Report to
The Vermont Legislature

In Accordance with Act 50, Sec. 27, Residential beds for Individuals Discharged from Inpatient Psychiatric Care

Submitted to:	House Committees on Health Care and Human Services Senate Committees on Appropriations and Health and Human Services
Submitted by:	Emily Hawes, Commissioner, Department of Mental Health
Prepared by:	Shayla Livingston, Policy Director, Department of Mental Health
Report Date:	January 15, 2022

VERMONT

Department of Mental Health
AGENCY OF HUMAN SERVICES

280 State Drive, NOB-2 North
Waterbury, VT 05671
www.mentalhealth.vermont.gov

Legislative Requirement

A.50, Sec. 27. RESIDENTIAL BEDS FOR INDIVIDUALS DISCHARGED FROM INPATIENT PSYCHIATRIC CARE

(a) On or before August 1, 2021, the Department of Mental Health shall issue a request for information from designated and specialized service agencies and peer-run agencies for developing and implementing programming for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care. Responses to the request for information shall be provided to the Department of Mental Health not later than December 1, 2021 and shall include provisions that address the need to develop and implement community residential programming for youths.

(b) The Department of Mental Health shall convene a steering group of interested stakeholders, including individuals with lived experience, to consider and provide input to the Department's prioritization process in determining the area of highest need across the mental health system of care with regard to additional bed proposals described in subsection (a) of this section.

(c) On or before December 15, 2021, the Department of Mental Health shall submit a report to the House Committees on Health Care and on Corrections and Institutions and to the Senate Committees on Health and Welfare and on Institutions containing the following:

(1) a review of all responses received pursuant to the request for information issued pursuant to subsection (a) of this section;

(2) a bed needs assessment for all levels of care in the mental health system, including an update to the statewide bed needs assessment conducted pursuant to 2019 Acts and Resolves No. 26, Sec. 2 with regard to inpatient beds and community residences;

(3) a summary of the input provided by the stakeholder steering group pursuant to subsection (b) of this section; and

(4) an analysis of opportunities under the American Rescue Plan Act of 2021, Pub. L. 117-2, for capital or operational bridge funding for additional unlocked community residential capacity described in subsection (a) of this section or additional similar community capacities.

Review of RFI Responses Received

The Department of Mental Health issued an RFI for developing and implementing programming in unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care in August 2021. By the closing date of the RFI on November 29, 2021, the Department had received six responses. All responses received and a copy of the RFI are attached to this report as Appendix A.

Summary of Input Provided by the Stakeholder Steering Group

To inform the Department's prioritization process in determining the area of highest need across the mental health system of care with regard to responses to the RFI, the department's policy advisor presented the legislative language of this Act, an overview of the RFI process and how it differs from a request for proposals (RFP) to the State Standing Committee (Adult) at their monthly meeting on

December 13th. Following the meeting, participants were provided an electronic copy of the legislative language, the RFI and all responses, and a link to an online survey with open ended response options. Participants were requested to submit input within a week (which the extended deadline of this report allowed for) and Committee member responses summarized herein reflect a total of six that were completed between December 16th and January 1st.

The six participants said the most important factor to them for ensuring a successful community residential program is: funding equivalent to medical care; The relationship between those receiving supports and those providing them; not having [a community residential program]; the staff; employing those with lived experience and paying them very well; and, it being peer run and peer staffed.

All participants agreed that it was very important to care for both youth and adults in such a facility but opinions varied on whether there should be any region that is prioritized.

When asked what they thought was important to emphasize in this report to the legislature, participants stated:

- *Prioritize peer-support programming*
- *Consider the role of peer support in step down and diversion (as well as in prevention from inpatient psychiatric care)*
- *Peer workers deserve a fair and equitable wage for their services*
- *Psych ward hospitalizations are generally traumatic and community-based care is strongly preferred*

Bed Needs Assessment

There are no updates to the Act 26 §2 (2019) bed needs analysis report. Bed numbers and resulting needs since that reporting have been profoundly influenced by the COVID-19 public health emergency, with closures across the state in response to public health safety requirements and lack of available workforce. Until bed capacity is at 2019 base level, any additional assessment may reflect the pandemic setting with the resulting adaptations, more than the long- term bed needs of the system.

Analysis of Opportunities under the American Rescue Plan Act (ARPA)

Potential opportunities for capital or operational bridge funding for additional unlocked community residential capacity or additional similar community capacities in the American Rescue Plan Act (Pub. L. 117-2) are presented below. The following data reflects federal ARPA opportunities (allocated to the U.S. Secretary of Health and Human Services, and active as of 12/13/21) that may be explored for capital

or bridge funding, and a link to that program for more information and the allocation to Vermont[1]. The Vermont Joint Fiscal Committee tracks Vermont allocations and spending of the below federally allocated funding. A spending update was provided on November 16, 2021.

ARPA funding is one-time opportunity funding. These funds could be used for initial investments needed to stand up beds, but ongoing general fund would be required for the continued staffing and reimbursement for these facilities.

FEDERAL ARPA GRANTS FOR PROGRAMS	VT ALLOCATION*	SUMMARY
HRSA: Health Center Construction and Capital Improvements (P.L. 117-2, Section 2601)	$6.98M	Announced 9/28/21 as part of ARP-Capital, C8E Period of performance: 9/1/21 - 8/31/24
SAMHSA: Mental Health Block Grant (P.L. 117-2, Title II)	$2.57M	Spending allowed through 2025.
HRSA: Community Health Centers - Expanded Access to COVID-19 Vaccines, Build Vaccine Confidence (P.L. 117-2, Title II)	$33.36M	The American Rescue Plan Act provides one-time funding (H8F) for a 2-year period of performance to support health centers funded under the Health Center Program to prevent, mitigate, and respond to COVID-19 and to enhance health care services and infrastructure.

[1] https://ffis.org/COVID-19

Request for Information

By the Agency of Human Services

Department of Mental Health

For

DEVELOPING AND IMPLEMENTING PROGRAMMING: UNLOCKED COMMUNITY RESIDENCES FOR TRANSITIONAL SUPPORT FOR INDIVIDUALS BEING DISCHARGED FROM INPATIENT PSYCHIATRIC CARE OR FOR INTERVENTION TO PREVENT INPATIENT CARE

PURPOSE

This Request for Information (RFI) is issued for the Vermont Department of Mental Health (DMH) to gather input and obtain information and cost estimates in proceeding with proposals from VT designated and specialized service agencies and peer-run agencies for developing and implementing programming for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care.

The DMH intends to evaluate the submissions by respondents to explore how these would meet the system needs and understand the related system development activities and cost associated with proposed solutions. The DMH shall not be held liable for any costs incurred by the vendors in the preparation of their submission, or for any work performed prior to contract issuance.

ELIGIBILITY TO SUBMIT AN RFI

Designated Agencies, Specialized Services Agencies, and peer-run agencies for mental health are encouraged to respond to this RFI. All parties responding to this RFI must identify themselves and provide a brief explanation of their interest in Vermont's System of Care.

RFI SUBMISSION QUESTIONS

Respondents are encouraged to respond to all questions. However, partial responses will be accepted and reviewed. Considering the information above, provide your thoughts about how you could enhance and creatively support children, youth, families and adults in a community-based setting.

1. In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults)
2. Is there a payment methodology which would assist in your ability to implement this programing?
3. What performance measures should be adopted to monitor and ensure the effectiveness of your programming?
4. What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care?
5. What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations?
6. What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)?

7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced?
8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots?
9. Respondents are welcome to include any other recommendations or thoughts for consideration.

REQUESTED INFORMATION

Each submission prepared in response to this RFI must include the elements listed below, in the order indicated.
The vendor, when presenting the response, must use the following outline:

- Cover Page
- Vendor Information
- Responses (full or partial) to prompts 1-9
- Cost Estimates (if applicable)

COVER PAGE

The first page of the vendor's RFI Response must be a cover page displaying at least the following:

- Response of RFI Title
- Vendor's Name
- Contact Person
- Telephone Number
- Address
- Email Address

RFI RESPONSE SUBMISSION

Written submissions must be received by November 29, 2021, by 4:30 p.m.

Submissions should be sent electronically in Microsoft Word or PDF format to Jennifer Rowell at jennifer.rowell@vermont.gov.

Additional questions may be directed to Samantha Sweet at samantha.sweet@vermont.gov or 802-241-0090.

ER Diversion: Living Room/Mobile Crisis Support for Youth and Adults

Counseling Service of Addison County (CSAC)

Contacts:

Alexander Smith, MA – (802)388-6751, asmith@csac-vt.org

Cheryl Huntley, MSW – (802)388-6751, chuntley@csac-vt.org

RFI – *Counseling Service of Addison County (CSAC) Living Room/ Mobile Crisis Support ER Diversion Resource*

1. *In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults)?*

   CSAC is interested in developing a resource that would seek to divert from ER based stays by offering welcoming comfortable space that people in distress would want to go towards rather than the adverse environment of a busy emergency room – as inspired by examples of the "living room model", the Vermont pilot model "PUCK", and the open door hospitality emphasis of the Trieste model. We would seek to have capacity to welcome both adults and youth in crisis. The staffing would start with a focus on increased capacity for open dialogue trained staff who can provide both mobile crisis response offsite and onsite crisis support, behavioral interventionist capacity for youth, and peer support staff for adults. There would be a subsequent goal to build 24/7 onsite residential support as funding and staffing becomes available.

   CSAC has extensively been looking into related models, including with a work group of clients, family members, and staff who have working on ways to avert some of the highly adverse experiences involved with involuntary hospitalizations. This group who recently had a consultation with a representative from the peer run living room program run by Advocates Inc. from Framingham MA. Concurrently we have been working on increasing linkages across youth and family and adult mental health programs through network based crisis response approaches organized around aspects of Open Dialogue/CNA. This project would be a natural extension of these current efforts and could draw on efficiencies through a combined effort and other existing staff resources. CSAC is looking at possibilities for using existing facility spaces as a further measure of possible efficiency.

2. *Is there a payment methodology which would assist in your ability to implement this programing?*

   We believe this kind of resource is best funded with cost based flexible case rate structure that can withstand variable utilization. This is key to sustainability---any funding model needs to recognize the need to maintain staffing capacity and readiness despite fluctuations in client need. We also encourage structures that enable low barrier access, which we have identified as a key variable in our inquiries into what has been successful with comparable models.
   We note the current challenges with recruitment and the need to be realistic regarding the job market and viable pay rates for any new initiatives like this.

   CSAC has been part of a group of DA's that had reached out to Sen. Sanders for a possible earmark which looks promising to proceed with possible one time funding that could help launch this initiative.

3. *What performance measures should be adopted to monitor and ensure the effectiveness of your programming?*

   Utilization of the program
   Tracking of perceived diversions
   Tracking of ER days
   Participant surveys
   Provider surveys
   Open CSAC clients will have CANS and ANSA data as further descriptors of need.

4. *What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care*?

   - Open dialogue practices with staff working in pairs flexibly and with mobility to try to slow the urgency for a quick decision and find other possibilities through dialogue with others involved in the personal network and treatment teams of the person in crisis has helped divert countless admissions and more coercive responses.
   - We have identified better engagement when we can offer low barrier access - listening and responding to stated needs from the person's own description of their experience first and collecting minimally necessary administrative details later.
   - Youth and Family has a long history of success with the Access team working closely with treatment providers and others involved. Ongoing strong core services have also been identified as successful in averting the use of ER's for youth in crisis.

5. *What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations?*

   - Flexible and transparent teaming during the course of hospitalization.
   - Options for intensive support upon discharge.

6. *What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)?*

   CSAC is active in multiple community resource planning groups that could help inform the development of this resource including CHAT, (local Accountable Communities for Health group) IFS /LIT Team, and the Community Health Needs Assessment Committee.
   We are in communication with Porter Hospital representatives who support the development of alternative resources. In addition there is community work forming to address coordination with police, DCF, and the hospital.
   We would reach out to peer organizations to explore possible partnerships around staffing and training.

7. *How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced?*

   Ongoing review of above listed data indicators and other observations of outcomes.

8. *Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots?*

   Last summer a workgroup of some of the smaller DA's took a look at a SAMHSA grant that could have funded Living Room/PUCK style initiatives and there was ongoing sharing of ideas and information about related models. These discussions have influenced our submission and I would assume will be reflected in others as well. We would welcome and encourage strong interagency collaboration with these paradigm shifting projects. This is an especially rich opportunity for deepened collaboration between peer based organizations and DA's.

9. *Respondents are welcome to include any other recommendations or thoughts for consideration.*

   Thank you for this inquiry. We support continuing efforts to develop community based resources that can reduce the need for costly and often adverse hospitalizations and hope comparable momentum can develop for the building of these capacities as there already is for the creation of more hospital beds.

Estimated Costs

Day time staffing – 2 FTE open dialogue clinicians ($25/hr.), 1 FTE behavioral interventionist ($17.50/hr.) , 1FTE peer support specialist ($17.50/hr.)* = $**307,698** including fringe and admin.

Additional residential support for overnight stays (19/hr.) – approx. **$255,024** additional including fringe and admin if 1 onsite at $based on full occupancy

**Members of the adult work group of clients, family members, and staff met just prior to the posting of this RFI response and recommendations included having more than one peer staff person possibly including someone who could have some background/ perspective regarding youth in transition. There were also recommendations to have ample budget for training and to set up warm and non- institutional space. Discussion is continuing regarding the potential role of other professionally trained staff.*

Department of Mental Health

Mental Health Treatment Center for the Northeast Kingdom

Betty and Chris Barrett

Contact: Betty Barrett
Phone: 802-334-5940
Address: P.O. Box 37
Newport Center, VT. 05857
E-Mail: bitalian@comcast.net

There is a need for a Mental Health Treatment Center
for Children, Youth, and/or Adults

RFI Submission Questions

#1. In the Northeast Kingdom, which consists of Caledonia, Essex and Orleans Counties, we are proposing the need for a Mental Health (in patient) Treatment Center.
To either: Utilize an existing structure, (that requires minimal upgrades), or build a new structure for in patient Mental Health Treatment Center to serve children, youth and/or adults.
In turn, would require follow-up treatment/programs planning by either/or both Northeast Kingdom Human Services, private Mental Health Counselors when released from in patient treatment/programs.

#2. For funding at this time we would need to look to State, Federal Grants as well as local funding, donations and fund raising.

#3. We would require oversight by the Vermont Dept. of Mental Health as well as: Board of Directors
Established Bi-Laws
Established Policies and Procedures
and State statutes governing Mental Health Treatment for Children,
Youth and/or Adults

#4. Begin to coordinate with NKHS (Northeast Kingdom Human Services), as well as private Mental Health Counselors to create an after in patient action/treatment plan.

#5. Support will be needed from the following: Family Members, Community, Friends as well as in place action/treatment programs as set up as follow through from release of in patient facility.

#6. Partnerships other than, including but not limited to mental health, developmental services education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition, would also include Churches (religious), Legal, Housing, Law enforcement, Hospitals, etc….

#7. After-Care Plans can be enhanced and utilized by the support from family, friends,church, community and Professional Providers.

#8. A Mental Health Treatment Center in the Northeast Kingdom would be an additional asset for the State of Vermont that would be beneficial for Children, youths and/or adults, as well as an additional tool for Agencies and Professionals “tool boxes”.

#9. There are some recommendations for consideration:

1 – Available land to build a new facility. (NVRH has land available).

2 – The former “Derby Green” owned by NCH (this was a former Alzheimer's facility)

3 – St. Mary’s star of the Sea Convent

4 – Former Sacred Heart School building

Items 2, 3, and 4 would require nominal repairs, (to get to code and compliance).

Note: At this time we don’t have any cost estimates, this is due in part of the early stages of this proposal.

RFI SUBMISSION QUESTIONS (submitted by Don Smith)

Respondents are encouraged to respond to all questions. However, partial responses will be accepted and reviewed. Considering the information above, provide your thoughts about how you could enhance and creatively support children, youth, families and adults in a community-based setting.

1. In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults)
   We see that some of the challenges from keeping the flow of patient step-downs from hospitals back into communities are the following: hospitals discharging patients when still too acute due to staff "burn out" with specific patients or getting in to a routine of admits/discharges of high use patients that cycle through frequently, as well as some patients whose conditions are so acute that there is very little stability even after a long term hospital stay (such as patients in the care of commissioner), the most intensive patients not being able to live on their own and coming to programs homeless, without resources and requiring care homes and supported living environments and actually the inability for programs to discharge a patient in a timely fashion. For example if they are "homeless" but not agreeable to working on options a discharge still takes a significant amount of time and can be challenged by the resident utilizing residential rights (which while very important, in this setting only serve to slow the process down. Legislators should be aware of this). Checks and balances are obviously important but as a result the beds quickly become full and unmoving for long periods of time. To improve this process there should be multiple step downs linked in a fashion that allows for discharges out of one program and in to another to alleviate some of the inertia that affects Vermont's process. This idea already exists but in action does not allow for a seamless flow or residents from one setting to the next.

   A Crisis Bed/Respite program should have a maximum stay that can be enforced (for example 2-8 weeks) with a secondary "partner" program that the resident moves to when that timeframe is up, with the programs in partnership with one another to allow for more seamless and quicker admits and discharges. For one, this helps provide a less restrictive setting for residents so they can continue to practice self-sufficiency and integrate back into the community more quickly. This also frees up beds for those that are in hospitals but are truly ready to leave that setting. In the less restrictive setting (the 2nd step down) the resident could have a longer stay, say 12-16 weeks and in this setting they could continue the work of securing an apartment, care home placement, etc. However it is important to note that it is these programs that would likely become the biggest bottlenecks because finding long term placements, apartments and care homes to accept these residents is a very difficult process (especially when they are known in a community and have "burned" many bridges).

   Due to the challenges of working with the most psychiatrically unstable patients who have a very cyclical process of hospitalizations it gets very difficult to assist them back to recovery and here are some of the reasons: First, at their baseline they still may be quite unwilling to: follow recommendations of not living alone when they need more support, continue taking their medications voluntarily after leaving the hospital, or agreeing to a certain living situation

such as a Community Care Home. Second, our model is very heavy on pharmacology and not on developing a community of supports where one begins to become more connected and supported by others which is shown to have a profound effect on mental health. Third, the state of healthcare and mental health workers is a challenged one where burnout is a real issue and a challenge to work around. Designated Agency case managers can "step away" when clients are in a hospital or step down facility giving them time to address other clients and take a break from such challenging cases. Hospital social workers likewise will attempt to discharge patients when not fully stable due to a number of reasons; insurance, complacency when they see this patient many times a year, the lack of benefit from such a long in-patient stay and sometimes the inability to fully stabilize some of the most sick mental health patients. Many times patients have been discharged from hospitals but completely unstable and even incomprehensible or only to immediately stop taking medications once in a voluntary setting. From the residential point of view we are seeing more and more violent referrals within a system that has little in place for this population. These hard to place individuals are not appropriate for many settings and should not even be considered in our residential programs. Repeat violent offenders need to have their own complete programing so as not to fuel the perpetual cycle of trauma that we see on the rise.

The peer model has some ability to provide a prominent role here. A proper model can allow for peers to follow the patient from the time they are in the hospital to the time the move from the 1st step down to the 2nd and to their next destination. The peers can serve as an advocate and interface with the hospital social worker, designated agency case manager, and the family or other supports. A robust and well trained peer program could benefit timelines of this process.

Lastly, residents could move on from the "2nd Step Down" to supported apartment environments such as, for example, the Great River Terrace program managed by Groundworks in Brattleboro. However, despite all the best efforts put in place what we see on the ground is that some individuals are unable to remain successful in any living environment and then cycle through this process over and over again. Also, Vermont laws do not allow the easy movement of individuals in these supposedly "short term" programs and thus backing up the flow of residents towards more independent living situations.

2. Is there a payment methodology which would assist in your ability to implement this programing?
   The state could have a mechanism to contribute funding that has resulted in saved money due to avoiding longer hospital stays and homelessness, motel use, etc. Medicaid is the other current funding source for Crisis Beds and TCR's (Therapeutic Community Residence).

3. What performance measures should be adopted to monitor and ensure the effectiveness of your programming?
   Natural measures such as improved stability, decreased hospital stays and the movement of residents to more stable and independent housing options. Increased levels of independence and self-satisfaction within residents is another key component and is the opposite of what we see with very lengthy hospital and crisis-bed stays where there is little independence and self-actualization and self-sufficiency that is occurring.

4. What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care?
   A program is ultimately only as good as its staffing. Pay needs to be robust for these programs and certainly more than the current wages of $15-19/hour. Programs that retain long term staff do not have the costs of re-training and inexperienced staff during crises. Also the promotion of self-care, proper eating and sleeping and rewarding staff for health and not overtime hours worked is critical in this field.

5. What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations?
   Again, a liaison that follows the patient during their final period of their hospital stay to a crisis bed program (1st step down) and then to a 2nd step down and eventually to an apartment or community care home. This could be performed by a peer program or a housing liaison. Designated Agency case managers are typically tasked with this job but with high caseloads and high turnover they are not always able to support this process fully.

6. What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)?
   The medical and mental health system is unemotional and bureaucratic and for those high needs and high users of the system they are met with an endless array of "intake interviews", HIPPA discussions, Releases of Info signed, etc. As a result sometimes going to the dentist or meeting a new therapist is difficult despite what it is intended to do for the individuals in care. The state of Vermont needs to streamline Releases of Information between various agencies and services, intake paperwork, asking of intrusive questions as all this makes individuals that already must interact with certain services reluctant to interface with others.

7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced?
   Programs can submit quarterly data on lengths of stay, census data, etc. though I imagine the state could collect this data internally. More importantly patients/residents should not be going from one destination to another (i.e. hospital to step down 1 or step down 1 to step down 2) without a simple universal update on multiple spheres of care: such as housing planning, medical concerns, etc. which are often left unaddressed with higher needs patients.

8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots?

9. Respondents are welcome to include any other recommendations or thoughts for consideration.

I share this information individually solely on my own accord to push the conversation further around our fragile system of care. As we have seen with COVID our systems of care are nothing without proper staffing and well trained and well cared for staff. The system also often lacks a human component which is why I believe peer and alternative models are increasing and why many people avoid hospitals and crisis screenings despite being in crisis. Lastly, for the people that are frequently in the care of hospitals, crisis bed facilities, designated agencies and so forth there is often a significant loss of self-care and self-actualization. From not having to clean a room or prepare a meal or turning to medications instead of a diet change or not getting out in nature, they all have a negative effect on one's ability to develop resiliency, self-reliance and self-worth. The system needs to make space for a change in these areas and ironically more affluent groups can access this alternative form of care in the form of yoga workshops, massage sessions, farmers markets, nature/outing groups, etc. effectively by-passing the bureaucracy and faceless aspects of health care and government programing.

WCMHS

Washington County Mental Health Services, Inc.

Where Hope and Support Come Together

Response to

Request for Information 1 (RFI1)

By
Vermont Agency of Human Services
&
Vermont Department of Mental Health

Developing and Implementing Programming:
Unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care.

Submission Date: November 29, 2021

Contact: John Caceres
John.Caceres@wcmhs.org
802.476.1732
PO Box 647
Montpelier, VT 05601

WCMHS RESPONSE: VT AHS/DMH RFI 1

Supporting the Vermont System of Care

For more than 50 years, Washington County Mental Health Services (WCMHS) has served the Washington County community and the towns of Orange, Washington and Williamstown through education, support, and treatment of individuals and families living with mental health challenges, substance use issues, and intellectual/developmental disabilities (IDD). Whether working with children in a school system, providing office-based therapy, or assisting with crisis response in our local hospital, or out in the community, WCMHS works toward successful outcomes and wellness for everyone the Agency serves whether in collaboration with other community providers or within our broad portfolio of services for the entire spectrum of life. This includes access to our emergency services; IDD services; outpatient services; children, youth, and family services; and community support services including robust peer support services.

Inherent in our service structure and programing is our interest in the Vermont's System of Care that touches all vulnerable populations whether IDD services, treatment of addiction/substance use disorder and ensuring that all Vermonters have the basic right to live in healthy and safe communities with access to locally provided medical and mental healthcare and support services. As evidence of the Agency's dedication to healthy communities, WCMHS has a history of innovation and thought leadership manifest in our programming. For example, WCMHS was the first to make use of Behavioral Interventionists related to the support provided to children and their family system. The Agency has always been a part of community in providing screeners/clinicians to support law enforcement and first responders in emergency scenarios underscored by a reported mental health crisis.

As a designated agency, WCMHS is a part of the VT System of Care.

1. In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care of for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults)

   We propose a Level 3 care home for aging adults with mental health issues and complex medical needs (Only clients with no extreme behavioral issues or assaultive/dangerous behaviors would/will be eligible). We are currently developing such a facility and would appreciate DMH/DAIL/AHS collaboration to help finance such endeavors in the future since this aging population is an exponentially growing need for which we lack proper resources.

2. Is there a payment methodology which would assist in your ability to implement this programing?

   Our recommended funding model will be a capacity-based model for the programming required for the difficulty of care level of the identified client population. The model would include funding from the Assisted Community Care Services [Title XIX], client

WCMHS RESPONSE: VT AHS/DMH RFI 1

room and board, as well as additional funding from the VT Department of Mental Health.

3. What performance measures should be adopted to monitor and ensure the effectiveness of your programming?

   The Agency would provide quarterly reports regarding its clinical operations. WCMHS shall also report client service encounters via the fiscal agent to a Monthly Service Report and shall also include this program in its monthly financial reports to the Department of Mental Health or Agency of Human Services, a requested.

   Each year, the Agency shall submit an annual program evaluation report covering the previous Fiscal Year to the requesting state agency. The evaluation will include a summary of:

   - Resident LOCUS scores at intake, periodic intervals during admission, and discharge;
   - Number of referrals to the programs and reasons if the referral is not admitted;
   - Number of admissions to the programs and number of discharges from the programs;
   - Length of stay in programs for discharged clients (target: admission duration of 3 to 24 months);
   - Review of employment placements and outcomes (target: 90-100% of residents participate in vocational or volunteer activity before discharge);
   - Review of participation in community-based support groups during admission, e.g., AA, NA, Psychiatric Survivors, WRAP, parenting groups (target: 90-100% of residents participate in vocational or volunteer activity before discharge);
   - Review of residents' access to resources in the community consistent with their recovery goals (i.e., activities that combat isolation, promote formation of supportive social network);
   - Consumer and family evaluation, feedback, and satisfaction data;
   - Description of program services and any changes made throughout the year;
   - Type of living situation upon discharge;
   - outcomes measures on reducing relapse to higher level of in-patient psychiatric and/or medical care;
   - Quality of life improvement measure, reduction in ongoing medical ED and specialist visits. Housing stability.

4. What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care?

   Immediate interventions within three days or less to provide support immediately at discharge, insure housing in the community or proper level of care in group homes, level

WCMHS RESPONSE: VT AHS/DMH RFI 1

3 care homes or other adequate facilities. When feasible, early discharge planning sometimes starting immediately when the client is hospitalized in an in-patient setting through rapid case management assignment. Wrap around services at discharge, including housing, psychiatric, medication assist, community integration, living coaches, ADL support, peer support and vocational support, where appropriate.

5. What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations?

   For the aging population with severe mental illness and complex medical needs, we need more higher care facilities able to help provide proper support for these individuals. There are currently very few resources/facilities able to provide such care in the state of Vermont.

6. What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, IDD services, education, medical/dental, substance use treatment, recreation, family partnership, independent living skills, and community transition)?

   Partnership with home health, medical centers like CVMC for our catchment area, AAA, rehab centers like Berlin Health and Rehab, Choices for Care, etc.

7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced?

   Resident progress is reviewed and tracked weekly via a care plan and biweekly/monthly team meeting. Progress measured through such means as reductions in hospitalizations and self-harm, reduction in substance use, maintaining stable relationships, and finding and maintaining employment.

8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots?

   Inherent in the WCMHS mission is working with all community partners, whether regionally or state-wide, to enhance the quality of care unique to each individual's needs. This would include use of peer support programs whether DS, SUD or other support services for mental health, licensed clinical support including psychiatric and behavioral health therapies, vocational assistance and when necessary, assistance with medical needs. Areas of support could include promoting social interaction, help/guidance with activities for daily living, and provide education and training in learning skills necessary for independent living.

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9. Respondents are welcome to include any other recommendations or thoughts for consideration.

   Programming levels would ideally and eventually allow for clients to be (re)-integrated into the community as contributing members.

Response to RFI 1

Developing and Implementing Programming: Unlocked Community Residences for Transitional Support for Individuals Being Discharged from Inpatient Psychiatric Care or for Intervention to Prevent Inpatient Care.

Vendor's Name: Inner Fire, Inc.

Contact Person: Beatrice Birch, Executive Director

Telephone Number: 802-221-8051 extension 1000

Address: 26 Parker Road, Brookline, Vermont 05345

Email Address: beatrice@innerfire.us

1. In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults). Inner Fire www.innerfire.us is in a unique position to offer alternative, proven therapeutic modalities for those adults afflicted with mental health and psychotropic medication-induced impairments in an unlocked community residence in southern Vermont. In over seven years of operation, Inner Fire has helped forty individuals live fulfilling lives with minimal or no reliance on prescribed psychotropic drugs.

During the mornings, the program focuses on becoming empowered by learning skills while working together for the betterment of the whole community. The individuals in need, who we refer to as 'Seekers', learn to cook, inspired by the GAPS informed, organic, wholefoods diet, which promotes gut health, they garden, sowing seeds, tending and harvesting them, they work in the forest creating trails, sawing and splitting wood, stacking it and eventually heating the farmhouse, they learn to build: hoop house, chicken coop and shelters, picnic tables and Adirondack chairs from boards made from our own lumber and they learn to clean with biodegradable cleaners.
In the afternoons, the individuals focus more on themselves via engaging in the comprehensive therapies that recognize and balance the relationship between the body, soul and spirit through artistic therapy, speech arts, movement therapies such as eurythmy, Tai-Chi, yoga, spatial dynamics, and somatic breath work as well as massage and psychosynthesis. Developing skills by working with glass blowers, stain glass artisans and other skilled craftspeople as well as writing poetry, all this and more help to kindle the creator within oneself thereby awakening a renewed sense of Self and an interest in the world around and within oneself.
The program calls upon, awakens and balances the whole human being of thinking, feeling and willing, the soul qualities which identify us as human beings. This means engaging in activities which ground the vulnerable individuals by drawing the energy from their "heads" down into their "bodies." Such daily activities also include supervised crafts, wood-splitting, animal care, and biodynamic gardening. In the final three months of the program, with insightful support, the Seekers prepare for their independent lives outside of Inner Fire by exploring employment opportunities, working with local artisans and volunteering in areas of interest which could develop and enhance their life skills and employability.

2. Is there a payment methodology which would assist in your ability to implement this programing? Inner Fire's ideally twelve-month intensive and comprehensive therapeutic program would be reimbursed on a pro rata annual tuition basis. Those funds would be applied for jointly by Inner Fire and the appropriate DA/SSA. The approved funds would be appropriated by DMH to Inner Fire under an "Outlier Funding" model or be carved out from the appropriate agency's budget and follow the individual. There is a similar contractual payment mechanism between DMH, DAs, and The Eagle Eye Farm.

3. What performance measures should be adopted to monitor and ensure the effectiveness of your programming? Suggested performance measures would include, but may not be limited to: 1) individuals' ability/success rates in slowly tapering off the too often debilitating and demoralizing cocktail of mind-altering psychotropic medications; 2) learning to connect with the part of themselves which is never wounded 3) recognizing oneself as a creator rather than a victim thereby cultivating wonder and trust in life 4) becoming proficient with NVC (non-violent communication) thereby learning to claim one's voice

and to listen as well 5) appreciating, understanding, and creating a wholesome and healthy diet; 6) becoming empowered by learning to cook healthy meals; 7) understanding and appreciating the beauty and wisdom of nature; 8) eliminating unhealthy addictions such as nicotine, alcohol, drugs, sugar etc. 9) learning basic life skills 10) learning how to claim feelings and also to know that we are more than our feelings 11) learning to tend and cultivate a garden thereby awakening nurturing qualities which serve one's social and community life 12) learning to balance the sympathy and antipathy in one's Self, thereby learning to have healthy boundaries 13) jointly designed quantitative performance measures such as progress reports, healing journeys, and program graduation rates.

4. What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care? As an unlocked, voluntary, residential artistic and land-based community, serving at the moment eight but eventually 12 Seekers from age 18, Inner Fire provides a loving, respectful, caring and safe environment where Seekers (those engaged in our program) participate in physical, creative, intellectual and heart-based work that grounds them and shifts their energy from their head- into-their-body. One can see psychosis as getting stuck in the head, thereby 'spinning off' having lost one's center. The Seekers, each with their own schedule, are very busy and highly engaged in learning how to cook, garden, sing and play music, engage in forestry and other outdoor work, participate in one on one artistic and movement therapies, psychosynthesis, hike, read and write poetry, attend to animal care, while offering and receiving peer support seven days a week. Residents are under the guidance of trained and skilled staff and therapists and actively participate in the life of the organization. We are confident that this therapeutic model with proven outcomes, would be successful in meeting the mental (soul) health and addiction issues, if replicated throughout the state.

5. What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations? In order to reduce hospitalization and to facilitate a seamless transition from inpatient to outpatient settings, we recommend including TCRs, such as Inner Fire, in the planning efforts at the state level.

Our organization is founded on European models which recognize the human being as having a body, soul and spirit and by combining loving insight and years of experience, with respect and a deep understanding for the striving individual, an appreciation that we are not machines and that healing takes time. Inner Fire offers resources and residential accommodations that may not be familiar to or understood by the mental health and addiction communities in Vermont.

Working in tandem with the psychiatric hospitals and DAs to evaluate each candidate's care requirements and to assess the cost of care, we would welcome the opportunity to be included on the planning and negotiating panels. Some additional specific examples could include 1) providing comprehensive client evaluations performed prior to discharge from inpatient care to ascertain if such individual could/would benefit from Inner Fire's services; and 2) accurate assessments that would match individuals to Inner Fire. Inner Fire can attest from its experience that individuals who are motivated to work on themselves and who are committed to stepping out of the medical model system of medicating rather than addressing the deeper lying issues, (the reasons for seeking support), decrease the likelihood of multiple hospitalizations.

6. What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)? Crafts persons, farmers, growers, artists, builders, tiny home builders, cooks, furniture makers, stonewallers, foresters, herbalists, and admirable initiatives which are inspiring and can awaken enthusiasm, make a remarkable difference in the lives of often very creative, sensitive and overwhelmed striving individuals. In our experience, many such individuals will 'find themselves' by getting out-of-their-heads, where they escape from their pain and vulnerability and into- their-limbs by doing good and respectful things. It is a hard world out-there, and a balance is needed; there is room for everyone to bring their gifts.

7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced? At Inner Fire, transitioning begins three months before the Seeker intends to graduate. During this time, the Seeker, is supported in finding a volunteer opportunity or job, to live independently in a 'Creative Living Community', in training or a course of some kind. The majority of Inner Fire Seekers transition back into life as opposed to another facility.

8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots? Inner Fire proposes to incorporate a systemic community approach to care coordination on existing or future projects and pilots by partnering with the Department of Mental Health, Department of Corrections, Law Enforcement, as well as the area Designated Agencies, Support Services Agencies, Peer-managed organizations, and psychiatric hospitals.

As a unique and unlocked Therapeutic Care Residence in Vermont that focuses on assisting individuals with their struggles to live free of psychotropic medications, Inner Fire would become a planning partner with a "seat at the table" to discuss options and alternative opportunities for unlocked adult residential accommodations. Inner Fire would work with DMH's hospital discharge planning committee to review candidates in need of residential placement for an immediate consideration. Inner Fire could also serve as a referral and/or placement resource system to the state's designated community agencies who may not have the resources, expertise, or facilities to assist those who have the desire and ability to live medication-free and thereby, reclaim their lives.

9. Respondents are welcome to include any other recommendations or thoughts for Consideration: *We* recently received this testimony from a former Seeker who is now applying to join us as a Guide, staff member:

Words cannot express the gratitude I have for the Inner Fire community. As one of the very first Seekers, I was drawn to Inner Fire because something in me knew that IF was where my soul needed and longed to be. At the time, my life in Boston was a mixture of suicidal depression and anxiety. I was put on medication at age 15 and by 28 had cycled through at least a dozen pharmaceuticals and developed other substance addictions. The thought of participating in a program like Inner Fire frightened me to death and yet the spark inside me knew to grow stronger it must go.

My year at Inner Fire was one of the most challenging I've had; fear and resistance dogged me throughout. Nevertheless, the seed that was planted 6 years ago, although it endured a cold and harsh winter, is beginning to bear fruit in what feels like the Spring of my life. The lessons about rhythm, nutrition, sleep, caring for the body, appreciating and learning from nature, caring for the living space, noticing and feeling gratitude for beauty outside and within, trusting the process of life, staying in the moment and allowing intuition to guide, imbuing action with love, listening with compassion and giving from the heart...all of these are taking shape in my life as I emerge as the woman I have always wanted to be.

I am ready to give back to Inner Fire as my inner fire is growing stronger and my spirit is learning to soar once again. Inner Fire is hard work, no one says it will be easy, but engaging changed the course of my life. The backbone of Inner Fire, the love, passion, fire, vision, kindness, compassion, courage, peace, and determination, is the founder Beatrice Birch. I am eternally grateful for her and all the Guides, Seekers, and members of the community who together are weaving Love and healing into the world, and who saved my life.

Julie
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Response of RFI 1

Developing and Implementing Programming: Unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care

Rutland Mental Health Community Care Network

Laura Kass

78 South Main Street

Rutland Vermont 05701

lkass@rmhsccn.org

(802) 775-5403

1. In your region, what programming would you propose to develop and implement for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care? Please specify the population this programming would serve (children, youth, and/or adults)

Community Care Network/Rutland Mental Health Services proposes to use 6 Royce Street in Rutland Vermont to create a long-term Mental Health Group Home. The property at 6 Royce Street is currently licensed as a level three care home and owned by CCN/RMH. Programming that was occurring at this location will be relocating due to specific program and client needs.

CCN/RMHS is requesting funding to support a five-bed long term residential facility for individuals who are diagnosed with a mental illness and have demonstrated an inability to live independently. Part of the referral process to this facility would request that the individual seek placement at local Community Care Homes prior to referral or cite specific clinical rational for needing the mental health expertise in the facility due to the limited capacity. Additionally, while an individual is residing at 6 Royce Street it would be necessary to consider discharge criteria: the individual no longer requires or meets criteria for a level three care home, voluntary discharge, or needs exceed level of care (requiring nursing home). Furthermore, it will be important for residents and providers to continue looking at local Community Care Homes as appropriate for transfer to support bed availability. In addition to providing standard level three care home supports/services, this location would offer 24/7 staffing trained to work with adults experiencing mental illness, prompting/support with activities of daily living, psychoeducation, activities off and on site, peer support, life skills, and healthy living skills.

2. Is there a payment methodology which would assist in your ability to implement this programing?

The creation of this additional level of care will require 2,240 hours per week of staffing time, 40 hours per week RN, and 80 hours per week for management of this facility. Payment methodology would be to incorporate this level of care into current case rate system. Additional costs for this facility will come from room and board.

3. What performance measures should be adopted to monitor and ensure the effectiveness of your programming?

Performance measures of this facility would look at the bed census, client satisfaction surveys, LOCUS/ANSA scores, reason for discharge, and tracking the individual use of the emergency department, psychiatric unit, and crisis services.

4. What actions are you currently taking that other regions could consider adopting to ensure children/youth and/or adults are supported to prevent inpatient care or upon discharge from inpatient care?

CCN/RMHS has attempted to meet current needs by utilizing our Crisis Stabilization and Inpatient Diversion (CSID) program, Maplewood IRR, Transitional Apartments, and Community based supports. These supports do not meet the growing need for long-term care as they are all time limited. CCN/RMHS partners with local Community Care homes to provide the mental health treatment and residential support in a fragmented way. As cited in Analysis of Need: Residential Mental Health Beds published by the Department of Mental Health: "Individuals who are aging are more likely to stay in place due to the lack of access to appropriate nursing facility and other long-term setting options for individuals with mental health needs. Community care homes (level 3) are also closing due to low reimbursement rates - these are privately owned residences that provide meals, med management, and psychosocial supports. Treatment is not typically provided within a Community Care Home. Mental Health treatment is provided by the local Designated Agency" (p10). CCN/RMHS has worked to provide trainings at these facilities, which has assisted in sustaining individuals' current placements, however the number of new referrals being accepted at these locations is almost none. This has resulted in less than quality care for our clients by way of the current system of care often times being stuck while searching and waiting for appropriate placements. Additionally, CCN/RMHS attempts to stretch resources to make what is available work as best as it can. However, individuals are still visiting the emergency department, and requiring inpatient psychiatric care at an increased rate due to inappropriate placements. As reported in Analysis of Need: Residential Mental Health Beds, "During the same time period, 15% of involuntary admissions came from Rutland County, 6% of IRR beds are filled with individuals from Rutland County (1% of Rutland Mental Health's entire CRT population), and 0% (Zero) group home beds are filled with Rutland County residents. Looking at these regions, one can see that as a percentage of their CRT population the use of IRR beds is consistent, however the Howard Center's use of Group Homes is much higher than in Rutland (9% vs 0%). Further evaluation is indicated to determine if this is a result of purely a lack of a resource (no Group Homes in Rutland) or a different philosophy related to group home usage" (p20). As this proposal suggests, this is a necessary resource within this area.

5. What supports and resources are needed to facilitate seamless transitions into and out of inpatient settings and to reduce the likelihood of multiple hospitalizations?

Vermont has an aging population, and those affected by mental illness struggle more significantly to find long term placements that are able to appropriately and effectively provide care. "Almost half of CRT

enrollees are between 50 and 64 years old. The next highest represented age group are 30- to 49-year-olds, who comprise about one-quarter of enrollees" (Rudge, Esq. 2020). Level three community care homes in Rutland County continue to dwindle including the closure of Maple Terrace in Rutland, Lake Wood in Castleton and the currently closing Owen house in Fair Haven, and "For Sale" sign on Misty Heather in Hydeville. This has created a significant shortage of placements for increasingly growing population of individuals who are older and/or unable to care for themselves. Individuals needing to discharge from the hospital do not have appropriate places to discharge to, and are then discharged to lower levels of care resulting in rapid re-admissions.

6. What partnerships could be established to provide the services needed by individuals and their families (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)?

Partnerships have been crafted between primary care offices, substance abuse services, developmental services, adult mental health services, care-giver support, wellness activities, vocational supports, the Emergency Department, Crisis stabilization, IRRs, transitional housing as Rutland Mental Health facilitates and/or is embedded with each of these community resources or level of care. These partnerships established support efforts to provide individuals with a wide range of services tailored to needs and preferences. This structure also assists with appropriate smooth transitions in a client's life.

Currently the Adult Behavioral Health management team is comprised of multiple departments including CRT, AOP, CSID, Maplewood, and DS residential services allowing for partnering across programs. In addition, the Adult Behavioral Health Director meets frequently with Director of Emergency Services, Substance Abuse, Child and Family, Developmental Services, and the Head of Social Work within local hospital. These regular connections allow for innovation, flexibility in accessing or utilizing resources available.

7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential or inpatient (when required) are reduced?

This proposal is asking to add an additional level of care to Rutland County. Previous commissioner Melissa Bailey expressed that the Department of Mental Health should prioritize "Continue to explore or build geriatric psychiatric capacity" in her presentation of goals for FY19. Vermont has an aging population, and those affected by mental illness struggle more significantly to find long term placements

that are able to appropriately and effectively provide care. "Almost half of CRT enrollees are between 50 and 64 years old. The next highest represented age group are 30- to 49-year-olds, who comprise about one-quarter of enrollees" (Rudge, Esq. 2020). CCN/RMHS has attempted to meet those needs by utilizing our Crisis Stabilization and Inpatient Diversion (CSID) program, Maplewood IRR, Transitional Apartments, and Community based supports. These supports do not meet the growing need for long-term care as they are all time limited. CCN/RMHS partners with local Community Care homes to provide the mental health treatment and residential support in a fragmented way. As cited in Analysis of Need: Residential Mental Health Beds published by the Department of Mental Health: "Individuals who are aging are more likely to stay in place due to the lack of access to appropriate nursing facility and other long-term setting options for individuals with mental health needs. Community care homes (level 3) are also closing due to low reimbursement rates - these are privately owned residences that provide meals, med management, and psychosocial supports. Treatment is not typically provided within a Community Care Home. Mental Health treatment is provided by the local Designated Agency" (p10). CCN/RMHS has worked to provide trainings at these facilities, which has assisted in sustaining individuals' current placements, however the number of new referrals being accepted at these locations is almost none. This has resulted in less than quality care for our clients by way of the current system of care often times being stuck while searching and waiting for appropriate placements. The goal is by adding another level of care to the current system, we will be able to utilize resources appropriately, transition individuals more quickly to appropriate placements, thus reducing tension on the larger system of care.

8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots?

CCN/RMHS attempts to stretch resources to make what is available work as best as it can. However, individuals are still visiting the emergency department, and requiring inpatient psychiatric care at an increased rate due to inappropriate placements. As reported in Analysis of Need: Residential Mental Health Beds, "During the same time period, 15% of involuntary admissions came from Rutland County, 6% of IRR beds are filled with individuals from Rutland County (1% of Rutland Mental Health's entire CRT population), and 0% (Zero) group home beds are filled with Rutland County residents. Looking at these regions, one can see that as a percentage of their CRT population the use of IRR beds is consistent, however the Howard Center's use of Group Homes is much higher than in Rutland (9% vs 0%). Further evaluation is indicated to determine if this is a result of purely a lack of a resource (no Group Homes in Rutland) or a different philosophy related to group home usage" (p20). As this proposal suggests, this is a necessary resource within this area to support the goals of older Vermonters aging in place, least restrictive approach to Mental Illness, and decrease utilization of Emergency Department and inpatient psychiatric care.

9. Respondents are welcome to include any other recommendations or thoughts for consideration.

Rutland Mental Health Services, Inc.
Proposed Budget
Mental Health Group Home - Royce Street, Rutland Vermont

	Description	Annual Amount
Salary and Wages:		
Residential Staff	*12 FTE, $17/hr*	$ 424,320
Supervisor	*1 FTE*	40,000
Manager	*1 FTE*	48,000
Peer Support	*.5 FTE*	16,640
Registered Nurse	*1 FTE*	70,000
Psychiatric Consultant		20,000
Total salary expense		618,960
Payroll Taxes and Fringe Benefits	*Approximately 33% of salaries*	204,260
Total Salaries and Benefits		823,220
Direct Operating Expenses:		
Recruitment Costs		4,000
Food		9,600
Operating/Medical Supplies		6,200
Vehicle Expenses		2,200
Property Taxes		5,700
Electricity		3,200
Heat		3,400
Other Utilities		8,600
Building Repairs		2,000
Other		5,000
Total Direct Operating Expenses		49,900
Subtotal - Direct Expenses		873,120
Indirect Expenses:		
Administrative Cost Allocation	*Approximately 12.50% of direct expenses*	106,875
Program Support Cost Allocation	*Approximately 10% of direct expenses*	87,312
Total Indirect Expenses		194,187
Total Expenses		**$ 1,067,308**

One-Time Costs:	
Chair Lift for Stairs	$ 13,000
Renovations - ADA Compliance Items	55,000
HVAC Inprovements	15,000
	$ 83,000