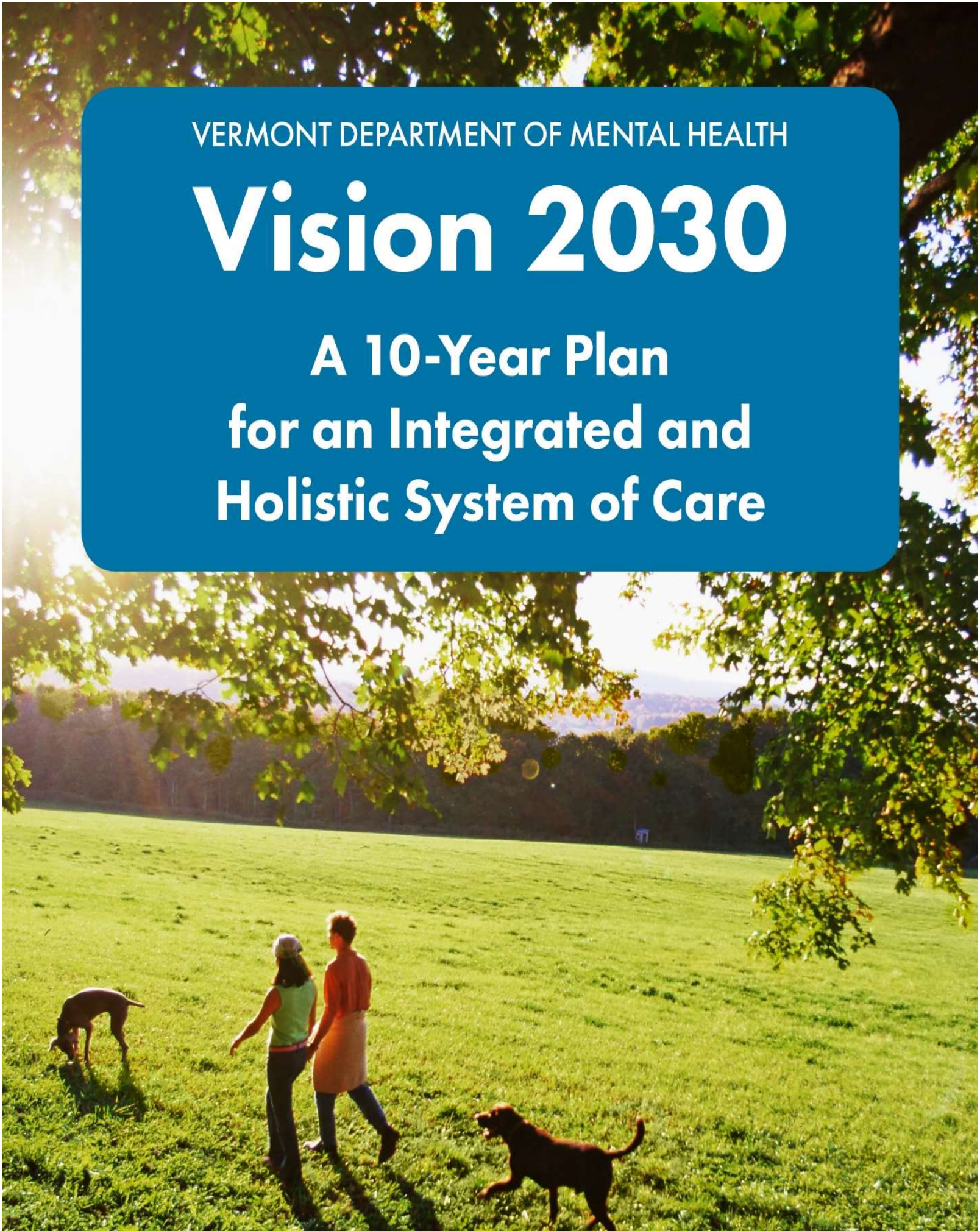


VERMONT DEPARTMENT OF MENTAL HEALTH

Vision 2030

A 10-Year Plan for an Integrated and Holistic System of Care

LEGISLATIVE CHARGE

In January of 2019, the Department of Mental Health submitted the legislative report, an "*Evaluation of the Overarching Structure for the Delivery of Mental Health Services"* as required by Act 82, Section 3(c) of the 2017 legislative session and as amended by Act 200, Section 9 of the 2018 legislative session. In that report, as noted below, the Department identified the need to engage in a robust stakeholder process to develop a 10-year vision and plan for delivery to the legislature by January 2020.

DMH responded to this Legislative Charge as noted below and this served as the basis for the development of a 10-year plan.

"*The Department of Mental Health is committed to working towards the articulation of a common, long-term vision and collective commitment towards full integration of mental health services within a comprehensive and holistic health care system, as identified as a key tenet in the overall charge of this report.*

DMH recommends further engagement with Vermont's Mental System stakeholders in a process to develop a 10-year vision to achieve a comprehensive, coordinated and integrated mental health system for Vermonters. This process should begin in the summer of 2019 and take place over a timeline the recognizes the urgency of the issue and deliver a report no later than January of 2020. This project will focus on maximizing the opportunity that Vermont has to build upon the existing mental health system in a more proactive, integrated, coordinated and holistic direction. Given the complexity of mental health challenges in Vermont we recognize that no single approach or group will solve this; we need a collective answer. We must come together to strategically align around a common 10-year vision, and to articulate the short term, mid-term and long strategies and actions necessary to advance Vermont's mental health system forward.

TABLE OF CONTENTS

LETTER FROM THE COMMISSIONER

In the past 10 years, Vermont has solidified its position as a national leader in healthcare reform. With our shift toward a value-based model, we streamlined funding and defined performance measures for providers that align our efforts and embrace data to demonstrate meaningful outcomes. We have strengthened resilience across the state with evidence-based initiatives like Building Flourishing Communities, Zero Suicide and the Success Beyond Six program. And today, in nearly 40% of Vermont schools every staff member is trained in trauma-informed practices. We have taken significant steps to decentralize our inpatient mental health system and expanded community-based partnerships and services to help us get the right care, at the right time to the right people.

Over the same time period, Vermont has also made tremendous progress toward building a world-class system of integrated care. People everywhere experience challenges to their mental health, but we are well above the national average in the percent of our population that uses the mental health services we offer. Through continued collaboration between our partners, we have created policies and practices that strengthen our capacity, build accountability and provide a foundation for an enduring, integrated system.

Despite our strength and determination, however, gaps remain in our system of care. We need payment parity for our care providers, who deserve a fair wage. We must improve access to care for rural Vermonters and included more peers in our treatment and recovery practices. We will continue to grow partnerships and innovative collaborations in local communities, and at the state and national level, to foster the integration of mental health within the broader health care system.

As we step into a new decade, we face significant challenges, but we arrive with immense strength and resourceful determination—something we witnessed this past summer during statewide listening sessions in Vermont communities. Hundreds of residents came out to share their vision for a system of care ten years from now. They told us they want timely, affordable care and that they need help navigating our supports and providers. We heard recommendations to partner with law-enforcement officers and educators in more impactful ways, so that our commitment to trauma-informed, person-led care extends deeper into their communities.

Vision 2030 is the result of a statewide engagement effort, conducted in accordance with Act 200, Section 9, which identified the need for engaging communities and stakeholders to inform successful strategies for “a 10-Year Plan for an Integrated and Holistic System of Care.” Vision 2030 identifies specific action areas to guide mental health stakeholders so they are aligned with the goals of our State Health Improvement Plan and our Governor’s strategy for health. Perhaps most importantly, Vision 2030 aligns with the vision of Vermonters and our care providers across the state.

If I have learned anything these past ten years, it is to never underestimate the power of collaboration when Vermonter’s align toward a goal. Ten years from now, we will be delivering our Vision 2030, an integrated and holistic system of care, in the same way that we all designed it—together.

Sarah Squirrell

Sarah Squirrell, Commissioner, Department of Mental Health

ACKNOWLEDGEMENTS

THINK TANK

MODERATORS

Jason Minor, Jeffords Institute
Kathy Hentcy, Director of Mental Health and Health Integration, *Department of Mental Health*

MEMBERS

Peter Albert. Pres. Vermont Collaborative Care

Joy Cohen, family member of person with lived experience

Kimberly Anne Cookson, RN, Clinical Nurse Manager, *Central Vermont Medical Center Inpatient Psychiatry*

Anne Donahue, person who identifies as a psychiatric survivor

Laurie Emerson, person who identifies as psychiatric survivor, consumer or peer

Lisa Flood, *Washington County Mental Health Services, Barre*

Mourning Fox, Deputy Commissioner, *Vermont Department of Mental Health*

Jenn Gordon, LICSW, ACO Clinical Consultant, OneCare

Keith Grier, Director, Community Support Program/Community Rehabilitation & Treatment, *Washington County Mental Health*

Mary S. Hooper, State Representative; *House Committee on Appropriations, Vice Chair; Joint Fiscal Committee; Joint Legislative Justice Oversight Committee*

Cheryl Huntley, Operations Director, Youth & Family Services, *Counseling Service of Addison County*

George Karabakakis, CEO, *Health Care & Rehabilitation Services*

Maureen Leahy, Administrative Director Psychiatry *UVMMC*

Ginny Lyons, Chair, State Senator; *Senate Committee on Health and Welfare, Chair; Senate Committee on Institutions; Health Reform Oversight Committee; Joint Legislative Child Protection Oversight Committee, Vice Chair; Joint Legislative Justice Oversight Committee; Legislative Committee on Administrative Rules*

Jill Maynard, RN, BSN, SANE, CEN, Director of Nursing, *Southwestern Vermont Medical Center*

Hilary Melton, Executive Director. *Pathways Vermont*, Burlington & family member of person with lived experience

Whitney Nichols, person who identifies as psychiatric survivor, consumer or peer

Laurel Omland, Director, Child & Adolescent Family Unit, *Vermont Department of Mental Health*

Simha E. Ravven, M.D., President-Elect *Vermont Medical Society*

Lucy Rogers, State Representative, *House Health Care Committee*

A.J. Ruben, Advocate for Disability Rights, *Disability Rights Vermont*

Catherine Simonson, Chief of Client Services, *Howard Center, Burlington*

Daniel Towle, person who identifies as psychiatric survivor, consumer or peer

Kari White, Director, Quality Initiatives & Compliance/Privacy Officer, *Northern Counties Health Care*

Matt Wolf, Peer & *Vermont Federation for Children's Mental Health*

DEPARTMENT OF MENTAL HEALTH

Sponsor

Sarah Squirrell, Commissioner, Department of Mental Health

Authors

Selina Hickman, Director of Policy
Kathy Hentcy, Director of Mental Health & Healthcare Integration
Tracey Mongeon, Senior Auditor and Program Consultant
Daisy Berbeco, Senior Policy Advisor

Contributors

Karen Barber, DMH General Counsel
Jessica Bernard, Assistant Director of Quality Management
Eva Dayon, Mental Health Quality Management Coordinator
David Goodman, Technology and Program Tech
Emily Hawes, Vermont Psychiatric Care Hospital CEO
Kathy Hentcy, Mental Health & Healthcare Integration Director
Selina Hickman, Director of Policy
Brian Isham, IT Manager
Alison Krompf, Director of Quality and Accountability
Michelle Lavallee, Secure Residential Program Director
Laura Lyford, Administrative Assistant
Patricia Singer, Adult Mental Health Operations Director
Tracey Mongeon, Senior Auditor and Program Consultant
Frank Reed, Director of Mental Health Services
David Rettew, CAFU Medical Director
Jennifer Rowell, Administrative Services Coordinator
Samantha Sweet, Director of Operations, Planning, and Development
Sarah Squirrell, Commissioner
Shannon Thompson, Financial Director
Cheryle Wilcox, Interagency Planning Director

THINK TANK ADVISORY COMMITTEE

Kristin Baker, Nurse Manager *UVMMC Emergency Department*

Dillon Burns, Mental Health Services Director *Vermont Care Partners*
Matthew Dove, MSN, NP-C, Nurse Practitioner *Brattleboro Memorial Hospital*

Kheya Ganguly, family member and Assistant Director, Youth & Family Services *United Counseling Services*

Emma Harrigan, Director of Policy Analysis and Development *Vermont Assn of Hospitals and Health Systems*

Tomasz Jankowski, DPT, MHA, MBA, President and Chief Executive Officer *Northeast Kingdom Human Services*

Daniel Lang, Director Clinical Resources & Initiatives *Brattleboro Retreat*

Danielle Lindley, Director Children, Youth & Family Services, *Northwestern Counseling Services*

Mariah McNamara, MD, MPH, Emergency Physician, *UVMMC*

Julie Poulin, MD, Psychiatrist *Gifford Hospital*

LISTENING TOUR PARTICIPANTS

This plan could not have been completed without the contributions of more than 300 Vermonters who attended Listening Tour sessions held around the State during the Summer of 2019. The Department of Mental Health extends its appreciation to the passion, vision and commitment of these individuals. Their words were the inspiration for all subsequent contributions to this effort.

ADDITIONAL REVIEWERS

Adult State Program Standing Committee

Bert Dyer
Malaika Puffer
Marla Simpson
Thelma Stoudt
Daniel P. Towle
Vicki Warfield

Children, Youth and Families State Program Standing Committee

Ron Bos-Lun
Tiffiny Moore
Laurie Mulhern
Ward Nial
Cinn Smith
Cindy Tabor

Act 264 Advisory Board

Heather Freeman
Kris Holsman-Francoeur
Alice Maynard
Tiffiny Moore
Doug Norford
Cinn Smith
Teresa Sunderland
Cindy Tabor
Matt Wolf

DISCLAIMER

This plan is the result of an in-depth public stakeholder engagement process by Department of Mental Health. Every effort was made to accurately represent the diverse perspectives of those who participated. If there are any errors or other concerns, please email Jennifer.rowell@vermont.gov with your feedback.

LISTENING TOUR CONTRIBUTORS

Department of Mental Health

Karen Barber, DMH General Counsel
Jessica Bernard, Assistant Director of Quality Management
Kaysha Coccia- MSW Intern
Eva Dayon, Mental Health Quality Management Coordinator
Laura Flint, Senior EBP Evaluator
Mourning Fox, DMH Deputy Commissioner
David Goodman, Technology and Program Tech
Emily Hawes, Vermont Psychiatric Care Hospital CEO
Kathy Hentcy, Mental Health & Healthcare Integration
Selina Hickman, Director of Policy
Skip Irish, UR Care Manager
Alison Krompf, Director of Quality and Accountability
Michelle Lavallee, Secure Residential Program Director
Laura Lyford, Administrative Assistant
Carolyn McBain, Employment Service Specialist
Tracey Mongeon, Sr. Auditor & Program Consultant
Allie Nerenberg, Adult Care Manager
Laurel Omland, Director of Children & Family Services
Kiah Palumbo, Children's Mental Health Care Manager
Frank Reed, Director of Mental Health Services
David Rettew, CAFU Medical Director
Anne Rich, Adult Care Manager
Erika Rojas, Children's Mental Health Care Manager
Jennifer Rowell, Administrative Services Coordinator
Patricia Singer, Adult Mental Health Operations Director
Brian Smith, Housing Program Administrator
Sarah Squirrell, DMH Commissioner
Samantha Sweet, Director of Operations, Planning, and Development
Shannon Thompson, Financial Director
Christina Thompson, Mental Health Quality Management Coordinator
Cheryle Wilcox, Interagency Planning Director

VISION 2030: A 10-YEAR PLAN FOR AN INTEGRATED AND HOLISTIC SYSTEM OF CARE

EXECUTIVE SUMMARY

Vision 2030 presents a path to a coordinated, holistic and integrated system of care for Vermont. Informed by direct input from hundreds of community members and stakeholders, it furthers the State Health Improvement Plan (SHIP) and Act 200, Sect. 9 (2019) by supporting systemic improvements in the mental health system of care. Vision 2030 weaves the health needs and goals of Vermonters into actionable strategies for taking policy into practice.

A national leader and pioneer in healthcare reform and community-based care, Vermont is unique in the ability to respond to social and environmental health risks by implementing timely policies and innovative practices. Vermont's active engagement with needs on the ground has shaped the national dialog on what is truly possible in community-based healthcare. Within the context of a national opioid crisis, Vermont has leveraged its strong social fabric to create scalable models and approaches that work for families far beyond our state borders.

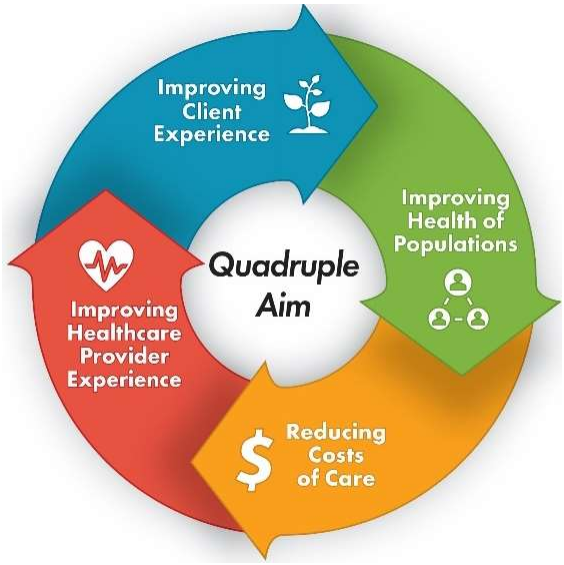


Figure 1: Quadruple Aim of Healthcare (Inst. of Medicine)

Vision 2030 aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience; 2) improving population health, wellness and equity; 3) lowering per capita costs; and 4) creating a better environment for Vermont's provider care teams. By fully embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, will be healthier and happier, and the state will realize significant economic benefits as a whole.[1]

[1] http://www.jabfm.org/content/30/1/25.full?sid=f635119b-7243-4bfe-bbd2-3241c11377f4; https://www.ncbi.nlm.nih.gov/pubmed/28379819; http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/integrating-primary-care-and-mental-health-key-im?page=full

Vision 2030 provides the state legislature, regulators, providers, peers and their families, advocates and the community at large, with a 10-year plan to achieve a holistic and integrated health care system.

This plan is the result of an extensive and comprehensive stakeholder engagement process conducted by the Department of Mental Health.

- More than 300 Vermonters participated in a statewide Listening Tour over the summer of 2019
- The DMH Think Tank met for five days to craft strategies
- The Think Tank Advisory Committee reviewed progress and provided feedback on drafts.

Holistic

PHILOSOPHY
characterized by comprehension of the parts of something as intimately interconnected and explicable only by reference to the whole.

HEALTH
characterized by the treatment of the whole person, taking into account mental and social factors, rather than just the symptoms of a condition.

The draft plan was posted online and shared with additional stakeholder groups for feedback prior to completion, including the Adult State Program Standing Committee; the Children, Youth and Families State Program Standing Committee; the Act 264 Advisory Board and all Listening Tour participants.

Figure 2: Centers for Disease Control- Social [Contributors] of Health

The 10-year plan is based on a population health approach to building a holistic and integrated system that includes all aspects of health. This is explicitly inclusive of social contributors[2] to health, which must be considered if we are to achieve healthy communities. As the Center for Disease Control's Social [Contributors] of Health diagram illustrates so well, healthy communities result from a robust system of wellness promotion, prevention, treatment of illness and, crucially, support for recovery.

INTEGRATION OF MENTAL HEALTH WITHIN A HOLISTIC HEALTH CARE SYSTEM

Since the de-institutionalization of mental health care began in in 1950s, states have redirected services primarily to community-based health care (CBHCs) providers. Key factors to Vermont's success in this have been our collective tenacity, innovation, and integrity when making change, and these tenets must continue to be embraced across sectors as we work to preserve our current system's strengths and leverage them to develop a more integrated, holistic system of care for the future.

With the more recent passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the landscape of healthcare shifted toward outcome-based models of service delivery and system design. Provisions in the ACA guided insurance, payment and service delivery redesign, with mental health and addiction parity in insurance plans, the option for states to expand Medicaid coverage, creation of health homes and other new service delivery models—that ultimately incentivized providers to improve access, quality of care, and reduce costs. These goals can best be realized with integrated care delivery - where all types of care providers are connected in delivering whole health care.

Vermont is already moving in this direction with the commitment and expansion of inpatient psychiatric beds within the accountable care organization, OneCare, which is our largest healthcare network. Importantly, many of the components of Vision 2030 align with the statutory evaluation components for accountable care organizations.[3] Continuing to evaluate the integration of mental health care within a holistic health care system as it relates to inpatient psychiatric treatment remains a strategic priority.

There are many models for delivering integrated care, but full integration as discussed in Vision 2030 includes primary care, mental health care, substance misuse treatment and alternative services providers working together with patients, families and community stakeholders. The goal of such teams must be to provide person-led care that strives toward the quadruple aim of

[2] Multiple stakeholders of the 10-year planning process recommended the use of the term "contributors" rather than "determinants." The Department agreed that the more common term of art "social *determinants* of health" implies a given or fated outcome and does not adequately recognize the agency of an individual to change or impact their future life outcomes. "Contributors" are the same factors as those listed as "determinants."
[3] 18 VSA 9382 (a)(9) and (17), and (b)(1)(G), (H), (I), (J), and (P)

healthcare (improving outcomes, reducing costs, improving quality and experience for care providers).

There are many examples of this work already underway in Vermont. Our CBHCs have embedded social workers in primary care and pediatric care offices, and many Vermont emergency departments are staffed with mental health and substance use specialists. Many of our care providers are sharing measurable outcome data and working on universal consent practices. And where providers remain physically separate, the use of shared-care plans and workflows has been shown to be effective in improving care and outcomes as well.[1]

These are just a few of the many integration efforts that our existing system has employed to move toward achieving the quadruple aim, while using system-learning approaches that continue to lend valuable insights to shape our innovation.

[1] https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc

A FRAMEWORK FOR ACTION

This plan identifies eight specific Action Areas to guide mental health stakeholders toward the Quadruple Aim, with short-, mid- and long-term strategies recommended for each action. These recommendations reflect the expertise and input gathered during statewide listening sessions and numerous planning activities with Think Tank members and advisory committees (including persons with lived experience, legislators, care providers, state agency representatives and community members). The processes of recruiting, selecting and incorporating the knowledge and creative thinking of several hundred Vermonters are described in Appendix B of this report.

Figure 3: Vision 2030 Goals and Action Areas – the eight Action Areas around the perimeter support the four goals of the Quadruple Aim, which are integral to an integrated and holistic system of care.

SUMMARY OF ACTION AREAS

The path to achieving Vision 2030 is organized into eight Action Areas culminating from the collective wisdom and vision of Vermonters gathered through the Listening Tour and Think Tank. Each theme under these Action Areas is defined and supported by short, mid and long-term strategies for implementation. Below is a summary description of each Action Area; detailed content, including strategies, are outlined further in the report.

Health and wellness promotion must lead any long-term planning for population health and requires partnerships across a broad range of stakeholders and safety-net providers. It must align practice improvement efforts with evidence-based health and wellness promotion that equally support children, youth, the middle-aged and elders while building connections between all ages. Approaches to promoting health and wellness must address social justice issues with anti-racism as a foundational principle. Effective health and wellness promotion overlaps with Action Area 2: Influencing Social Contributors to Health.

To effectively promote whole-person health and wellness, we must commit to several fundamental and sustained actions.

- Provide communities with information and resources that are culturally and linguistically appropriate
- Partner with peers[4], statewide programs and initiatives to improve and expand the resources and tools for whole-person prevention and health promotion
- Expand insurance coverage for employee wellness programs
- Support development of trauma-informed, diverse workplaces where people want to come—and stay—to make valuable contributions to our communities

[4] In the mental health field, "peer" is usually used to refer to someone who shares the experience of living with a psychiatric disorder and/or addiction. https://www.mhanational.org/what-peer

Social Contributors[5] to Health affect a wide range of health outcomes and quality-of-life—in addition to affecting the cost of delivering care. Influencing social contributors to health is foundational to all Action Areas and is intimately woven throughout the work of Action Area 1 - Promoting Health & Wellness. Vermont communities must have the resources necessary to ensure their residents can meet their most basic needs if we are to build and sustain healthy communities.

- Ensure that all Vermonters' most basic needs are met, including, but not limited to, food stability; housing; transportation; affordable, accessible childcare; employment; a community responsive to their needs; a medical home; access to mental health services
- Develop a social policy agenda that helps align all providers and community partners in a wellness model
- Build, empower and sustain a strong peer network throughout Vermont

Eliminating stigma and discrimination is fundamental to achieving Vision 2030 and improving the health of Vermonters. Stigma is a significant barrier in accessing quality care and prevents many people in need from seeking help; it also stops many from acknowledging they may be experiencing symptoms of mental illness[6] and can result in poor or harmful treatment if providers stigmatize those with mental illness. Many individuals who would benefit from mental health services and treatment choose not to seek them because of labeling, prejudice and judgement.[7] The following steps will be key to eliminating stigma and discrimination.

[5] Multiple stakeholders of the 10-year planning process recommended the use of the term "contributors" rather than "determinants". The Department agreed that "social determinants of health" implies a given or fated outcome and does not adequately recognize the agency of an individual to change or impact their future life outcomes.
[6] See glossary in Appendix D for definition
[7] Assessment of Patient Nondisclosures to Clinicians of Experiencing Imminent Threats, JAMA Netw Open. 2019;2(8):e199277 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747759

- Public messaging and education through evidence-based and best practice programs such as Mental Health First Aid, Emotional CPR[8] and other approaches[9] that build awareness and understanding of mental health and wellness

- Education and increased collaboration across all partners

- Integration of mental health awareness and understanding into the structure of our communities, health care practices and other services provider locations

Vermont has in place many of the necessary elements of a robust community-based care system. These elements, however, are inconsistently available throughout the state and are often supported by short-term or insufficient funding. SAMHSA's behavioral health barometer[10] scorecard shows that in 2017 only 58% of Vermont adults with a mental health condition were receiving the treatment they needed—and fortunately that number has been increasing. We must improve Vermonter's experience within our system and increase this number long before 2030.

Improving policies and practices that expand access to care requires a data-driven approach informed by multiple stakeholders and people with lived experience in our system of care. Some first steps we will take toward an integrated system with access for all who need it follow.

- Assess gaps in our care continuum and use a data-driven approach to practice improvement and resource allocation

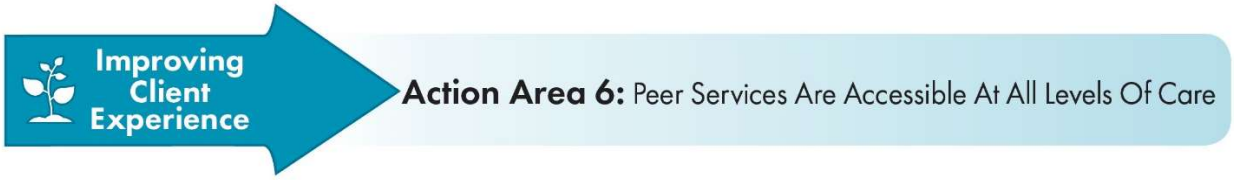
- Improve client navigation supports

- Increase outreach and education in communities

[8] https://www.emotional-cpr.org/
[9] https://www.ncbi.nlm.nih.gov/books/NBK384914/
[10] https://www.healthvermont.gov/scorecard-mental-health

Vermonters need additional supports in times of crisis. We must also provide needed and appropriate supports, interventions and planning that save both resources and lives. Action Area 5 presents longitudinal strategies across three primary focus areas: Access; Transitions; Outreach and Coordination. Key requirements to achieve these strategies are below.

- Clear, consistent information and support for people in crisis
- Implementing practices that improve an individual's experience while in a crisis
- Education and training for community providers in trauma-informed, person-led care
- Strengthening prevention, care coordination, and hospital diversion programs
- Development of alternative options to utilization of emergency departments



Strategies to expand peer support across systems of care have shown impressive potential and client experience outcomes in other states. Models include peers in prevention and at all levels of community and healthcare provider planning and delivery. The key steps needed are below.

- Peer-led work group to make recommendations about whether and how credentialing and Medicaid reimbursement should be considered or implemented
- Expansion of peer-supported models such as 2-bed peer respite programs[11] and making peer supports accessible in the emergency department and in inpatient settings
- Exploration of new models such as Peer Navigators[12] that provide guidance through our system of care

[11] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700451
[12] https://www.integration.samhsa.gov/workforce/Brekke_Research.pdf

A critically important area for improving client experience in our system is building a culture of care that treats those seeking care with respect and dignity, while supporting them to lead the development of their own treatment plan and recovery goals. Strategies in this section require holding the person's individual needs, values and interests as the guiding beacon of our system of care. To facilitate this paradigm shift we must take some critical first steps.

- Reshape practices to include advance directives so that individuals can take the lead in their care from a position of wellness, rather than at the point of a mental health crisis
- Redesign service delivery to provide same-day access and brief, solution-focused interventions for people asking for help for all health care issues
- Incorporate outcome measures and a clear system of feedback to support continual improvement of person-led service delivery

Workforce development is paramount to achieving Vision 2030. Without offering the resources, tools and employee benefits our dedicated community care providers deserve, we cannot meet the urgent health needs of our vulnerable populations. We must equip our direct care staff, care managers, supervisors and peers with the opportunities, resources and tools they need to foster the wellness, innovation and leadership that will continue to position Vermont as a leader in healthcare reform and wellness, as the additional steps, below, describe.

- Implementation of approaches from the 2017 report to the legislature, *Mental Health, Developmental Disabilities and Substance Use Disorder Workforce Report*[13]
- Further development and definition of professions, such as community health workers and peers

[13] https://legislature.vermont.gov/assets/Legislative-Reports/Act-82-Sec.9-Workforce-Report.pdf

- Training and professional development in diversity and inclusion; mental health and wellness; anti-racism; reducing coercion; motivational interviewing and others
- Payment parity across health insurers
- Expanding coverage for all services for all Vermonters regardless of their insurance

DATA-INFORMED SERVICE DELIVERY

Healthcare reform introduced the practice of data collection to support demonstration of measurable outcomes in service delivery. More than ever, service delivery data must be actionable, and ultimately prove that effective and quality care is being delivered to our most vulnerable populations across the full continuum of care (Figure 4). Systematic approaches to data collection and analysis can streamline practice improvement and inform effective policy making, reducing the time it takes to get the right care to the right people, when and where they need it.

Based on a model first presented in a 1994 Institute of Medicine report, [14] the Behavioral Health Continuum of Care Model illustrates areas of mental health and addiction care that are delivered by the providers referenced in this Plan, and includes the following components:

PROMOTION: These strategies are designed to create environments and conditions that support good health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of care.

PREVENTION: These interventions are intended to prevent or reduce the risk of developing a health problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.

TREATMENT: These services are for people who are seeking help with a health issue.

RECOVERY: These services support individuals on their recovery journey and to live productive lives in the community.

DEMOGRAPHICS

This section discusses some of the demographics that will shape mental health care needs in Vermont in the coming decade and provides the starting point for our Vision 2030. Along with the demographic trends discussed in this section, Act 200, Section 9 (2019) *Evaluation of the Overarching Structure for the Delivery of Mental Health Services,* describes in detail the current

[14] https://www.wibha.org/our_aims/continuum_of_care.php

state of our system of care and where it is not meeting Vermonter's needs. Importantly, this data is the driving force for so many providers giving their best every day to move us all toward a healthier Vermont.

Vermont has ranked as one of the five healthiest states in the nation every year since 2003,[15] and the national non-profit organization, Mental Health America, ranks Vermont third in the nation for overall mental health. While Vermonters may be experiencing less mental illness than our fellow Americans, the difference may only be significant when compared to those US states where outcomes are the very worst. Globally, for example, the US ranked 28th out of 188 countries in a 2016 analysis of 33 health-related indicators. Vision 2030 is a plan for addressing our local gaps in care access and delivery, while aiming for second-to-none population health outcomes.

MENTAL HEALTH ACROSS THE LIFESPAN

The picture of Vermont's mental health and wellness becomes more varied when the data are separated by age, as well; Vermont drops to 12th in the nation for adult mental health and 7th for youth mental health.

The 1998 Adverse Childhood Experiences (ACE)[16] study and subsequent decades of neuroscientific research have shown that the biological impact of traumatic experiences in childhood correlate to increased health and well-being risks. Today we know that one of every seven adults in Vermont carries a burden of early adversity that is strongly linked to poor health outcomes. In addition, approximately one of every 13 children in our state has experienced adverse family experiences (AFEs), such as living with domestic violence, substance abuse, community violence or experiencing discrimination, having a symptomatic mentally ill family member, financial hardship, losing a parent to death, having a parent incarcerated, or having divorced parents.

Many children represented in the AFE survey, in addition, are young and therefore at risk of experiencing more adversities before their 18th birthday. The data suggests that by the time these children become adults, it is likely that their burden of adversity will be similar or higher than the current generation of adults.

By 2030, more than 25% of the state population will be over 65 years old. As a result, providers can anticipate additional costs across an aging population as chronic disease and disability

[15] America's Health Rankings (AHR)

[16] Felitti VJ1, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998 May;14(4):245-58. https://www.ncbi.nlm.nih.gov/pubmed/9635069

increases, functioning is reduced, and there is a growing need for services ranging from health care to housing, transportation and social connection.

ADDICTION

There are other areas of health at risk, as well, regardless of age. Addiction is intimately tied to mental health and wellness, with approximately 80% of individuals with a serious and persistent mental illness also living with an addiction.[17] The nation is in the midst of a public health crisis—the opioid epidemic—and although Vermont has been a leader in innovating care coordination for those effected, there were 114 opioid-related fatalities reported in Vermont in 2017.[13] Overall, in 2018, 17 out of every 100,000 people in Vermont died a drug-related death.

Alcohol and tobacco also present significant health risks in the coming decade. Nearly 20% of Vermonters report that they drink excessively, and 16% smoke tobacco. More of us age 12 and over drink alcohol than the national average, and our reported binge drinking rate is higher than the national average.

SUICIDE

While Vermont's suicide rate was 26th in the nation in 2018, the growth in our rate was among the fastest in the nation.[18] For Vermont youth between the ages of 15 and 34, suicide is the second leading cause of death, and for the state as a whole, suicide is the eighth most common cause. Nationally, suicide is the 10th leading cause of death. In Vermont, the rate of death by suicide for men over the age of 65 is 45 per 100,000,[19] compared to a national rate of 32 per 100,000.

For populations that experience high levels of discrimination of all types, such as youth who are lesbian, gay, bisexual, transgender, or questioning, the risk of attempted suicide is four times that of their white, CIS gender peers. Asian American females between the ages of 15 and 24 in Vermont have the third highest suicide rate of all females in the same age group. Native American youth as a group have the highest suicide rate of all racial/ethnic groups and age groups at 25 per 100,000 people, which is more than twice the overall U.S. suicide rate.

Suicide rates in general are highest among the unmarried and for those living in the most rural areas, an important point for Vermont, which is ranked by the U.S. Census bureau as the

[17] https://www.drugabuse.gov/opioid-summaries-by-state/vermont-opioid-summary
[18] Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide 2015 MMWR Morb Mortal Wkly Rep 2018;67:617–— 27 States,
24. https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6722a1-H.pdf
[19] http://vtspc.org/wp-content/uploads/2018/10/Delaney-9_27_18-VT-recent-suicide-data.pdf

second-most rural state in the nation, behind Maine. Of those who die by suicide, more than half of all men use firearms, while the same is true of just over 30% of all women.

STRENGTHS OF THE SYSTEM: LISTENING TOUR SUMMARY

During the summer 2019 Listening Tour, the Department used an Appreciative Inquiry approach to ask more than 300 participating Vermonters to identify examples of what works well and to describe how that excellence can be replicated across a system or organization. Vermonters described a system that is ready to look at health differently and to expand on new ways of providing integrated services.

STATE CULTURE AND IDENTITY

Vermonters repeatedly described our state as "different" in that we are community-focused and strive to take a neighbor-to-neighbor approach. Many people also noted that the natural beauty of our state is beneficial to people's health and well-being. In addition, participants noted that the rural nature of the state makes it easier and more attractive to spend time outside exercising, which also supports health.

PEER SERVICES AND ADVOCACY ORGANIZATIONS

Listening Tour participants often noted the impressive outcomes from using peer services at organizations such as Pathways, Soteria, Another Way and Alyssum, as well as such services provided by people with lived experience who work in the Designated Agencies. The National Alliance on Mental Illness, Vermont Psychiatric Survivors, Vermont Federation of Families for Children's Mental Health, Vermont Family Network and others were also discussed as valuable resources with several community-based opportunities for people to join.

COMMUNITY-BASED SERVICES

In every region, participants described specific services and opportunities that their community offers, from Designated Agencies and primary care offices, to schools, churches, libraries and other community centers. Many of the strengths described include integrated approaches with multiple stakeholders in the community coming together to create a healthy and safe environment. For example, Street Outreach in Chittenden County was identified as an asset and for being preventative in their approach, as was Addison County's "OK, You Got This" resilience-building project for children. Additionally, Rutland's Project VISION was named as a community-based initiative that creates better alliances between law enforcement and the community.

SERVICE DELIVERY MODELS

Many components of the mental health service delivery system were applauded, including the use of Open Dialogue, a family and social network approach to first episode psychosis care, and the response for early episode psychosis in most regions. Pathways' Housing First model and their "Warm Line" were named by many as strengths in the system of care. Some regions have a "Clubhouse" model that could be expanded throughout the state, and there was strong interest in the DULCE model (Developmental Understanding, and Legal Collaboratives for Everyone) for new parents. School based mental health services were also named as an example of a collaborative process between mental health and the education system to help youth and families. Additionally, Parent Child Interactional Therapy, Pediatric collaborative relationships and Child Parent Psychotherapy where discussed as strengths within the children and family mental health system. Many stakeholders said that Designated Agency staff is overworked, but that are caring and compassionate toward people and their mental health.

COLLABORATION THROUGH DELIVERY SYSTEM AND PAYMENT REFORM

Listening Tour participants across the state said that collaboration is a strength for our system of care, and the Department of Mental Health was credited for creating a strong collaborative relationship with the Designated Agencies through recent mental health payment reform efforts. Other payment and healthcare models that have been having a positive effect in communities include the Blueprint for Health initiatives, Accountable Communities for Health through the Accountable Care Organization (OneCare), and care coordination efforts in the Federally Qualified Healthcare primary care practices that help bridge services and increase communication and collaboration for those seeking services.

ACT 264 (1988)

This Act requires the Agency of Human Services and the Agency of Education to work together for better outcomes for children and families. This was named in several listening sessions as a model for positive collaboration between community members acting in the best interest of the children and youth in their communities.

GUIDING PRINCIPLES

Each of the strengths identified by the Listening Tour participants are woven through the eight Action Areas of the plan to enhance and build upon as we create a system of care that is inclusive and holistic for all Vermonters. From this basis and with the additional work of the Think Tank and Advisory Committee members over a seven-month period, we developed a set of guiding principles. The principles are assumed to apply even when not explicitly stated as a part of each Action Area strategy.

- A population health approach is foundational
- All policies and practices support health equity and social justice
- We are working to eliminate stigma and discrimination
- Service delivery is person-led
- The health care system is integrated and takes a holistic approach to care
- A life-span approach that links generations is universal

IMPLEMENTATION STRATEGY

IN PURSUIT OF THE QUADRUPLE AIM

This plan identifies eight specific Action Areas to guide mental health stakeholders toward the Quadruple Aim, with short, mid and long-term strategies recommended for each action. These recommendations reflect the expertise and input gathered during statewide listening sessions and numerous planning activities with Think Tank members and advisory committees (including persons with lived experience, legislators, care providers, state agency representatives and community members). The processes of recruiting, selecting and incorporating the knowledge and creative thinking of several hundred Vermonters are described in Appendix B of this report.

Figure 3: Vision 2030 Goals and Action Areas – the 8 Action Areas around the perimeter support the four goals of the Quadruple Aim, which are

IMPLEMENTATION TIMELINE AND MILESTONES

INTEGRATED SERVICE DELIVERY

National trends and practices are moving towards the integration of mental health and physical health care to improve access, quality of care, parity and efficiency. Given the work on healthcare and payment reform Vermont has undertaken over the previous decade, we are poised for thoughtful discussion on our future approaches to the mental health system of care in Vermont. The underlying framework for Vision 2030 is for a high quality, accessible mental health system that is integrated within a holistic health care system, and that provides a continuum of care and supports, including promotion, prevention, treatment and recovery.

Successful implementation will require the buy-in and engagement of cross-discipline partners including healthcare and mental health. The Department of Mental Health recommends engaging the legislature in the creation of an appropriate structure such as a council or board with authority to oversee and guide strategies in this plan that require commitments to a common vision across multiple sectors to support the integration of mental health within a holistic healthcare system.

STRATEGIES

Each Action Area is a collection of strategies designed to make actionable vision of Vermonters for the future of an integrated healthcare system. They are grouped by themes and milestones.

Short-term strategies focus on research, analysis and identification of needs, resources and strengths of current systems. Specific initiatives are recommended in the short term that have a high potential for immediate success.

Mid-term strategies generally rely on analysis and investigation of short-term strategies, and/or require additional resources and stakeholders to be implemented.

Long-term strategies are generally more conceptual in nature, relying on short-term analysis and success of mid-term pilots in order to be fully implemented. Some-long term strategies are specific but include considerable complexity.

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
PRACTICE IMPROVEMENT	Practice Improvement efforts aligned with health and wellness promotion	Expanded health and wellness initiatives such as peer supports; screenings and same-day access	Universal screening and assessment, and statewide same-day access
COLLABORATION	Strengthened partnerships in youth leadership, school mental health and family health	PBIS, MTSS are expanded; public awareness campaigns designed jointly between DOC and DMH	All school implementation of PBIS, MTSS. Expanded public awareness campaigns. Public safety partnerships yielding results
WORKPLACE WELLNESS	Improve access to workplace wellness supports; advocate for parity in insurance coverage	Improved reimbursement of employee wellness programs; choice in health benefits	Culturally competent, trauma-informed employee wellness programs Health benefits meet employee needs Wide use of wellness coaches

UNDERSTANDING HEALTH AND WELLNESS

Vermonters' vision of a holistic and integrated system includes all aspects of health including health and wellness promotion.[20] Essential to this vision is the concept of healthy *communities*, without which individual health will be compromised.

Public health promotion not only provides people with information that can help them improve and protect their health, it also requires social and environmental interventions that address and prevent root causes of poor health, which include stigma and discrimination, lack of access to affordable, nutritious food, lack of affordable, stable housing, lack of social connections and lack of meaningful employment.

[20] The mental health intervention spectrum for mental disorders (from Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention by Patricia Beezley Mrazek, Institute of Medicine (U.S.). Committee on Prevention of Mental Disorders, United States. Congress)

Health and wellness promotion require work across all levels – from promoting whole-person health to preventing the initial onset of illness or incapacity. There also must be attention to providing support and thinking broadly in order to prevent family support members, peers or staff from suffering undue stress in their roles. Health and wellness promotion is a critical ingredient for the success of this 10-year plan and many of the strategies listed here will necessarily link to other strategies in this plan.

SHORT-TERM STRATEGIES

PRACTICE IMPROVEMENT

Practice improvement efforts are culturally appropriate and evidence-based and support the following goals.

- Building trauma-informed communities and safe spaces that are person-led
- Strengthening parental supports and families (e.g. expansion of parental leave, pre-k programming, financial assistance, connections and access to parental education)
- Best practices in prevention, treatment and recovery for co-occurring disorders
- Addressing health disparities and economic inequities across the life span
- Supporting community-based public health initiatives that improve population health with a focus on prevention

COLLABORATIONS

Strengthen or create new partnerships to improve the following.

- Youth leadership (Vermont Governor's Institute; Youth in Transition; Youth Thrive; Building Flourishing Communities and others)
- School-based mental health (i.e. partner with Agency of Education to support and expand mental health and wellness promotion in schools, including Positive Behavior Interventions & Supports21 and Multi-tiered System of Supports[22])
- Family health (i.e. strengthen partnership with the Maternal Child Health Division, Alcohol & Drug Abuse Prevention Division), public messaging campaigns, data and resource mapping to support the State Health Improvement Plan

[21] https://www.pbisrewards.com/blog/what-is-pbis/
[22] https://www.pbisrewards.com/blog/what-is-mtss/

WORKPLACE WELLNESS

- Partner with the Department of Health's Worksite Wellness program,[23] to explore creating a focus on direct care providers
- Coordination and action for parity in insurance coverage
- Support direct care providers to adopt and maintain policies that support and further the overall aims of Vision 2030

MID-TERM STRATEGIES

PRACTICE IMPROVEMENTS

- Make Peer Supports accessible in all aspects of care as described in Action Area 6
- Expand the practice of screening for social contributors to health; consider using health-related quality of life screens; see also Action Area 2
- Expand same-day-access models which can include short term solution-based interventions; this strategy would also directly support suicide prevention efforts

WORKPLACE WELLNESS

- Promote improved reimbursement of culturally competent, trauma-informed employee wellness programs that support diversity and inclusion
- Preserve choice in health benefits that meet employee needs (Employee Assistance Program, flexible work arrangements)
- Create and/or expand use of wellness coaches

COLLABORATIONS

- Through expanded partnership with the Agency of Education, support and expand Positive Behavior Interventions & Supports and Multi-tiered System of Supports (see short-term strategies above), and achieve full implementation in half of all schools
- Test and assess joint programs between Departments of Mental Health and Corrections designed to improve public safety and reduce recidivism for individuals with mental illness who are involved in the criminal justice system
- Implement and evaluate outcomes of public awareness campaigns designed to reduce substance misuse and mental health risks associated with them

[23] https://www.healthvermont.gov/wellness/worksite-wellness

LONG-TERM STRATEGIES

PRACTICE IMPROVEMENTS

- Universal use of the Child Health & Adolescent Needs & Strengths tool (CANS) for children and health-related quality of life screen for adults
- Fully implement same-day access for support which can include short term solution-based interventions (this directly supports suicide prevention efforts)
- Establish sustained support for tertiary prevention such as Supported Employment, peer living homes, independent living homes, Wellness Recovery Action Plans (WRAP[24]) and Assertive Community Treatment programs (ACT[25]) for adults
- For children, establish sustained support for integrated pediatric care, Youth Thrive and Strengthening Families outreach

WORKPLACE WELLNESS

- Ensure employee wellness programs are culturally competent, trauma-informed and that they support diversity and inclusion
- Provide health benefits that meet employee needs (EAP, flexible work arrangements)
- Support widespread use of wellness coaches

COLLABORATIONS

- Expand partnership with Agency of Education to achieve full implementation of Positive Behavior Interventions & Supports and Multi-tiered System of Supports (see short-term strategy, above), and expansion of the AWARE grant in all schools
- Refine and expand joint programs of Departments of Mental Health and Corrections to improve public safety and reduce recidivism
- Refine and expand public awareness campaigns to reduce substance misuse

[24] https://mentalhealthrecovery.com/wrap-is/
[25] https://store.samhsa.gov/system/files/evaluatingyourprogram-act.pdf

PROMISING PRACTICES IN PROMOTING HEALTH AND WELLNESS

Assertive Community Treatment programs (ACT)

Building Flourishing Communities

Employee Assistance Program

Multi-tiered System of Supports (MTSS)

Peer and Independent Living Homes

Positive Behavior Interventions & Supports (PBIS)

Supported Employment

Vermont Governor's Institute

Wellness Coaches

Trauma-informed employee wellness programs

Wellness Recovery Action Plans (WRAP)

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
BASIC NEEDS	Convene council to define priorities for health and wellness integration Public education campaigns on health equity and mental health	The Council builds a social policy agenda on community supports for basic needs Expanded support for housing, transportation and workforce through healthcare reform Expand partnerships to meet community food and housing needs	Enact social policies recommended by the council Provide Vermonters, access to high-fidelity supported-employment services, as well as training on rights to housing and transportation benefits
PROTECTIVE FACTORS	Implement supporting strategies at Action Area 1 such as insurance parity, housing partnerships and universal screening and assessments Adopt and identify systems for social-emotional learning across the lifespan	Disseminate draft policies and practices that prioritize social contributors to health Explore use of Multi-Tiered Systems of Support as universal system for education on social-emotional development Support care providers to apply health and wellness concepts	Continue to build and maintain partnerships with stakeholders to broaden impact of previous work in the area of promoting health, wellness and prevention in communities Identify and track savings realized as result of expanded primary prevention efforts and reinvest within the system

UNDERSTANDING SOCIAL CONTRIBUTORS TO HEALTH

Social contributors (see note, pg. 10 re: "determinants") to health are "conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[26] The Centers for Disease Control says that these conditions, which constitute "place," must be thought of in a larger context.

> "… patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing,

[26] www.healthypeople.gov

access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins."[27]

Employment is another fundamental contributor to health and a powerful catalyst for recovery and change. For individuals living with a mental illness, the importance of employment in recovery and on-going wellness is hard to overstate.[28]

The actions necessary to address social contributors to health are: 1) ensuring basic needs are met (i.e. safe housing and food [29]) and, 2) supporting protective factors (parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, adults understand how to support the social and emotional competence of children). While collaboration is always important, the broad nature of social contributors to health make teaming across community resource providers essential. Identifying current work and new initiatives focused on enhancing and supporting collaboration is key for this action area.

SHORT-TERM STRATEGIES

BASIC NEEDS

- Adopt or develop health equity and mental health public education campaigns

PROTECTIVE FACTORS

- Work with education to require social-emotional curricula for all years of schooling
- Provide social-emotional skill building for adults and the aging population
- Address insurance parity as mentioned in Action Area 1
- Identify effective housing partnerships; work to expand them statewide
- Explore universal adult screening with health-related quality of life assessments as described at Action Area 1

MID-TERM STRATEGIES

BASIC NEEDS

- Continue to use payment reform and health system funds to expand support for housing, transportation and workforce support models
- Expand effective partnerships to address community food and housing needs

[27] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[28] https://choosework.ssa.gov/blog/2016-05-27-mental-illness-on-meaningful-work-and-recovery
[29] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

PROTECTIVE FACTORS

- Draft organizational policies and practices that prioritize employment as a key goal or measure at organizations that serve Vermonters with mental health challenges
- Explore use of Multi-Tiered Systems of Support as universal system for education
- Use universal adult screening with health-related quality of life assessments to help care providers apply health and wellness concepts in their work with individuals and families

LONG-TERM STRATEGIES

BASIC NEEDS

- Enact social policies as recommended by a cross-sector council or board
- Provide Vermonters who may experience challenges or barriers to employment, housing and transportation, access to high-fidelity supported-employment services and training on rights to housing and transportation benefits

PROTECTIVE FACTORS

Continue to build and maintain partnerships to broaden impact of promoting health & wellness

- Explicitly support mental health and addiction awareness and recovery options
- Support mental health initiatives at institutes of higher education
- Support universal parenting education and parental supports for the first year
- Identify, track and reinvest savings (as described by James Heckman[30])

[30] https://heckmanequation.org/about-professor-heckman/

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
EDUCATION	Initiatives to educate and inform on the prevalence of mental health challenges and their effects	Increase support for community resilience-building Strengthen CQI processes Assess expansion of school-based mental health collaboration	Fully implement nursing curricula, consider opportunities for expansion across healthcare Ensure statewide standards and programming to eliminate stigma and discrimination Ensure feedback is continually solicited and applied
SOCIAL-EMOTIONAL DEVELOPMENT	Support programs for social-emotional development of children and youth in schools and communities	Develop updated law enforcement supports for youth mental health Strengthen mental health training curricula for health care providers	Fully integrate mental health education in all aspects of education, workforce, community partnerships, early education, family and parent education, and corrections Use meaningful quality measures to create uniformity in outcome expectations and improvement markers for success
WELLNESS	Plan for provider trainings based in wellness model	Evaluate wellness model trainings and begin implementing	Evaluate progress in moving to a wellness model across all services Adjust as necessary

UNDERSTANDING STIGMA AND DISCRIMINATION

Vermonters repeatedly advised that we must focus attention on eliminating stigma and discrimination related to mental illness. Stigma and discrimination stop many from seeking help or even from acknowledging they may be experiencing symptoms of mental illness; it can result in poor or harmful treatment if providers stigmatize or are discriminatory. To eliminate stigma and discrimination will require deep understanding of mental health, mental illness, and how stigma and discrimination play out in everyday interactions. In turn, while eliminating stigma

and discrimination is key, building a health system that treats everyone with dignity and respect is crucial. To achieve the depth of understanding this requires, we need new and/or strengthened relationships with and among all agencies that provide services, and all discussions must include people with lived experience.

SHORT TERM STRATEGIES

EDUCATION

Support and expand initiatives to educate the public about mental health and supports

- Identify effective community resilience-building initiatives
- Use continuous improvement approaches to ensure services are provided in environments based on dignity and respect
- Engage staff from designated agencies and the department of mental health to attend town meetings and community events to discuss mental health
- Expand trauma-informed practices within the healthcare system and law-enforcement
- Partner with hospital emergency departments to eliminate use of “sitters” for people who voluntarily enter the emergency department in crisis
- Explore opportunities for training and support in the geriatric nursing facilities
- Encourage professionals to discuss their own experiences; provide clinician support and training on how to self-disclose appropriately; examine regulatory requirements that may prohibit self-disclosure

SOCIAL-EMOTIONAL DEVELOPMENT

Increase support for evidence-based/best practice programs that teach about and/or support social and emotional development of children and youth in schools and communities

WELLNESS

Identify and plan trainings for providers based in wellness rather than on a disease model

MID-TERM STRATEGIES

EDUCATION

- Increase support for effective community resilience-building initiatives and continue to strengthen these initiatives with a continuous quality improvement method

- Evaluate opportunities to expand and strengthen school-based mental health collaboration between mental health and local education agencies
- Team with institutes of higher education to explore how they can support initiatives
- Work with medical staff to support and enhance anti-stigma and discrimination training for nursing staff, including psychiatric nurses working with geriatric populations

SOCIAL-EMOTIONAL DEVELOPMENT

- Develop updated teacher/school resource officer/police training and supports regarding youth mental health
- Strengthen mental health training curricula for health care providers where possible

WELLNESS

- Evaluate wellness model trainings and begin implementation

LONG-TERM STRATEGIES

EDUCATION

- Implement collaborative, enhanced anti-stigma and discrimination training for nursing staff; consider opportunities for expansion across healthcare
- Assess/measure/restructure statewide standards and programming to support eliminating stigma and discrimination
- Implement oversight and accountability to ensure patient/consumer/client experience is continually solicited and applied

SOCIAL-EMOTIONAL DEVELOPMENT

- Fully integrate mental health education in all aspects of education, workforce, community partnerships, early education, family and parent education, and corrections
- Identify and implement meaningful quality measures to create uniformity in outcome expectations and improvement markers for success

WELLNESS

- Evaluate progress in moving to a wellness model across all services, and adjust as necessary to ensure progress continues

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
PUBLIC EDUCATION	Create public education about the current array of community resources	Implement a public education and training campaign about the current array of community resources	Continuous improvement of public messaging about access to mental health services
CENTRALIZED RESOURCE	Develop a centralized resource and referral hub to help Vermonters navigate available supports	Implement the most effective service to provide information on resources for all Vermonters specific to their region	Ongoing implementation of resource hub with continuous updating of resources
LOCAL/REGIONAL SERVICES	Evaluate options for a system of local services vs. regional access Use a multi-partner, data-driven approach to expansion of community-based programming	Implement options for a system of local services vs. regional access Implement programs on a small scale with achievable measurable outcomes Ongoing Mental Health Service Providers broaden services to include prevention and intensive community support for higher levels of need	Continuous improvement of expansions to community-based programming Ensure savings are invested into community Formalize relationships to monitor progress achieving the 10-year vision
EVIDENCE-BASED PRACTICE	Identify gaps in available evidence-based services for underserved Vermonters	Address gaps in evidence-based mental health treatment through increased training and professional development opportunities	Increased and ongoing trainings in evidence-based treatments identified as key to increasing capacity

STRATEGIES FOR IMPROVING ACCESS IN THE COMMUNITY

Vermonters are concerned about access to mental health services and what happens when access is delayed. This Action Area highlights the need to improve access to community-based care through expansion and enhancement of existing programming and exploration of

promising approaches, especially in more rural areas.[31] Vermonters also stated the need for a balanced approach to expansion, recognizing that increased capacity in acute care without increasing capacity in the community, or vice versa, may result in bottlenecks that limit system flow.

Given the multiplicity of options and the recognized need for additional community-based care resources, this plan recommends a data-driven approach to making decisions about where to invest in programming. A diverse group of stakeholders should be included in the decision-making and planning process, including people with lived experience and people currently being served. Some strategies will require additional resources. For this reason, a complete analysis of resource requirements is a recommended next step.

SHORT-TERM STRATEGIES

PUBLIC EDUCATION

- Create a public education campaign about the current array of community resources[32] and how to access them
- Identify non-emergency department supports for after-hours and weekends
- Increase community knowledge about suicide prevention efforts including Zero Suicide, UMatter, Crisis Text Line and the Pathways Warm Line
- Explore additional funding resources to spread information about prevention efforts
- Provide first contact with someone who knows the resources[33]
- Implement with robust training, tools and resources

CENTRALIZED RESOURCE

- Develop a centralized resource and referral hub to help Vermonters navigate supports
    - Assess the effectiveness of 2-1-1 for people experiencing a mental health crisis; consider Help Me Grow Vermont as a model; research other effective models
    - Assess programs that provide real-time online data to locate available mental health professionals (e.g. Howard Center's Partners in Access program)
    - Explore enhancing availability of mental health workers who are knowledgeable about the system and linked to the Designated Agencies in primary care offices

[31] Strategies around inpatient and emergency department access are explored in more detail under Action Areas 5.
[32] See also Action Area 5 about enhancing Crisis Intervention and Discharge Planning Services
[33] See also Action Area 7 about the commitment to workforce development.

LOCAL/ REGIONAL SERVICES

- Evaluate systems of local services vs. regional, including assessments of location and travel times, population demand and adequacy of alternatives including telehealth
- Acknowledge differences in care statewide and in needs based on region
    - Inventory and assess current programs and services in every region
    - Perform internal resource analysis including staffing and cost-to-charge ratios and share outcomes across providers
    - Inventory "promising programs,"[34] for efficacy, promotion of holistic and integrated care, scalability and funding source
- Develop a multi-partner, data-driven approach to expansion of community services
    - include persons with lived experience, family members, state and local entities
- Analyze data re: lack of private practice outpatient psychiatrists (see Action Area 8)

EVIDENCE-BASED PRACTICE

- Identify gaps re: availability of evidence-based mental health treatment and service delivery for underserved Vermonters (e.g. aging population, early childhood, school-based interventions, ACT[35] and WRAP[36] services)
    - Broaden services to include prevention and intensive community support for higher levels of need in the community (e.g. residential care, supported housing, assertive community treatment, wrap-around services, MRSS).

MID TERM STRATEGIES

PUBLIC EDUCATION

- Implement a public education and training campaign on community resources
- Provide ongoing and consistent community education about how to reach services
- Enhance non-emergency department supports for after-hours and weekends
- Ensure widespread ongoing community knowledge about suicide prevention efforts including Zero Suicide, UMatter, Crisis Text Line, Pathways Warm Line
- Secure additional funding resources to spread information about prevention efforts

[34] See collaboration between the Green Mountain Care Board and the Health Resource Allocation Plan (HRAP) https://gmcboard.vermont.gov/sites/gmcb/files/FINAL%20HRAP%20update%20to%20Board_9.26.18_DRAFT.pdf
[35] https://www.nami.org/learn-more/treatment/psychosocial-treatments
[36] https://mentalhealthrecovery.com/wrap-is/

CENTRALIZED RESOURCE

- Implement the most effective region-specific resource information services

LOCAL/ REGIONAL SERVICES

- Implement options for a system of local services vs. regional access
    - assess service locations and potential travel times for those seeking services
    - assess adequacy of existing alternatives including telehealth
    - assess crisis and hospital diversion programs in the region
    - assess availability/feasibility of mobile services, enhanced service delivery
- Upon completion of the “promising program” inventory, partner with local communities to implement programs on a small scale with achievable measurable outcomes
- Implement multi-partner, data-driven approach to expansion of community-based programming.
- Mental Health Service Providers broaden services to include prevention and intensive community support for higher levels of need with the following steps
    - Continue to increase capacity to serve higher levels of need in the community, e.g. residential care, supported housing, assertive community treatment, wrap-around services, MRSS
    - Partner with private providers to problem-solve lack of private practice outpatient psychiatrists in the state
    - Continuously perform Provider Internal Resource Analyses including staffing, cost-to-charge ratios, and share outcomes across providers

EVIDENCE-BASED PRACTICES

Address gaps regarding availability of types of evidence-based mental health treatment through increased training and professional development opportunities

LONG TERM STRATEGIES

PUBLIC EDUCATION

- Apply continuous improvement strategies for ongoing public messaging about access to mental health services regionally and statewide

CENTRALIZED RESOURCE

- Ongoing implementation of resource hub with continuous updating of resources

LOCAL/REGIONAL SERVICES

- Continuous improvement on expansions to community-based programming
    - Identify new/remaining areas of need in the system and evaluate effects across the 10-year Plan with special attention to Vermont's changing demographic and health trends (e.g., aging population, substance use, suicide and children's mental health)
- Assuming increased availability of community-based services result in savings, ensure that savings are invested into sustained community-based programming
    - Apply ongoing Internal Resource Analyses including staffing, cost-to-charge ratios, and share outcomes across providers
    - Study and evaluate the impact of mid-term targeted investments and pilots to determine which to continue and which to end or adjust
- Formalize relationships between community partners and levels of care to monitor progress achieving the 10-year vision
- Implement and evaluate initial programs to increase numbers of private practice outpatient psychiatrists

EVIDENCE-BASED PRACTICES

Continue and expand trainings in evidence-based treatments identified as necessary/beneficial

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
ACCESS	Mobile response pilots in progress Areas for targeted practice improvement in emergency departments have been determined	New service-expansion settings being implemented	Hospital diversion programs and mobile crisis response is available throughout Vermont. Inpatient bed capacity meets needs of state
TRANSITIONS	Most programs are utilizing CQI methods. Teams are becoming trauma-informed Care coordination best practices are explored and decided	All mental health care teams are trauma-informed Care coordination is streamlined	Community safety net providers are trauma-informed. Crisis encounters are all person-led
Outreach and Coordination	Universal messaging system in development Hospital diversion program assessed	Universal messaging system is implemented in most regions Improved understanding of factors resulting in emergency room visits	Individuals have access to acute care in times of crisis, and timely discharge to appropriate levels of care in their community. They have community-based prevention and recovery supports at all times

STRATEGIES FOR ENHANCING CRISIS INTERVENTION AND DISCHARGE PLANNING SERVICES

A nationwide survey conducted in 2018 by the National Council for Behavioral Health[37] reported that, of those who have never sought treatment or helped a friend or family member find mental health services, 46% do not know how to find such services.

Vermont has 14 emergency departments across the state. In 2018, they saw more than 10,000 individuals with a mental illness—nearly half of whom were discharged into the community.[38] These numbers are concerning since our emergency departments are not currently designed to

[37] https://www.thenationalcouncil.org/policy-action/what-is-the-state-of-americas-mental-health/
[38] Vermont DMH. *Data Collection and Report; Patients Seeking Mental Health Care in Hospital Settings*. 1/31/19

provide mental health treatment or to coordinate community-based care to effectively support an individual's recovery.

The Vermonters who informed this Plan advocated for an integrated care system, with community investments in hospital diversion strategies. They also emphasized the importance of the role played by law enforcement officials in mental health crisis situations, reflecting current studies on police involvement in mental health crises. For example, a 2015 report by the national non-profit Treatment Advocacy Center found that 1 in 10 police responses involved an individual with a serious mental illness.[39] Our Think Thank also noted initiatives to fund additional inpatient beds for adults and highlighted this as an unmet need for youth and children, who also need access to appropriate levels of care in times of crisis.

Action Area 5 presents longitudinal strategies across three primary focus areas to improve crisis intervention, treatment and discharge planning: Access, Transitions, and Outreach & Coordination.

PROMISING PRACTICES IN ENHANCING CRISIS INTERVENTION AND DISCHARGE PLANNING

Development of alternative locations for care in a crisis

Facility-based Crisis Stabilization and Support Services

Crisis Stabilization and Hospital Diversion for Children and Youth

Intensive residential recovery (IRR) treatment facilities

2-Bed Peer-Run Crisis programs

Mobile Response and Stabilization Services (MRSS)

The Living Room Model

Crisis Intervention Teams (SAMHSA Evidence Based Practice)

Peer Recovery Coaches

Mental health Urgent Care Model

The Parachute Project (NYC)

SHORT TERM STRATEGIES

ACCESS

- Pilot mobile response with continuous assessment and outcome measures
- Implement approaches such as the Living Room Model as alternative care settings to emergency rooms
- Determine potential improvements to address emergency department wait times, delays in discharge from emergency and inpatient, and conduct gap analysis of existing resources
- Assess the current state inpatient bed capacity and make recommendations regarding any need for increased capacity for youth and children aligned with integration practices
- Explore and design a model that provides mental health care and support within our "Urgent Care" provider system

[39] https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

TRANSITIONS

- Implement Continuous Quality Improvement for transitions in care
- Identify areas for improvements in care for individuals experiencing a crisis such as:
    - Embracing a person-led approach[40]
    - Evaluating the relationship between person-led services and involuntary care
    - Creating/maintaining trauma-informed teams and care settings

OUTREACH AND COORDINATION

- Assess prevention, care-coordination, and hospital diversion efforts
- Develop universal messaging and support system for those in crisis and their families (see Action Area 4)
- Assess factors influencing emergency department visits
- With input of individuals with lived experience, identify best practice models for care coordination for timely discharge of clients to appropriate level of mental health care
- Engage community assess efficacy and viability of regional hospital diversion programs

MID TERM STRATEGIES

ACCESS

- Implement new service expansion such as the Living Room Model or MRSS for children, youth and families, and a children's mental health urgent care unit where appropriate
- Implement Mobile Response in all regions of Vermont
- Adjust inpatient bed capacity based on outcomes of regional crisis hospital diversion programs
- Create transportation solutions with state and local partners to improve care access and experience for persons in crisis
- Implement of regional hospital diversion/ crisis beds

[40] See also Action Area 6.

TRANSITIONS

- Conduct Continuous Quality Improvement for transitions in care
- Strengthen prevention, care coordination, and hospital diversion programs
- Improve care for individuals experiencing a crisis
    - Emergency departments and supervision supports are trauma-informed
- Care providers take a person-led approach[41]
- Implement practice improvements to address wait times, delays in discharge and results of gap analysis

OUTREACH AND COORDINATION

- Implement universal messaging and support system for Vermonters in crisis and their families

LONG TERM STRATEGIES

ACCESS

- Implement models like the Living Room Model in all hospitals regionally and statewide
- Provide appropriate inpatient bed capacity based on outcomes of regional crisis hospital diversion programs
- Employ mobile crisis response teams in all regions of Vermont

TRANSITIONS

- Continue to use Continuous Quality Improvement for transitions in care
- Continue to strengthen prevention, collaboration, and hospital diversion programs
- Provide quality care and transitions for individuals experiencing a crisis
    - Emergency departments and supervision supports are trauma-informed
    - Individuals are empowered to identify needs and goals of an emergency department visit
    - Emergency department wait times are minimized, with no delays to discharge
    - All crisis encounters are person-led and engage peers and community members in coordinated care process.

[41] See also Action Area 6.

OUTREACH AND COORDINATION

- Continued collaboration with stakeholders, partners and peers to maximize care coordination
- Maintain access to local community-based care providers
- Provide consistent and timely discharge of clients to the appropriate level of care
- Universal messaging and support system is in place for Vermonters in crisis and their families

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
STANDARDS AND GUIDANCE	Standards and guidance recommended for Vermont Peers in Workforce	Peer Group and DMH collaborating on reimbursement models and creating a certification program for peer support workers Evidence-based peer-led educational programming available in designated agencies and hospitals	A diverse group of peers are certified for employment in community-based care settings
INFORMING PROGRAMMING	Actionable areas defined for care providers to utilize peers as part of service delivery and planning	Community-based Peer-led pilot programs are determined	Community-based peer-led programs are offered throughout Vermont
STRATEGIC PLACEMENT	Peer workgroup meeting regularly with DMH to discuss collaborations and expansion Care providers engaged with exploring placement options for peers in service delivery and planning	Peer navigators and peer support workers are widely used in Vermont's system of care	Certified peers are embedded at all levels of care in a reimbursable cost model

STRATEGIES FOR MAKING PEERS ACCESSIBLE IN ALL LEVELS OF CARE

Peers are a critical component of effective systems that serve Vermonters and can make valuable contributions at all levels of health care in human/social services. However, stigma faced by people living with mental illness affects the ability of everyone to benefit from having more of those with lived experience working in our systems of care.

Listening Tour participants and Think Tank members repeatedly advised that Vermont should strengthen and expand its peer (youth, family and adult) support workforce, citing impressive potential and demonstrated outcomes of other states' models. Many participants called for credentialing of peers, yet others cautioned that such systems typically rely on having a clinician "sign off" or "approve" a "unit" of work. This, participants said, is contradictory to how peers work and are most effective – in looser, more organic interactions that are foundational to building relationships and ultimately improving the quality of care for populations we serve.

Overall, stakeholders advised more structural supports for peers such as supervision and self-care time, while building a system that relies on peers at all levels including youth mentoring programs for teens and young adults.

SHORT-TERM STRATEGIES

STANDARDS AND GUIDANCE

A peer-led work group will develop recommendations for

- Credentialing and aligning standards across adult, youth or family services;
- Opportunities for federal reimbursement of peer services, and
- Guidance and educational opportunities for community providers on inclusion of people with lived mental health experience in service delivery.

INFORMING PROGRAMMING

- Explore actionable areas for peers to inform planning of programs and their delivery
    - At peer-run wellness centers, crisis settings, designated agencies and hospitals
    - In budgeting processes, program design and implementation

STRATEGIC PLACEMENT

- Begin conversations with care providers to discuss including peer services in their treatment models

- Peer workgroup meets with DMH leadership on a quarterly basis to discuss opportunities for expansion and collaboration with mental health and healthcare partners

MID-TERM STRATEGIES

STANDARDS AND GUIDANCE

- Design implementation plan with the Peer Workgroup described above to
  - explore opportunities discussed in the Peer Workgroup for reimbursement and credentialing of peer support workers
  - enhance peer-based educational programming in the Designated Agencies and Hospitals based on evidence-based practices (e.g. Intentional Peer Support)
  - support continuous expansion of peer-based services.

INFORMING PROGRAMMING

- Explore implementation of peer-based pilots (see Action Area 2)
  - consider expansion of the current two-bed peer respite program (Alyssum[42]) to other regions in Vermont[43]

STRATEGIC PLACEMENT

- Follow-through on recommendations to expand peer workforce
  - Hire Peer Navigators[44] to provide support and guidance to people seeking treatment
  - Increase the number of peer support workers in inpatient settings
  - Test-fund structures/methods across different types of peer services

LONG-TERM STRATEGIES

STANDARDS AND PRACTICE

- Assess and improve upon implementation Plan with the Peer Workgroup described above to create a responsive peer inclusive workforce

[42] https://mentalhealth.vermont.gov/sites/mhnew/files/documents/events/102219/2019_Oct%2023_White_Paper_Appendix_FINAL.pdf
[43] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700451
[44] https://www.integration.samhsa.gov/workforce/Brekke_Research.pdf

- work with state agencies to implement opportunities discussed in the Peer Workgroup for reimbursement and credentialing for peer support workers
- expand opportunities to make peer-based educational programming available in the Designated Agencies Hospitals (e.g. Intentional Peer Support) based on peer-led trainings

- Continue quarterly meetings to support continuous expansion of peer-based services
- Identify an ongoing funding structure

INFORMING PROGRAMMING

- Assess the implementation of peer-based models through outcome data and improve upon implementation strategies (see Action Area 2)
  - expand the current two-bed peer respite program (Alyssum[45]) to other regions in Vermont[46]
  - solidify funding structure

STRATEGIC PLACEMENT

- Expand peer services inclusion and accessibility in the emergency department or primary care settings
  - Assess success of Peer Navigators[47] through outcome data and improve on areas that are identified
  - Increase use of peer support workers in inpatient settings
  - Test funding structures/methods across different types of peer services

[45] https://mentalhealth.vermont.gov/sites/mhnew/files/documents/events/102219/2019_Oct%2023_White_Paper_Appendix_FINAL.pdf
[46] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700451
[47] https://www.integration.samhsa.gov/workforce/Brekke_Research.pdf

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
SERVICES	Develop a more active and transparent response to requests for services Stakeholders conduct review of current policy, practice for person-led delivery	Appropriate avenues are in place for feedback on service delivery	Clear feedback-loop and outcome measures are implemented that support continual improvement of person-led services
WORKFORCE	Identify and support provider practices to increase the use of advance directives Curriculum is developed/ adopted to assist providers in using person-led treatment planning	Staff trained in person-led service delivery approaches	Advance directives are in place for all appropriate level of clients Person-led treatment planning is used across Vermont

STRATEGIES TO ENSURE SERVICE DELIVERY IS PERSON-LED

Person-led care empowers people to identify and achieve their health goals while diminishing barriers to healthy living. Person-led *systems* provide both expertise and resources to support an individual's goals. Strategies in this section present pathways to prioritizing an individual's needs, values, cultural identity, and interests— even when care is provided on an involuntary basis.

SHORT-TERM STRATEGIES

SERVICES

- Engage stakeholders to review current policy and practices and assist in development of new solutions that support person-led service delivery
- Explore best-practices in person-led service delivery, and policies that are trauma-informed and that support diversity and inclusion
- Develop a more active and transparent response to requests for services

- Identify and support provider practices to increase the use of advance directives so that individuals can direct their care from a position of wellness
- Enhance infrastructure to express needs and provide appropriate avenues for feedback on service delivery

WORKFORCE

- Identify/develop training curriculum for providers in person-led treatment planning, and supporting people in identifying their priorities in ways that are less hierarchical and more relational (introduce roles such as coach, educator, consultant, or brief interventionist)
- Identify and provide resources to clients that support care coordination and active engagement in therapy across providers
- Engage stakeholders to review current practices and inform development of solutions
- Consider expanding models that make mental health staff and persons with lived experience available and accessible in emergency departments
- Clarify and disseminate standards for Orders of Non-Hospitalization and Emergency Examinations
- Ensure alignment of the adult and children's state program standing committees administrative rules and practices with the goals of Vision 2030

MID TERM STRATEGIES

SERVICES

- Assess policies for degree to which they support person-led service delivery, trauma-informed practice, diversity and inclusion
- Continue to educate the public about advance directives and encourage implementation across providers
- Assess the effectiveness of transparency and responsiveness of requests for service
- Through agency review and designation, ensure proper procedures are followed for grievances and appeals processes outlined in Designated Agency manuals
- Work with the state program standing committees to ensure alignment with the goals of Vision 2030

WORKFORCE

- Invite people with lived experience to participate in development and implementation of practice improvement initiatives
- Solicit ongoing feedback on quality improvement measures from stakeholders
- Continue to explore or expand models that make mental health staff and persons with lived experience available and accessible in the emergency department
- Explore legalities and viability of standards for Orders of Non-Hospitalization and Emergency Examinations
- Ensure stakeholders feel safe voicing concerns and Designated Agencies respond in a timely manner

LONG TERM STRATEGIES

SERVICES

- Ensure policies support person-led service delivery
- Continue to educate the public about advance directives
- Assess the effectiveness of transparency and responsiveness of requests for service
- Continue to ensure proper procedures are followed for grievances and appeals processes outlined in Designated Agency manuals
- Continue to work with the adult and children's state program standing committees to ensure alignment with the goals of Vision 2030

WORKFORCE

- Invite people with lived experience to participate in development and implementation of practice improvement initiatives
- Solicit ongoing feedback on quality improvement measures from stakeholders
- Continue to explore or expand models that make mental health staff and persons with lived experience available and accessible in the emergency department
- Ensure stakeholders feel safe voicing concerns and community mental health and other health care providers respond in a timely manner

IMPLEMENTATION THEMES AND MILESTONES

Themes	Short-Term	Mid-Term	Long-Term
CAPACITY	Initiate workforce recruitment strategies from the 2017 report to the legislature Ensure parity in reimbursement rates for mental health professionals	Fully implement workforce capacity strategies from the 2017 legislative report targeted to the community-based system of care. Finalize work to reach parity in reimbursement rates for mental health professionals	Payment parity is fully implemented Multi-payer coverage of community-based services, expanded emergency/crisis supports and integrated care approaches
QUALITY	Improve working conditions/supports across services agencies Design methods to evaluate progress on strategies	Ensure that mental health clinicians who follow evidence-based practices have necessary legal protections Create practice algorithms/ protocols/clinical pathways to improve practice Begin evaluating progress	Evaluate effectiveness of changes to protections for practitioners Evaluate effectiveness of new protocols/clinical care pathways/algorithms in improving care Evaluate effectiveness of trainings to reduce coercion
TRAINING	Ensure available training to support provider wellness Offer training on mental health and wellness Providing training on HIPPA, 42 CFR part 2 and FERPA	Expand training access for private mental health practitioners Train in practices proven to reduce coercion. Train care coordination teams in coaching and motivational interviewing	Make expansions in training and education opportunities Update trainings to reduce coercion
DIVERSITY & INCLUSION	Assess hiring tools for diverse workplace settings Identify effective anti-racism trainings Expand use of peer supports	Implement regular anti-racism trainings provide foundational training for all new staff ensure that long-term staff receive progressive training	Determine effectiveness of trainings Update trainings as necessary Explore additional methods to improve on diversity, equity and inclusion in the workforce

STRATEGIES FOR COMMITTING TO WORKFORCE DEVELOPMENT AND PAYMENT PARITY

Workforce development and payment parity underpin a strong system that delivers high quality services and supports. Workforce development includes opportunities to support emerging professions and roles in the system of care, such as peers, as discussed at Action Area 6.

Payment parity refers to equal rates of payment for the same services when provided by mental health professionals as compared to physical health professionals with the same levels of education and training. It also includes equal rates of payment for the same professionals and services provided in inpatient vs. community-based settings.

SHORT-TERM STRATEGIES

CAPACITY

- Increase the workforce by initiating strategies from *Mental Health, Developmental Disabilities and Substance Use Disorder Workforce Report* [48]
    - licensing reforms
    - loan repayment
    - tax abatement
    - long-term employment agreements

- Ensure parity in reimbursement rates for mental health professionals
    - use the Milliman analysis[49] to identify opportunities to improve commercial rates

QUALITY

- Improve working conditions/supports across services agencies, including but not limited to
    - ensuring mental health professionals earn a living wage in the community
        - ✓ examine payment models and rate assessments to identify adequate rates to support the workforce necessary to provide needed services
    - allowing staff to work remotely as appropriate
    - cautiously expanding the use of telehealth and telemedicine, as appropriate
    - improve access to quality clinical supervision

- Design methods to evaluate progress on strategies in this section

---

[48] https://legislature.vermont.gov/assets/Legislative-Reports/Act-82-Sec.9-Workforce-Report.pdf

[49] Melek, S.P., Perlman, D., & Davenport, S. (2017). *Milliman research report: Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates: A qualitative approach to investigating nonqualitative treatment limitations: 42 million lives, three years, state-by-state analysis.* Retrieved from: http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

TRAINING

- Ensure there is training for all mental health services providers, including administrators, in trauma-informed care and building resilience to support wellness
- Offer training for non-mental health professionals on mental health and wellness
    - enhance current emergency department staff training about mental health and how to provide trauma-informed care as described in Action Area 5
    - explore incentives to provide trauma-informed care
    - partner with ED staff to implement effective approaches for supporting someone in a mental health crisis
    - expand effective partnerships between peer workers, staff with a mental health background, and emergency departments
- Adjust curricula to explicitly support mental health and wellness
    - partner with educational institutions, commercial insurers and businesses on small-scale innovative pilots that expand workforce knowledge and competencies in mental health for potential scale-up
    - create a community health nursing practicum to support instructors of nursing programs to focus on education, community wellness and prevention
    - provide training on HIPPA, 42 CFR part 2 and FERPA for purposes of information sharing with consents

DIVERSITY AND INCLUSION

- Assess hiring tools that support creation of diverse workplace settings inclusive of minority populations and representative of the community being served
- Identify effective anti-racism trainings
- Expand use of peer supports as described at Action Area 6

MID-TERM STRATEGIES

CAPACITY

- Fully implement strategies from the 2017 *Mental Health, Developmental Disabilities and Substance Use Disorder Workforce Report* that are targeted to retention and recruitment of professionals into the community-based system of care. Follow-up on initiatives listed above, including
    - licensing reforms

- loan repayment
- tax abatement
- long-term employment agreements

- Finalize work to reach parity in reimbursement rates for mental health professionals
- Explore avenues for commercial insurers to support workforce development initiatives
- Develop strategies to retain and recruit professionals into community-based system of care

QUALITY

- Ensure that mental health clinicians who follow evidence-based practices have necessary legal protections

    - identify gaps in legal protection and pursuing changes through rule changes or legislation as necessary
    - identify needed culture change to fully implement evidence-based practices (e.g. faster discharge of inpatients when appropriate)

- Create practice algorithms/protocols/clinical pathways to improve practice including but not limited to

    - faster discharge of patients when appropriate
    - eliminating the use of “sitters” for voluntary patients in the emergency department
    - peers are accessible at all levels of care

- Begin evaluating progress on the items in this section

TRAINING

- Partner with payers of mental health services and organizations such as AHEC to explore how to engage more private mental health practitioners in training and education opportunities

- Train workforce in practices proven to reduce coercion

- Train care coordination teams in coaching and motivational interviewing to improve their interaction with those seeking services to

    - strengthen person-led approach
    - ensure that all care providers, peer support person and family members as appropriate are included in care discussions

DIVERSITY AND INCLUSION

- Implement regular anti-racism trainings identified under short-term strategies
    - provide foundational training for all new staff
    - ensure that long-term staff receive progressive training at bi-annual intervals

LONG-TERM STRATEGIES

CAPACITY

- True payment parity is fully implemented
- Payers reimburse community-based services and integrated care approaches
- Establish multi-payer coverage of traditional Medicaid supports such as home-based services for children and families and expanded emergency/crisis supports

QUALITY

- Evaluate effectiveness of changes to protections for practitioners
- Evaluate effectiveness of new protocols/clinical care pathways/algorithms in improving care
- Evaluate effectiveness of trainings to reduce coercion

TRAINING

- Working with identified partners, expand training and education opportunities for private practitioners
- Update trainings to reduce coercion as needed and continue

DIVERSITY, EQUITY, AND INCLUSION

- Partner with evaluators to determine effectiveness of trainings
    - Update trainings as necessary and continue
- Explore additional methods to improve on diversity, equity and inclusion in the workforce

ADDITIONAL AREAS FOR CONSIDERATION

- Forensic system of care
- Geriatric psychiatry
- Suicide prevention

IMPLEMENTATION RESOURCES

One final consideration for Vision 2030 is how to provide resources for the recommended expansion, education and collaboration noted across various Action Areas. Members of the Think Tank grappled with funding considerations and provided the following examples as methods for consideration by the state legislature, payers of health care, and any potential board or council that may seek to advise and oversee this work in the future.

1. Funding for a holistic and integrated system of care must be considered within the framework of existing State-Federal Agreements such as the All-Payer Accountable Care Organization Model Agreement and the Global Commitment to Health waiver. Points that were considered as necessary or needing further exploration are below.
    a. Flexible funding models for health promotion and wellness which are supported by health insurance payment reforms
    b. Shared accountability payment models to help shift funds from high cost, upstream services to lower cost, downstream services
    c. Implementation of multi-year budgeting as a potential tool to invest in strategies that are expected to achieve impacts over a greater length of time
    d. Identifying and pursuing those goals we can achieve easily, such as introduction and expansion of billable codes for services like care coordination
    e. Engaging payers and providers in strategies to thoughtfully shift resources over time
    f. Allocation of more funding to prevention
2. Addressing Social Contributors to Health is supported by payment reform approaches, but statewide adoption of a holistic and integrated system of care should include population health approaches and a social policy agenda about basic needs that is broader than what is defined as “health care.”
3. Some resources could be shifted through changes in coverage that more closely align other payers with Medicaid coverage for mental health services including expansion of care coordination and home-based services.
4. Defining qualifications, credentials and scope of practice for the peer workforce can pave the way for expanded reimbursement by all payers as well as adding workforce capacity to the system.

IMPLEMENTATION NEXT STEPS

UPON SUBMISSION, THE DEPARTMENT WILL BEGIN IMPLEMENTATION BY PURSUING THE FOLLOWING STEPS

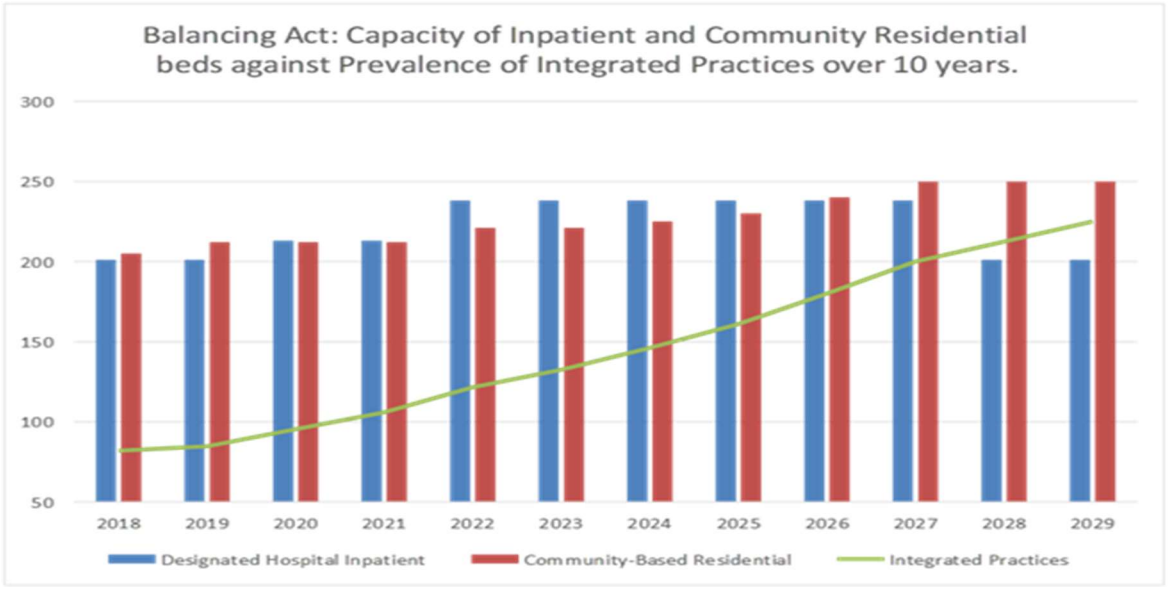
- Engage the legislature in the creation of an appropriate structure such as a council or board with authority to oversee and guide strategies in this plan that require commitments to a common vision across multiple sectors to support the integration of mental health within a holistic healthcare system.
- Initiate forums and partnerships for areas of the plan requiring mutual accountability and that are beyond the traditional scope of the Department
- Conduct an inventory and analysis of short-term actions and the resource assets that can be further built upon or require expansion
- Initiate short-term actions in the plan that can be supported within existing resources and authority of the Department
- Finalize the Department of Mental Health's 2020-2023 State System of Care Plan using information and strategies from Vision 2030
- Include in the Department of Mental Health's annual Act 79 report an update to the legislature on the progress of Vision 2030
- Create an evaluation framework for monitoring and measuring success of this plan

CONCLUSION

Vision 2030 is a catalyst and a compass for change that will evolve as we expand our partnerships, improve our understandings, and refine our approach to the tasks at hand. It continues work begun years ago when Vermont embarked upon building a community-based system of care.

The Act 200 Sect. 9 report[1] (2019) depicted one aspect of the change that is needed with a graph illustrating tensions in the change process (see below). An essential element of this vision is to shift the balance between mental health services provided in the hospital to services delivered in the community. In addition, services delivered in the community must be provided in a coordinated and integrated continuum of care. The graph, below, shows that while inpatient capacity must grow initially, additional capacity in community residential levels of care and expansion of integrated care approaches may alleviate the need for inpatient level of care over time. Prevention and health promotion activities should also help decrease the number of Vermonters who find themselves in need of such levels of care. Inpatient levels of care are illustrated to be stable for several years while the growth and impacts of improved community capacity, integrated care approaches and prevention activities are evaluated for impact.

[1] https://legislature.vermont.gov/assets/Legislative-Reports/Act-200-Section-9-Report_FINAL_-1-v2.14.19.pdf



To succeed at this complex work, however, will take more than changing practice. We need the commitment from a broad range of partners to change culture as well. To have an integrated, health-promoting culture, we need an integrated, strengths-based approach to one another. We must address mental health challenges with the acceptance we bring to physical health challenges. And while issues of prevention are complex across the entire disease-spectrum, it will be necessary to have a general public awareness that most mental illness can be prevented, given healthy beginnings and appropriate and timely support when needed.

To have a healthy Vermont, where Vermonters flourish and addiction, suicide and chronic disease are rare, all Vermonters must be treated with dignity and respect, at every age and in every condition. To achieve this, Vision 2030 focuses on eliminating stigma and discrimination. And while we start with the more obvious examples of stigma and discrimination, we must also address the stigma and discrimination that is often hidden deep within the structures that support the services that bear on health and well-being – from public health to health care offices of all kinds, and from hospitalization to palliative care.

APPENDIX A- LISTENING TOUR VISION STATEMENTS & THINK TANK TIMELINE TABLES

Listening Tour participants described what the system should look like 10 years from now. All of the notes from the Listening Tour can be found on the DMH website. We have tried, also, to provide a summation of the end states described by Listening Tour participants below.

Please note that these end states and the Action Areas detailed in the plan are not the same. The Action Areas were developed from the totality of the work done by Listening Tour participants, Think Tank members and Advisory Committee members as well as feedback from other members of the public or advocacy groups. We have organized the end states, below, according to the categories that were outlined in the Act 200, Section 9 (2019) report (there were six: Access & Flow, Coercion, Funding & Parity, Integration & Structure, Person-Centered & Equity, Quality).

End State 1- Access and Flow- Every person has access to the appropriate level of care at the earliest identified opportunity, whether the need is identified by the team or individual.

Discussion: Access to care must not vary based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, or residential location. "Access" is commonly defined as "the timely use of personal health services to achieve the best health outcomes,"[50] and includes a variety of elements:

- The ability to gain entry to prevention and wellness promotion services, as well as the health care system (usually through health insurance coverage)
- The ability to access a location where needed health care services are provided (geographic availability)
- Finding a health care provider whom the individual trusts and can communicate with (i.e. personal relationship)

End State 2- Coercion- Involuntary treatment is significantly reduced.

Discussion: The current array of community-based systems of supports, greatly expanded under Act 79 (2012), introduced or further developed support options that addressed more person-centered support options.

[50] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to Health Care in America. Millman M, editor. Washington, DC: National Academies Press; 1993.

End State 3- Funding and Payment Parity- Align payers to ensure all funding contributions occur in an equitable manner.

Discussion: Act 200, Section 9 (2018) required the Agency of Human Services to make recommendations regarding funding and payment parity.

- (pg. 5, Req. 8) recommendations for encouraging regulators and policymakers to account for mental health care spending growth as part of overall cost growth within the health care system rather than singled out and capped by the State's budget; and
- (pg. 5, Req. 9) recommendations for ensuring parity between providers with similar job descriptions regardless of whether they are public employees or are employed by a State-financed agency

End State 4- Integration and Structure- We have a system in which every person has a multi-disciplinary care team including peers and natural supports that is aligned with their health and wellness needs, including their own goals and priorities.

Discussion: Integrated care and services can be seen in any situation in which the foundational role of mental health in overall health is fully recognized and all health care and services reflect that recognition.

- Integrated care addresses the needs of the whole person, rather than being limited to treatment for specific illnesses; the need of the person seeking support is considered in the context of that person's comprehensive needs; the foundational focus is on wellness and prevention
- Integrated care results when a team of primary care and mental health clinicians work together with patients and/or families using a systematic approach to provide patient-centered care

End-State 5- Person-led Services- The person's individual needs, values and interests are held at the forefront and lead the delivery of health care (even if they cannot direct care at the time).

Person-led care helps people identify and achieve their health goals and diminish barriers to healthy living.

Person-led systems provide knowledge and resources to support the person's decisions to attain their goals.

End State 6- Quality- Create a coordinated, data driven, multi-organizational statewide surge capacity plan

Discussion: Quality is a measure of the ability of programs and services to achieve desired outcomes.

- Measuring quality is integral to the delivery of services for all participants in the mental health system.
- For an individual engaging in services, quality ensures that they receive evidence-based interventions that appropriately address their needs and result in an improvement in their quality of life.
- Service providers within mental health systems often think of quality to ensure effectiveness and efficiency of the services they provide and typically rely on utilization reviews, perception of care surveys, and data to assess quality.
- For policy makers, quality assists in analyzing and improving the mental health of the population, while ensuring compliance with state and federal laws and regulations.

APPENDIX B- ENGAGEMENT PROCESS

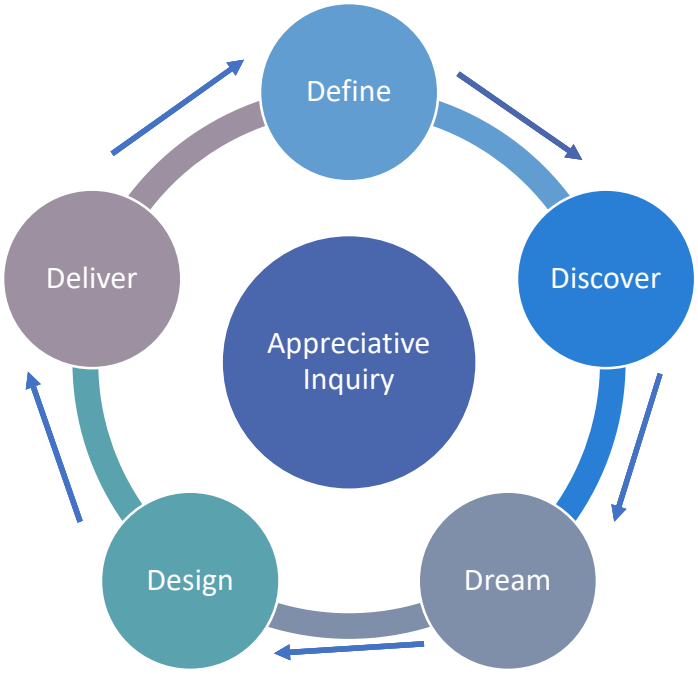
STATE OF VERMONT LISTENING TOUR

In follow-up to the 2019 legislative session and the Department's submission of the *Evaluation of the Overarching Structure for the Delivery of Mental Health Services* report in January of 2019, the Department of Mental Health (DMH) implemented a statewide listening tour in order to ensure that the voices of Vermonters were driving the creation of a common, long-term vision for full integration of mental health services within a comprehensive and holistic health care system.

The Department began its stakeholder engagement process in June, traveling to Rutland, Burlington, St. Johnsbury, Randolph and Brattleboro for a total of 10 listening sessions. More than 300 people attended those sessions, in which Department staff facilitated small group discussions in order to receive detailed input on what is needed to build a holistic, integrated health system for Vermont.

To accomplish this, the Department used the Appreciative Inquiry model. Appreciative Inquiry asks participants to identify examples of what is best and to describe how that excellence can be replicated across a system or organization. For the listening tour, participants were asked to identify strengths in the mental health system of care, and then to identify the common factors across those examples. Finally, participants were asked to describe the key elements of a future system that achieves full integration of mental health services within a comprehensive and holistic health care system. For this portion, participants were provided with prompts to think about specific elements of that ideal future, including access, quality, person-centered care, wellness & prevention, integration, treatment, recovery, parity and stigma, structure, funding, coercion and data sharing, and were encouraged to include any other topics they wanted to consider. The Department made some tweaks to materials and question prompts over the course of the tour based on feedback received from participants.

The Appreciative Inquiry Model



Details on the listening sessions can be found here[51] and all of the notes from those listening sessions can be found here[52].

MENTAL HEALTH THINK TANK

After the Listening Tour was complete, the Department organized notes from the sessions by theme and began planning for a "Think Tank" of experts to complete the final phases of "design and delivery" in the Appreciative Inquiry process. Think Tank members represented a cross-section of the current system, including people with lived experience, peer support specialists, providers at various levels of care, legislators and others interested in the mental health system of care.

In order to ensure the Think Tank would be representative of the broad range of stakeholders and yet be small enough to work efficiently, we selected members via an application process. The application was emailed to all contact lists the department has for designated agencies, hospitals, advocacy groups, standing committees and more. It was also posted on the DMH website, which was announced at each listening session. A full list of members can be found in the Acknowledgements section of this plan.

[51] https://mentalhealth.vermont.gov/about-us/department-initiatives/10-year-planning-process-mental-health-think-tank
[52] https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/TT_LS/Combined_Notes_by_Region.pdf

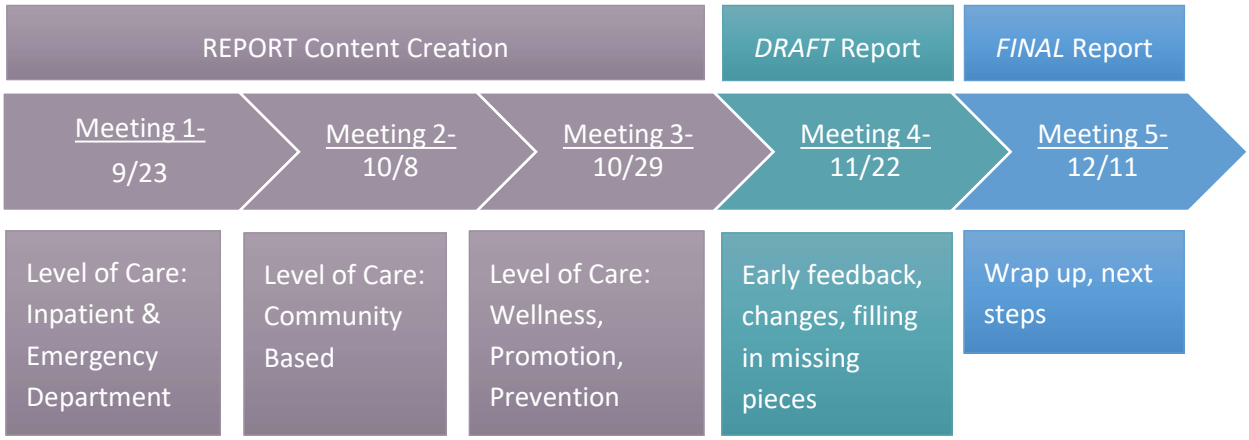
THINK TANK ADVISORY COMMITTEE

Inevitably, more people applied to be members on the Think Tank than was feasible to include. In order to ensure that we heard from these individuals, and others, DMH formed an Advisory Committee. This group met twice to review the work of the Think Tank and to provide their input. The Advisory Committee members provided a valuable check on the work, identifying gaps and suggesting useful areas where more detail or a different perspective was helpful.

THINK TANK PROCESS

The Think Tank met five times between September and December of 2019 and had the task of translating the 10-year vision statements of Vermonters collected from the listening tour into concrete and actionable short-term, mid-term and long-term strategies, which are posted as notes from each day of the Think Tank on the Department of Mental Health website.[53] To achieve this, the group split into six working groups focused on specific thematic areas and then organized the conversation between levels of care on each day that the Think Tank met.

Think Tank Design



The Department employed two methods to ensure additional feedback and review of the Think Tank strategies. One was to ensure a continuous feedback loop with the Think Tank participants, sharing individual workgroup strategies with all group members as they were drafted and then refining the components through a "strategy preview" exercise at the start of each Think Tank session. The second was to obtain feedback from experts outside of the Think Tank, both through creation of an Advisory Committee as well as by obtaining review and feedback from members of the Department's statutorily required Standing Committees for

[53] https://mentalhealth.vermont.gov/about-us/department-initiatives/10-year-planning-process-mental-health-think-tank

Adults and Children. The Advisory Committee met after the first meeting of the Think Tank to orient itself to the process and day one results, and then met again to review the Draft report and provide feedback prior to finalizing the 10-year plan with the Think Tank in December. The State Standing Committees each set aside time at their December meetings to review and provide feedback on the pre-final report.

APPENDIX C: PROMISING PRACTICES

URGENT MENTAL HEALTH CARE AND CRISIS DIVERSION

DEVELOPMENT OF ALTERNATIVE LOCATIONS FOR CARE IN A CRISIS

Alternatives to emergency department treatment should meet both "step up" and "step down" needs so that needs are met at the right time and in right place. These strategies seek to build on the strengths of the existing system as well as filling gaps that are contributing to increasing the use of emergency departments by individuals who are experiencing a mental health crisis.

STRENGTHS THAT CAN BE EXPANDED

Facility-based Crisis Stabilization and Support Services: This is a Designated Agency Crisis Bed system for adults, which could be enhanced and/or expanded in order to maximize the resource as an alternative for individuals that may end up in emergency departments.

Crisis Stabilization and Hospital Diversion for Children and Youth: There are currently three programs in the State that provide facility-based crisis stabilization programs for children and youth. These can be expanded in different regions throughout the state.

Intensive Residential Recovery (IRR) Treatment Facilities: This is another potential asset and source of experience within the existing system of care for adults. Staff are trained in supporting individuals who may be experiencing a crisis. There may be an opportunity to build off the specific strengths of this residential model wherein living arrangements and staff are organized to support individuals at risk of crisis.

2-Bed Peer-Run Crisis Programs: Alyssum is currently the only peer run crisis program in the state. This can be expanded to different communities.

PROGRAMS NOT YET ADOPTED IN VERMONT

Mobile Response and Stabilization Services: MRSS differs from traditional crisis services in that it provides more upstream services. A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention for a child/youth and their family, before emotional and mental health difficulties escalate. MRSS has been shown in other states to be clinically responsive to child, youth and family needs, and cost effective in "averting unnecessary" higher levels of care in settings such as emergency departments, inpatient

psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families[1].

The Living Room Model: This model aims to decrease the use of emergency departments for mental health crises and provides guests with support long-term in order to minimize their need of further visits. The Living Room is available 24/7 by walk-in or referral. It is a comfortable space that is designed and furnished to have a home-like feeling with common areas and personal rooms with triage occurring as necessary by peer specialists, licensed counselor/social workers and a psychiatric nurse. In its first year of operation, the original Living Room model, located in Illinois, had 228 visits from 87 unique individuals, most of them diverted from the emergency room, and saved the State of Illinois approximately $550,000.[1] The Living Room model has been used in at least six states to provide alternatives to emergency departments.[1]

EVIDENCE-BASED MODELS ADOPTED IN OTHER STATES WITH SUCCESS

Crisis Intervention Team (SAMHSA Evidence Based Practice): The Crisis Intervention Team (CIT) program has become a globally recognized model for safely and effectively assisting people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, mental health and substance use treatment providers, people with mental and substance use disorders, along with their families and others. While law enforcement agencies have a central role in program development and ongoing operations, a continuum of crisis services available to citizens prior to police involvement is part of the model. These other community services (e.g., mobile crisis teams, crisis phone lines) are essential for avoiding criminal justice system involvement for those with mental health challenges

Peer Recovery Coaches: Originally developed for supporting those addressing substance use issues, these coaches are also being used to support those with mental health challenges.

Peer support is when people with lived experience of mental illness and/or substance use disorders share their recovery stories and offer support. It is an important part of many people's recovery journeys. Peer support can come from traditional, 12-step self-help groups such as Alcoholics Anonymous. It can also come from peer specialists, recovery coaches, and others who help encourage individuals to talk about their recovery from addiction and mental health conditions. Talking with others who have similar experiences and have "been there" helps to promote hope and provides positive role models for those in recovery.

The Peer Recovery Coaches in the Emergency Department Program was introduced by the Department of Health in close collaboration with three of the state's Turning Point Centers, their local hospitals and the Vermont Recovery Network. The partners are the Turning Point Centers of Bennington, Chittenden County and Central Vermont. The participating hospitals are Southwestern Vermont Medical Center, University of Vermont Medical Center and Central Vermont Medical Center. The Central Vermont and Chittenden locations launched their programs at the beginning of July 2018, with the Bennington location starting in August.

Mental Health Urgent Care Model: The urgent care model allows people to access assistance for issues which cannot wait for a primary care appointment but have the potential to escalate into an emergency. This model provides the following benefits to people: shorter wait times, walk-in availability, a quiet and comfortable setting, and referrals to other resources in the community. By accessing services in this way, children, youth or adults are given a high quality of care without the wait times or crisis feeling experienced in a hospital emergency room.

The Parachute Project (NYC): Is an innovative "open dialogue" program based out of New York City that has various levels of support including mobiles crisis, outreach and respites programs to help support people to learn how to live with acute stress. Teams of people including social workers, psychiatrists, peers and family members work together in a non-hierarchical manner to encourage people living with mental health issues to develop their own route to recovery. The teams encourage open and equal dialogues to help individuals learn to live their lives with acute stress and develop ways to manage their own health and mental health. This program has a focus on meeting people where they are with their readiness to engage in treatment and offer different solutions for people that are not interested in full engagement in treatment. There is significant peer involvement in every component of Parachute NYC; besides mental health services, peers will work as peer health navigators to integrate medical health into the continuum of care.

APPENDIX D- GLOSSARY OF TERMS

8 Dimensions of Wellness model- The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified eight dimensions of wellness to focus on to optimize health. The eight dimensions include: emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social. Wellness can be compromised by lack of support, trauma, unhelpful thinking styles, chronic illness/disability, and substance use.

42 CFR part 2- 42 CFR Part 2 applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Access – Access to care is commonly defined as "the timely use of personal health services to achieve the best health outcomes,"[1] and includes a variety of elements including:

1. The ability to first, enter the health care system (usually through health insurance coverage)
2. Accessing a location where needed health care services are provided (geographic availability)
3. Finding a health care provider whom the individual trusts and can communicate with (i.e. personal relationship).

Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

ACT 79 Report- Notwithstanding 2 V.S.A. § 20(d), the Department of Mental Health shall report annually on or before January 15 to the Senate Committee on Health and Welfare and the House Committee on Human Services regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available.

The Adult Needs and Strengths Assessment (ANSA)- is a multi-purpose tool developed for adult's mental health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Advance directives- An advance directive is a document by which a person makes provision for health care decisions if, in the future, he/she becomes unable to make those decisions.

Adverse Childhood Experiences Study (ACES)- Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years) such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die

by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, untreated mental health problems, or instability due to parental separation or incarceration of a parent, sibling, or other member of the household.

Application for Emergency Examination (EE) – A document completed by a designated QMHP and a physician, which authorizes the State to involuntarily hold individuals for the purposes of their admission to a psychiatric hospital.

Application and Warrant for Emergency Examination (Warrant) – A document completed by a QMHP or law enforcement officer and approved by a judge which authorizes the State to involuntarily hold individuals for the purposes of their admission to a psychiatric hospital.

Application for Involuntary Treatment (hospitalization) – A legal document filed in the Family Court seeking a person's involuntary hospitalization for psychiatric treatment and authorizing the State to continue to hold the person on an involuntarily basis until a court hearing is held.

Application for Continued Treatment – A legal document filed in the Family Court seeking a person's continued involuntary treatment on either an inpatient or outpatient basis.

Assertive Community Treatment (ACT) - Assertive community treatment (ACT) is a form of community-based mental health care for individuals experiencing serious mental illness that interferes with their ability to live in the community, attend appointments with professionals in clinics and hospitals, and manage mental health symptoms.

Blueprint for Health- The Vermont Blueprint for Health designs community-led strategies for improving health and well-being. Current Blueprint programs include Patient-Centered Medical Homes, Community Health Teams, the Hub & Spoke system of opioid use disorder treatment, the Women's Health Initiative, Support and Services at Home (SASH), Self-Management and Healthier Living Workshops, full population data and analytics for policy makers, communities, and practices, and a series of learning labs for providers and community teams.

Building Flourishing Communities- Building Flourishing Communities is spreading the information about how to help our children grow up with strong, addiction-resistant brains, the ability to build meaningful relationships, focus on their work, and remain calm under stress. This proven public health model provides important information about early childhood development to Vermonters and engages Vermonters in discussion and action to address the factors that lead to poor health outcomes and much of the difficulty so many have in succeeding at work and in family life. BFC is creating an enduring vision of flourishing communities, and supporting the actions to achieve them.

The Child and Adolescent Needs and Strengths (CANS)- is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Centers for Medicare and Medicaid Services (CMS) – Part of the U.S. Department of Health and Human Services, CMS oversees many federal health care programs, including those that involve health information technology. Medicare is the federal health insurance program for the elderly and Medicaid is the federal needs-based program that helps with medical costs. services

Civil Commitment – Civil commitment is another term commonly used to describe the process for involuntarily committing someone to the custody of the Commissioner of Mental Health through the Family Court (as opposed to through the Criminal Court). See Application for Emergency Examination, Application and Warrant for Emergency Examination, and Application for Involuntary Treatment above. It also applies to the process whereby a person is committed to the Commissioner's custody on an outpatient basis through the Family Court. See Order of Non-Hospitalization below. The involuntary commitment process is governed by 18 V.S.A. Chapter 181. The process begins with an application for emergency examination is completed by a qualified mental health profession (QMHP) and a licensed physician or psychiatric advanced practice registered nurse (APRN) certify that an individual, because of his or her mental illness, poses a danger of harm to self or others and that there is no less restrictive alternative to involuntary hospitalization that can provide the individual with adequate and appropriate treatment. In instances where a physician or psychiatric APRN is not available, a QMHP or law enforcement officer may apply to the court for a warrant for emergency examination. Within 24 hours, a psychiatrist must concur and an application for involuntary treatment (AIT) be filed in the Family Court in order to keep the individual involuntarily hospitalized.

Clinical Pathways- Clinical pathways (CPWs) are a common component in the quest to improve the quality of health. CPWs are used to reduce variation, improve quality of care, and maximize the outcomes for specific groups of patients

Community-Based Care - Community-based treatment enables people with mental health needs to maintain family relationships, friendships and jobs while receiving treatment, which facilitates early treatment and rehabilitation. This type of care is also associated with continuity of care, greater users' satisfaction, increased adherence to treatment, better protection of human rights, and prevention of stigma.

Court Order for Psychiatric Examination – The Criminal Court may issue an order, on its own motion or that of the defendant's attorney, requiring that a criminal defendant be examined by

a psychiatrist to determine if the defendant is competent to stand trial and/or was insane at the time of the alleged crime. If the defendant's condition is found to require inpatient treatment, the court may issue an inpatient order for psychiatric examination. Otherwise, the examination is to occur on an outpatient basis. The process is governed by 13 V.S.A. Chapter 157. If the individual is not found to need hospitalization, the individual must be released or detained per conditions set by the Criminal Court.

Crisis bed – Crisis beds are community-based hospital diversionary programs that offer emergency, short-term, 24-hour residential supports in a setting other than the person's home. Emergency services provided by the Designated Agencies are the initial point of access for crisis beds.

Crisis Stabilization Units - Crisis Stabilization Units (CSU) are small inpatient facilities of less than 16 beds for people in a mental health crisis whose needs cannot be met safely in residential service settings. CSUs may be designed to admit on a voluntary or involuntary basis when the person needs a safe, secure environment that is less restrictive than a hospital. CSUs try to stabilize the person and get him or her back into the community quickly.

https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis

Crisis text line- Free support at your fingertips, **24/7Crisis Text Line** serves anyone, in any type of crisis, providing access to free, 24/7 support and information via the medium people already use and trust: text.

Decentralized System of Inpatient Care – People in need of hospitalization are provided treatment at either the state-run inpatient facility, or one of the five Designated Hospitals throughout the state. Designated hospitals provide treatment to both voluntary and involuntary patients:

> **Level 1 Involuntary** – Involuntary hospitalization stays paid at-cost to contracted and state providers for people who are the most acutely distressed who require additional services.
>
> **Non-Level 1 Involuntary** – Involuntary hospitalization stays for individuals who do not require additional resources.
>
> **Voluntary** – Voluntary hospitalization stays *(see also Voluntary Patient, Voluntary Admission and Voluntary Outpatient Treatment).*

Designated Agency (DA) – A community mental health (and developmental disabilities) agency designated under contract with the state for the provision of mental health services to those in need of care.

Designated Hospital – A hospital or part thereof that is designated by the Department of Mental Health to provide psychiatric services to individuals on an involuntary basis.

Designated Qualified Mental Health Professional (QMHP) – is an individual designated by the Department of Mental Health and employed by a DA to assess individuals experiencing a mental health crisis for their need for involuntary hospitalization. Such persons may also be referred to as crisis clinicians or screeners.

Emergency Involuntary Procedures (EIP)– means restraint, seclusion or emergency involuntary medication.

Emotional CPR- Emotional CPR (eCPR) is a public health education program designed to teach people to assist others through an emotional crisis by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing. eCPR was developed by people who have learned from their own experience how to get through an emotional crisis and integrate the experience into a broader understanding of themselves and others.

Federally Qualified Healthcare Center - Federally Qualified Health Centers are community-based health care providers that receive funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

Forensics – There are four categories of individuals who receive "forensic" psychiatric care:

1. Individuals who are awaiting a psychiatric evaluation as part of a trial
2. Individuals who have been found incompetent to stand trial
3. Individuals who were tried and found not guilty by reason of insanity
4. Individuals who have been convicted and are in DOC custody who develop the need for acute psychiatric care on either a voluntary or involuntary basis

Forensic psychiatric care is provided by either DOC or DMH, depending on the level of care required for the individual.

Health Services Area – A health service area is a geographic region that delineates where most people residing in that area will seek care.

Help Me Grow- Help Me Grow is dedicated to the success and wellbeing of Vermont's families and the communities they live in. Help Me Grow helps early childhood partners work together to build strong, connected communities and healthy, resilient families.

Holistic- Holistic is characterized by the treatment of the whole person, considering mental and social factors, rather than just the symptoms of a condition.

Information & Referral Service – A free service, typically available 24 hours/day by phone. In Vermont, we have 2-1-1, which on its website says that I&R is "the art, science and practice of bringing people and services together. I&R resource databases contain detailed descriptions of the programs and services provided by community, social, health, and government organizations.

According to 2-1-1, callers to their service connect with "trained, empathetic I&R Specialists who assess their needs in a non-threatening, non-judgmental and confidential manner and help them understand their situations and make informed decisions about possible solutions. The I&R Specialist can, when necessary, assist people who are in crisis and emergency situations. I&R Specialists can also advocate on behalf of individuals who need additional support."

Inpatient – an individual is considered a hospital inpatient once a doctor has written orders for admission and the hospital has formally admitted the individual to a room. This is different from being sent to the hospital for tests, or a doctor telling someone to go to the emergency room for immediate assessment. To qualify as an inpatient, an individual must be under the care of a doctor (with admitting privileges at that hospital) who then writes orders to admit the individual and gives instructions for the patient's care while in the hospital. Someone is generally an inpatient until (and including) the day before discharge. In some cases, an individual may stay overnight at a hospital without having inpatient status.

Integration- Integrated care is a general term for any attempt to fully or partially blend mental health services with general and/or specialty medical services. This blending can occur within inpatient or ambulatory clinical settings. By treating both the mental and physical needs of children, adolescents, and adults, we will better meet the triple aim of improved patient outcomes and satisfaction at a lower cost by addressing common, disabling and costly mental health problems

Intensive residential recovery (IRR) treatment facilities- See below under "Residential Services."

Intentional Peer support (IPS)- Intentional Peer Support is a way of thinking about purposeful relationships. It is a process where both people (or a group of people) use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things. IPS has been used in crisis respite (alternatives to psychiatric hospitalization), by peers, mental health professionals, families, friends and community-based organizations.

IPS is different from traditional service relationships because:

- It doesn't start with the assumption of "a problem." Instead people are taught to listen for how and why each of us has learned to make sense of our experiences, and then use the relationship to create new ways of seeing, thinking, and doing.
- IPS promotes a 'trauma-informed' way of relating- instead of asking 'what's wrong' we think about 'what happened'?
- IPS looks beyond the notion of individuals needing to change and examines our lives in the context of our relationships and communities.
- Peer Support relationships are viewed as partnerships that enable both parties to learn and grow- rather than as one person needing to 'help' another.
- Instead of a focus on what we need to stop or avoid doing, we are encouraged to move towards what and where we want to be.

Living Room Model- is a community crisis respite program called THE LIVING ROOM. Although community crisis respite programs of this type are relatively rare in the US they are increasingly recognized as an effective way to reduce psychiatric ED visits while improving outcomes for people in crisis. While a focus of THE LIVING ROOM is to help those in crisis avoid using the ED, the service philosophy also embraces the Recovery Model. The concept of recovery "Involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993). THE LIVING ROOM reflects many of the Recovery Model's concepts, including autonomy, respect, hope, empowerment, and social inclusion.

Mental Health First Aid (MHFA)- Mental Health First Aid trains individuals to assist someone experiencing a mental health or substance use-related crisis. In the Mental Health First Aid course, participants learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help.

Mental Illness – A substantial disorder of thought, mood, perception, orientation, or memory any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include intellectual disability. 18 V.S.A. § 7101(14).

Mobile Response and Stabilization Services (MRSS) - differ from traditional crisis services in that MRSS provides more upstream services. A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention for a child/youth and their family, before emotional and mental health difficulties escalate. MRSS has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018). MRSS is not the same as **Street Outreach**.

Pathways warm line- Different from a crisis helpline or emergency hotline, the Vermont Support Line is a "warm line" — your go-to support resource that can help prevent a situation from escalating to an emergency. We focus on mental health help and counseling for a wide range of issues: from the anger you feel after a bad day, to times when you feel alone, to when you need support for substance abuse, medical concerns, relationship challenges, or thoughts of suicide.

Peer Navigators- is an expansion of the Warm Line program and connects individuals with serious mental illness, their family members, and caregivers to culturally relevant health services.

Peer Run Residential – Vermont has two peer-run residential programs, **Alyssum,** which operates a two-bed program providing crisis respite, hospital diversion, and step-down, and **Soteria**, which operates a five-bed, peer supported alternative residential program which provides specialized treatment and support for individuals experiencing first break psychosis who are seeking to avoid or reduce their reliance on medications.

Peer Support Services - are designed and delivered by those who have been successful in the recovery process, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Their experience and knowledge provide hope to those in the earliest stages of recovery. Peer services also can bring treatment services outside clinical setting into the daily settings of those seeking to achieve or sustain recovery.

https://store.samhsa.gov/system/files/sma09-4454.pdf

Positive Behavioral Interventions and Supports (PBIS)- is an evidence-based three-tiered framework to improve and integrate all of the data, systems, and practices affecting student outcomes every day. PBIS creates schools where all students succeed. PBIS improves social, emotional and academic outcomes for all students, including students with disabilities and students from underrepresented groups.

Primary prevention—measures that promote wellness and/or prevent the onset of illness or injury before the disease process begins. For physical health & wellness, we often hear about the importance of exercise and eating well.

Secondary prevention—measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to prevent more severe problems from developing. In the world of physical health, we are told we should have regular screenings of our blood pressure, for example.

Tertiary prevention—measures aimed at rehabilitation following significant illness. In the physical health world, we might think of someone in a rehabilitation program following a heart attack, or physical therapy for regaining strength in a broken limb.

Residential Services – Supports and services provided in staffed residential settings.

> **Intensive Residential Recovery** – Intensive Residential Recovery Programs support individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. Programs provide both transitional and longer term supports, with an average length of stay between 12-18 months. 18 V.S.A. § 7101(5).
>
> **Secure Residential** – Middlesex Therapeutic Community Residence is Vermont's only Secure Residential treatment facility and is currently in a temporary location. All residents are in the Commissioner's custody under a court order (Order of Non-Hospitalization). The facility is physically secure with 14' fence surrounding the facility and locked doors. The facility provides onsite nursing, onsite and telephonic access to psychiatry, and case management services. The facility is intended for residents who no longer meet hospital level of care but have shown significant difficulty managing safely in the community and require continued intensive supports. 18 V.S.A. § 7620(e)(2).

Support and Services at Home (SASH)- SASH coordinates the resources of social-service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a SASH Care Coordinator. SASH serves older adults as well as people with special needs who receive Medicare support. SASH touches the lives of approximately 5,000 people throughout Vermont.

State –The government of the State of Vermont and subdivisions thereof.

Street Outreach – outreach staff are typically mental health professionals who develop relationships with people who may be homeless and who have mental health and/or substance use challenges, and other unmet needs. The outreach staff coordinates services for willing individuals, and addresses behaviors that might otherwise put the individual at risk of police intervention or of coming to harm.

Strengthening Families Framework- The Strengthening Families framework is a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. We work to engage families, programs, and communities in building the five protective factors. States apply the Strengthening Families approach in early childhood, child welfare, child abuse prevention, and other child- and family-serving systems.

Team Two – A collaboration between the Departments of Mental Health and Public Safety, Team Two trains first responders (including 911 dispatchers, police, mental health crisis workers, EMTs, State's Attorneys and emergency department staff) on how to respond to a person experiencing a mental health crisis. Team Two trainings provide an overview of relevant mental health statutes, a refresher of the mandatory mental health training for law enforcement (ACT 80), and a review of resources available in the local region.

Telehealth/Telemedicine- telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

UMatter- UMATTER was developed based upon a review of other suicide prevention programs to determine key concepts. Research from the American Association of Suicidology and the academic literature regarding suicide were applied. Once program goals and objectives were developed, experiential learning activities were designed to reach all learning preferences and styles of participants to ensure the maximum transfer of knowledge, skills, and attitudes.

Vermont 2-1-1- Vermont 2-1-1 is the number to dial to find out about hundreds of important community resources, like emergency food and shelter, disability services, counseling, senior services, health care, child care, drug and alcohol programs, legal assistance, transportation agencies, educational and volunteer opportunities, and much more.

Vermont Association of Hospitals and Health Systems (VAHHS)- is a member-owned organization comprised of Vermont's network of not-for-profit hospitals. We are committed to building a vibrant, healthy Vermont. Our work includes advocacy, policy development, education and research.

Vermont Care Partners (VCP)- is a statewide network of sixteen non-profit community-based agencies providing mental health, substance use, and intellectual and developmental disability services and supports.

Voluntary Patient – means an individual admitted to a hospital voluntarily or an individual whose status has been changed from involuntary to voluntary. 18 V.S.A. § 7101(24).

Voluntary Admission – (a) Any person 14 years of age or over may apply for voluntary admission to a designated hospital for examination and treatment.

(b) Before the person may be admitted as a voluntary patient, he or she shall give his or her consent in writing on a form adopted by the Department. The consent shall include a representation that the person understands that his or her treatment will involve inpatient

status, that he or she desires to be admitted to the hospital, and that he or she consents to admission voluntarily, without any coercion or duress.

(c) If the person is under 14 years of age, he or she may be admitted as a voluntary patient if he or she consents to admission, as provided in subsection (b) of this section, and if a parent or guardian makes written application.

18 V.S.A. § 7503.

Voluntary Outpatient Treatment for Minors – A minor may give consent to receive any legally authorized outpatient treatment from a mental health professional, as defined in section 7101 of Title 18 V.S.A. Consent under this section shall not be subject to disaffirmance due to minority of the person consenting. The consent of a parent or legal guardian shall not be necessary to authorize outpatient treatment. As used in 18 V.S.A. § 8350, "outpatient treatment" means psychotherapy and other counseling services that are supportive, but not prescription drugs. 18 V.S.A. § 8350.

Wellness Coaches - A wellness coach is a person trained to help peers (persons living with a mental illness, hereafter referred to as service recipient or peer) establish a link to primary health care and health promotion activities. The wellness coach can assist peers in reducing high risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise. Wellness and coaching principles assist the service recipient in making changes leading to positive lifestyle improvement. A wellness coach is someone who can help a peer set and achieve a wellness or health goal by offering support and encouragement and asking questions to see what would be most helpful.

The Wellness Recovery Action Plan® or WRAP® - is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be. It was developed in 1997 by a group of people who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals. It is now used extensively by people in all kinds of circumstances, and by health care and mental health systems all over the world to address all kinds of physical, mental health and life issues.

Wellness Center Model- Mental wellness centers are places that promote mental health wellness on both an individual level and community level. Mental wellness centers work hard to provide mental health and wellness services to those in need while promoting more awareness and tolerance for those who are seeking or feel they may benefit from mental health services. Mental wellness centers educate the community about mental health and wellness, organize mental wellness activities, and provide services to individuals, couples, families, children and community groups.

Youth in Transition (YIT)- Young adults, families/adult allies and community partners collaborate to develop a system of care to support transition to adulthood. The system builds upon the strengths of young adults and creates an array of specialized mental health and related services to meet their unique and changing needs. The system also fosters young adult leadership.

Youth Thrive- *Youth Thrive* is a research-informed model that combines the most current science about adolescent brain development, trauma, resilience, and the importance of social connections into one framework (see image) to ensure young people in our care thrive as evidenced by:

- physical and emotional health,
- success in school and workplace,
- ability to form and sustain caring, committed relationships,
- hopefulness and optimism,
- compassion and curiosity, and
- service to community, school or society.

Zero Suicide- The Zero Suicide framework is a system-wide, organizational commitment to safer suicide care in health and mental health care systems. The framework is based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system. A systematic approach to quality improvement in these settings is both available and necessary.