clinical review of UR decisions on a weekly basis.

Ensuring access to services is a broad based objective for the DMH. This is accomplished through multiple activities that are supported through state funding and guidelines. The DMH Clinical Care Management Team and staff of the Commissioner's Office work directly with the following partners: DHs, DAs, Alyssum, hospital emergency departments, Pathways to Housing, AHS Field Directors and others to ensure access to services for the individuals needing them. Oversight is provided for all patients who need involuntary hospitalization and/or are in the process of moving through that level to a less-restrictive level of care on a daily basis during the work-week and 24/7 through on-call staff. The teams work with DH and community DA staff to support and provide resources to assist in transitioning patients to appropriate levels of care and to facilitate hospital admission or alternative placements, when needed, within a system of limited capacity. Individuals served are primarily those who are involuntarily hospitalized and/or on Orders of Non-Hospitalization (ONH).

Effectiveness of the collaborative relationships is addressed during the hospital re-designation process. Through this process, DMH Quality Management evaluates relationships between the designated hospital and designated agencies and community providers. Opportunities for improved collaboration

and communication are addressed in order to improve patient transitions between different levels of care and facilitate referrals within the system of care.

Collaboration with the Department of Corrections

DMH has developed a protocol for working with Department of Corrections on admissions for people needing voluntary and involuntary psychiatric hospitalization. DMH and Department of Health's Alcohol and Drug Abuse Programs must continue efforts to collaborate on some standards for Recovery Centers, Preferred Providers within Designated Agencies, and Hub and Spoke initiatives. DMH has worked collaboratively with DAIL on many individual clinical situations and placement issues, and worked on plan to add a VCIN bed to state system. DMH has closely followed Vermont's Blueprint for Health and Health Care Reform Initiatives, and presented to Green Mountain Care Board staff on health integration at the Transformation Council. This work is continuing on a regular basis.

Quality Management

A Director of Quality and Care Management was hired in August, 2012, and over the past 18 months, the DMH Quality Team has been assembled, adding two coordinator positions. With the Quality Management Team in place, DMH is an active participant and co-facilitates a monthly Designated Hospital Meeting. The bi-annual Designation process for the hospitals serving persons in need of involuntary treatment is completed for 2013, and the process for re-designation of community mental health agencies is ongoing. The group has identified the need to define quality outcomes and indicators for the Department, using Results Based Accountability (RBA) tools to address and work to improve services in the community. Some of the measures that are being reviewed for both hospital and community settings are below and the DMH is working with AHS and other stakeholders to align quality measures with national standards and benchmarks where available.

The AHS has adopted use of the Results Based Accountability (RBA) Model of Quality Improvement as a methodology to identify and implement performance improvement projects to be accomplished in FY 2014-2015. In addition, DMH participates in the AHS wide Agency Improvement Model project (AIM).

DMH receives Certificates of Need for using seclusion and/or restraint in a hospital setting on involuntary patients from the designated hospitals, and critical incident reports from designated hospitals and designated agencies, as well as residential programs.

A work-group has been formed to study the issue of Emergency Department and Department of Corrections wait time for admission to a psychiatric hospital, with the goal of identifying barriers and solutions to removing those barriers. The DMH has also added a care manager who will focus on the population of persons in need of care who are also involved in the criminal justice system. The following are measures that have been identified by the DMH and for which data is gathered and provided on a periodic basis.

Community Services performance measures:

1. Placement in least restrictive environments;
2. Hospital diversion when appropriate;
3. Clients in CRT programs will achieve the highest level of independence possible;
    1. Permanent housing (tenure in community),
    2. Rates of employment,

3. Receive medical health care services.

Designated Hospitals performance measures:

4. Rates of hospitalization will decrease;
5. Decrease length of stay in most restrictive settings;
6. Decrease use of seclusion and restraint;
7. Decrease recidivism-readmission rates;
8. Decrease in rates of involvement with law enforcement;
9. ED and DOC wait times for inpatient admissions will be reduced.

Hospital Designation Process

Access to services and treatment in the designated hospitals is reviewed during the bi-annual designation process. The designation review allows DMH to maintain oversight over hospitals' policies, procedures, treatment program, and quality initiatives. DMH Quality Management ensures patients have access to legal representation and patient advocates (including Vermont Psychiatric Survivors and Disability Rights Vermont). The DMH collects information about involuntary treatment and care as part of its continuing monitoring activities of inpatient hospital-level care.

Agency Designation Process

Designated agencies are reviewed every four years for compliance with administrative rules and the minimum standards of care. In addition, the requirements of the Master Grant are reviewed during an on-site review of agency operations and a review of clinical documentation. Designated agencies submit changes to the local of system of care document annually. The documents provide information on the current quality work being done by the agency. This information is collated, reviewed and used to plan services and trainings in support of the agencies.

Levels of Care

The integrity and effectiveness of the clinical resource management system is monitored through multiple avenues, and most specifically via the care management team which reviews all treatment plans for those under the care and custody of the commissioner, who are hospitalized.

Development of criteria for levels of care has been identified as a need. Currently, there is a standardized tool for level of care review: the LOCUS. Further work needs to be done in the coming year, to address differences in admission and discharge criteria for crisis beds and the mechanism for ongoing assessment of service needs at all levels of care. The subcommittee responsible for this work identified the processes developed and implemented below:

Level 1 and Involuntary Criteria for Psychiatric Admission to a DH

1. Criteria and procedures described in memo 'Psychiatric Inpatient Billings Procedures', effective July 2012.

2. DMH UR staff review Level 1 eligibility of all involuntary admissions at FAHC, GMPCC, BR and RRMC.

Level of Care Utilization System (LOCUS)

3. DMH UR staff use LOCUS scores for all hospital admissions, continuing stay review, and discharge criteria. DMH UR staff also work closely with DVHA UR staff to align reviews between the two departments for consistency with inpatient providers.

4. Intensive residential and crisis beds record admission and discharge LOCUS scores.

Hospital level of care

1. Ongoing meetings of UR staff at DMH and DVHA to review use of LOCUS. The next meeting is scheduled for January 2014.

Intensive Residential Programs

2. Care management team will review annual reports, discuss findings with the residential staff, and make recommendations regarding admission, continuing stay, and discharge criteria, as well continued use of LOCUS or other tools. To be completed by April 2014.

3. Meeting with staff from Second Spring, Hilltop and Meadowview is scheduled 1/17/14 to review current use of LOCUS and GAF.

Crisis beds

4. Care management team will review annual crisis bed reports, discuss findings with DA emergency services staff, and make recommendations regarding utilization of these beds, including continued use of LOCUS. To be completed by April 2014.

5. Universal referral form for crisis beds was developed and put in use in May, 2013

Middlesex Therapeutic Recovery Program

6. Review admission, continuing stay and discharge criteria, and utilization of specific tools. To be completed by April 2014.

Intensive Residential Services

7. Review admission, continuing stay and discharge criteria, and utilization of specific tools. To be completed by April 2014.

Medical Clearance Guidelines

DMH reviewed and communicated with the field, proposed medical clearance guidelines for admission to a psychiatric unit. DMH also sent out a protocol for communication and responsibilities between Emergency Rooms, DMH and Designated Agencies to help clarify roles when individuals are held involuntarily in an Emergency Room due to lack of psychiatric bed availability. The following details the progress to date:

Medical clearance guidelines

1. DMH reviewed and distributed medical clearance guidelines for admission to a psychiatric unit.

Bed location

2. The Electronic Bed Board is fully operational and is used to identify placement options at all levels of care inclusive of hospital, intensive residential, secure residential and crisis beds. (see below for further explanation)

Transportation

3. Protocols have been established and implemented (further information below)

Census management

4. Census management is conducted at many levels of the DMH, using the electronic bed board as a primary resource.

5. DMH sent out a protocol for communication and responsibilities between Emergency Rooms, DMH and Designated Agencies to help clarify roles when individuals are held involuntarily in an Emergency Room due to lack of psychiatric bed availability.

Discharge or transition planning

1. During weekly discussions between Designated Hospitals, UR staff, and Designated Agencies, discharge and/or transition planning is discussed in detail and an individual plan is made to assure all entities are informed and involved in the planning process.

Existing guidelines in use

1. In coordination with DVHA UR staff, review and document UR standards and goals for discharge and transition planning from hospital level of care going forward.

Patient Care: Transportation

Goal: Coordinate transportation resources so that individuals may access the least restrictive mode of transport consistent with safety needs.

Although humane transport initiatives have been in place for transport of individuals on involuntary status since the passage of Title 18, 7511 (Added 2003, No. 122 (Adj. Sess.), § 141e; amended 2005, No. 180 (Adj. Sess.), § 2; 2007, No. 15, § 14; 2011, No. 79 (Adj. Sess.), § 24, eff. April 4, 2012), these efforts had largely been geared toward adults and children who were on emergency, involuntary status (Emergency Exam or EE), and were transported by sheriffs in handcuffs. It was not long after the passage of Act 79 and the establishment of the decentralized system of Level 1 care that the Department of Mental Health (DMH) recognized that transportation was going to be an important aspect in the new system of care. The department operationalized regional humane transport teams from previously established, grant-funded programs and launched a pilot program with law enforcement that was predicated on collaborative partnership. DMH provided funding which allowed for the development of secure 24/7 transport utilizing civilian vans and plain-clothes details whenever possible. Training and support was provided for the pilot program officers to help them build rapport and to de-stigmatize mental suffering in crisis. Data collection and legislative reporting was enhanced to 100% accuracy starting in July 2012. It should be noted that DMH has fielded calls of interest from other states on these initiatives (Kentucky and Oklahoma).

In December 2011 DMH formed the Involuntary Transport Work Group with members from DMH, law enforcement, peer community, mental health, advocates/Disability Rights Vermont (DRVT) and one

representative from the Legislature, and began meeting on a regular basis. The definitions listed below were the result of successful field work and reports back to work group including monthly data demonstrating a striking decrease in application of metal handcuffs during involuntary care. As a result the work group ended having its last meeting in November 2012. The following are the current definitions of secure and non-secure transportation from the Protocol:

Secure Transport:

Secure transport is defined as involving the application of mechanical restraints depending on which is least restrictive under the circumstances of the individual being transported. As the system of less restrictive transport evolves and other creative entities share in involuntary transports it becomes necessary to revisit and redefine 'Secure'. When the clinical team requests mechanical restraint, sheriffs will be ordered.

Non-Secure Transport:

Persons on involuntary status who are deemed safe for non-secure transport in collaboration with their clinical team shall have a broader range of transportation alternatives including but not limited to:

- At least two trained transporters in DMH-approved, insured vehicle
- Ambulance with ambulance personnel only
- Ambulance with trained transporter as ride-along
- Ambulance with sheriff as ride-along
- Designated Peer Transport
- Transporter following in private vehicle

The work group utilized Guiding Principles in developing a rubric for the transportation protocol which was implemented in 2013.

Guiding Principle: If a patient has severe physical disabilities, has been chemically restrained or exhibits a condition which may require medical monitoring in transit, emergency room staff ought to confer with the Qualified Mental Health Professional (QMHP) regarding the need for ambulance transport.

Patterns in humane transport by sheriffs and ambulance have some regional differences but in general are as follows. These practice patterns apply to those on involuntary status:

- There are two pilot programs with law enforcement: North (Lamoille County Sheriff,) and South (Windham County Sheriff). The demarcation of territory for pilot participants is generally north and south of I-89 respectively. The two pilot programs have alternative modes of transport, dress and mechanical restraints and their mission is to use the least restriction.
- Involuntary transports out of Rutland Regional Emergency Department are transported exclusively by ambulance with Sheriff ride-along. It should be noted as a practice pattern that these transports occur without mechanical restraint other than the usual and customary gurney that is based on safety and ambulance policy—not mental health involuntary status.

- To transport a child under the age of nine in metal handcuffs, it is required that the Commissioner of Mental Health or Designee be contacted through GMPCC admission 24 hours a day-state wide (Hartmann, 2007, Oliver 2011, rev. Dupre 2013).

- Regional humane transport teams that have been supported by DMH grants since the beginning of humane transport initiative (2007) serve various purposes. These teams include Howard Center, CSCORP Flex team out of Second Spring in Williamstown and HCRS Transport Team serving Points South. All three of these teams use trained experienced mental health staff and Howard Center will sometimes use paid, experienced peers, in recovery when appropriate.

- Data on ambulance use is reliant on the statewide Transportation checklist, which is reconciled to the monthly list of involuntary examinations and sheriffs and provider invoices. The process is under review to enhance efficiency and accuracy of information gathering.

- All Sheriff's Departments have had soft restraints purchased by DMH and training provided on using them. There have been multiple regional and statewide trainings and presentations at conferences, meetings and small groups by different members of DMH's legal, care management and leadership staff. Delivery of training for sheriffs regarding "Building Rapport with People in Mental Health Crisis" and "Safe Transport Strategies".

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

Progress is monitored through monthly data tracking that is completed by mid-month, the following month and submitted To Department of Mental Health Research and Development Division for the creation of reports. This will be ongoing for department and legislative oversight.

Electronic Bed Board

DMH E-Bed Board has been fully functional and accessible as a public website since 08/2012.

As designed, the bed board tracks bed availability for:

- In-patient units at designated hospitals

- DA crisis beds

- Intensive Residential facilities

- DA residential facilities

Designated staff at each facility updates the bed availability. "Real time" reporting is encouraged, however, there are established "minimums" based upon the type of facility.

- In-patient units: every 8 hours

- DA crisis beds: every 8 hours

- Intensive Residential facilities: every 8 hours

- DA residential facilities: every 168 hours (weekly)

There is a designated "facility administrator" for each facility who is responsible for updating program description, and who receives an e-mail notice if an update is past due. A copy of the late notice is also sent to the designated DMH administrator. If a late notice indicates that it has been almost 24 hours since the last census update, the designated DMH administrator contacts the facility administrator via e-mail. This inquiry is both to ensure the facility administrator is aware of the late updates and to ensure there are not technical difficulties preventing an update from being entered. Historically these situations have included: loss of Internet access at the facility level, users being "locked out", and changes in staffing. To the extent possible, the designated DMH administrator reviews late notices, and responds to technical difficulties, during traditional off duty hours. DMH's E-Bed Board also includes program descriptions inclusive of defining the target population, the referral process/protocol, and contact information.

A formal census report is sent to the in-patient and crisis facilities on the 15th and again at the end of each month. The facilities are asked to review and report any questions to the designated DMH administrator.

At the request of DVHA, the vendor for the bed board has added "click count" functionality. This function will document the number of times the bed board is accessed for information.

The designated DMH administrator has met with representatives of the crisis programs to answer questions regarding bed board functionality and to hear recommendations for changes to the bed board. One of the changes requested, and implemented, was the formula used to calculate daily census. The census is now reported by the highest bed occupancy for the reporting day.

Peer Services

As a component of ensuring quality care and gaining the involvement of patients and their supports in treatment decisions, peer services were developed and have been implemented. With the allocation of $1 million from Act 79, DMH has expanded services provided by individuals with the lived experience of mental illness (peers) as follows:

- Vermont Psychiatric is now operating a new program in Rutland called *Community Links*, which includes four Peer Outreach Staff that provide support and crisis prevention services for individuals with serious mental illness coming out of RRMC, Corrections, the homeless shelter and Turning Point Recovery Center.
- Vermont Psychiatric Survivors has also increased statewide outreach staffing to provide additional support (e.g. support groups) and crisis prevention for individuals who avoid professional services.
- Pathways Vermont is operating a *Statewide Support Line* eight hours per day and seven days a week that provides pre-crisis mental health support and outreach.
- Another Way in Montpelier has increased staffing to provide support and crisis prevention in Montpelier for individuals who typically avoid traditional mental health services.
- Northeast Kingdom Youth Services has added two Peer Outreach Staff that provide support (e.g. WRAP groups) and crisis prevention for young adults at risk of hospitalization.
- The Vermont Center for Independent Living has established a statewide *Wellness Workforce Coalition* for peer services and is providing core training (Wellness Recovery Action Planning,

Intentional Peer Support), mentoring, and competency development for all peer service providers in the state.

Along the lines of expanded services by persons with lived experience of mental illness, the DMH has worked to identify current methods of receiving direct patient input on treatment opportunities and location of services. Consumer satisfaction surveys have been reviewed to learn how such information is gathered and used in both community and hospital based settings. DMH reviews opportunities patients have to provide feedback regarding their treatment through the hospital designation process. DMH Quality Management staff reviews each facility's quality assurance and performance improvement initiatives in response to patient satisfaction survey results biannually during the re-designation process. Hospitals are required by DMH to identify a member of the inpatient treatment team who is responsible for collecting and addressing feedback from clients receiving care in the inpatient setting. The Brattleboro Retreat, Fletcher Allen Health Care, and Rutland Regional Medical Center hold regular patient feedback groups as part of their inpatient unit daily schedule.

Access to Patient Representatives

It is DMH's responsibility to ensure that individuals under the care and custody of the commissioner who are being housed at designated hospitals and residential recovery program (Hilltop, Second Spring, Meadowview) have access to a patient representative, and have asked them to work closely with Vermont Psychiatric Survivors in the coming months to establish a memorandum of understanding regarding the specific roles and expectations of the VPS patient representative, methods for communication (including a primary contact from the facility), and ways for patients to access the patient representative at the facility.

DMH has contracted with Vermont Psychiatric Survivors for two .5 FTE patient representatives, to act in this role. The responsibilities and expectations of the patient representatives include:

1. Works collaboratively with providers.
2. Supports the incorporation of recovery principles as described in SAMHSA's National Consensus Statement on mental health recovery into supports provided in the designated sites.
3. Demonstrates effective communication skills, including the ability to speak and write clearly enough to represent the patient's perspective accurately.
4. Maintains a professional level of commitment to protecting patient and staff privacy and confidentiality.
5. Meets with each patient after admission if requested by the patient and provides information about the patient's rights, the facility's grievance process, and the role of patient representative.
6. Provides patient with grievance forms if requested and may assist patient with completing form.
7. Maintains a confidential log for VPS of number of contacts and services performed as well as number of refusals. A separate log of contacts with names will be available to the designated contact person at each facility that is working with the patient representative.
8. Attends treatment planning and treatment team meetings, if requested by a patient, to provide support and encourage self-advocacy skills.

9. May be involved in group activities that support patient recovery.

Protection of Health Information:

Martha Csala, AHS Assistant Attorney General who specializes in HIPPA for AHS, presented on HIPPA to the CRMS workgroup. A sub workgroup was formed and met with Martha to discuss HIPPA and Health Information Exchange. It was agreed that the communication between different parts of the system including DMH Care Managers is legal under HIPPA regulations. It was agreed as well that the Health Information Exchange is still under construction but that in very limited circumstances, there may be a need to refine how some information is exchanged.

Summary and Next Steps

Extensive groundwork has now been laid for the functioning of a system of care based on decentralized psychiatric hospital and outpatient organizations. The input and collaborative participation by all of the identified stakeholders has been invaluable and we are beginning calendar year 2014 with a well-established E-Bed Board, Utilization Review process and clarity of admission/discharge criteria, additional resources for providing community based services to divert individuals from hospitalization, where appropriate, and for placement in the level of care that is warranted. DMH staff is working collaboratively with DA representatives to continue the process of streamlining communication protocols, developing core quality measures, enhancing efficiency of service delivery and maximizing resources across the state. An example of this is the development of the Universal Referral form for Crisis Bed Program admission. This form is now available for each hospital and other settings, to make a referral to a crisis bed for either step down or diversion purposes.

Next steps include continued work to formalize some of the systemic functions, continued development of criteria for crisis bed step-down and diversion, responding to the need to reduce ED wait times with a plan to reduce the mean time that individuals are waiting for placement, opening of the new Vermont State Psychiatric Hospital, and assessing the outcomes of the enhancements made to the outpatient and emergency services of the Designated Agencies.

The work group will be reconstituted going forward in 2014 in order to both monitor the progress of the work that has begun, and to enhance the functioning of the system as a whole, while identifying gaps and ongoing needs.

Appendix D: Pictures of Enhanced Funding

Figure 1: NCSS Bayview Crisis Program

Figure 2: LCMH Oasis House Crisis Program

Figure 3: RMHS Maplewood Recovery Residence (constructed in 2014)

Figure 4: Embedded Clinician in Law Enforcement