REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

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PRELIMINARY REPORT ON THE IMPACT OF PROVIDER RATE INCREASES

In accordance with
Section E.301.3 of Act 185 of 2022: An act relating to making appropriations for the support of government.

Submitted to: Vermont General Assembly

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LEGISLATIVE REQUEST

Section E.301.3 of Act 185 of 2022 calls on the Agency of Human Services to provide a preliminary report to the General Assembly on the impact of provider rate increases on or before April 15, 2023. The statute appropriates $294.5M to mental health, $282.2M to developmental services, and $247.2M to long term care and requires recipients of these funds to be transparent in the use of these funds through timely and accurate reporting. In turn, the preliminary report from the Agency of Human Services shall utilize submitted information from the Designated and Specialized Service Agencies and the Home Health Provider Agencies. The preliminary report shall focus on whether the fiscal year 2023 provider rate increase is having an impact on:

(1) reducing the wait times for community-based mental health services or community-based home health services under the Choices for Care Program;
(2) reducing the use of emergency department resources at local hospitals for mental health related incidents; and
(3) improving the staff vacancy rate at these providers through their ability to recruit and retain employees.

EXECUTIVE SUMMARY

There are multiple ways to assess the impact of a funding increase on staffing levels, wait times, and emergency department use. In the most straightforward manner, did relevant metrics improve after the infusion of funding? To add a level of complexity, one could also ask how the metrics would have performed without the intervention. Finally, one could ask if the impact is likely to take more than two quarters to be evident.

In the most straightforward assessment, the immediate impact appears to be quite limited. To sum up this report: there does not appear to be a correlation between the fiscal year 2023 (FY23) infusion of funding and first-half of FY23 staffing levels, wait times, and emergency department use.

First, the goal of increasing staff capacity was not met – at least not at the organization-wide level. Rather than growing, the number of filled positions at all Designated and Specialized Service Agencies (DA/SSA) actually decreased by nearly 58 full-time equivalents (FTE) from the third quarter of FY22 to the second quarter of FY23.[1] Likewise, on the Home Health Agency (HHA) side, the ten agencies' filled positions collectively fell by more than 156 FTE, a drop of nearly 12%.

The trend was not uniform across agencies, however. Nine DA/SSAs collectively achieved net growth of 188 filled FTEs over the evaluation period, while eight others lost 246. For HHAs, only one (Lamoille Home Health Agency) increased the number of filled positions.

Second, the goal of reduced wait times for services is obscured by data limitations but likewise appears to be mixed. Several organizations' wait times improved while others worsened.

Third, the assessment of emergency department resources is unclear. Of the three, this goal suffered the most from data quality issues, extreme variance, and imperfect proxy metrics.

The Vermont Agency of Human Services (AHS) does not have the capacity to model results that could have been expected from no intervention. However, two metrics from the U.S. Bureau of Labor Statistics offer some perspective. First, a measure of job openings in health care and social assistance nationally peaked in March 2022 then softened through the end of 2022. Second, a measure of Vermont's broad labor tightness fell year-over-year the last six months of 2022. While the Bureau does not track Vermont's health care sector specifically, these proxies suggest hiring and retention should not have been harder in late 2022. The fact that staffing levels fell suggests that the FY23 investment did not significantly impact hiring and retention - at least not in the short-term.

In reviewing available data, AHS makes three recommendations:

1) **Share the approaches of providers that have excelled** on these metrics and explore whether successful strategies are applicable to other providers. Continue to monitor metrics at the individual agency level to ensure that system-wide averages do not mask important trends and differences among providers.
2) **Increase data quality and consistency** while taking steps to reduce the reporting burden through the use of the Vermont Health Information Exchange and standardized dashboards.
3) **Conduct an analysis of fiscal year-end provider staffing levels** to continue to monitor potentially lagging impacts. AHS will update the numbers and review the recommendations based on the data, including analyzing staffing and vacancy data not just at the organization level but also by employee type, a criterion that AHS is collecting for FY23 for grant purposes.

[1] Excludes one Designated Agency that had not submitted mid-year data as of April 15.

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INTRODUCTION

While the COVID-19 pandemic disrupted all Vermonters' lives, it wreaked particular havoc on health care and human services workers. Many left their jobs. Employers found it difficult to hire replacements in a tight job market. They faced the unenviable options of either hiring high-cost contract workers like travelling nurses, cutting back service levels, or putting a heavier workload on those who remained.

Recognizing the challenge, the State of Vermont's fiscal year 2023 (FY23) budget appropriated $294.5M to mental health, $282.2M to developmental services, and $247.2M to long term care. Statute requires recipient providers of these funds to be transparent through timely and accurate reporting so the State could determine the impact of the investment. In particular, it seeks to assess impact in three domains:

> (1) reducing the wait times for community-based mental health services or community-based home health services under the Choices for Care Program;
> (2) reducing the use of emergency department resources at local hospitals for mental health related incidents; and
> (3) improving the staff vacancy rate at these providers through their ability to recruit and retain employees.

To assess the impact on the three specified domains, the Vermont Agency of Human Services (AHS) consulted the Department of Disabilities, Aging and Independent Living (DAIL), Department of Mental Health (DMH), and the providers' trade associations.

This report explores whether relevant metrics improved after the infusion of funding. It then asks how the metrics would have performed without intervention, seeks to identify shortcomings in available data, and shares a set of recommendations. Finally, the appendices discuss the status of work with AHS and designated and specialized service agencies on data connectivity (Appendix A) and share graphs, tables, and links associated with the assessment of impact.

Providers Covered in Report that Received Premium Pay for Workforce Recruitment and Retention Grants		
Designated Agencies (DAs)	Specialized Service Agencies (SSAs)	Home Health Agencies (HHAs)
• Clara Martin Center (CMC) • Counseling Service of Addison County (CSAC) • Health Care and Rehabilitation Services (HCRS) • Howard Center (HC) • Lamoille County Mental Health Services (LCMHS) • Northeast Kingdom Human Services (NKHS) • Northwestern Counseling and Support Services (NCSS) • Rutland Mental Health Services (RMHS) • United Counseling Service of Bennington County (UCS) • Upper Valley Services (UVS) • Washington County Mental Health Services (WCMHS)	• Champlain Community Services (CCS) • Families First (FF) • Green Mountain Support Services (GMSS) • Northeastern Family Institute, VT (NFI) • Lincoln Street Incorporated (LSI) • Pathways Vermont (PV) • Specialized Community Care (SCC)	• Addison County Home Health and Hospice (ACHHH) • Bayada Home Health Care (Bayada) • Caledonia Home Health Care (Northern Counties Health Care) • Central VT Home Health and Hospice (CVHHH) • Franklin County Home Health and Hospice (FCHHH) • Lamoille Home Health and Hospice (LHH&H) • Orleans-Essex VNA and Hospice (OEVNA) • UVMNH Home Health and Hospice (UVMHHH) • Visiting Nurse Association of Vermont and New Hampshire (VNH) • VNA & Hospice of the Southwest Region (VNAHSR)

IMPACT ON STAFFING LEVELS

To assess the impact on staffing levels and vacancy rates, AHS analyzed staffing data submitted by DA/SSAs, HHAs, and eight other provider types as part of the Premium Pay for Workforce Recruitment and Retention grant program (figures 1, 2). When the providers applied for grants in spring 2022, applicants submitted data on the status of their filled positions and vacancies for January to March 2022 (Q3 FY22). They were directed to do so again in January 2023 for October to December 2022 (Q2 FY23). AHS was thus able to compare staffing data from before and after the provider rate increases and premium pay grants.

The data do not show success in increasing staff capacity. Rather than growing, the number of filled positions at all responding DA/SSAs actually decreased by nearly 58 full-time equivalents (FTE) from the third quarter of FY2022 to the second quarter of FY2023 (figures 3, 4). Likewise, on the HHA side, the ten agencies' filled positions collectively fell by more than 156 FTE, a drop of nearly 12% (figures 5, 6).

Two notable observations:

1) **The downward trend was not uniform across agencies.** Nine DA/SSAs collectively achieved net growth of 188 filled FTEs over the evaluation period, while eight others lost 246. Two SSAs (GMSS and UVS) reported zero vacancies in Q2 FY23, while one DA (HCRS) added 88 FTEs. For HHAs, only one (Lamoille Home Health Agency) increased the number of filled FTEs. At the start of 2022, two DA/SSAs and two HHAs had vacancy rates over 20%; at the end of the year, three DA/SSAs and five HHAs did.
2) **Vacancy rates ticked up but to a lesser degree than staffing levels fell.** For example, the average HHA vacancy rate only rose from 16 to 18% even as staffing levels saw double-digit percentage drops. The reason for this phenomenon is that the number of budgeted positions also fell over the course of the year. Multiple organizations report that they evaluate prospects quarterly and adjust staffing targets accordingly.

But how would the vacancy and staffing metrics have performed without the intervention? AHS does not have the capacity to model results that could be expected with no intervention. However, job opening and separation data from the U.S. Bureau of Labor Statistics indicate unmet demand for labor and serve as proxies for tightness within job markets. The data show national job openings in health care and social assistance peaked in March 2022 then softened through the end of 2022 (figure 7). Likewise, year-over-year Vermont nonfarm separations - a measure of Vermonters leaving jobs in all sectors except farming - fell in each of the last six months of 2022 (figure 8). While the Bureau does not track the Vermont health care sector specifically, these two proxies suggest that hiring and retention should have become relatively easier in late 2022.

Conclusion: The fact that DA/SSA and HHA staffing levels fell even as the job market was loosening suggests that the FY23 investment did not significantly impact hiring and retention - at least not in the short-term.

IMPACT ON WAITLISTS

Designated and Specialized Service Agencies

To assess the impact on DA/SSA wait times, AHS analyzed two datasets: 1) waitlists and estimated wait times submitted quarterly by the agencies with regard to outpatient therapy for all ages and residential therapy for adults, and 2) the percentage of clients to whom each agency offers a face-to-face or telehealth contact within five calendar days of initial contact with agency.

The first set of metrics started with the DAs and Vermont Care Partners as an informal point in time survey for advocacy purposes before migrating to AHS for the purposes of this report. As such, some agencies are still working to improve data integrity. AHS offered agencies the opportunity to add additional context and has included submissions in Appendix D. Also of note, many DAs offer clients group treatment and other services while they await individual therapy.

AHS looked at waitlists for the ten DAs for January 2023 compared to February 2022 (the most recent metrics approximating year-over-year). Over that period, the average waitlists and wait times improved considerably for Child/Youth Outpatient Therapy (from 493 people expecting to wait 133 days on average to 285 people expecting to wait 77 days) but worsened slightly for Adult Outpatient Therapy (from 330 people expecting to wait 79 days on average to 346 people expecting to wait 85 days). For Adult Mental Health Residential, the waiting list stayed constant (25 people) but the expected wait time nearly doubled from 129 to 233 days (figure 9).

As with vacancies, waitlist trends were not uniform across agencies. Of note:

- **Adult Outpatient** – While the average wait time bumped up to 79 days statewide, eight of ten DAs had wait times of 60 days or less. Expected wait times ballooned by 50% at Howard Center and WCMHS to 180 and 84 days respectively. These two providers account for a majority of adults waiting and pulled up the average. Of note, UCS cut its waitlist by more than half and its wait time by nearly two-thirds (figure 10).
- **Child/Youth Outpatient** – Seven DAs reduced their waitlists, while waitlists grew at the other three. Wait times shortened at five and lengthened at four. Notably, Howard Center cut both the number waiting and the anticipated wait time by more than 80% (figure 11).
- **Adult Residential** – Waitlists shrunk with three DAs and grew at three others. Wait times shortened at three and lengthened at three. A majority of adults waiting statewide (15 of 25) are served by either Howard Center or UCS and can expect to wait 11 or 12 months. The remaining adults are waiting at WCMHS, RMHS, NCSS, and CSAC and can expect waits of one to five-and-a-half months, depending on the DA (figure 12).

The second metric is a component of Department of Mental Health's value-based payment measures and is deemed important because research has shown clients who are offered a timely first visit after contacting a mental health treatment provider are more likely to engage and remain in services. The measure looks at an agency's role in providing clients a reasonably convenient opportunity for initial engagement. Collectively, DAs improved to offer timely appointments to 68% of clients in the last quarter of calendar year 2022, the highest level since early 2021 (figure 13).

As with other metrics, performance varied greatly across DAs. The value-based payment target is defined as 80% of the mean across all agencies for the previous three reporting years. For

calendar year 2022, this equated to offering timely visits to 48% of clients. In the last two quarters of 2022, six agencies met the target both quarters, while two met one and missed one, and the other two did not meet the target either quarter. Figure 14 shows the wide variance in performance, with HCRS and UCS continuing to set the bar by continually offering timely appointments to over 90% of clients, CMC and NCSS jumping from low performance to meeting the target, and LCMHS and RMHS falling from stellar performance on this measure at points in 2021 to offering timely appointments to 25% or fewer of clients at the time of their last report.

Conclusion: More time is needed to see if clearer trends emerge. The various waitlist and wait time metrics saw mixed results, with several organizations improving while others worsened. An overall rise in timely offer of appointments to the highest levels since early 2021 offers cause for optimism, with more organizations improving than worsening.

Home Health Agencies

AHS examined two datasets on the HHA side: 1) monthly reports of the number of Moderate Needs Households Waiting for Homemaker Services, and 2) the Department of Disability, Aging, and Independent Living's (DAIL) survey of Choices for Care case management agencies.

The first dataset relies on reporting from the agencies to DAIL and has some gaps. Looking at data from the six agencies with complete submissions doesn't show a clear improvement from SFY22 to the first half of SFY23 (figure 15). In fact, the three agencies with the largest waitlists – VNH, UVMHHH, and FCHHH all saw increased waitlists over those periods.

Missing data from late or omitted monthly reports also pose a challenge. Assuming the most recent reported waitlist figures held true for subsequent months with missing data, the overall year-over-year waitlist for July to December 2022 vs. 2021 saw a 7% increase in the overall waitlist. As with the DA/SSAs, the performance was not uniform across all agencies. Orleans/Essex reported no waitlist throughout the entire period and Caledonia was able to reduce their waitlist to a monthly average of just three (figure 16).

The second dataset, the survey of Choices for Care case management agencies, included qualitative feedback from both Home Health Agencies and Area Agencies on Aging. The Area Agencies on Aging in particular spoke to the workforce shortage's impact on clients, especially Moderate Needs Households, who are not counted on waitlists because they receive some services but don't have the opportunity to utilize their full care plans.

Conclusion: As could be expected, waitlists appear to correlate inversely to staffing. With HHA filled positions down 12% from the first to last quarter of calendar year 2022, homemaker services waitlists expanded by 19% over the same period.

IMPACT ON EMERGENCY DEPARTMENT USE

For the third assessment domain – impact of emergency department (ED) resources – AHS examined two datasets: 1) Vermont Care Partners' reports of ED use by Children, Youth, Family Services (CYFS) and Community Rehabilitation Services (CRT) clients aggregated across all agencies, and 2) An analysis of the number of crisis services delivered in emergency departments.

Children, Youth, and Family Services provides supports for children's mental health conditions. Agencies strive to provide supports and services where children and families are in their daily lives, at home and in settings like childcare, schools, primary care offices, teen centers, etc. The Community Rehabilitation Services (CRT) program serves adults with the most serious mental illnesses. If a person is determined to be eligible, the individual is the highest priority for designated agency or specialized services agency treatment services. People are assigned a treatment team of providers which may include a therapist, case manager, psychiatrist, nurse, and a supported employment specialist.

If CYFS and CRT clients are well-served in the community setting, their likelihood of presenting at the ED for a mental health crisis can decrease. Year-over-year data from the Vermont Care Partners Data Repository for the second half of calendar year 2022 vs. 2021 shows double-digit decreases for both populations, with CYFS clients cutting ED use by more than half (figures 17, 18). If reliable, these data represent tremendous progress in reducing the use of EDs for mental health services. Further analysis would be needed to determine if the improvements are similar across regions and agencies.

The second dataset looks at a broader population. The analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit examines the number of ED crisis services reported by DAs in their Monthly Service Reports. Analysis includes services for clients with primary program assignments of Adult Outpatient and Emergency as well as CYFS and CRT.

The broader emergency department crisis services Monthly Service Reports also show a decrease (6%) in the second half of calendar year 2022 vs. 2021. However, a breakout by DA shows extreme variance. Only one agency (Howard Center) demonstrated a moderate drop (9%). Three organizations went dramatically in the other direction, with HCRS quadrupling the number of crisis services delivered in the ED, WCMHS nearly tripling, and CMC nearly doubling. On the other end of the spectrum, NKHS (down 96%) virtually dropped off the map while CSAC and RMHS each cut their ED assessments by about half. NKHS went from an average of 40 ED assessments per month to 1.5 per month (figures 19,20).

A deeper review of the data suggests that high utilization of telemedicine during the pandemic may be responsible for the data anomalies, particularly for agencies with sharp increases in 2022. DMH determined there was an issue where individuals seen in the ED via telemedicine in 2021 were coded by some agencies as "Telemedicine" location, rather than ED. DMH requested that DAs report uniformly based on location of the client in 2022. For agencies relying heavily on telemedicine, this could explain significant reported increases in ED location reporting that do not accurately represent a true increase. More work is also needed to determine whether significant reported decreases represent true decreases.

If reliable, an 11% year-over-year drop in crisis services could convey an impressive but realistic step toward the goal of providing service to clients while alleviating burden on EDs. However, the extreme variance at the agency level suggests more research is needed to understand care coordination and efforts to reduce ED burden.

Conclusion: Metrics for emergency department use appear to be limited by data quality issues, extreme variance, and imperfect proxy metrics. AHS, DMH, and the DAs are working together to hone DA-ED care coordination plans in order to report more solid metrics in the months ahead.

RECOMMENDATIONS

In reviewing available data, the Agency of Human Services makes three recommendations:

1) **Share the approaches of providers that have excelled on these metrics and explore whether their strategies are applicable to other providers.**

    - Pathways (+26% filled FTEs), HCRS (+19%), and Families First (+12%) grew their staff by double digits while most DA/SSAs and HHAs lost staff;
    - UCS cut its adult outpatient waitlist by more than half and its wait time by nearly two-thirds;
    - Howard Center cut both the number of children/youth waiting for outpatient therapy and the anticipated wait time by more than 80%;
    - NCSS jumped from offering appointments to 12% of clients within five days in the last quarter of SFY22 to 69% in the second quarter of SFY23, while HCRS has exceeded 90% for at least eight straight quarters.

    How did these agencies achieve these successes? Are there strategies that other agencies could adopt?

2) **Increase data quality and consistency while taking steps to reduce reporting burden by using the Vermont Health Information Exchange and standardized dashboards.**

    Data integrity presents a challenge for many agencies. At the same time, manual reporting can be burdensome. Many provider types use Electronic Health Record vendors and the Vermont Health Information Exchange (VHIE) to automate data submissions. The DA/SSAs are working with AHS and Vermont Information Technology Leaders (VITL), the operator of the VHIE, to establish the ability to electronically transfer data by July 1, 2023 (Appendix A). AHS and its departments should continue to work with agencies to complete connectivity and data governance planning, work to streamline reporting to essential metrics, and automate as much reporting as possible to improve integrity and reduce burden.

3) **Conduct an analysis of fiscal year-end provider staffing levels to continue to monitor potentially lagging impacts.**

    Could it be that the impact of the FY23 funding infusion will take more than two quarters to manifest in staffing, wait time, and emergency department use? AHS proposes updating this analysis in fall 2023 based on full FY23 metrics. The next analysis will be able to look at staffing and vacancy data not just at organization level but also by employee type, a criterion that was added for 2023 reports.

APPENDIX A: STATUS OF DESIGNATED AND SPECIALIZED SERVICE AGENCY DATA CONNECTIVITY

In the SFY23 Provider Agreements with AHS departments, the Designated and Specialized Service Agencies (DA/SSAs) agreed to electronically connect to the Vermont Health Information Exchange (VHIE). The DA/SSAs agreed to propose to AHS a detailed process to enable connectivity between the DA/SSAs' Electronic Health Record vendors and the VHIE by January 1, 2023, and to continue working with Vermont Information Technology Leaders (VITL), the operator of the VHIE, to establish an electronic transfer of data by July 1, 2023.

AHS agreed to host monthly meetings with the DA/SSAs in advance of the proposals until December 2022, to respond back to DA/SSAs proposals within 60 days of receipt of those proposals, and to collaborate with the DA/SSAs on data governance starting March 2023.

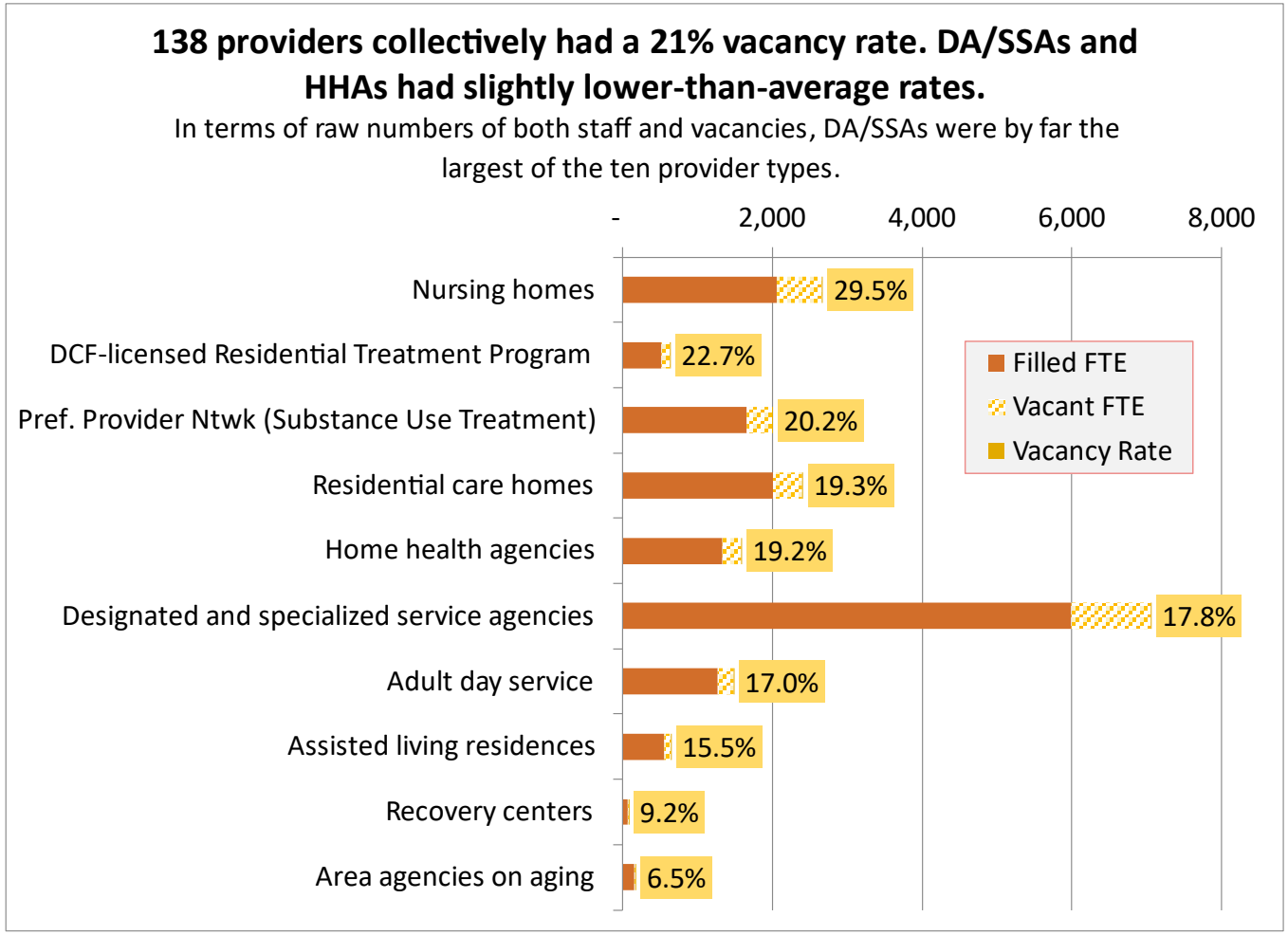
AHS hosted several operational/technical assistance meetings with the DA/SSAs, Vermont Care Partners (VCP) and VITL in late 2022 and early 2023. These sessions had strong representation and engagement from all concerned parties. In December, the DA/SSAs requested – and AHS granted - an extension on their proposal submission to February 1. The DA/SSAs continued to work collaboratively with the partners. All met the extended deadline.

On February 28, 2023, AHS fulfilled its obligation of providing a list of specific data elements it is seeking to access and the intended uses of the data. AHS responded to each of the eleven proposals within the contractually obligated timeframe. Based on the proposals eight were conditionally accepted and three required additional follow up and detail to the AHS, particularly based on estimated connectivity costs. AHS' concern was the cost estimates from these three DA/SSAs was four to five times higher than the other proposals despite using the same Electronic Health Record vendors. These three DA/SSAs that required additional follow up have been prompt in responding to AHS. Two of the three have scheduled meetings with AHS during the first week of April 2023 to discuss further. The remaining one has re-submitted their projected connectivity cost and AHS is reviewing that information. These discussions are ongoing at the time of writing this report and AHS is optimistic the DA/SSAs and AHS can reach an agreement on reasonable costs. AHS has offered, and conditionally approved eight proposals, to pay for the connectivity costs for the DA/SSAs to connect to the VHIE. AHS and the DA/SSAs have agreed to undertake this project in phases, iteratively, the scope of the first phase being achieving initial connectivity via a standard Health Level Seven (HL7) Admission Discharge Transfer (ADT) message type by July 1, 2023.

As stated in the Provider Agreements, AHS initiated data governance conversations in March 2023. The DA/SSAs, VCP, VITL, and AHS have agreed to work in partnership to establish data governance that will provide the oversight of data management practices and processes. This work is underway as of the writing of this report. DA/SSAs will not be required to share any data as of the connectivity deadline absent agreement as to the data elements and governance structure. It is worth noting, in November 2022 the federal Substance Abuse and Mental Health Services Administration released a proposed rule that seeks to better align the Confidentiality of Substance Use Disorder Patient Records regulations under 42 CFR part 2 with the regulatory requirements under the Health Information Portability and Accountability Act. As such, the goal of the data governance effort will be to satisfy the current rules while providing flexibility to evolve with the changing rules and regulations.

APPENDIX B: DATA RELATED TO STAFFING LEVELS

Figure 1 GRAPH: Full-time Equivalents and Vacancy Rate by Provider Type - Q3 FY22 (Jan-Mar 2022)



Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

Figure 2 TABLE: Staffing Reported by Providers to AHS for Q3 of FY22 (Jan-Mar 2022)

Provider Types	# of Grantees	Total Budgeted Positions		Vacancy Rate		
		Filled FTE	Vacant FTE	Vacancy Rate	Min Vacancy Rate	Max Vacancy Rate
Nursing homes	33	2,057	607	**29.5%**	0.9%	53.8%
DCF-licensed Residential Treatment Program	8	515	117	**22.7%**	0%	38.2%
Pref. Provider Ntwk (Substance Use Treatment)	12	1,663	336	**20.2%**	0%	38.2%
Residential care homes	34	2,012	387	**19.3%**	0.0%	40.0%
Home health agencies	10	1,331	255	**19.2%**	5%	31.9%
Designated and specialized service agencies	18	5,986	1,063	**17.8%**	6.5%	23.0%
Adult day service	13	1,266	215	**17.0%**	0%	45.9%
Assisted living residences	14	558	87	**15.5%**	0%	40.7%
Recovery centers	10	73	7	**9.2%**	0%	22.2%
Area agencies on aging	5	161	10	**6.5%**	0%	12.9%
Total (deduplicated)	**138**	**11,779**	**2,332**	**19.8%**	**0.0%**	**53.8%**

Notes: 1) If a grantee selected multiple provider types, they show up in multiple rows but are not double counted in the total.

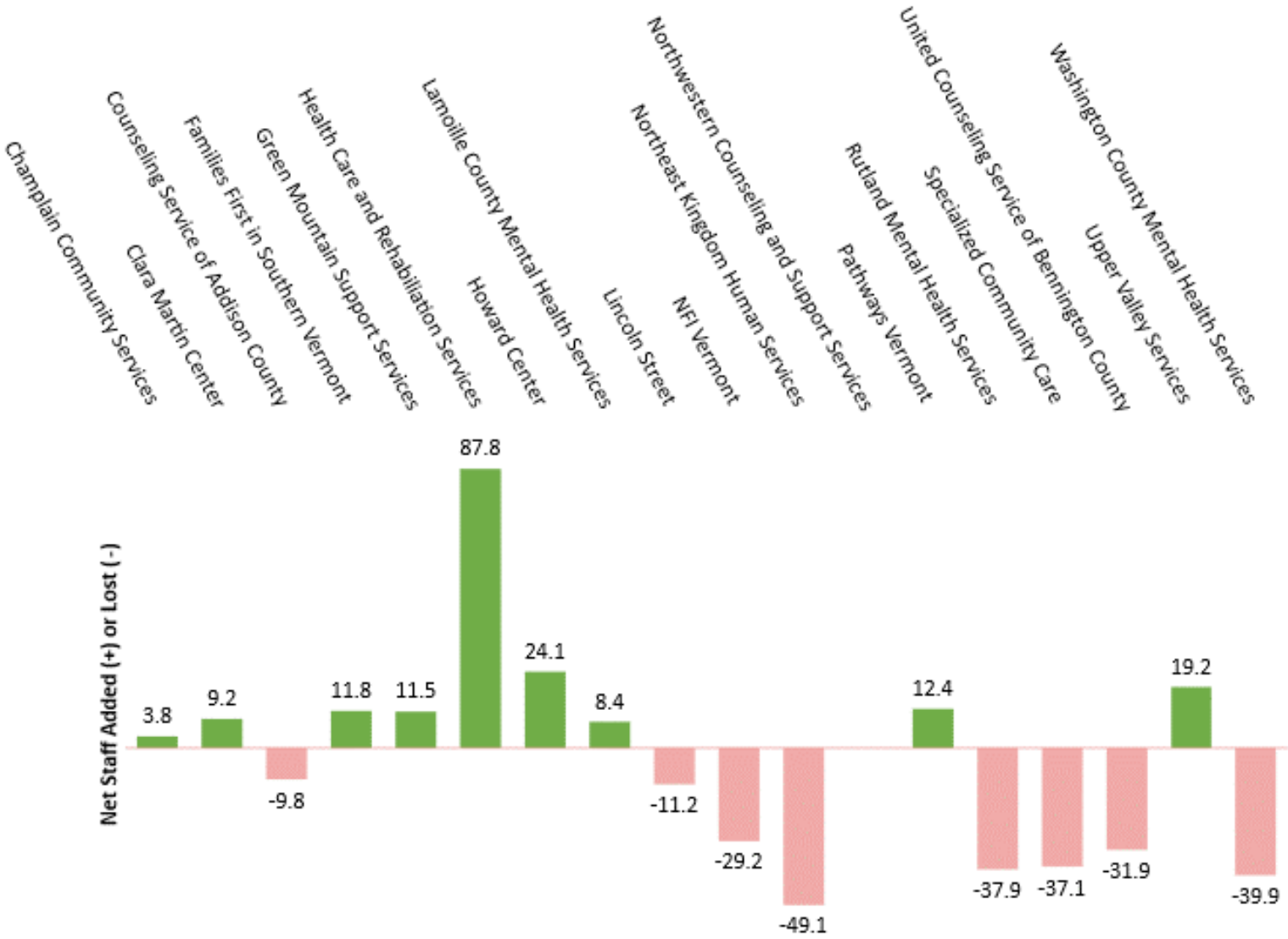
2) Shared Living Providers (SLPs) were eligible for Premium Pay grant funds and are included in DA/SSA staff counts above.

3) If a provider uses a contractor such as a traveling nurse to cover a vacant staff position, that FTE is counted as 'vacant' not 'filled.'

4) ARIS received a grant for independent contractors but is not included here.

Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

Figure 3 GRAPH: Change in Filled DA/SSA Positions, Q3 FY22 to Q2 FY23



Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

Figure 4 TABLE: Change in Filled DA/SSA Positions, Q3 FY22 to Q2 FY23

DA/SSA	Filled Positions (FTE) including SLPs - 2022				Filled Plus Vacant Positions (FTE) - 2022				Vacancy Rate (incl. SLPs)		
	Jan-Mar	Oct-Dec	Change (#)	Change (%)	Jan-Mar	Oct-Dec	Change (#)	Change (%)	Jan-Mar	Oct-Dec	Change
Champlain Community Services	90.9	94.7	3.8	4%	109.2	109.7	0.5	0.5%	17%	14%	-3%
Clara Martin Center	142.6	151.8	9.2	6%	185.3	189.4	4.1	2.2%	23%	20%	-3%
Counseling Service of Addison County	276.6	266.8	-9.8	-4%	312.2	307.4	-4.8	-1.5%	11%	13%	2%
Families First in Southern Vermont	101.6	113.4	11.8	12%	111.6	118.4	6.8	6.1%	9%	4%	-5%
Green Mountain Support Services	158.5	170	11.5	7%	169.5	170.0	0.5	0.3%	7%	0%	-7%
Health Care and Rehabilitation Services	465.4	553.2	87.8	19%	565.4	622.4	57	10.1%	18%	11%	-7%
Howard Center	1245.6	1269.7	24.1	2%	1,538.1	1,509.3	-28.8	-1.9%	19%	16%	-3%
Lamoille County Mental Health Services	227.5	235.9	8.4	4%	286.0	298.7	12.7	4.4%	21%	21%	1%
Lincoln Street	183.6	172.4	-11.2	-6%	200.0	192.4	-7.6	-3.8%	8%	10%	2%
NFI Vermont	252.5	223.3	-29.2	-12%	299.8	288.5	-11.3	-3.8%	16%	23%	7%
Northeast Kingdom Human Services	566.1	517	-49.1	-9%	628.1	579.0	-49.1	-7.8%	10%	11%	1%
Northwestern Counseling and Support Services											
Pathways Vermont	47	59.4	12.4	26%	50.4	69.9	19.5	38.7%	7%	15%	9%
Rutland Mental Health Services	388	350.1	-37.9	-10%	421.9	402.1	-19.8	-4.7%	8%	13%	5%
Specialized Community Care	116.5	79.4	-37.1	-32%	134.5	98.4	-36.1	-26.8%	13%	19%	6%
United Counseling Service of Bennington County	235.2	203.3	-31.9	-14%	271.8	208.5	-63.3	-23.3%	14%	3%	-11%
Upper Valley Services	282.8	302	19.2	7%	306.0	302.0	-4	-1.3%	8%	0%	-8%
Washington County Mental Health Services	635.8	595.9	-39.9	-6%	783.3	788.9	5.6	0.7%	19%	25%	6%
TOTAL	**5416.2**	**5358.3**	**-57.9**	**-1%**	**6,373.1**	**6,255.0**	**-118.1**	**-1.9%**	**15%**	**14%**	**-1%**

Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

Figure 5 GRAPH: Change in Filled HHA Positions, Q3 FY22 to Q2 FY23

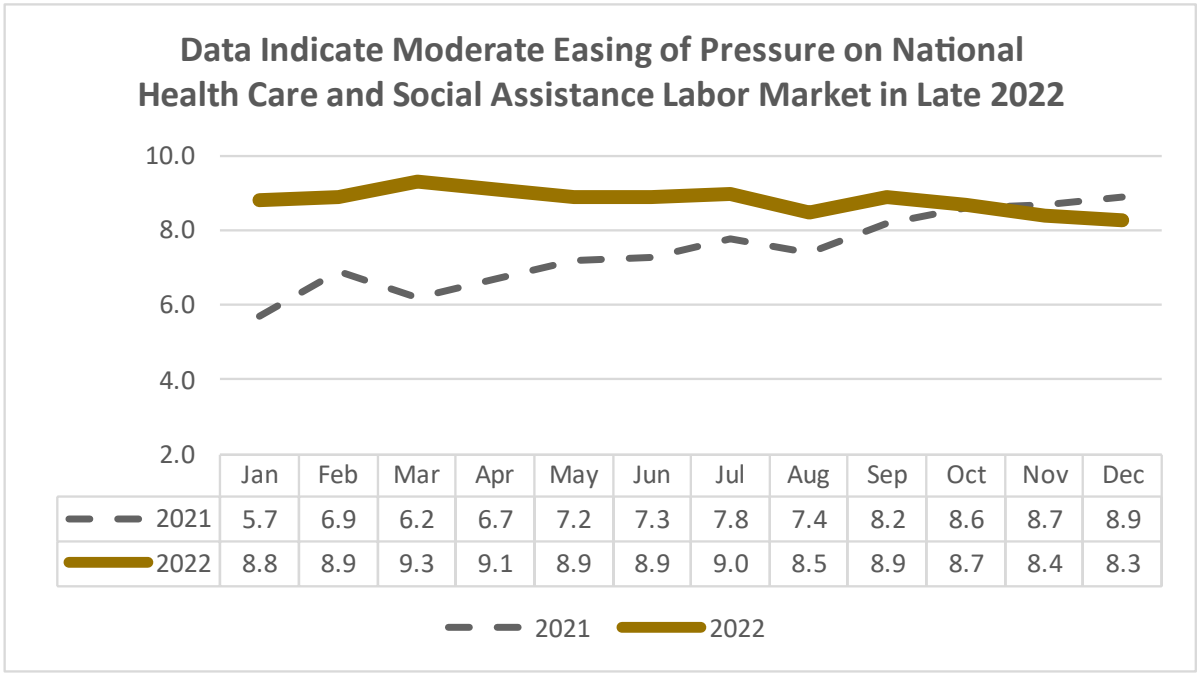
Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

Figure 6 TABLE: Change in Filled HHA Positions, Q3 FY22 to Q2 FY23

Home Health Agency	Filled Positions (FTE) - 2022				Filled Plus Vacant Positions (FTE) - 2022				Vacancy Rate		
	Jan-Mar	Oct-Dec	Change (#)	Change (%)	Jan-Mar	Oct-Dec	Change (#)	Change (%)	Jan-Mar	Oct-Dec	Change
Addison County Home Health and Hospice	74	71.9	-2.1	-2.8%	78.2	79.9	1.7	2.2%	5%	10%	5%
Bayada Home Health Care	280	247.4	-32.6	-11.6%	336.5	316.4	-20.1	-6.0%	17%	22%	5%
Central Vermont Home Health and Hospice	116.7	110.2	-6.5	-5.6%	129.4	121.8	-7.6	-5.9%	10%	10%	0%
Franklin County Home Health Agency	84.6	71.1	-13.5	-16.0%	105.5	95.7	-9.8	-9.3%	20%	26%	6%
Lamoille Home Health Agency	69.6	76.5	6.9	9.9%	75.4	78.1	2.7	3.6%	8%	2%	-6%
Northern Counties Health Care	60.2	56.6	-3.6	-6.0%	64.2	60.6	-3.6	-5.6%	6%	7%	0%
Orleans Essex VNA and Hospice	41.8	35.2	-6.6	-15.8%	49.2	46	-3.2	-6.5%	15%	24%	9%
UVM Health Network Home Health and Hospice	291.9	198.1	-93.8	-32.1%	342.9	255.7	-87.2	-25.4%	15%	23%	8%
Visiting Nurse Assoc. and Hospice of VT and NH	140.3	137.3	-3	-2.1%	206	178	-28	-13.6%	32%	23%	-9%
VNA and Hospice of the Southwest Region	172.3	170.6	-1.7	-1.0%	199.4	200.3	0.9	0.5%	14%	15%	1%
TOTAL	**1331.4**	**1174.9**	**-156.5**	**-11.8%**	**1586.7**	**1432.5**	**-154.2**	**-9.7%**	**16%**	**18%**	**2%**

Calculations from data submitted by Premium Pay for Workforce Recruitment and Retention Round 1 grantees to AHS.

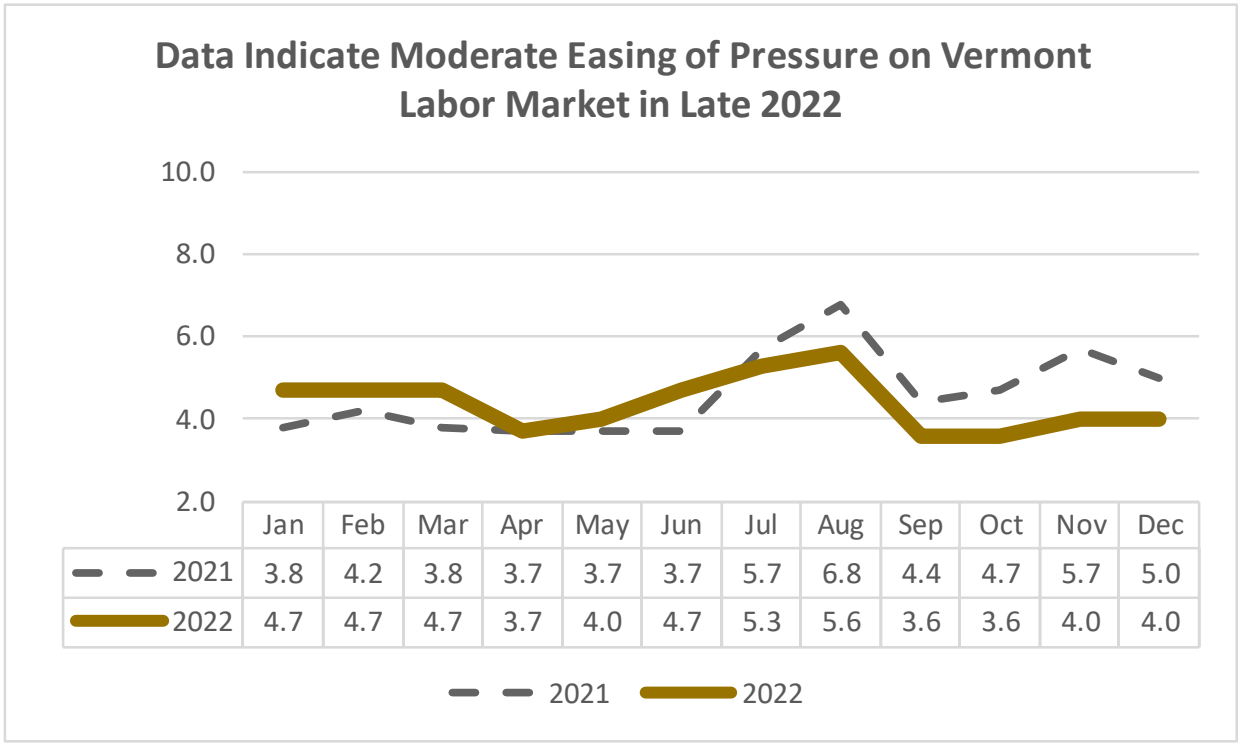
Figure 7 GRAPH: U.S. Rate of Health Care and Social Assistance Job Openings



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	5.7	6.9	6.2	6.7	7.2	7.3	7.8	7.4	8.2	8.6	8.7	8.9
2022	8.8	8.9	9.3	9.1	8.9	8.9	9.0	8.5	8.9	8.7	8.4	8.3

Data from Bureau of Labor Statistics, Series ID JTS620000000000000JOR

Figure 8 GRAPH: Vermont Rate of Total Nonfarm Separations



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	3.8	4.2	3.8	3.7	3.7	3.7	5.7	6.8	4.4	4.7	5.7	5.0
2022	4.7	4.7	4.7	3.7	4.0	4.7	5.3	5.6	3.6	3.6	4.0	4.0

Data from Bureau of Labor Statistics, Series ID JTS000000500000000TSR

APPENDIX C: DATA RELATED TO WAITLISTS

Figure 9 TABLE: Wait Times by DA

Feb 2022 - Adult Mental Health Outpatient Therapy		
DA	Anticipated days to wait (average)	Number of adults waiting
CMC	0	0
CSAC	10	20
HCRS	0	0
Howard	120	65
LCMHS	60	15
NCSS	7	19
NKHS		0
RMHS	0	0
UCS	120	79
WCMHS	56	132
AVERAGE	**78.5**	**33**
Total		**330**

Feb 2022 - Child/Youth Outpatient Therapy (not school-based)		
DA	Anticipated days to wait (average)	Number of children/youth waiting
CMC	0	0
CSAC	70	45
HCRS	135	51
Howard	365	75
LCMHS	75	55
NCSS	42	68
NKHS	180	68
RMHS	90	56
UCS	36	24
WCMHS	63	51
AVERAGE	**133.4**	**49**
Total		**493**

Feb 2022 - Adult Mental Health Residential Services*		
DA	Anticipated days to wait (average)	Number of adults waiting
CSAC	180	0
Howard	180	12
LCMHS	90	1
NCSS	180	4
RMHS	8	1
UCS		
WCMHS	35	7
AVERAGE	**128.9**	**4**
Total		**25**

Jan 2023 - Adult Mental Health Outpatient Therapy		
DA	Anticipated days to wait (average)	Number of adults waiting
CMC	30	32
CSAC	50	16
HCRS	60	24
Howard	180	60
LCMHS	30	2
NCSS	3	10
NKHS	9	19
RMHS	0	0
UCS	42	31
WCMHS	84	152
AVERAGE	**85.3**	**35**
Total		**346**

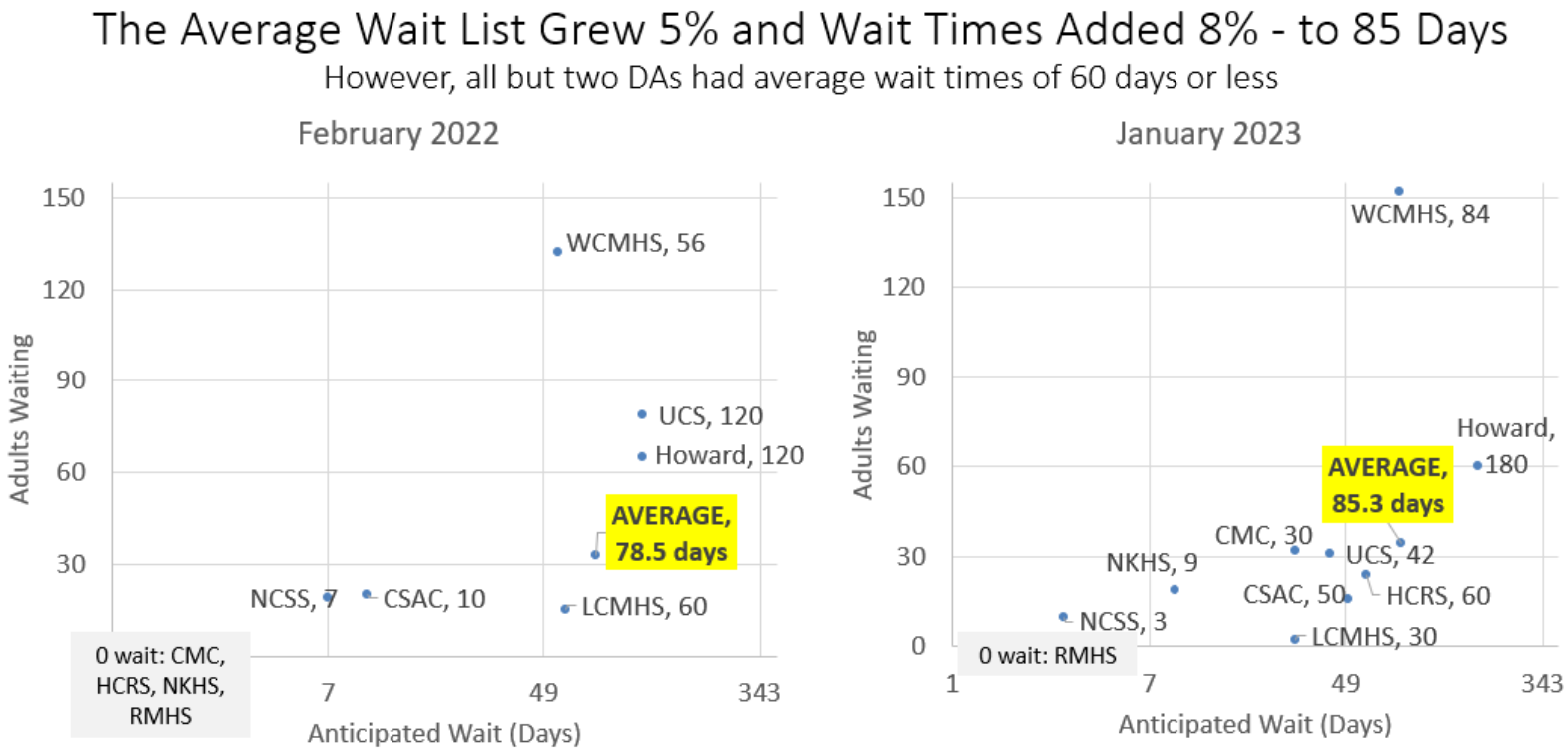
Jan 2023 - Child/Youth Outpatient Therapy (not school-based)		
DA	Anticipated days to wait (average)	Number of children/youth waiting
CMC	30	18
CSAC	54	65
HCRS	60	36
Howard	45	10
LCMHS	90	27
NCSS	28	5
NKHS	90	25
RMHS	90	31
UCS	42	12
WCMHS	84	56
AVERAGE	**76.9**	**29**
Total		**285**

Jan 2023 - Adult Mental Health Residential Services*		
DA	Anticipated days to wait (average)	Number of adults waiting
CSAC	170	1
Howard	330	12
LCMHS	0	0
NCSS	150	1
RMHS	90	3
UCS	365	3
WCMHS	35	5
AVERAGE	**232.8**	**4**
Total		**25**

* Counts the number on agency residential program waitlists, not the number of CRT CSP clients waiting for any residential bed.

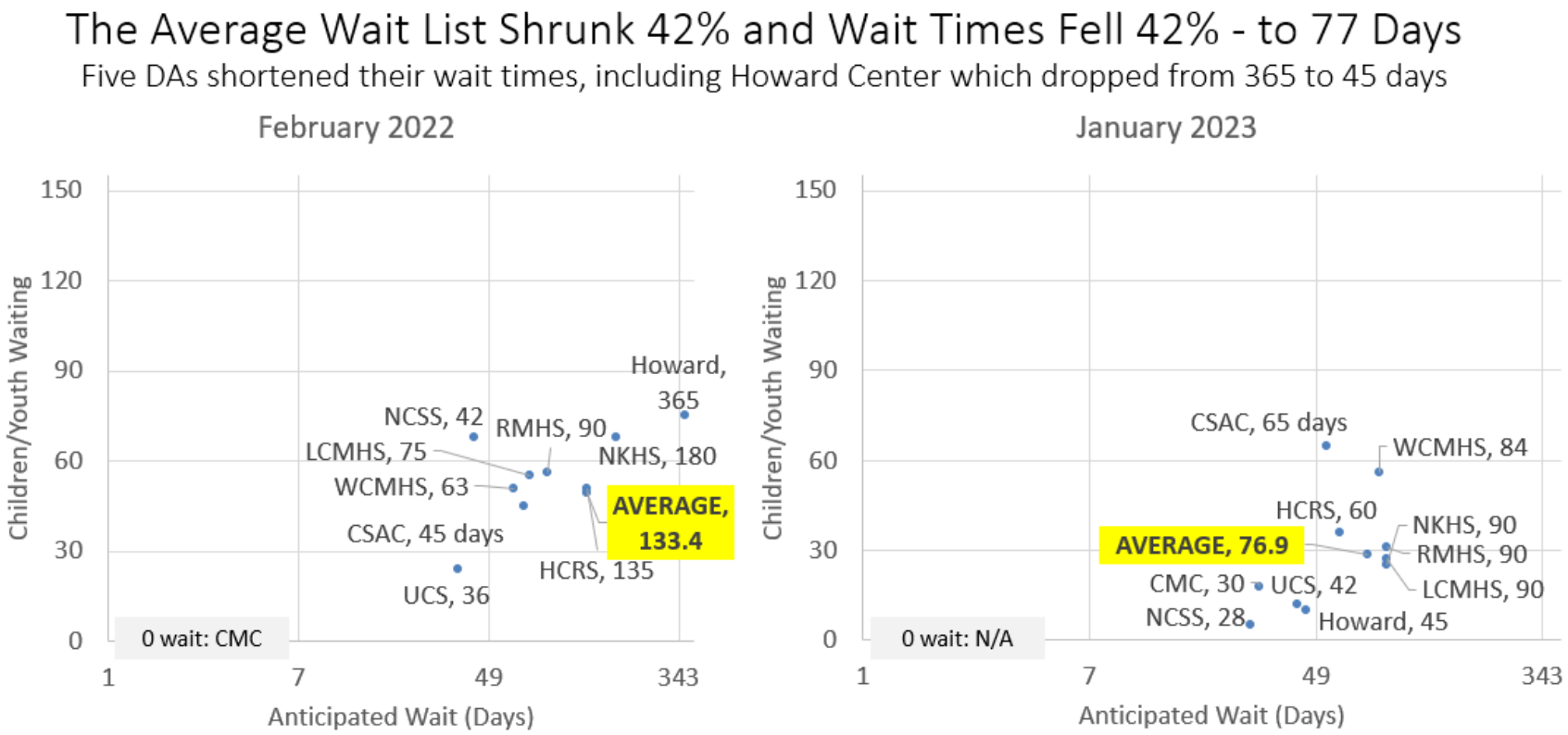
Data submitted by DAs to Vermont Care Partners (for February 2022) and AHS (for January 2023).

Figure 10 GRAPH: Adult Mental Health Outpatient Therapy Wait Times by DA



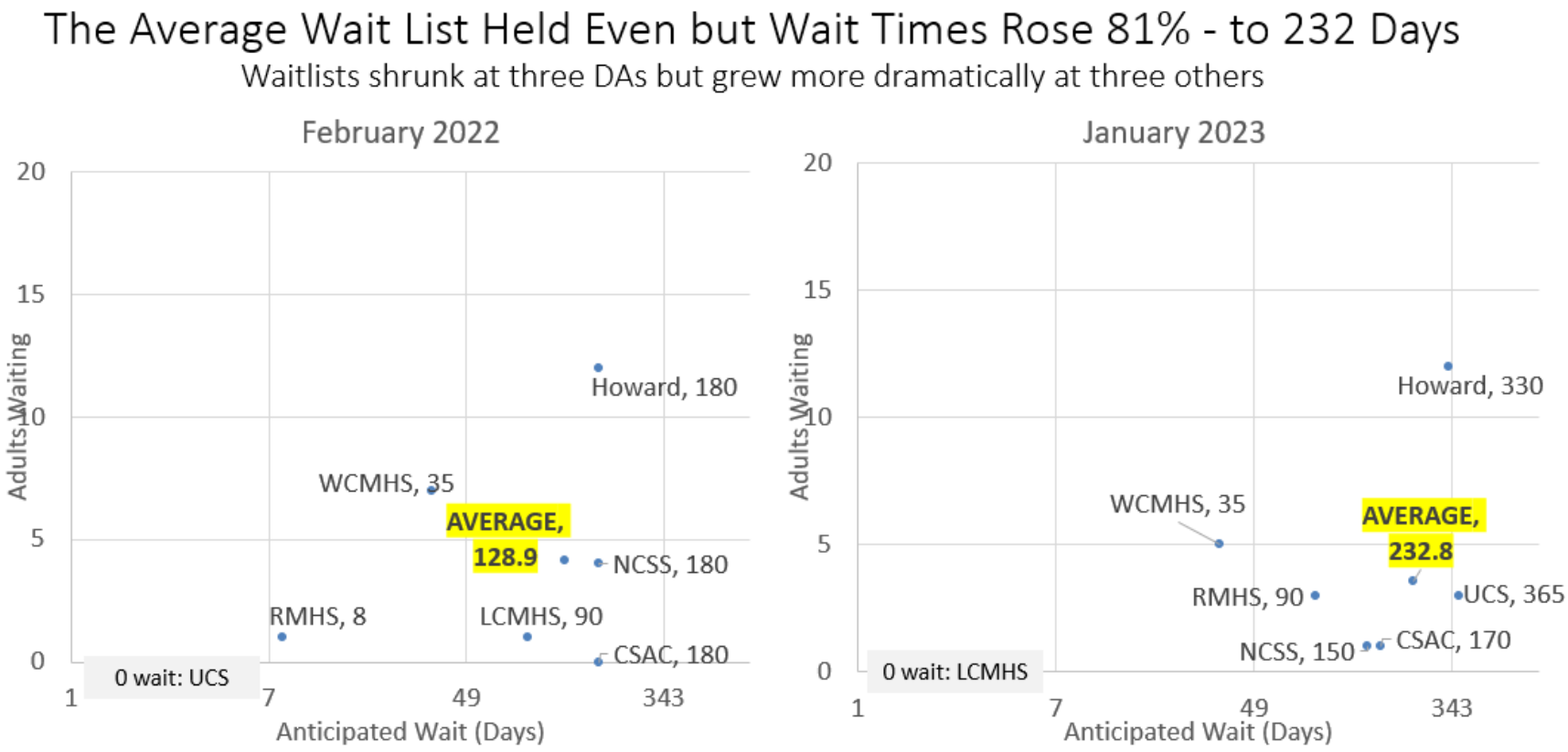
Data submitted by DAs to Vermont Care Partners (for February 2022) and AHS (for January 2023).

Figure 11 GRAPH: Children/Youth Outpatient Therapy Wait Times by DA



Data submitted by DAs to Vermont Care Partners (for February 2022) and AHS (for January 2023).

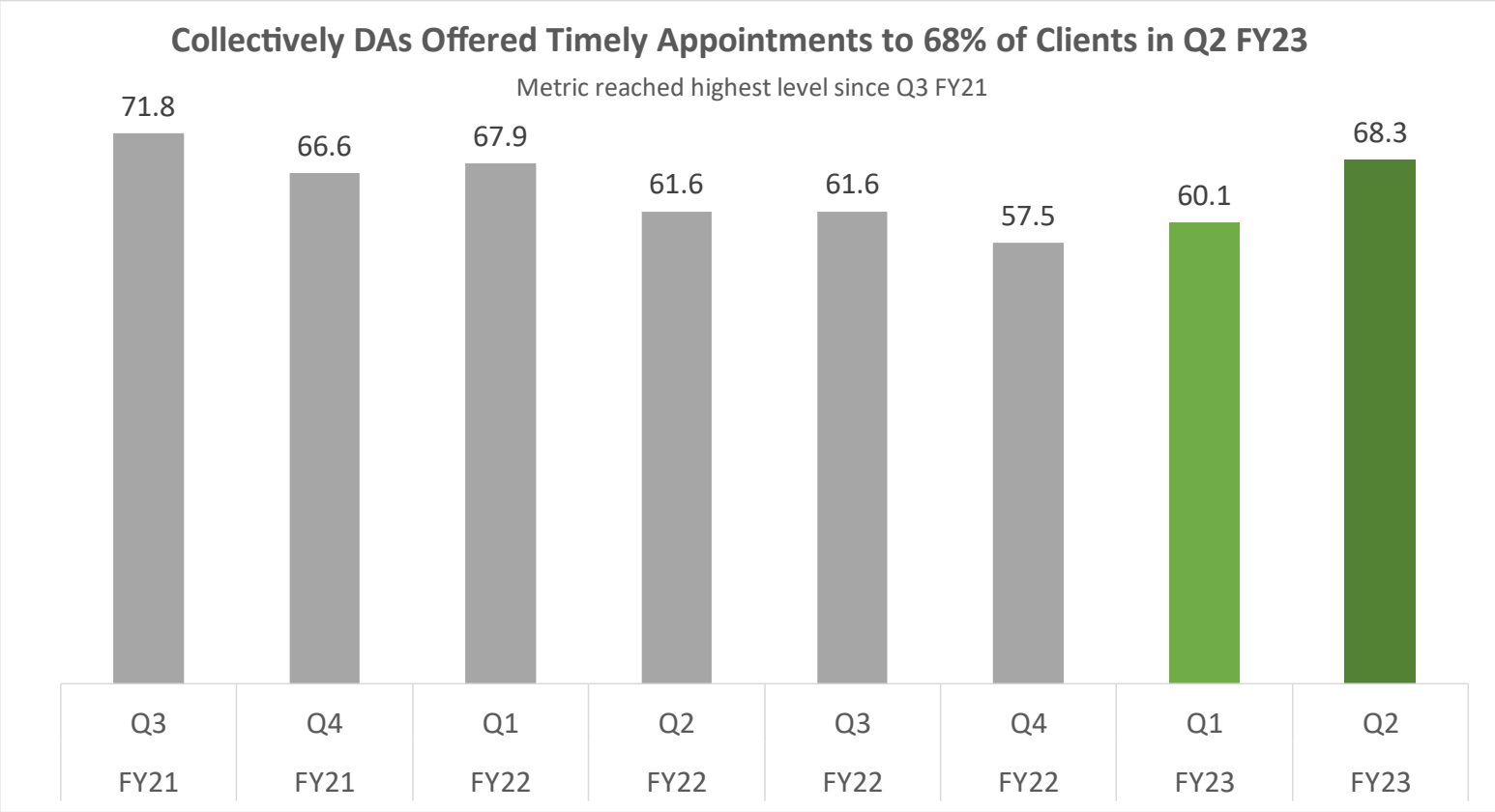
*Figure 12 GRAPH: Adult Mental Health Residential Wait Times by DA**



* Counts the number on agency residential program waitlists, not the number of CRT CSP clients waiting for any residential bed.

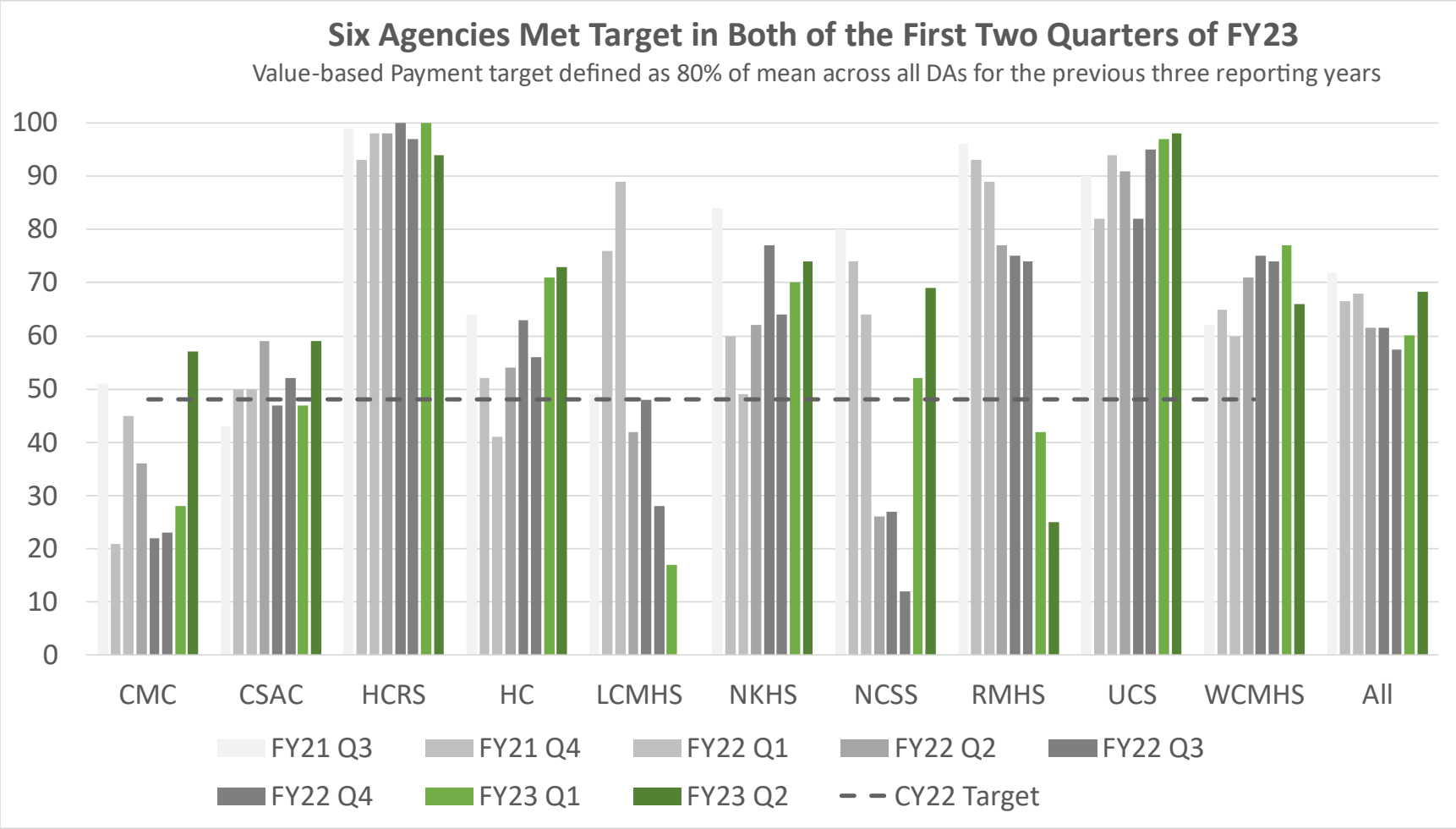
Data submitted by DAs to Vermont Care Partners (for February 2022) and AHS (for January 2023).

Figure 13 GRAPH: % of Clients to Whom the DAs Offer a Face-to-face Contact within Five Calendar Days of Initial Contact



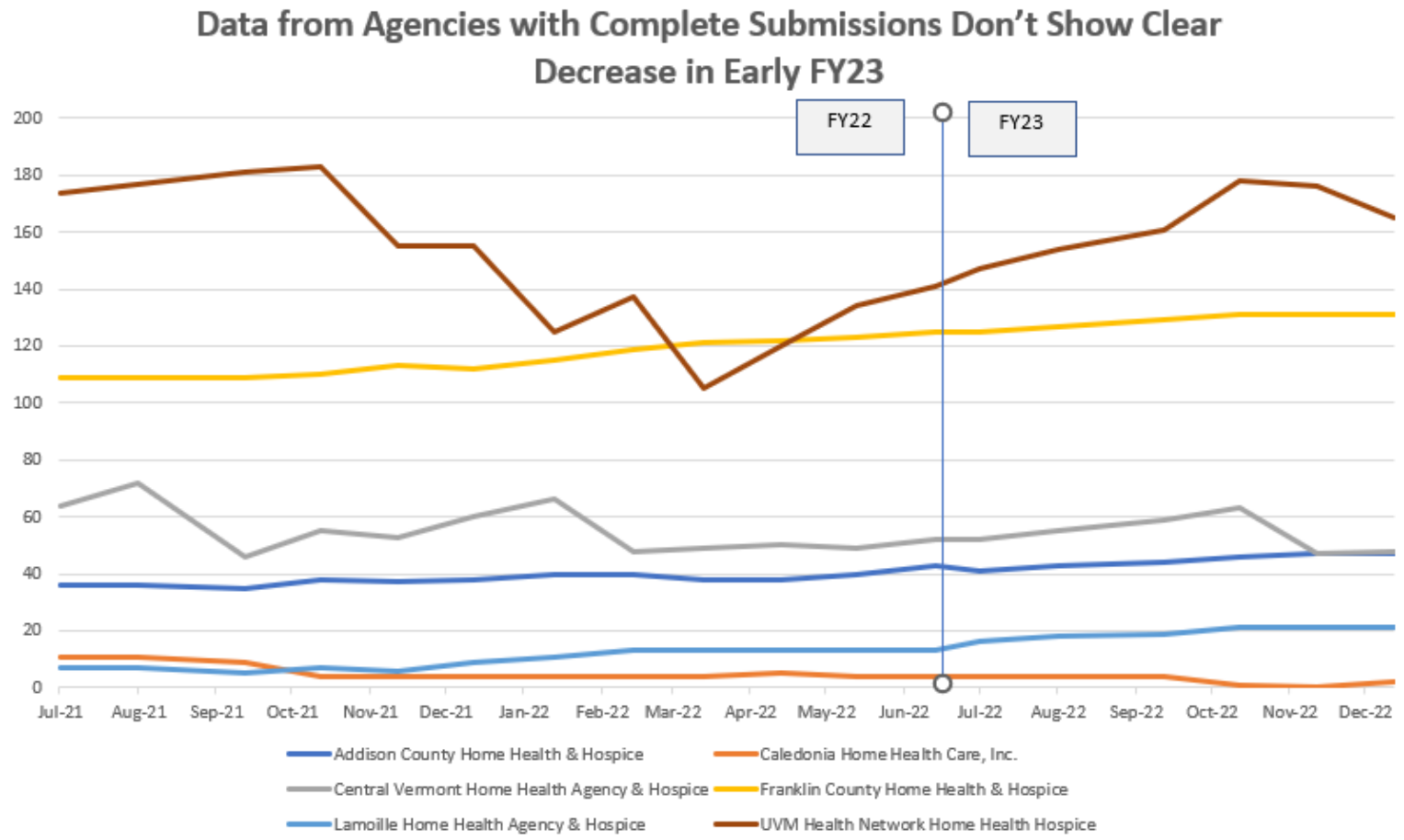
Data submitted by DAs to DMH as part of Value-based Payment measures.

Figure 14 GRAPH: % of Clients to Whom Each DA Offered a Face-to-face Contact within Five Calendar Days of Initial Contact



Data submitted by DAs to DMH as part of Value-based Payment measures.

Figure 15 GRAPH: Moderate Needs Households Waiting for Homemaker Services



Data submitted by HHAs to DAIL.

Figure 16 TABLE: Moderate Needs Households Waiting for Homemaker Services

Number of Moderate Needs Households Waiting for Homemaker Services (Monthly Average per Period by Agency)				
1 y/y	Jul-Dec '21	Jan-Jun '22	Jul-Dec '22	Jul-Dec y/y change
Addison County Home Health & Hospice	37	40	45	22%
Caledonia Home Health Care, Inc.	7	4	3	-65%
Central Vermont Home Health Agency & Hospice	58	52	54	-7%
Franklin County Home Health & Hospice	110	121	129	17%
Lamoille Home Health Agency & Hospice	7	13	19	183%
Orleans / Essex VNA Association & Hospice	0	0	0	0%
VNA/Bennington SW Council on Aging	8	4	10	29%
UVM Health Network Home Health Hospice	171	127	164	-4%
VNA of Vermont & New Hampshire	200	203	219	9%
TOTAL MNG Homemaker Wait List	598	564	641	7%

Calculations based on data reported by HHAs to DAIL. For the purposes of this analysis, the number of households waiting in any unreported months was assumed to be the same as the prior reported month.

APPENDIX D: ADDITIONAL CONTEXT FROM DA/SSAs ON WAITLIST / WAIT TIME DATA

From Counseling Service of Addison County:

"CSAC's Youth and Family Program waitlist numbers are impacted by several factors---the primary contributing issues are workforce shortages, increased requests for service, and increase in crisis calls. For example, in FY 17, CSAC had 210 intake requests. In FY22, that number jumped to 327 requests---the highest number we have ever received. It is important to note, however, that funding increases during this time helped to retain staff, but did not increase our capacity to serve youth, and we have not been able to fill our clinical vacancies---impacting our waitlists. We are careful to triage for acuity and offer crisis support daily. We are committed to being a resource for our community and despite a waitlist we continue to accept referrals. Our current and on-going focus is on hiring, retention, and increasing capacity through options such as group and brief treatment."

From Health Care & Rehabilitation Services of Vermont:

"The information about our waitlist that I'd like to share is that it has been a manual process for the past few years. We are in the process of developing waitlist management within the Credible system."

From Howard Center:

"Howard Center's waitlists have been exacerbated by unprecedented staff vacancies. Despite pervasive and dogged recruitment efforts, programs remain under-resourced related to positions. That in turn, has limited our ability to take on new clients despite need remaining high in our community. Recruitment efforts in Chittenden County continue to be hampered by intense competition from local organizations as Howard Center at times struggles to match compensation offers for similar positions. Despite these noted challenges, our organization engaged in a robust triage process and offered group options and supportive intake navigation without undue wait times for individuals in need."

From Northeast Kingdom Human Services:

"In some of the data submissions I think NKHS' lack of data is a result of the EHR system that was being used at the time. We were unable to query that information easily for reporting purposes. The lack of 2021 data doesn't reflect lack of a waitlist, but rather the inability to track it well. Since we have updated our EHR system we can track and report on those numbers without as great of an administrative burden."

From United Counseling Service:

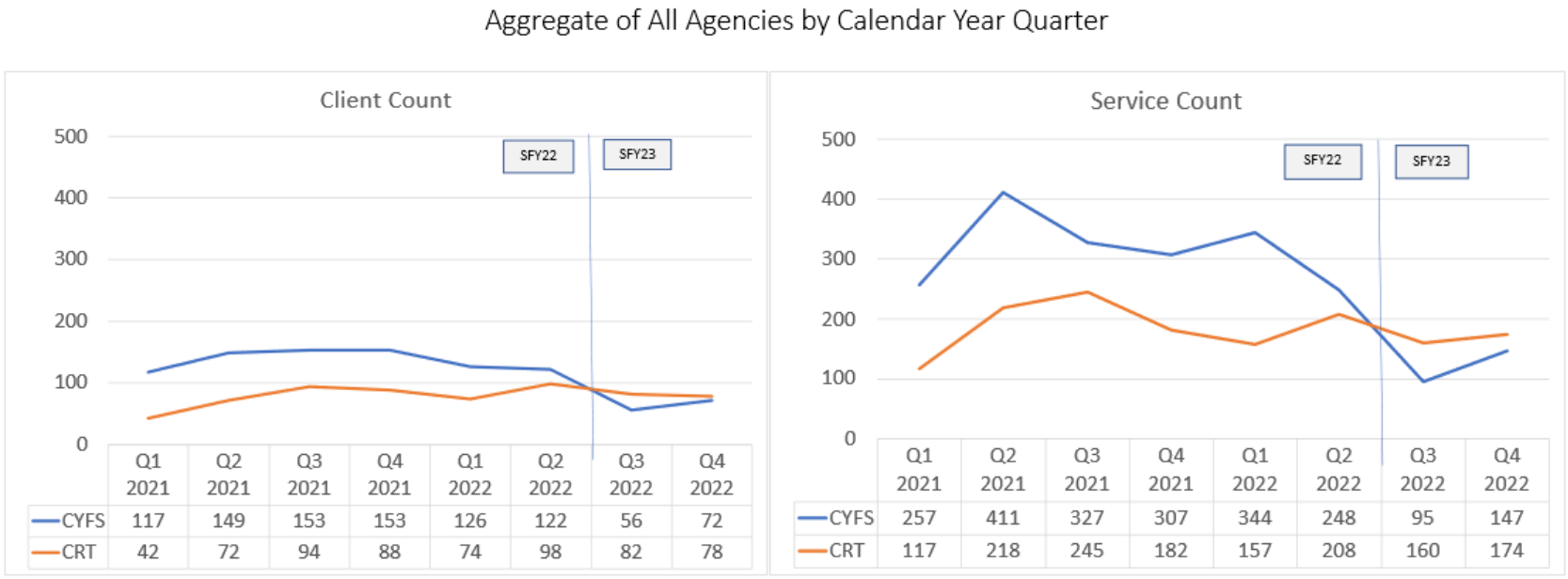
"The changes in the waitlist data for United Counseling Service (UCS) can be attributed to several factors over the course of the last 12-18 months. This includes the sustained increased need for services in our communities throughout the COVID-19 pandemic, staff turnover, challenges in recruitment of qualified staff and innovative and strategic planning of our service delivery methods. To address barriers to individuals accessing care during periods in which we were maintaining a sizeable waitlist, UCS developed and implemented Finding Access to Services and Treatment (FAST) in January of 2022. FAST is a prong of our agency's Same Day Access (SDA) model, ensuring that individuals are offered the right care, at the right time, in the right place with the right provider. FAST provides individuals with care, using methods based on Collaborative Network Approach (CNA). The model is designed to help assess, triage, and respond efficiently and effectively to those in need. Individuals can be seen in our Same Day Access episode of care for up to 30 days. Individuals who would benefit with a longer episode of care, complete a clinical assessment during a FAST session, and are aligned and scheduled with a treatment provider following their session. In this model, 38% of the individuals who were seen in FAST in 2022 were not opened to longer episodes of care. This model has supported a decrease in our waitlist for services."

From Washington County Mental Health Services:

"At WCMHS, addressing waitlists for outpatient therapy is a priority for both Adults and Children. WCMHS has a well-established outpatient therapy program that serves over 1100 adults annually according to The Department of Mental Health's most recent annual report. A review of our Adult Mental Health data demonstrates that the agency exceeds the state's case rate expectations, and 77% of clients receive an initial service within 5 days, which is higher than the statewide average of 60%. WCMHS has a unique Access program for both Adults and Children which enables clients who need immediate support to receive it. We monitor the number of individuals waiting for individual therapy that are also receiving services from our Access teams. This number has consistently been 1/3rd of clients. In addition, all clients are offered wellness groups while they wait and have emergency services available if needed. While staff vacancies have contributed to waitlist numbers, we also believe that we are under resourced in the number of clinical positions it would take to make a meaningful impact on the total number waiting. As we continue to address the waitlist, different ideas have emerged, including reaching out to private providers, studying what other agencies have done to reduce their caseloads, and more frequent analysis of waitlist data."

APPENDIX E: DATA RELATED TO EMERGENCY DEPARTMENTS

Figure 17 GRAPH: Emergency Department Use by Children, Youth, Family Services (CYFS) and Community Rehabilitation Services (CRT) Clients



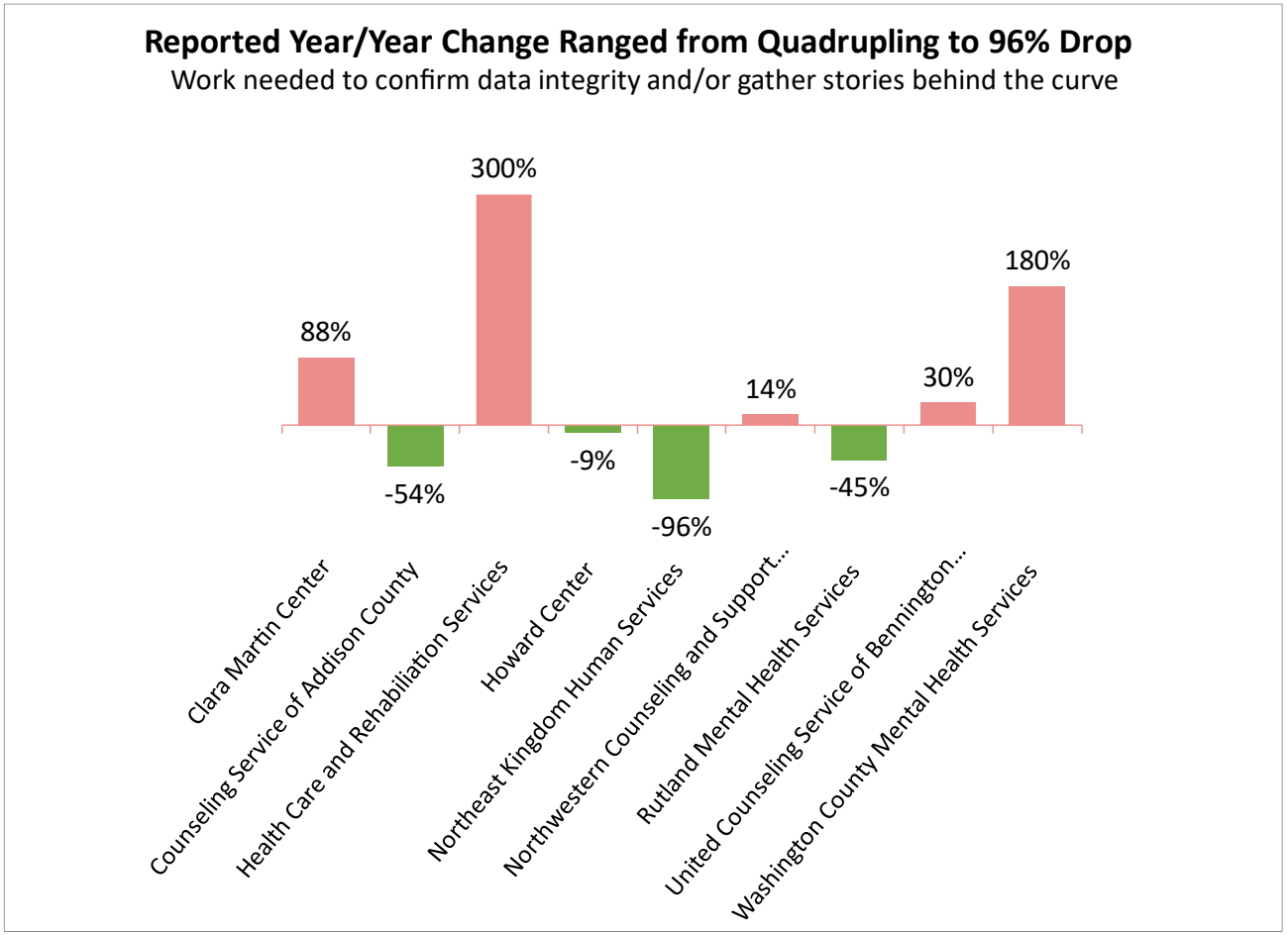
Calculations from data provided by Vermont Care Partners Data Repository

Figure 18 TABLE: Emergency Department Use by Children, Youth, Family Services (CYFS) and Community Rehabilitation Services (CRT) Clients

Data from Vermont Care Partners Data Repository Shows Large Decrease in Number of Clients from All DAs who Received a Service Coded with an Emergency Department Location				
	Jul-Dec '21	Jan-Jun '22	Jul-Dec '22	Jan-Jun '22 y/y change
CYFS Clients	306	248	128	-58%
CYFS Services	634	592	242	-62%
CRT Clients	182	172	160	-12%
CRT Services	427	365	334	-22%

Calculations from data provided by Vermont Care Partners Data Repository

Figure 19 GRAPH: Year-over-year Change in Crisis Services Delivered in Emergency Department, Q1-2 FY22 to Q1-2 FY23



Calculated from Monthly Service Report data submitted by DAs to DMH. LCMHS data not available at time of this report.

Figure 20 TABLE: Year-over-year Change in Crisis Services Delivered in Emergency Department, Q1-2 FY22 to Q1-2 FY23

Number of Crisis Services Delivered in an Emergency Department Setting (Total per Period from Monthly Service Report Data)				
	Jul-Dec '21	Jan-Jun '22	Jul-Dec '22	Jul-Dec y/y change
Clara Martin Center	64	60	120	88%
Counseling Service of Addison County	87	26	40	-54%
Health Care and Rehabilitation Services	53	143	212	300%
Howard Center	2338	2493	2121	-9%
Lamoille County Mental Health Services				
Northeast Kingdom Human Services	238	124	9	-96%
Northwestern Counseling and Support Services	229	246	261	14%
Rutland Mental Health Services	321	226	176	-45%
United Counseling Service of Bennington County	253	362	328	30%
Washington County Mental Health Services	51	124	143	180%
TOTAL	3634	3804	3410	-6%

Calculated from Monthly Service Report data submitted by DAs to DMH. LCMHS data not available at time of this report.