VERMONT *2014*

Reforming Vermont's Mental Health System

Report to the Legislature on the Implementation of Act 79
Report from the Commissioner of Mental Health
to the General Assembly
January 15, 2014

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Executive Summary: The Mental Health System of Care

The Department of Mental Health (DMH), with the Designated Hospitals (DHs) and Designated Agencies (DAs), as well as other community and AHS partners, has continued to work throughout the past year to move the system of care forward within Vermont for people with mental health needs. The first Act 79 report addressed rebuilding a system of care in the time of crisis following Tropical Storm Irene. This year has focused on continuing to build capacity within the inpatient and outpatient systems, expansion of quality and evaluation activities, increased focus on the transitions of care, and internal changes and restructuring within the Department.

A system of care begins with availability of strong community support for people with mental health needs in the most integrated and least restrictive setting available. Act 79, passed by the 2012 Vermont Legislature, moved to strengthen a well-respected community mental health system, bolstering supports and filling gaps to assist people living and receiving treatment in their communities. This includes an increase in capacity of case management services for designated agency outpatient clients and emergency outreach services in every community, which has been in place for approximately 18 months.

Peer support programs have expanded to include the development of a warm line, a statewide hotline that is intended to provide 24/7 access and outreach services. Peers are also working within some designated agencies to provide supports to patients awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services. These service enhancements have coalesced and we expect to place more emphasis on assessing outcomes within the coming year.

Crisis services act as the gatekeepers for crisis beds and hospital beds for psychiatric care throughout the state. Working closely with law enforcement is essential to this process. A statewide inter-disciplinary training program between law enforcement personnel and mobile crisis responders has entered the second phase of its development.

The emerging DMH care management system, and its current care manager base, is an active driver within the system of care assisting crisis services teams and providers to triage individuals into programs for admission, as well as directing individuals to step-down programs, transitional housing programs, and supportive housing units when they return to the community. To accomplish this task, the team works closely with hospitals, holding weekly clinical team meetings regarding patient status and supporting discharge planning, creating a bridge to community programming, with referral to additional technical supports, if necessary. Acting as a managed care organization in partnership with the Department of Vermont Health Access (DVHA), a segment of the team performs utilization review for Community Rehabilitation and Treatment (CRT) clients and designated agency Adult Outpatient (AOP) clients receiving Medicaid benefits who are hospitalized.

The DMH technical support team is comprised of three licensed psychologists, a consulting psychiatrist, and a nurse care manager. The team receives referrals from both community and hospital providers and works with the residents of the Middlesex Therapeutic Community

Residence (MTCR), as well as providing consultation and direct services to those clients who are now treated in specialized wraparound community placements.

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through DMH at two statewide conferences, the new DMH Cooperative for Workforce Development and Practice Improvement is getting underway through a grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and will be accessible to the entire state provider community.

Current and future work includes stakeholder involvement. Throughout this past year, change processes have been transparently reported to stakeholders through various communication and input forums. DMH produces a general semi - monthly update that provides current progress reports and identifies upcoming open public and planning meetings for different initiatives that are underway. DMH provides monthly updates and a discussion forum via the Transformation Council and the State Program Standing Committees for Adult Mental Health and for the Child, Adolescent, and Family Unit (CAFU). Annually, the Mental Health Block Grant Planning Council brings together multiple stakeholders to provide input on the distribution of federal mental health dollars to various state initiatives for adults with severe mental illness and for children and adolescents experiencing a serious emotional disturbance and their families.

The “Planning for the Future” section of this document outlines the path to move forward. DMH realizes that many of the new programs put into place have been recent, and careful monitoring of results will be needed to assure that we fully realize the goals of program enhancement. DMH looks to the legislature, stakeholders, and their colleagues in the DHs and DAs to continue to work together towards improving care and the quality of life for adults with severe mental illness.

2013 Accomplishments

DMH is responsible for mental health services provided under state funding to special-needs populations including children with severe emotional disturbances (SED) and adults with severe mental illnesses. Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to 10 Designated Agencies (DAs) and one Specialized Service Agency (SSA) located across the state of Vermont for the provision of Community Rehabilitation and Treatment services (CRT) for adults with severe and persistent mental illness; Adult Outpatients (AOP), adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions; Emergency Services, for anyone, regardless of age, in a mental health crisis; and Children Adolescent and Family Services for children and adolescents with SED and their families. DMH also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the DA in their catchment area.

DMH has made significant progress since the emergency closing of the Vermont State Hospital (VSH) in late August of 2011 following Tropical Storm Irene. Inpatient care is being provided using a decentralized system of one state-run interim hospital and five Designated Hospitals (DHs) located across the state. Community services have been enhanced and support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for care. In many cases, treatment can be provided closer to patients' homes.

Green Mountain Psychiatric Care Center (GMPCC) opened an eight-bed hospital in January 2013 and acute inpatient treatment units for Level 1 patients were opened at the Brattleboro Retreat (BR) and the Rutland Regional Medical Center (RRMC) in April of 2013. These hospitals, along with Fletcher Allen Health Care (FAHC), are treating patients within our state who are experiencing the most severe psychiatric symptoms. Patients with acute care needs who would have been treated at VSH in the past and need additional resources to meet their unique clinical needs such as more staff time and access to low stimulation areas are identified as Level 1 patients. The acuity of these patients is generally marked by higher risk of significant danger to themselves or others, manifestation of behaviors that are highly disruptive to the treatment milieu and require intervention management for safety, or to mitigate significant personal vulnerabilities in the areas of self-care and protection. Central Vermont Medical Center (CVMC) and the Windham Center (WC) also provide psychiatric care services; however they do not admit Level 1 patients.

Local hospitals throughout the state provide screening, stabilization and limited treatment until admission to a psychiatric inpatient bed can be facilitated. As part of "decentralizing high intensity inpatient mental health care"[1], DMH is also working to preserve the rights afforded to patients who would have been involuntarily hospitalized at the VSH.

[1] http://www.leg.state.vt.us/docs/2012/Acts/ACT079sum.htm

DMH has initiated a rulemaking process to establish standards that meet or exceed standards set by the Centers for Medicare and Medicaid Services and the Joint Commission for the use and reporting of the emergency involuntary procedures (EIP). DMH proposed an EIP Standards Rule that was reviewed by the Interagency Committee on Administrative Rules (ICAR) in mid-January, and by the Legislative Committee on Administrative Rules (LCAR) in September, 2013. In early December, 2013, LCAR indicated its objection to the proposed EIP Rule and notified chairs of the committees of jurisdiction that additional clarity regarding the intent of Act 79 may be needed. In the interim, DHs follow established regulations for the use of EIPs as required by CMS and JCAHO. In addition, DMH will be reviewing all emergency involuntary procedures for involuntary patients with the hospitals where they are performed. Emergency involuntary procedures reports will also be routinely shared with Disability Rights Vermont in its capacity as Mental Health Ombudsman for these patients.

Per Act 79, DMH contracted with Vermont Psychiatric Survivors (VPS) to increase the capacity of the Patient Representative from .5 FTE to 1.0 FTE. This provides increased access to these advocacy positions for individuals being treated at GMPCC, the designated hospitals, the Middlesex Therapeutic Recovery Program (MTCR), and the intensive residential recovery programs. Patient Representatives serve as advocates for these patients, and foster communication between patients and their treatment providers.

Under Act 79, DMH continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements by category include:

- Hospital beds
    - Designated units at the Brattleboro Retreat and Rutland Regional Medical Center; additional 7 beds on line
    - Opening of an interim eight-bed psychiatric hospital (GMPCC), while building a state operated hospital in Berlin, VT
    - Planning and development of a new 25 bed psychiatric hospital currently scheduled to open in July, 2014

- Community Services
    - Increased capacity within CRT and peer programs to provide community support, outreach, and crisis response
    - Development of non-categorical case management services for Adult Outpatient programs
    - Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
    - Additional supports to assist individuals in finding and keeping stable housing

- Residential and Transitional Services
    - Development of additional intensive residential and crisis beds for hospital diversion and step-down

- Development of a universal referral form to be used by DHs in assisting individuals transitioning to the community
- Opening of a secure residential recovery (SRR) program; the Middlesex Therapeutic Community Residence (MTCR), serving 7 individuals.

DMH is continuing to build a clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system" as written in Act 79. This system encompasses the following functions:

- DMH Clinical Care Managers provide assistance to crisis services clinicians in the field, DA case managers and DH social workers to link individuals with the appropriate level of care and services as well as acting as a bridging team for discharge planning from hospital inpatient care to community care
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis services
- Patient transport services have been developed and are coordinated through DMH Admissions and Central Office
- Supervision by law enforcement for individuals in Emergency Departments on Emergency Examination status who are awaiting admission to a DH is ongoing and coordinated through DMH
- Review and approval of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress

The remainder of this report will provide more in-depth information about utilization, capacity, and outcomes of these programs within the Adult Mental Health System of Care.

Utilization of Services and Capacity

The DMH has been working closely with the Administration and multiple stakeholders to monitor and enhance the development of services to those requiring mental health care in Vermont, while it works to rebuild a hospital and community based system following the closure of VSH. This process is reflected in monthly and annual reporting on utilization of these services and is described in detail below.

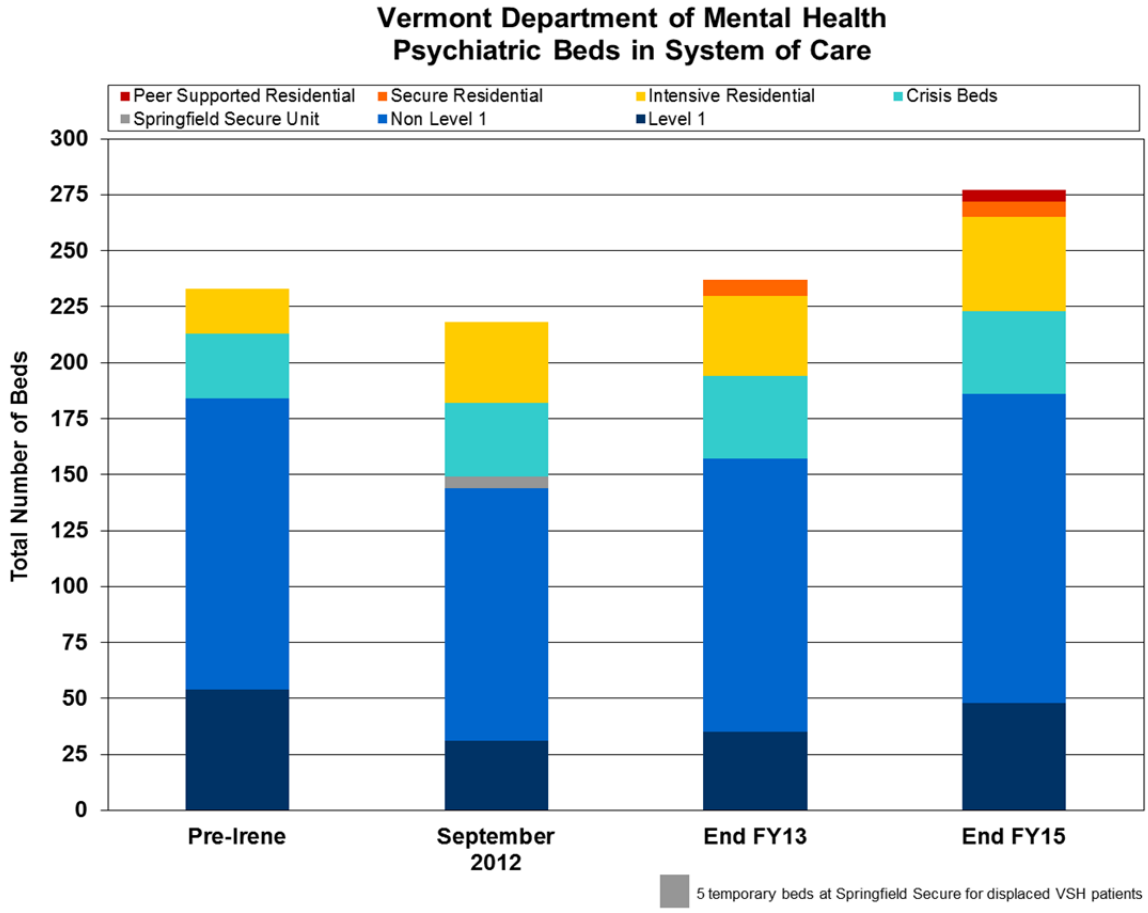
Inpatient Care

Many changes have been implemented in the last 12 months, in adherence to the intent of Act 79. DHs serve as our decentralized system of inpatient psychiatric care. DHs have accepted the most acutely distressed and involuntary individuals who had been previously treated primarily at VSH. These individuals are currently identified as Level 1 and are served primarily at the BR, GMPCC and RRMC, and to a lesser extent, FAHC. GMPCC will transition to the Vermont State Psychiatric Hospital in July 2014, and the MTCR will continue to operate as a secure therapeutic community residential program in which individuals can continue their individual course of recovery.

Demand for inpatient care frequently exceeds current capacity. An electronic bed board is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. DMH leadership and its care management staff work to resolve issues as quickly as possible. Emergency departments across the state have had to hold individuals needing inpatient psychiatric care while waiting for an open bed. This is disruptive to the emergency care setting and not a standard that DMH regards as adequate for individuals requiring inpatient treatment services. Expanding the number of inpatient beds, whether in-state or out-of-state, over the next year will alleviate some of this pressure on the system.

The following set of figures illustrates utilization of inpatient care services.

Chart One: Psychiatric Beds in the System of Care

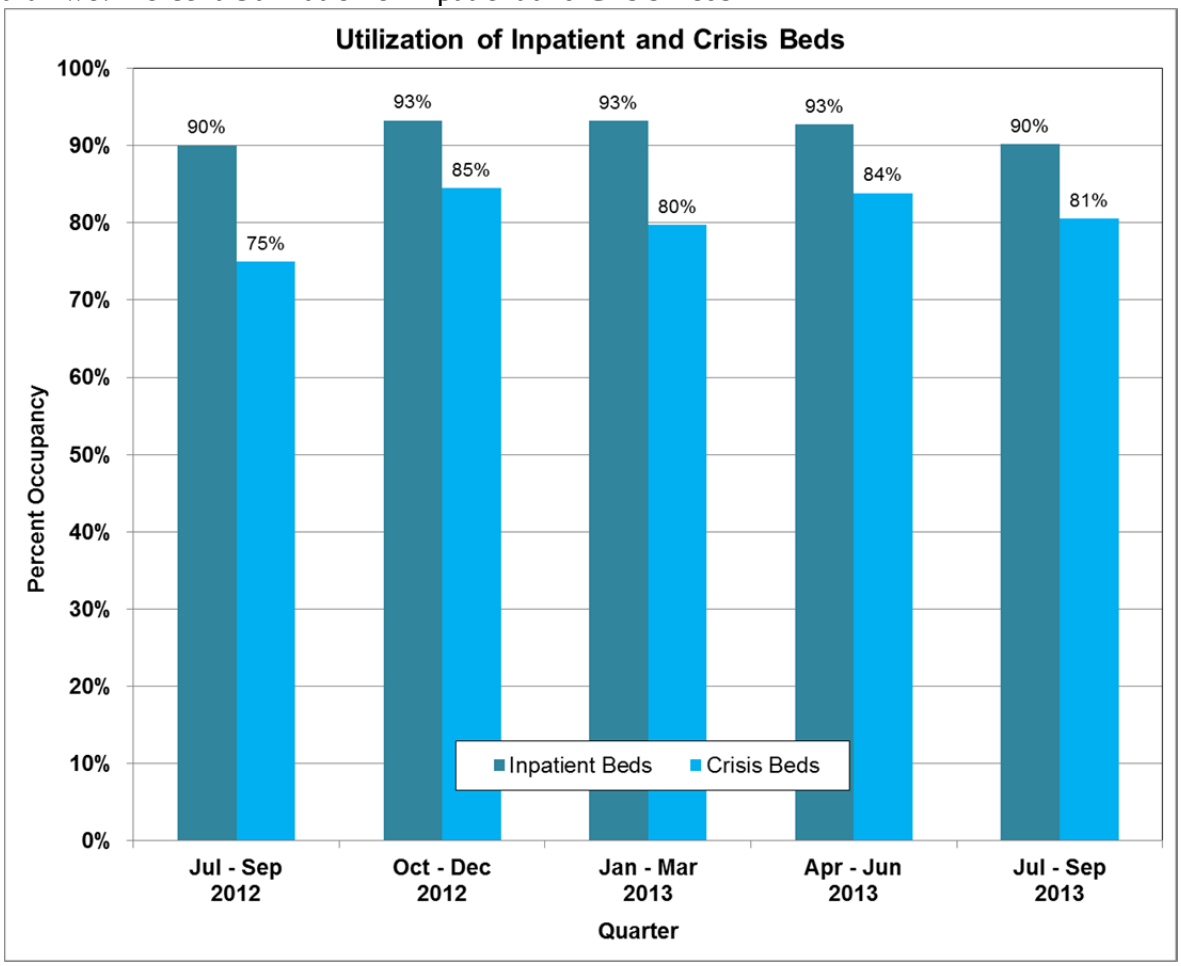


The total number of inpatient beds in a state-operated psychiatric hospital will not return to the previous level, as expanded residential and outpatient services will allow a shift in care to more community-based services in less restrictive settings. This continues to move our system of care forward by treating individuals in the least restrictive setting possible. Chart One shows all of the psychiatric placements changes, since August of 2011, including inpatient psychiatric treatment beds, residential treatment, crisis beds and peer - supported placements for transition through what is anticipated by FY 2015.

Crisis and intensive transitional residential beds have increased from 34 to 39 over the past 12 months. Additional funding supported expansion of crisis beds for hospital diversion and step-down care; these beds are now available at all 10 Designated Agencies. Increased funding has allowed the expansion of eight intensive residential beds at Second Spring-Westford. Not reflected in these numbers are four intensive residential beds that will open in 2014 in Rutland County.

A number of these beds provide access to peer support services, and the number of peer-supported residential beds will increase during the next fiscal year when Soteria-Vermont opens a five-bed facility in Chittenden County for individuals experiencing first-break psychosis.

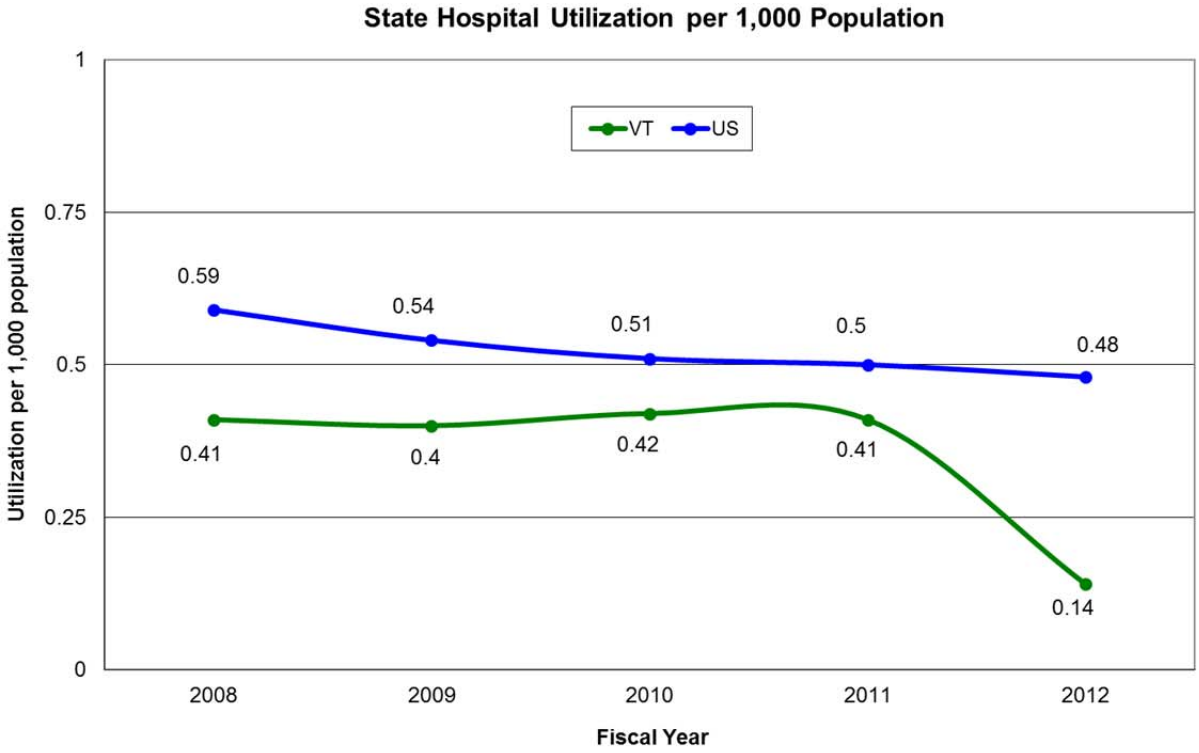
Chart Two: Percent Utilization of Inpatient and Crisis Beds

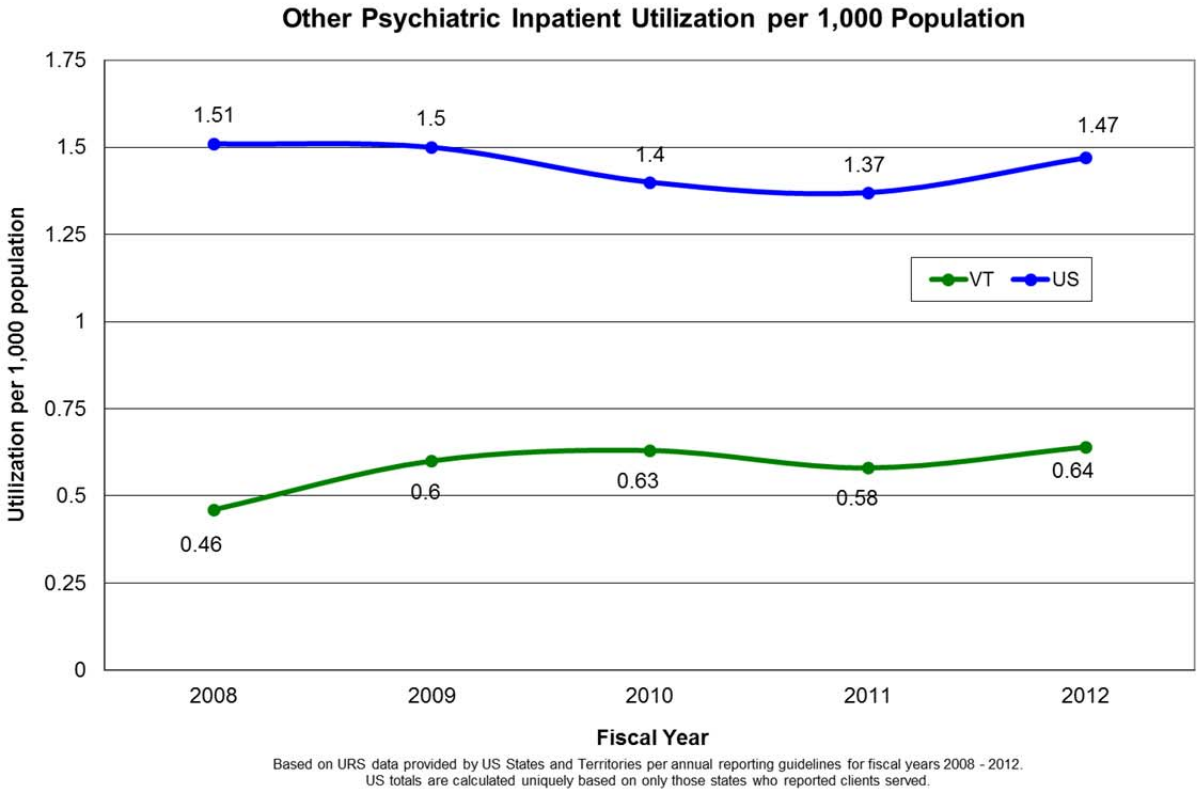


Occupancy of inpatient and crisis beds is shown over time. Occupancy of crisis beds has remained fairly consistent with the addition of five new crisis beds (increasing from 34 to 39 beds) documenting the need for the increased capacity at this level of care. The target occupancy rate is 80% with crisis bed occupancy falling at approximately 84-85% on average. While we have set our target at 80%, there are many factors that influence this data including the time to move people in and out of the facility, staffing, preparation for new admissions, and assuring clients' needs are met.

It is important that, as we build inpatient capacity, we compare our utilization to national benchmarks. The following two charts provide information for state hospitals as well as other psychiatric inpatient hospitals and illustrate utilization compared to national benchmarks.

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





Vermont's rate of inpatient utilization as compared to the national average in the United States continues to be lower for both the State Hospital and for other psychiatric inpatient admissions. The lower rate of utilization is impacted by the fact that the national data is predicated on state hospital utilization and since the closing of the VSH; our decentralized system of care represents those patients who would have been at VSH as being Level 1 in designated hospitals.

Chart Five: Adult Inpatient Utilization and Bed Closures

Adult Inpatient Utilization and Bed Closures

2013

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
ADULT INPATIENT UNITS											
Total Beds	147	148	149	162	157	157	157	157	157	169	169
Average Daily Census	137	132	136	134	135	146	138	139	139	143	149
Percent Occupancy	93%	89%	92%	83%	86%	93%	88%	90%	90%	89%	90%
# Days at Occupancy	0	0	0	0	0	0	0	0	0	0	0
# Days with Closed Beds	26	24	31	30	30	29	31	31	30	31	30
Average # of Closed Beds	2	4	4	3	2	4	6	6	7	9	10

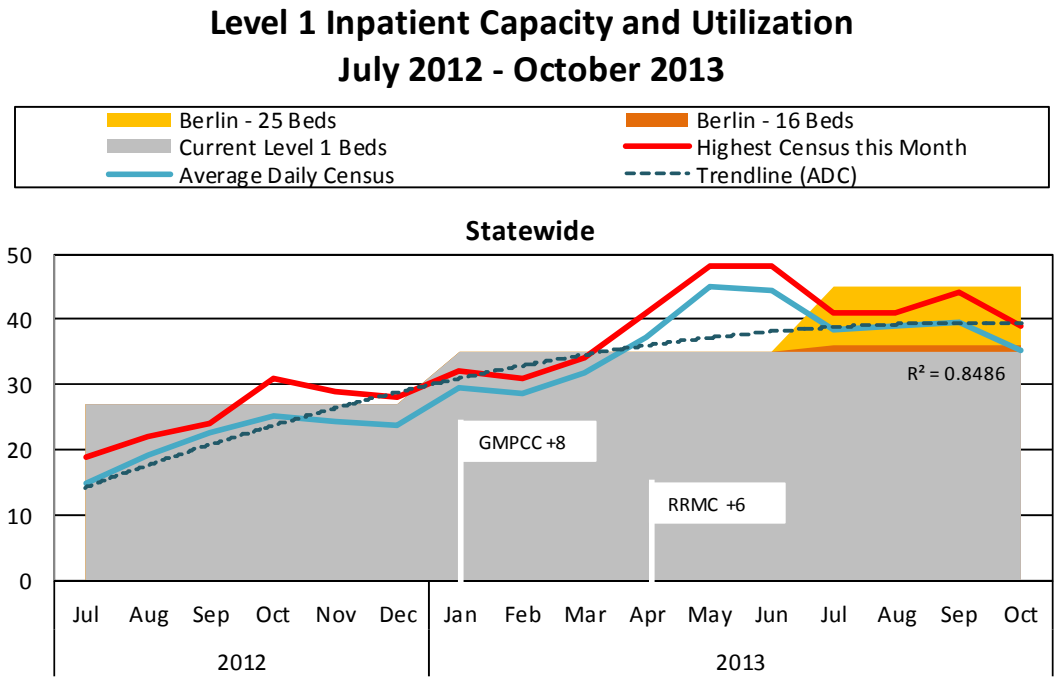
Based on data reported to the Vermont Department of Mental Health (DMH) by designated hospitals (DH) for adult inpatient care using the electronic bed boards system. Beds at inpatient settings can be closed based on the clinical decision of the director of each inpatient unit.

This chart depicts the total census capacity and average daily census across the Vermont DH system for the current calendar year. Bed closure may be due to renovation, staffing, patient safety and care, or other causes. DMH, with the DHs, work to maintain the maximum compliment of beds and utilization of these beds through the bed board system.

Level 1

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

Chart Six: Level 1 Inpatient Capacity and Utilization

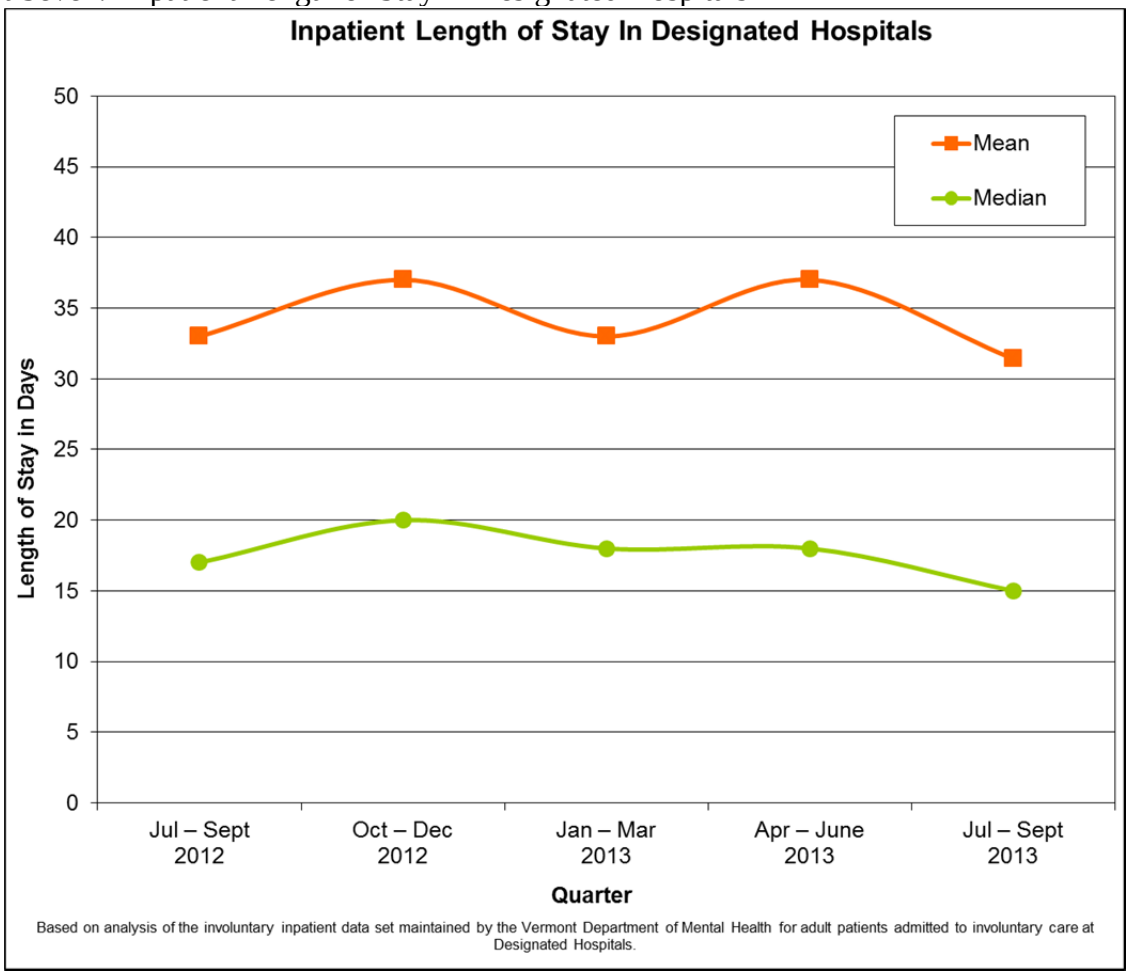


The number of Level 1 patients receiving acute inpatient care in any hospital setting including those other than the renovated unit at Rutland Regional Medical Center (RRMC), the renovated unit at the Brattleboro Retreat (BR), and Green Mountain Psychiatric Care Center (GMPCC), including the number of individuals treated in each setting, and the single combined one-day highest number each month.

The trend lines drawn by this graph represent both the statewide and hospital specific (RR, BR) census trajectories between July 2012 and September 2013.The graphs depict the number of current Level 1beds with the average daily census, and the highest monthly census. The Berlin Hospital is superimposed on the trend line, showing both 16 and 25 beds respectively, to address the increase in utilization. .

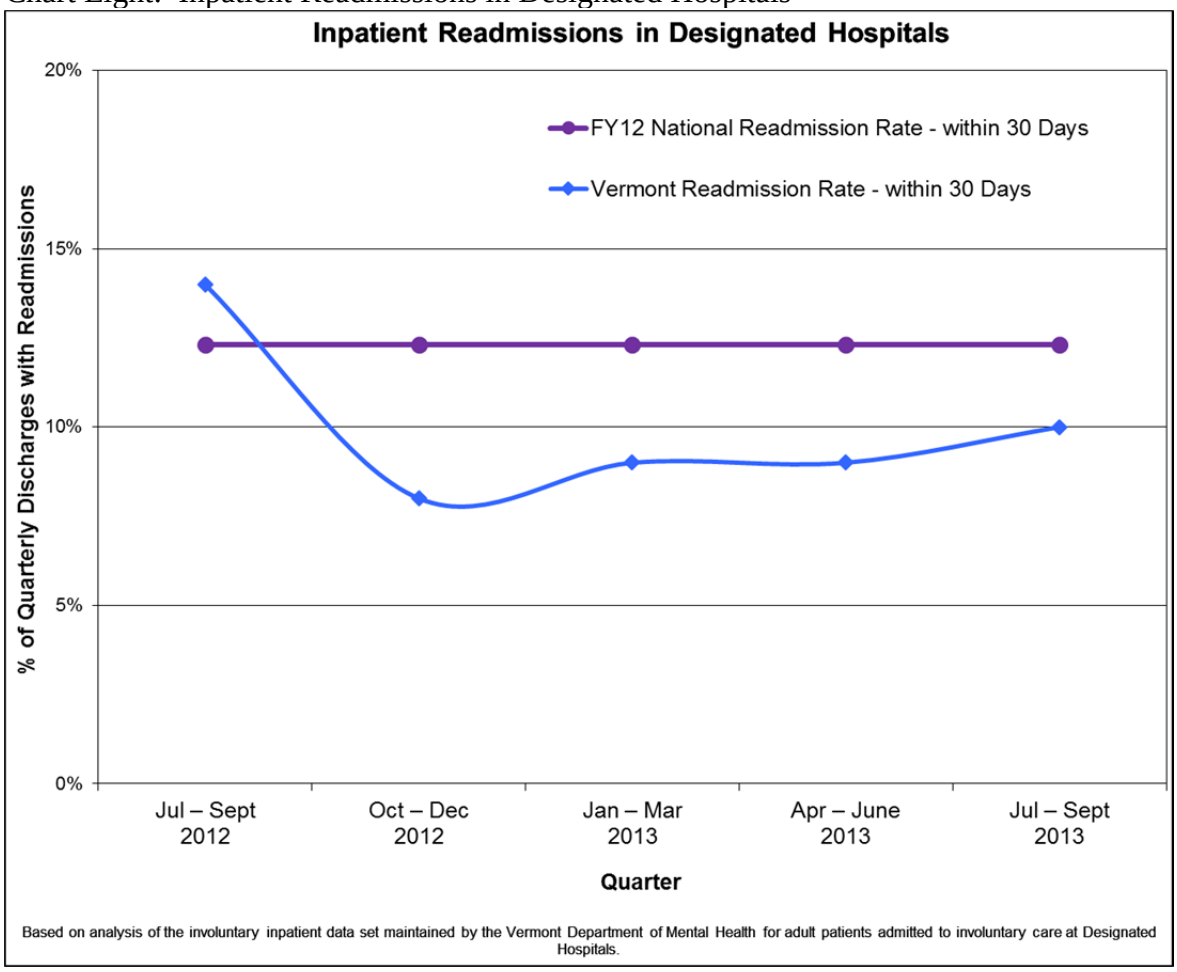
The data for the year indicate that there has been a steady movement to place the majority of Level 1 patients in designated units when available. There are 35 beds currently designated for Level 1 patients throughout the state while the new hospital beds are under construction. The highest average number of Level 1 patients in FY 13 was 40. The average daily census is approximately 37, which is 2 more people than contracted Level 1 beds.

Chart Seven: Inpatient Length of Stay in Designated Hospitals



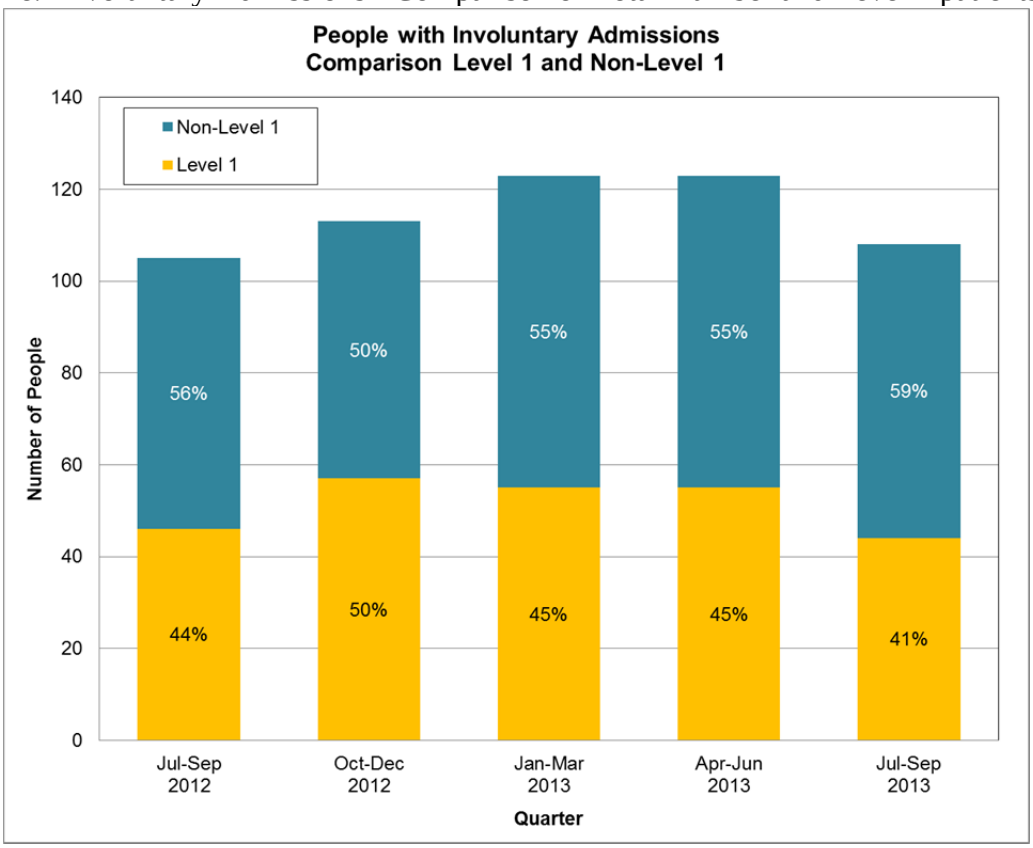
This chart depicts the mean and median lengths of stay (LOS) for psychiatric patients since the 4th Quarter of FY 2012 to the 1st Quarter of FY 2014. The trend indicates a decreased length of stay in hospital settings, despite some initial concern after the closing of VSH that the length of stay would possibly increase as a result of the systemic changes including the decrease in available beds. It appears that patients with higher acuity are being treated on an inpatient basis and others are appropriately being treated in the community through continuum-of-care alternatives such as crisis beds and/or enhanced wraparound services through the DA programs. The median length of stay is fairly stable while the average length of stay has steadily declined over the reporting period. The Care Management Team's active participation around timely disposition placement might be reflected in the decreased LOS figure. Level 1 patients' LOS during FY 2013 showed a trending upward, reaching a mean of close to 58 days in the 4th quarter of FY13 and remaining at 53 days for the first quarter of FY 14. Given this increase in length of stay for Level 1 patients, it could be postulated that wait times for admission may have been affected for this cohort.

Chart Eight: Inpatient Readmissions in Designated Hospitals



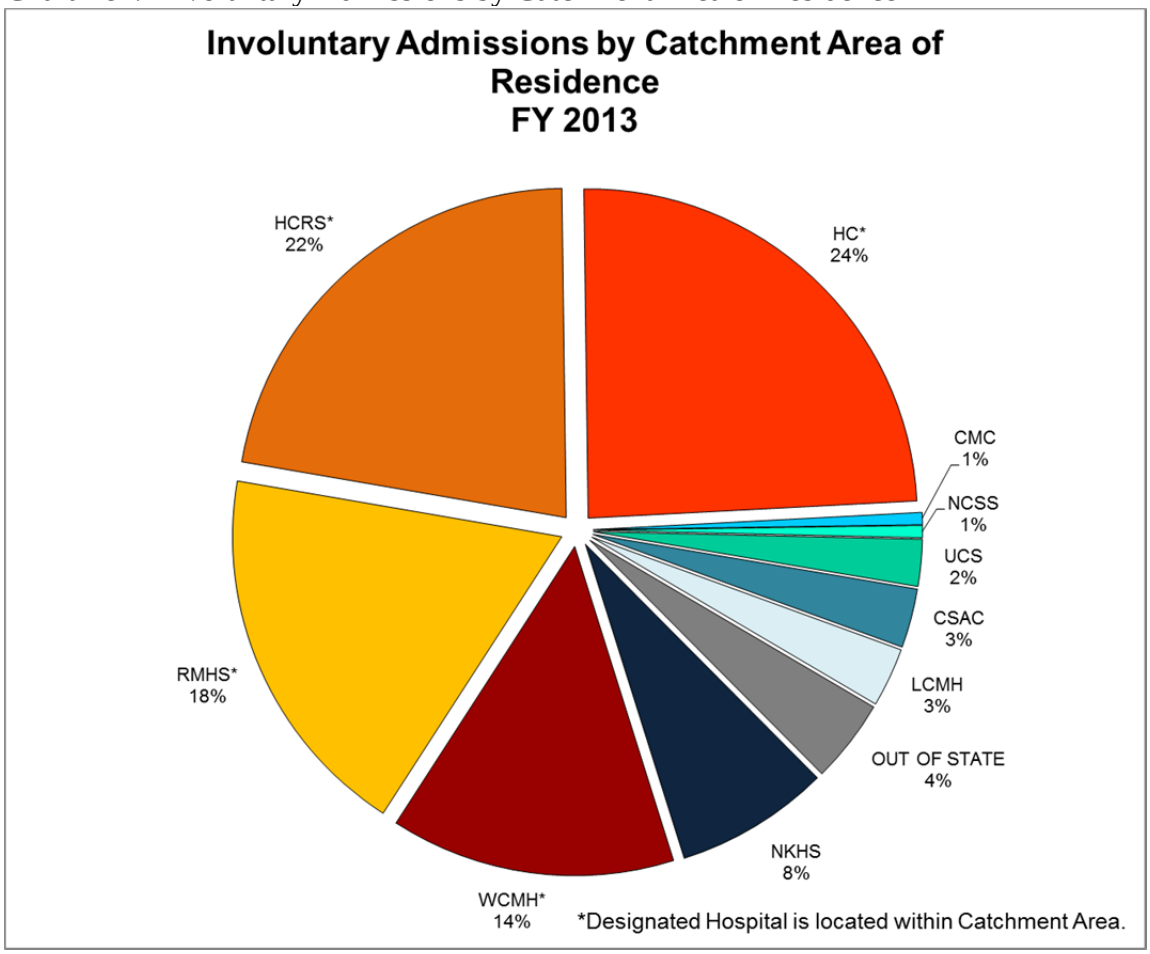
Readmission rates within 30 days of discharge were calculated and compared to national benchmarks. This graph shows a steep downward trend for July through December 2012. Readmissions increased slightly in the third quarter of FY13, stabilized during the fourth quarter of FY 13, followed by a slight increase in readmissions during the first quarter of FY14. There can be multiple contributing factors to this trend, and it is of note that while the length of stay has decreased in general, the readmission rates for the periods reported have held steady, between 8% to 10%; two percent lower than the average national rate presented in the National Outcome Measures (NOMS). It may be that the increased readmission rates in part reflect the loss of VSH capacity to treat the Level 1 population: high-need/high-risk clients often require more intensive and more frequent hospital admissions to be stabilized. DMH care managers and the quality management unit are working with the DHs and the DAs to identify relevant factors contributing to readmission rates.

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



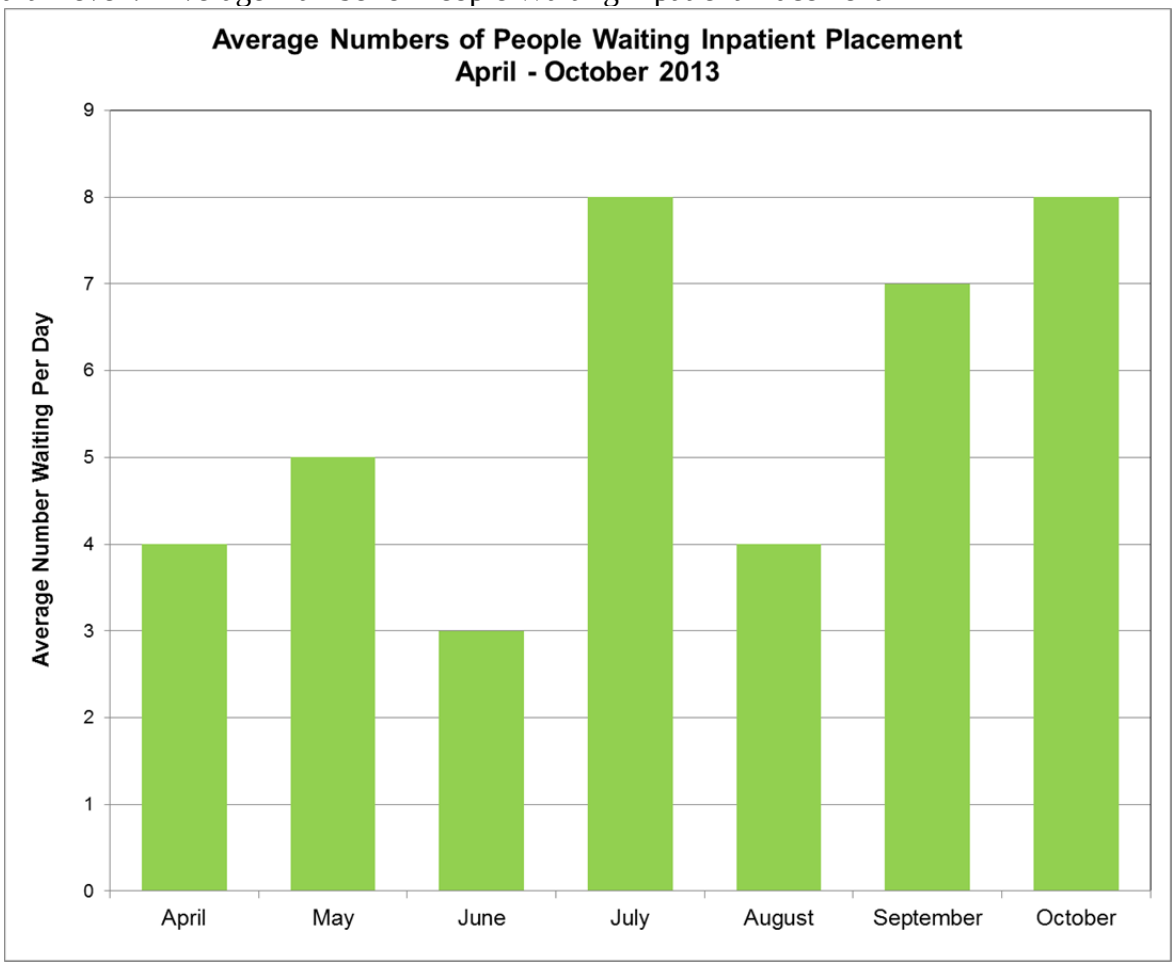
The number of involuntary applications for emergency examinations (admissions) was at its highest in the third quarter of FY13 at 129, approximately the same number as the prior year third quarter. Given the reduction in capacity of inpatient psychiatric beds and their geographic placements in different parts of the state, the system of care continues to manage the challenge of access for those in need of inpatient psychiatric care. Of the total number of admissions for the third and fourth quarters of FY13, the percentage of patients who were designated Level 1 was 45%, and 41% for the first quarter of FY 14; less than half of all involuntary hospitalizations for that time period.

Chart Ten: Involuntary Admissions by Catchment Area of Residence



This chart provides information on the location of individuals who are admitted to an inpatient setting. As expected, larger agencies have a greater number of admissions as they are treating more individuals.

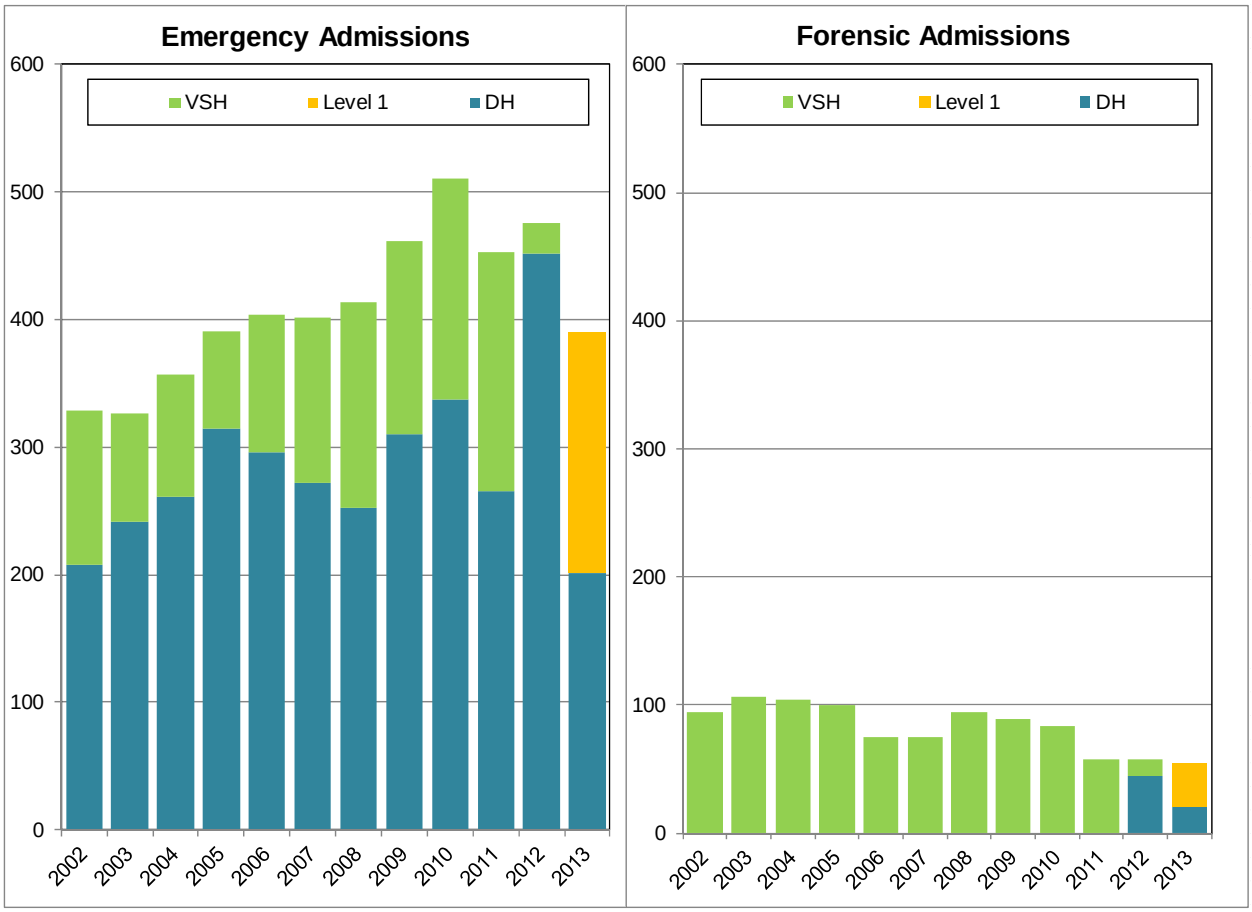
Chart Eleven: Average Number of People Waiting Inpatient Placement



The average number of individuals per day who are waiting for admission to a psychiatric treatment bed have fluctuated over the time period but show a steady upward trend. Given the decreased capacity in total beds across the state and until new beds come on line at the new hospital, timely flow of these inpatient resources requires active management on a daily basis for individuals who are the subject of an application for emergency examination or involuntary hospitalization for a mental health crisis.

Chart Twelve: Emergency and Forensic Admissions

Vermont State Hospital and Designated Hospitals
Emergency and Forensic Admissions
FY2002-FY2013



Analysis based on the Vermont State Hospital (VSH) Treatment Episode Database. Includes all admissions during FY1985 - FY2013 with a forensic legal status or emergency legal status at admission.

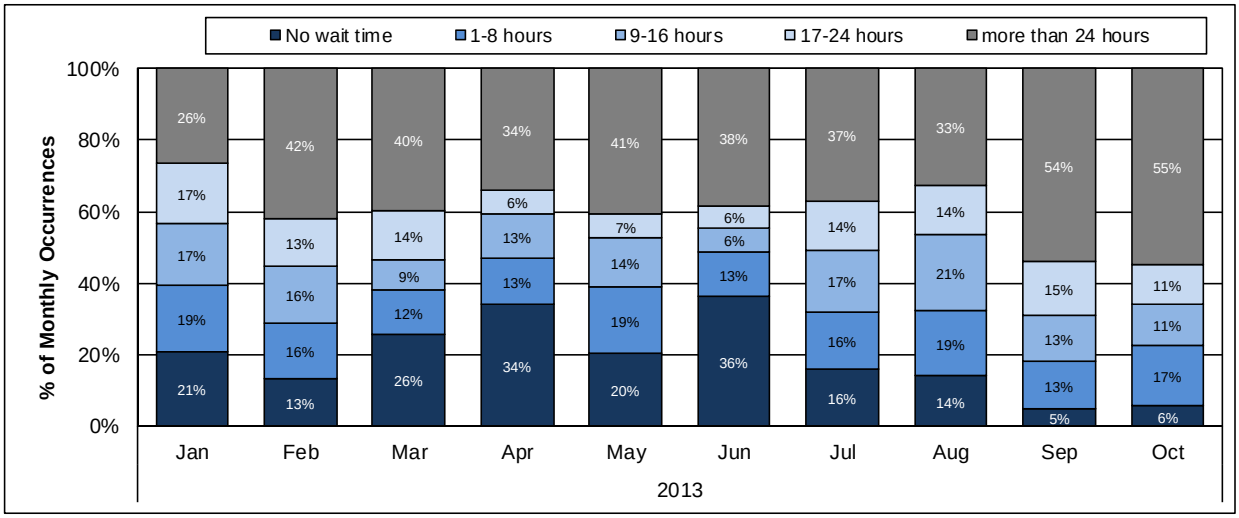
The number of Emergency and Forensic admissions has decreased slightly in the past year. As the chart indicates, we see an increase in the number of Level 1 admissions in each category as would be expected by the closing of VSH, but overall, the numbers of emergency and forensic admissions has not changed significantly over the past three years.

Chart Thirteen: Emergency Department Times to Involuntary Admission

Emergency Exams, Warrants, Court Ordered Forensic Observations, and Youth

Wait Times in Hours for Involuntary Inpatient Admission

2013



	2013									
Wait time	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
No wait time	11	5	15	16	12	17	13	6	3	3
1-8 hours	10	6	7	6	11	6	13	8	8	9
9-16 hours	9	6	5	6	8	3	14	9	8	6
17-24 hours	9	5	8	3	4	3	11	6	9	6
more than 24 hours	14	16	23	16	24	18	30	14	33	29
Total	53	38	58	47	59	47	81	43	61	53
Wait Time in Hours										
Youth Mean						17	20	23	20	40
Median						21	17	15	18	35
EEs/Wrts Mean	19	33	29	26	37	29	35	22	67	44
Median	13	16	18	8	14	6	15	12	37	24
OBS Mean	16	56	77	223	87	75	277	269	468	374
Median	0	48	0	229	69	34	278	277	489	353
Total Mean	19	37	32	47	40	33	57	45	76	69
Median	12	17	18	8	14	11	16	15	25	27

Analysis based on data maintained by the GMPCC admissions department that is collected from paperwork submitted by crisis and designated agency/hospital screeners. Wait times are defined from determination of need to admission to disposition, less time for medical clearance, for persons on warrant for immediate examination, applications for emergency exam, Court Ordered Forensic Observations, and Youth waiting for inpatient admission. Wait times are point in time and are categorized based on month of service, not month of disposition, for clients who have a disposition.

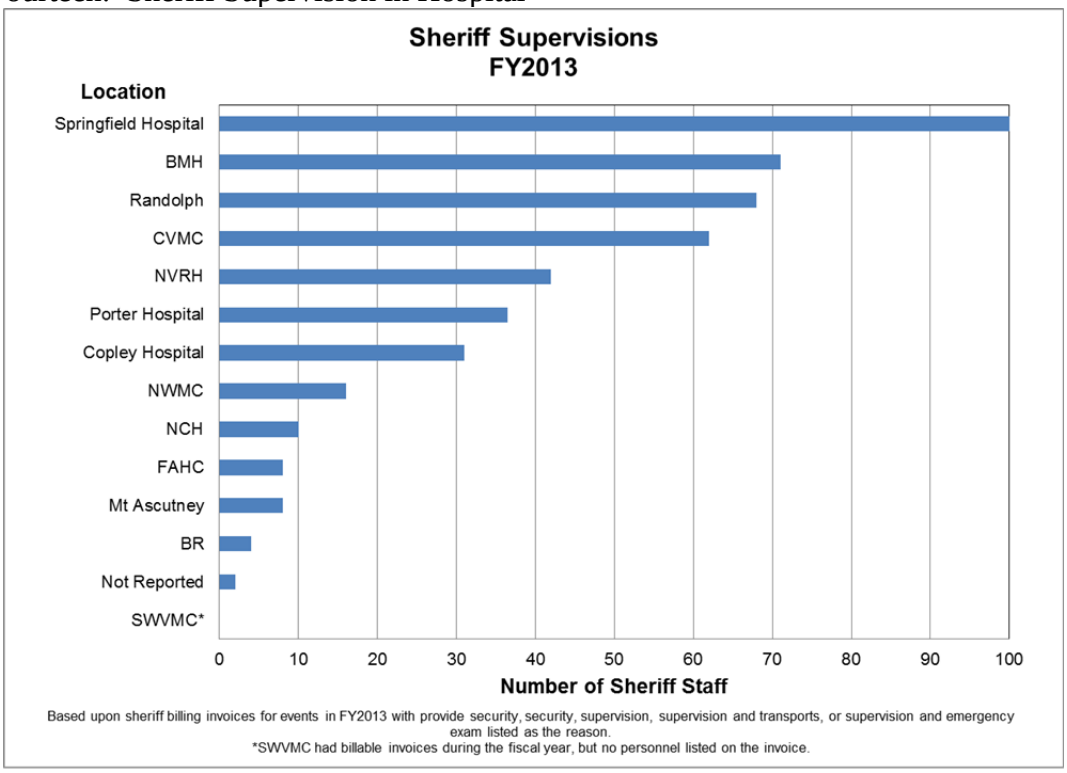
ED wait time calculates the time an individual enters the Emergency Department (ED) for services until placement in a psychiatric bed or discharge from the ED unit if a patient's mental status improves and they are no longer in need of an involuntary admission. ED screening routinely includes medical assessment in conjunction with assessment of an individual for an involuntary psychiatric admission. While any wait is undesirable, wait time for general ED services nationally is in excess of four hours on average, with longest waits of over eight hours for emergency care.[2] As illustrated in the table above, the majority of individuals needing hospitalization waited less than 24 hours with the exception of September and October of 2013,

[2] http://www.pressganey.com/Documents_secure/Pulse%20Reports/2010_ED_Pulse_Report.pdf?viewFile

when more than half waited 24 hours or more. Reviewed as a whole, the total mean wait time for the 10 months measured is 45.5 hours or less than two days. This number is greatly affected by the discrepancy between the average wait times for those on Emergency Examination (EE) or Warrant status and those on Court Orders, who are waiting in Corrections. Those waiting in Corrections have significantly longer wait times for admission to hospital beds.

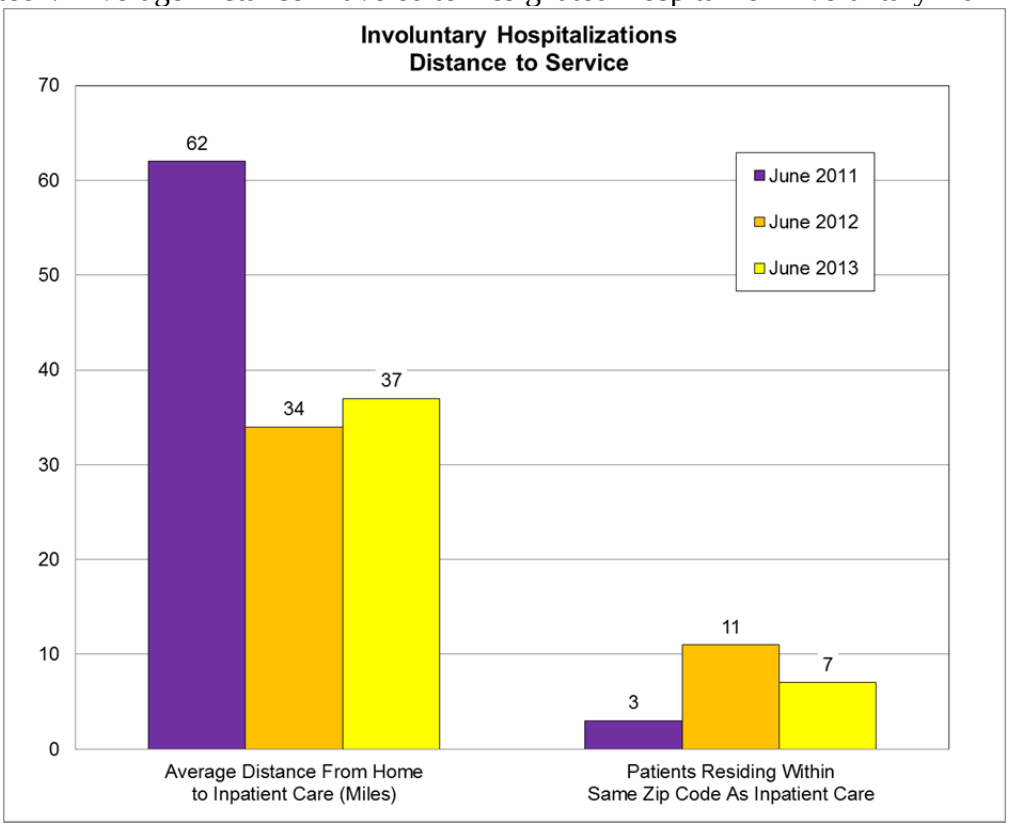
The rate of inpatient placement being delayed in Vermont has increased over time, though the number of involuntary applications has remained stable. This is due to the overall reduction in inpatient beds and the intensity of services required. When patients are awaiting placement for treatment in a psychiatric hospital setting, supervision assistance by Sheriff Deputies are sometimes required. This is a service which is funded through the DMH and the chart below illustrates utilization of sheriff supervision.

Chart Fourteen: Sheriff Supervision in Hospital



A hospital's ability to deal with the supervision of a patient waiting for an inpatient psychiatric bed varies greatly. This may be due to the high need displayed by the patient in order to maintain a safe surrounding, the inability of the designated agency to provide a support person for the patient, or the lack of security services at the hospital.

Chart Fifteen: Average Distance Traveled to Designated Hospital for Involuntary Admission



The closing of VSH resulted in an increased use of beds in DHs for involuntary psychiatric hospitalizations. The decreased distance required to travel to an inpatient bed post-Irene, as demonstrated in the graph above, reflects the greater use of beds at nearby DHs.

Involuntary Medications

The ability to care for those most acutely ill individuals may require the need for the DH to seek the ability to provide medication to a patient against their wishes. This is an issue which has garnered state-wide attention by multiple stakeholder groups and the Administration, as well as the Legislature.

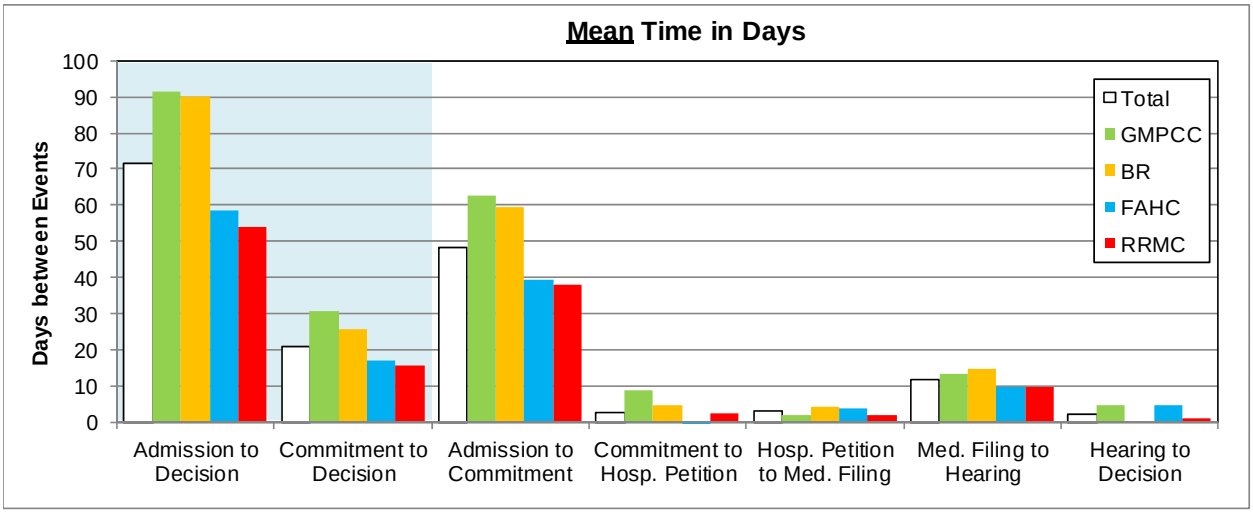
During the summer and fall of 2013, DMH convened a Mental Health Judicial Proceedings / Involuntary Treatment Laws Work Group to examine current Vermont statutes pertaining to judicial proceedings and involuntary treatment in Title 18, Part 8 and develop recommendations for a summary or report that would inform possible legislation in January 2014. The group examined issues leading up to court-ordered involuntary medications, including data compiled by the Mental Health Law Project, the Vermont Association of Hospitals and Health Systems (VAHHS), and the Department of Mental Health on the time frames starting with admission to a hospital to the date of commitment to the order of involuntary court-ordered medication. Based on the work of this workgroup, DMH has decided to not pursue the passage of S.128, an act relating to mental health judicial proceedings, or submit new legislation that would make changes to Title 18 related to Mental Health Judicial Proceedings / Involuntary Treatment for

this legislative session. However, some work group members expressed interest in having DMH continue its work with the Mental Health Law Project and VAHHS to pursue a closer examination of the cases in which there appeared to be extended lengths of time between any of the data points listed above in an effort to better understand the causes of those extended delays. This examination may result in a specialized report examining common causes for extended delays.

A data analysis work group that includes representatives from DMH, DRVT and Legal Aid has been formed to further study this issue and to recommend systemic changes. The following chart illustrates the process and the time between significant points in the process.

Chart Sixteen: Involuntary Medications

Court Ordered Involuntary Medication
Time Between Significant Events
January 2012 - November 2013
All Orders



Mean Time in Days

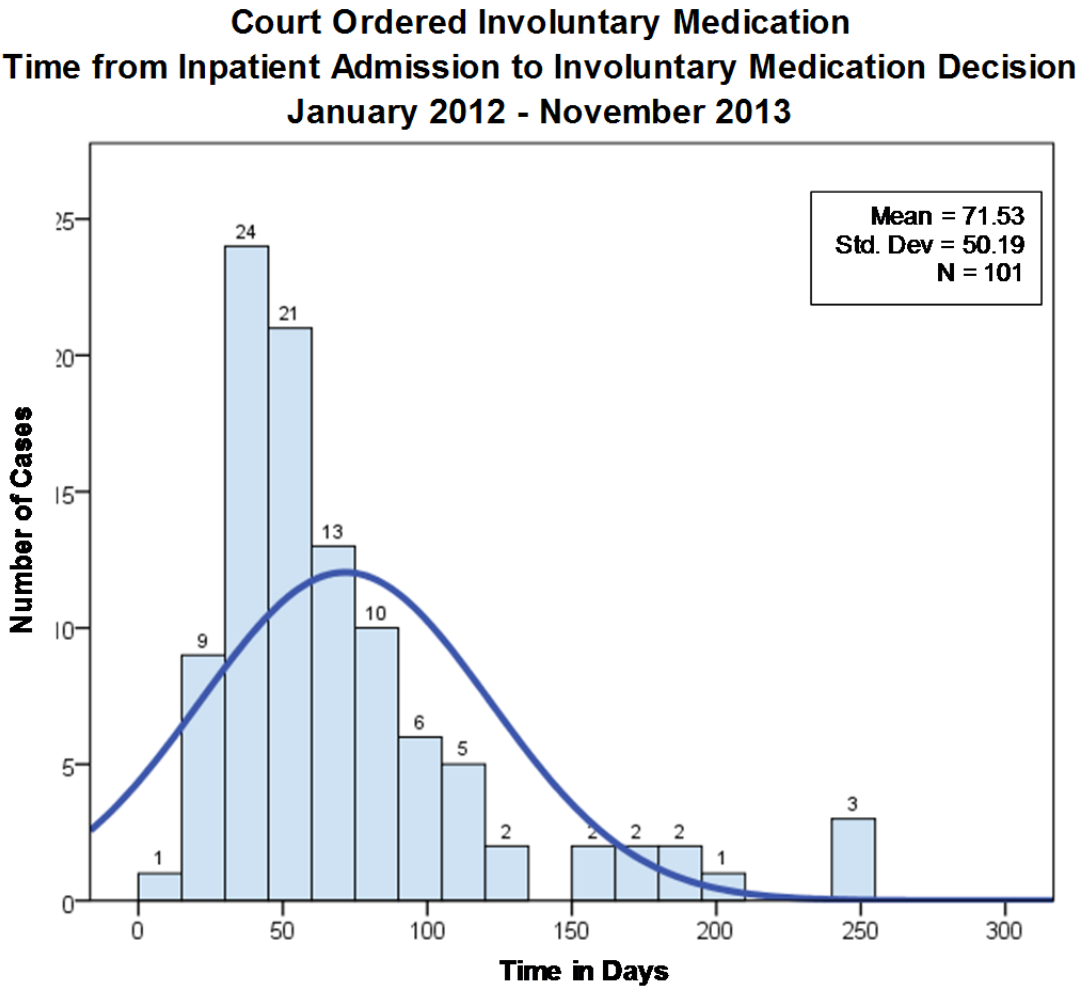
Hospital	Admission to Decision # Cases	Admission to Decision Days	Commitment to Decision # Cases	Commitment to Decision Days	Admission to Commitment #Cases	Admission to Commitment Days	Commitment to Hospital Petition #Cases	Commitment to Hospital Petition Days	Hospital Petition to Med. Filing #Cases	Hospital Petition to Med. Filing Days	Med. Filing to Hearing #Cases	Med. Filing to Hearing Days	Hearing to Decision #Cases	Hearing to Decision Days
BR	34	90	33	26	34	59	34	5	36	4	27	15	25	0
FAHC	27	59	25	17	25	39	25	-2	27	4	22	10	22	5
GMPCC	11	91	10	31	11	63	11	9	12	2	8	14	7	5
RRMC	29	54	29	16	29	38	29	3	29	2	22	10	22	1
Total	**101**	**72**	**97**	**21**	**99**	**48**	**99**	**3**	**104**	**3**	**79**	**12**	**76**	**2**

The definition of involuntary medication for a patient requires that the individual meet criteria for the presence of a mental illness and clear evidence of being in need of treatment in accordance with V.S.A. Title 18 §7624-7627. Involuntary medication in a non-emergency situation may be administered to an involuntarily admitted person only through a court order. If a treating physician feels it is necessary, formal requests are made to the court.

The mean time in days between steps to involuntary medication orders is depicted in the graph above by hospital. A total of 101 cases were identified for the time period between January 2012

and November 2013. The average number of days to decision by the Court on involuntary medication was 72 days for this time period. The time from filing to Hearing and the Court order was variable among patients for whom petitions were filed.

Chart Seventeen: Time in Days from Admission to Court Ordered Medication



This graph illustrates all of those who have had applications filed for involuntary medication between January 2012 and November 2013. The average (mean) length of time between an admission to the medication decision is approximately 72 days, with a small number of outliers on either end of the curve. Twelve percent waited between 110 to 150 days and approximately nine percent waited between 150-250 days. Given that the standard deviation is approximately50 days, and mean is near 70, the spread expected would be 20 to 120 days. This illustrates the variability in this measure across time and jurisdictions, with over half waiting less than the average period of time.

Transportation

Chart Eighteen: Use of Restraints in Adult Involuntary Transport

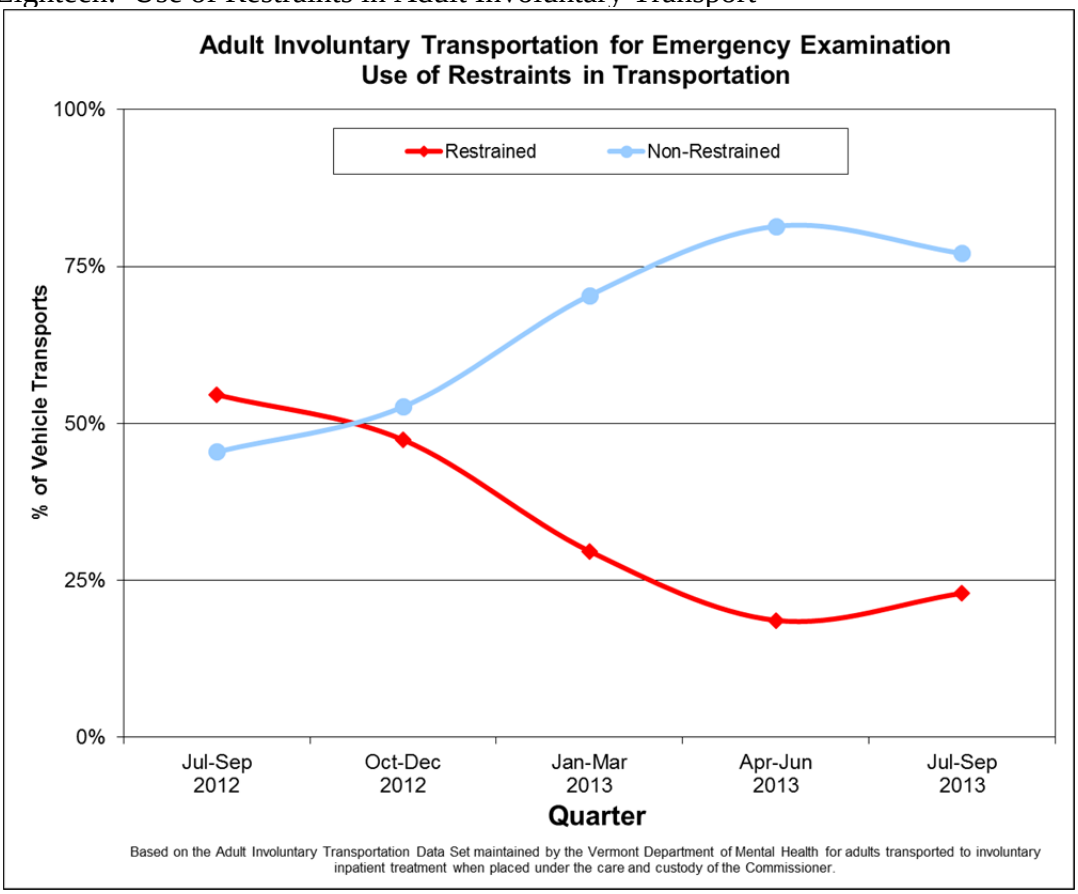
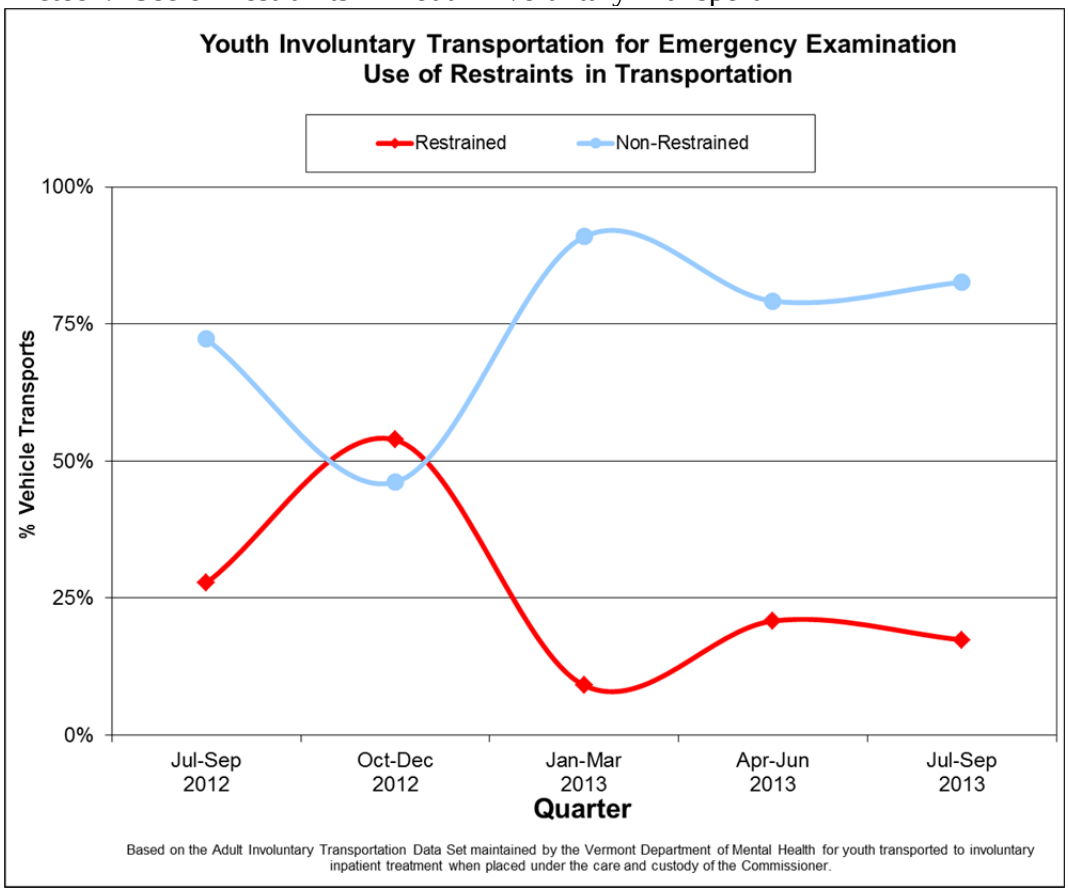


Chart Nineteen: Use of Restraints in Youth Involuntary Transport



Since April 2012, DMH has developed an aggressive implementation plan for changing the manner in which individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. This plan is in response to Act 180, Title 18 §7511, relative to transportation of people who are found to need involuntary psychiatric hospitalization and is directly connected to reduction in trauma for the patient in transport. The steps taken and goals that were achieved are as follows:

- Development of a Transportation Work Group to outline the issues, to establish and support a plan, and to provide input on definitions, data collection, and training
- Development of a transportation protocol
- Examination of transport practice patterns for adults and youths throughout the state by sheriffs and ambulance
- Promotion of a policy for utilization of soft restraints in transport when restraints are necessary
- Delivery of training for sheriffs regarding “Building Rapport with People in Mental Health Crisis” and “Safe Transport Strategies”

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

For many years, secure transport was defined as a transport by sheriffs. The current definition of secure transport is defined as the application of mechanical restraints, either soft or metal. This change in terms evolved out the success of the involuntary transportation workgroup.

Chart Twenty: Use of Metal Restraints in Adult Involuntary Transport

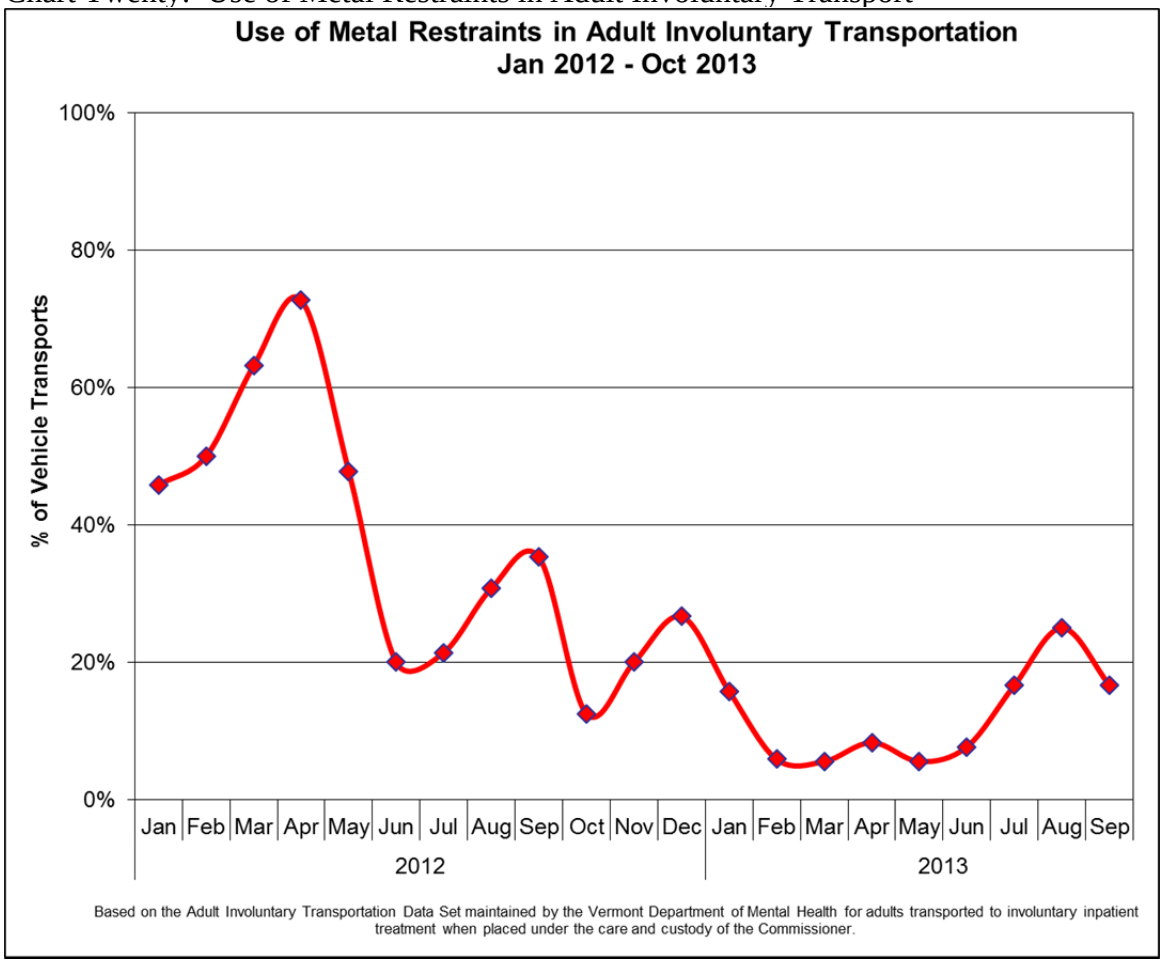


Chart Twenty-One: Use of Metal Restraints in Youth Involuntary Transport

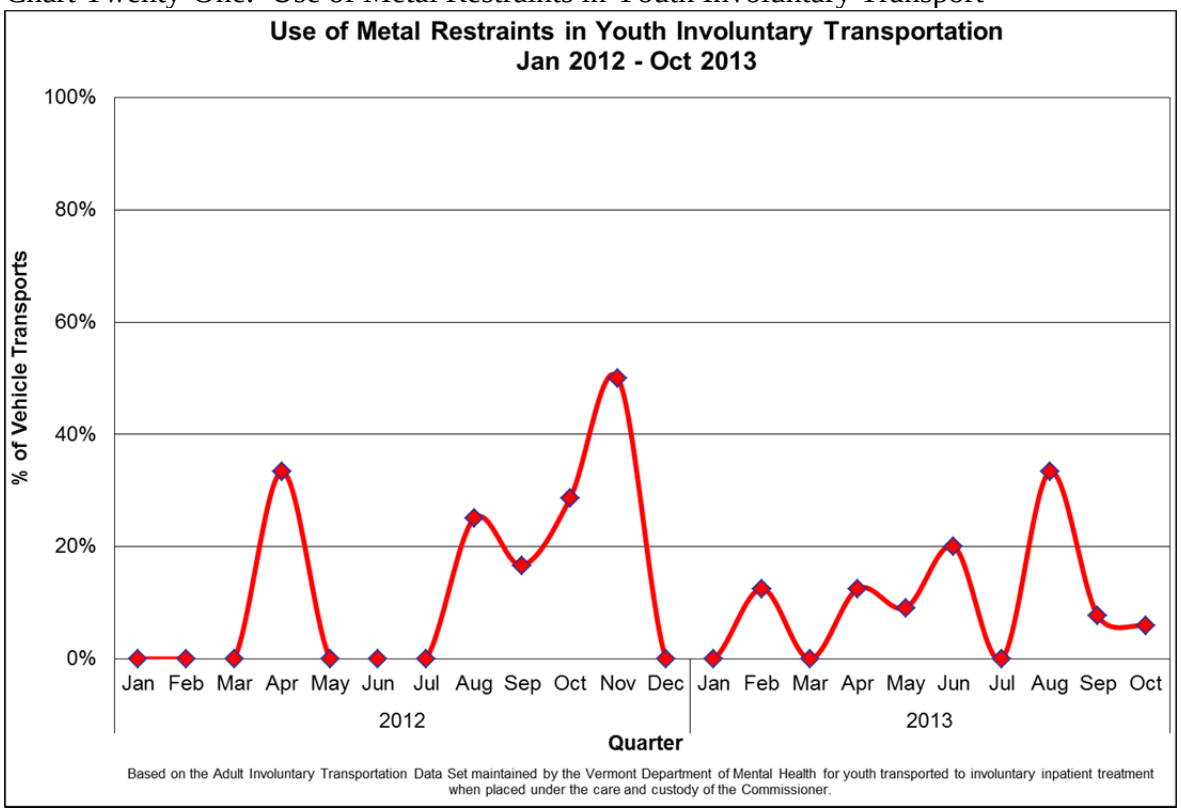


Chart Twenty-Two: One year overview of Adult Involuntary Transport

Vermont Department of Mental Health
Adult Involuntary Transportation for Emergency Examinations
One Year Overview (December 2012-November 2013)

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Annual
Transportation Type													
Restrained	8	8	1	7	2	4	2	5	3	3	0	1	44
Non-Restrained	7	11	16	11	10	14	11	13	9	15	15	15	147
Missing	0	0	0	0	0	0	0	0	0	0	0	0	0
Restraints Used in Transport													
None	7	11	16	11	10	14	11	13	9	15	15	15	147
Metal	4	3	1	1	1	1	1	3	3	3	0	1	22
Soft	4	5	0	6	1	3	1	2	0	0	0	0	22
Missing	0	0	0	0	0	0	0	0	0	0	0	0	0
% All vehicle transports that use Metal	27%	16%	6%	6%	8%	6%	8%	17%	25%	17%	0%	6%	12%
Vehicle Used in Transport													
Ambulance	0	4	8	6	4	2	2	2	3	2	4	3	40
MH Van Alternative	2	0	0	1	0	0	0	0	0	0	0	0	3
Private Transport	0	0	0	0	1	1	2	0	0	0	1	1	6
Sheriff Alternative	4	8	6	5	5	6	7	6	7	10	5	6	75
Sheriff Cruiser	9	7	3	6	2	9	2	10	2	6	5	6	67
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	0
No Data	0	0	0	0	0	0	0	0	0	0	0	0	0
%Vehicle Transports that use Ambulance		21%	47%	33%	33%	11%	15%	11%	25%	11%	27%	19%	21%
%Vehicle Transports that use MH Van Alternative	13%			6%									2%
%Vehicle Transports that use Private Transport					8%	6%	15%				7%	6%	3%
%Vehicle Transports that use Sheriff's Alternative	27%	42%	35%	28%	42%	33%	54%	33%	58%	56%	33%	38%	39%
%Vehicle Transports that use Sheriff's Cruiser	60%	37%	18%	33%	17%	50%	15%	56%	17%	33%	33%	38%	35%

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Annual
EE's with Sheriff Involvement	13	15	9	11	7	15	9	16	9	16	10	12	142
TOTAL EE Transports	**15**	**19**	**17**	**18**	**12**	**18**	**13**	**18**	**12**	**18**	**15**	**16**	191

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Youth Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner.

Date of Report: 1/2/2014

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

Vermont Department of Mental Health
Youth Involuntary Transportation for Emergency Examinations
One Year Overview (December 2012-November 2013)

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Annual
Transportation Type													
Restrained	0	0	2	0	1	3	1	0	3	1	1	0	12
Non-Restrained	2	10	6	4	7	8	4	4	3	12	16	4	80
Missing	0	0	0	0	0	0	0	0	0	0	0	0	0
Restraints Used in Transport													
None	2	10	6	4	7	8	4	4	3	12	16	4	80
Metal	0	0	1	0	1	1	1	0	2	1	1	0	8
Soft	0	0	1	0	0	2	0	0	1	0	0	0	4
Missing	0	0	0	0	0	0	0	0	0	0	0	0	0
% All vehicle transports that use Metal	0%	0%	13%	0%	13%	9%	20%	0%	33%	8%	6%	0%	9%
Vehicle Used in Transport													
Ambulance	1	6	3	2	3	4	3	4	3	7	12	1	49
MH Van Alternative	0	2	1	1	2	0	0	0	0	0	1	2	9
Private Transport	0	0	1	0	0	1	0	0	0	0	3	0	5
Sheriff Alternative	1	2	1	1	2	1	0	0	1	4	1	0	14
Sheriff Cruiser	0	0	2	0	1	5	2	0	2	2	0	1	15
Other	0	0	1	0	0	0	0	0	0	0	0	0	1
Not Applicable ("Walk Up")	0	0	0	0	0	0	0	0	0	0	0	0	0
No Data	0	0	0	0	0	0	0	0	0	0	0	0	0
%Vehicle Transports that use Ambulance	50%	60%	33%	50%	38%	36%	60%	100%	50%	54%	71%	25%	53%
%Vehicle Transports that use MH Van Alternative		20%	11%	25%	25%						6%	50%	10%
%Vehicle Transports that use Private Transport			11%			9%					18%		5%
%Vehicle Transports that use Sheriff's Alternative	50%	20%	11%	25%	25%	9%			17%	31%	6%		15%
%Vehicle Transports that use Sheriff's Cruiser			22%		13%	45%	40%		33%	15%		25%	16%

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Annual
EE's with Sheriff Involvement	1	2	3	1	3	6	2	0	3	6	1	1	29
TOTAL EE Transports	**2**	**10**	**8**	**4**	**8**	**11**	**5**	**4**	**6**	**13**	**17**	**4**	92

Analysis conducted by the Vermont Department of Mental Health Research & Statistics Unit.
Based on the Youth Involuntary Transportation Data Set maintained by the VT Department of Mental Health for transports to involuntary inpatient treatment when an individual is placed under the care and custody of the Commissioner.

Date of Report: 1/2/2014

DMH approach to this initiative has proven to be effective in that there is a marked decrease in restraints used since April of 2012. Starting in 2009, DMH introduced soft restraints as an alternative to metal or polyurethane restraints. Between December, 2012 and November, 2013 only 12% of vehicle transports for adults utilized metal restraints; for youth only 9% were transported in metal restraints. Examining the use of metal restraints by month, there are two periods with significantly higher uses of metal in June and August, though the numbers did not increase at that time. In general, the use of metal restraints for both adults and youth is significantly lower, reflecting the ongoing effort of DMH to ensure transportations use metal restraints as an option only when other means have been exhausted

The drop in secure transport is directly attributable to the Lamoille County pilot as it responds to the entire northern tier of the state, an area where metal restraints continue to be used by Chittenden, Franklin/Grand Isle, Orleans, and Caledonia sheriffs as a matter of policy. All other Sheriffs' Departments have transitioned to soft or no restraints.

Ambulance transport is required by Rutland and Bennington counties, and all sheriffs now ride in ambulances, as requested by DMH. The specific breakdown of transport type can be reviewed

in the Department of Mental Health Involuntary Transport report for the period October 2011 – November 2012. This report includes both adults' and children's transportation data.

Outpatient Care and Utilization

Outpatient services are provided through a system of care that includes the Designated Agencies (DAs) in addition to private practitioners and other state and local social services agencies. The DAs provide comprehensive services to individuals with severe mental illness through the CRT programs, and they support and manage crisis beds and hospital-diversion services, intensive residential beds, residential beds, supportive housing, wrap-around programs, and peer services. In addition, DA services include Adult Outpatient counseling for individuals and families, case management and services to families with children experiencing a severe emotional disturbance. Availability of the continuum of outpatient services is limited geographically because of the rural nature of the state.

In order to maximize utilization of limited resources in the community and DHs, DMH developed a care-management system that employs clinicians as key contacts and liaisons between DAs and DHs, ensuring that people in need of treatment receive the appropriate levels of care.

Peer services have expanded in the past year and will continue to expand. DMH has increased funding for peer programs to provide additional outreach, community support, crisis intervention and respite, linkages to Recovery Turning Point Centers, hospitals, and the correctional system, and the establishment of a statewide telephone warm-line.

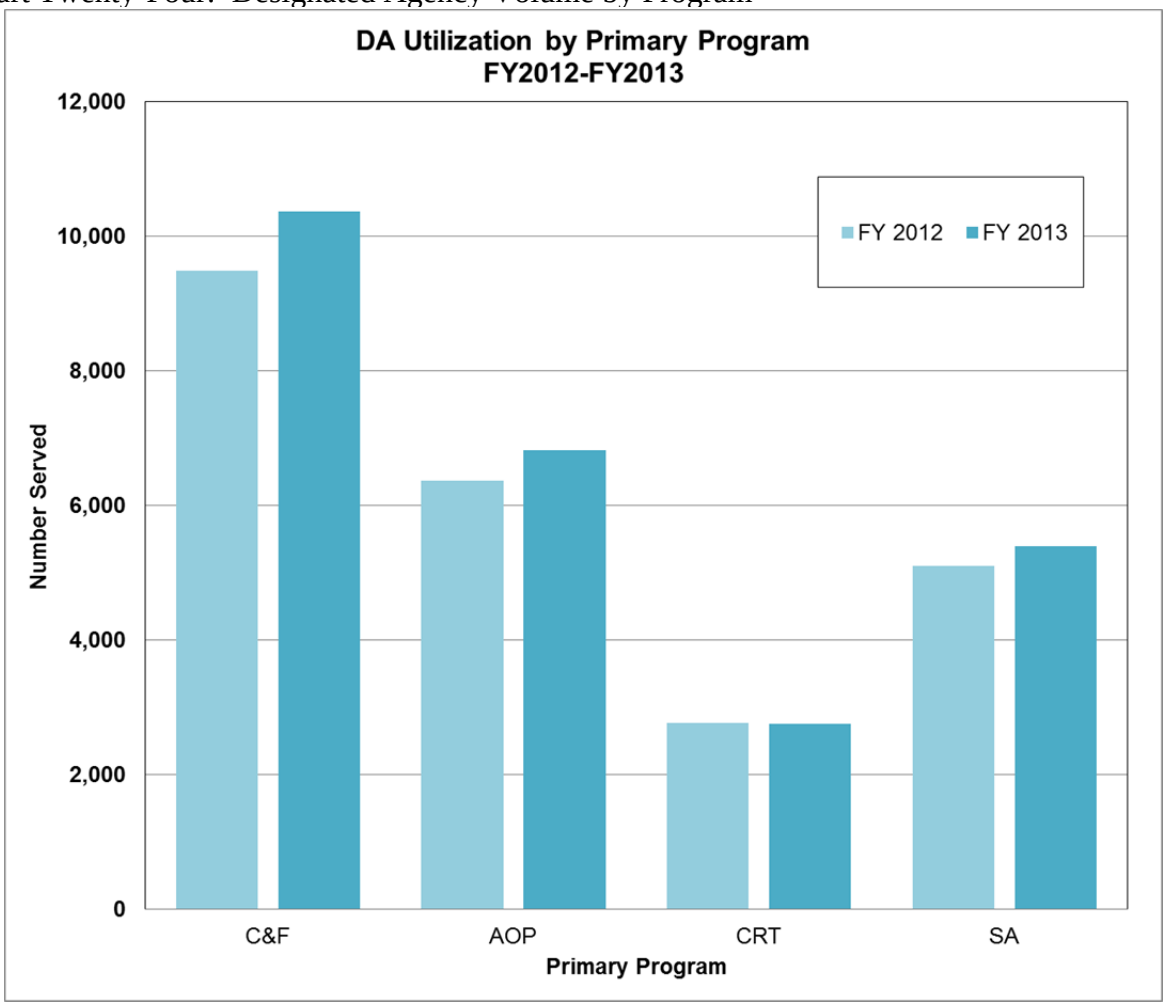
The continuity of care requires that CRT program staff within the DAs interact with those clients being discharged from the inpatient setting as soon as possible after discharge to ensure a smooth transition to the community with a range of services in place as indicated by discharge and treatment plans. This period of time ranges from one hour to within one week of discharge. The DMH expects that individuals are seen in the DA within one-week of hospital discharge, and case managers/social workers and others working with this population from both the community and the hospitals are required to work collaboratively to assure a timely visit. Trending of data indicates a slight increase in the number of persons seen within this time frame. Reasons for not being seen include decisions by the individual or family to delay or cancel appointments.

Although DMH provided enhanced community services funding through increased appropriations to key mental health programs in the community in FY13, staff recruitment to ramp up these service levels has taken time. Information provided by the DAs in the Local System of Care Plans continues to identify staffing, both recruitment and retention, as a major barrier to increasing services. Consistent with this report, the numbers served in community programs through FY13 remained relatively stable and do not yet reflect any statistically significant upward trend in persons served.

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

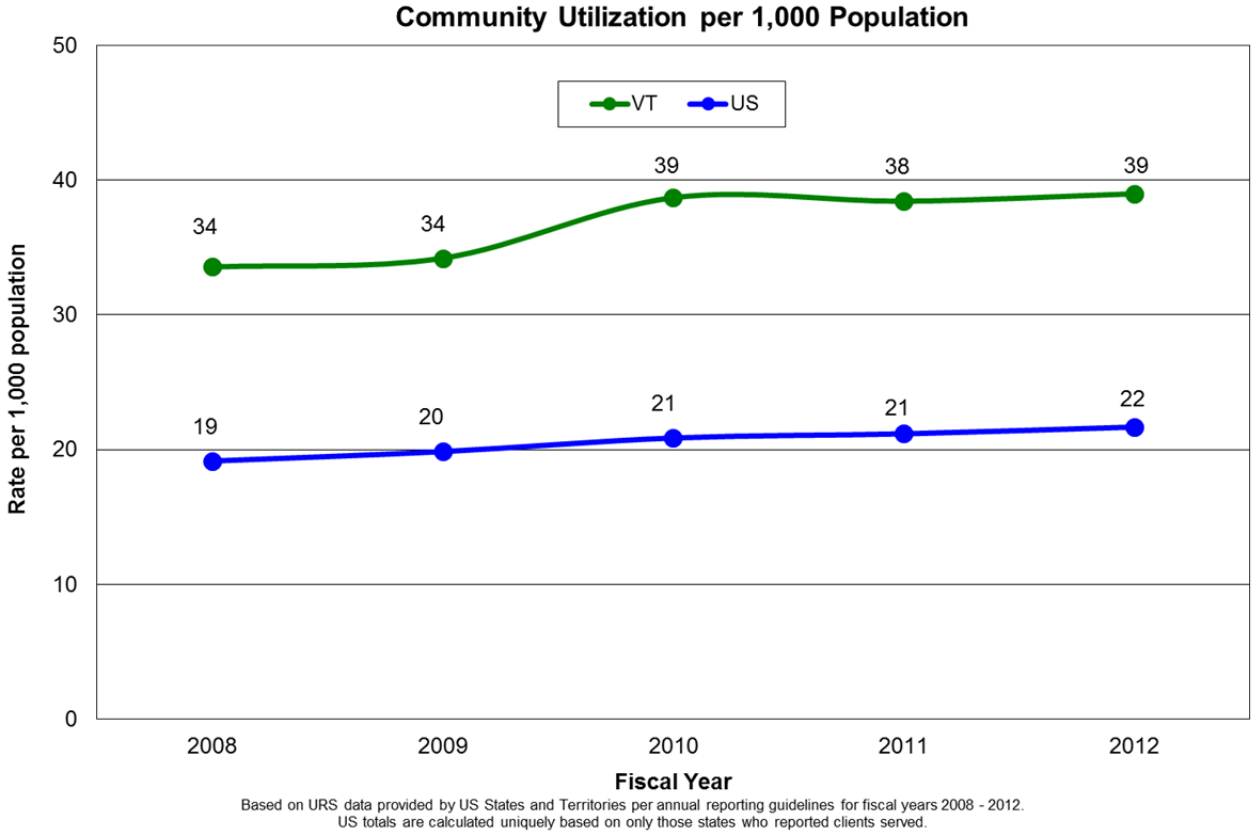
increase in numbers served. It is still early to evaluate whether enhanced services and capacity appears adequate to meet the unmet needs identified prior to the infusion of enhanced program funding for community services.

Chart Twenty-Four: Designated Agency Volume by Program



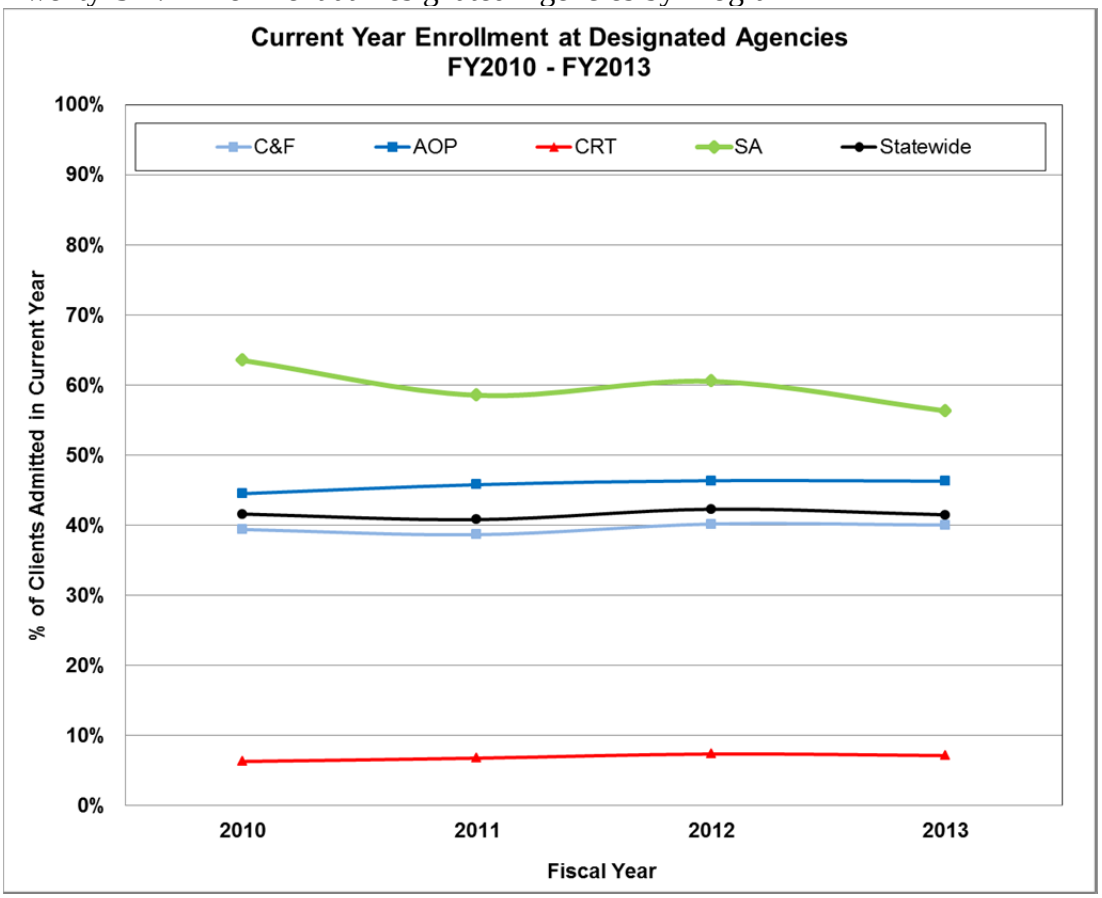
The highest number of persons served by a program offered by the DAs is in services for children and families, while the lowest numbers of persons served by a DA program are those in the CRT programs. The volume of clients served in CRT programs has been fairly static over time. It is too early to see all the changes from enhanced funding that began in May 2012, but a notable increase in case management services to outpatient clients is discussed later in this report.

Chart Twenty-Five: Community Utilization per 1,000 Populations



The number of individuals served in the community per 1,000 populations in Vermont is 38, or 75% higher than the national figure.

Chart Twenty-Six: Enrollment at Designated Agencies by Program



The system of care is predicated on the recognition that people move through a continuum of needs for care. Ideally, individuals would receive community-based treatment appropriate to their needs, and move to higher or lower levels of care only as needed to support return to baseline or above. For many who have a chronic illness, this is more challenging, requiring continued higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services. In addition, clients may have co-occurring conditions and receive treatment in more than one area at any given time.

The most significant finding across the four years studied for this report is that over 41% of the CRT client population has been engaged and retained in treatment for 11 or more years. The next highest length of stay is three to ten years. This indicates that approximately half of the seriously mentally ill population may be significantly older at this time and that the number of clients new to the system (enrolled within the last one to two years) has decreased. The clients served by the CRT programs are chronically ill and require ongoing care. The numbers of clients in the age ranges of 35-64 have increased over the past 4 years, while the numbers of clients between 20 and 34 years of age have decreased. These decreases in younger adults participating in CRT programs may indicate a need to review models of treatment that have been geared for what is now an older cohort of clients.

Chart Twenty-Seven: Intensive Residential Bed Utilization

Legislative Report to Mental Health Oversight Committee
and Health Care Oversight Committee
Intensive Residential Census Report
November 2012 - November 2013

Adult Intensive Residential Facilities

	Hilltop	Meadowview	Second Spring Williamstown	Second Spring Westford	Middlesex	State Avg	State Avg Excluding Middlesex
November							
Total Beds	8	6	20			35	
Monthly Avg.	7	4.96	19.87			24.43	
Monthly % Occupancy	87.5%	82.7%	99.3%			69.8%	
December							
Total Beds	8	6	20			34	
Monthly Avg.	7.00	5.12	18.87			22.87	
Monthly % Occupancy	87.5%	85.3%	94.3%			67.3%	
January							
Total Beds	8	6	20			34	
Monthly Avg.	6.62	5.92	19.04			24.19	
Monthly % Occupancy	82.7%	98.7%	95.2%			71.2%	
February							
Total Beds	8	6	20			36	
Monthly Avg.	6.08	5.64	21.14			31.21	
Monthly % Occupancy	76.0%	93.9%	105.7%			89.2%	
March							
Total Beds	8	6	20			36	
Monthly Avg.	7	6	21.9			32.58	
Monthly % Occupancy	87.5%	100.0%	109.5%			90.5%	
April							
Total Beds	8	6	20			36	
Monthly Avg.	6.03	6.00	21.90			33.13	
Monthly % Occupancy	75.4%	100.0%	109.5%			92.0%	
May							
Total Beds	8	6	20			36	
Monthly Avg.	6.31	6.00	21.73			32.94	
Monthly % Occupancy	78.9%	100.0%	108.6%			91.5%	
June							
Total Beds	8	6	20		7	43	36
Monthly Avg.	7.00	6.00	21.40		2.00	34.13	33.53
Monthly % Occupancy	87.5%	100.0%	107.0%		28.6%	79.4%	93.1%
July							
Total Beds	8	6	20		7	43	36
Monthly Avg.	7.83	5.42	21.71		2.71	37.42	34.71
Monthly % Occupancy	97.9%	90.3%	108.5%		38.7%	87.0%	96.4%
August							
Total Beds	8	6	20	8	7	49	42
Monthly Avg.	7.97	4.58	21.19	1.00	4.97	39.13	34.16
Monthly % Occupancy	99.6%	76.3%	99.8%	12.5%	71.0%	86.2%	89.1%
September							
Total Beds	8	6	20	8	7	49	42
Monthly Avg.	6.79	4.77	18.90	3.36	6.00	38.80	32.80
Monthly % Occupancy	84.8%	79.4%	94.5%	42.0%	85.7%	82.5%	82.0%
October							
Total Beds	8	6	20	8	7	49	42
Monthly Avg.	6.68	4.13	17.84	6.54	6.81	41.35	34.55
Monthly % Occupancy	83.5%	68.8%	89.2%	81.7%	97.2%	84.4%	83.8%
November							
Total Beds	8	6	20	8	7	49	42
Monthly Avg.	6.22	5.33	15.77	7.00	7.00	40.70	33.70
Monthly % Occupancy	77.8%	88.9%	78.8%	87.5%	100.0%	84.4%	81.8%

Based on data reported to the Vermont Department of Mental Health (DMH) by intensive recovery residence beds for adult care using the electronic bed boards system. Programs are expected to report to electronic bed boards a minimum of once per day to update their residential census. Lower percentages in earlier months are attributed to gaps in daily reporting from programs. State averages for November 2013 and subsequent months have been adjusted to exclude programs on days w here there were no updates submitted to the bed board.Middlesex Therapeutic Community Residence began accepting placements on June 20th, 2013 and began reporting to electronic bed boards system on June 21, 2013. Before the opening of Second Spring -Westford on August 19, 2013, Second Spring Williamstow n had 2 crisis beds that could be reallocated to intesive residential as needed, bringing their total capacity to 22 during some days in each month. This is reflected in months w here percent occupancy exceeds 100%.

The intensive residential recovery programs are meeting a key transition need for a significant number of individuals who are ready to leave the hospital level of care, but who still require intensive supervision and support before taking steps toward more independent living. Second Spring and Meadowview programs pre-Irene provided these transitional supports effectively for a number of residents moving through their programs, each operating within a 12-18-month time frame for resident aftercare planning and transition. Immediately following the closure of VSH, Second Spring increased its licensed bed capacity from 14 to 22 beds temporarily to meet the emergent need of individuals who could be discharged to an intensive residential recovery environment, and Hilltop, a new eight-bed intensive residential recovery environment, was added to the service continuum in the fall 2012. FY13 saw the openings of Second Spring-Westford and the Middlesex Therapeutic Community Residence.

In accordance with creating movement within the system of care, the development and support of increased crisis bed capacity has been a focus of FY13. Below is the Table which depicts Crisis Bed occupancy for FY 13. Utilization has been good, with between 77% to 85% occupancy rates; close to the target of 80%, as represented in the table below.

Chart Twenty-Eight: Crisis Bed Census Report

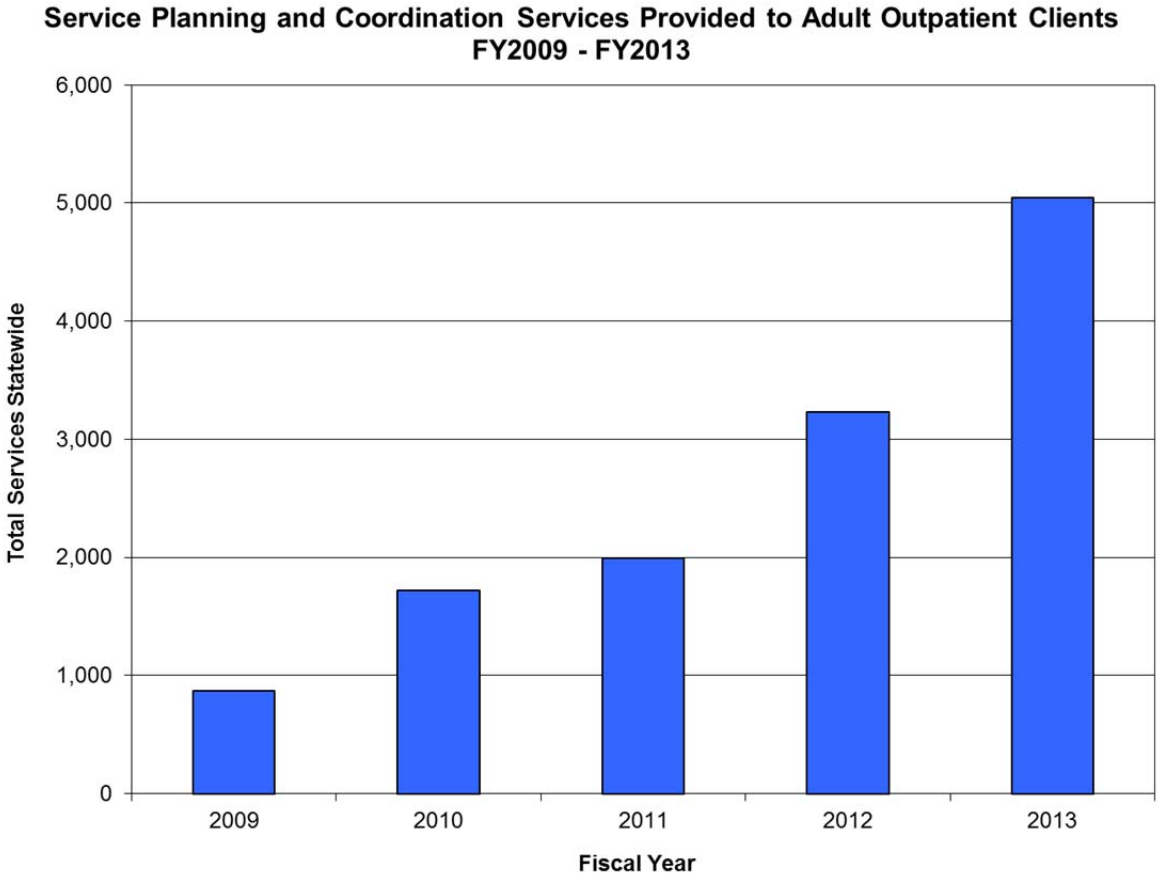
Legislative Report to Mental Health Oversight Committee
and Health Care Oversight Committee
Crisis Bed Census Report
2013

Adult Crisis Bed Units

	HCRS Alternatives	HC Assist	UCS Battelle House	WCMH Home Intervention	NCSS Bayview	NKHS Care Bed	LCMH Oasis House	Second Spring Williamstown	Alyssum	RMHS CSID	CSAC Cottage Crisis	CMC Chris' Place	State Avg
January													
Total Beds	6	6	6	5	2	2	2	2	2	2	1	1	37
Monthly Avg.	5.87	5.74	3.60	3.23	1.71	1.39	0.57	0.88	1.90	2.13	0.77	0.77	27.48
Monthly % Occupancy	97.8%	95.7%	60.0%	64.5%	85.5%	69.4%	28.3%	43.8%	95.2%	106.5%	77.4%	77.4%	77.4%
February													
Total Beds	6	6	6	5	2	2	2	2	2	3	1	1	38
Monthly Avg.	5.57	5.43	3.39	3.07	1.64	1.82	1.36	-	1.82	2.75	1.00	0.79	27.68
Monthly % Occupancy	92.9%	90.6%	56.5%	61.4%	82.1%	91.1%	67.9%	-	91.1%	91.7%	100.0%	78.6%	79.2%
March													
Total Beds	6	6	6	5	2	2	2	2	2	3	1	1	37
Monthly Avg.	5.65	4.93	4.23	3.42	1.84	1.52	1.52	-	1.94	2.87	1.00	0.81	29.35
Monthly % Occupancy	94.1%	82.2%	70.4%	68.4%	91.9%	75.9%	76.0%	-	96.8%	95.7%	100.0%	80.6%	82.6%
April													
Total Beds	6	6	6	5	2	2	2	2	2	3	1	1	37
Monthly Avg.	5.90	5.11	4.34	2.97	1.87	1.27	1.13	-	1.97	3.30	1.00	0.60	28.80
Monthly % Occupancy	98.3%	85.2%	72.4%	59.3%	93.3%	63.3%	56.5%	-	98.3%	110.0%	100.0%	60.0%	81.8%
May													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.81	4.61	5.37	3.52	1.97	0.84	1.81	-	1.74	3.71	1.00	0.87	30.71
Monthly % Occupancy	96.8%	76.9%	89.4%	70.3%	98.4%	41.9%	90.3%	-	87.1%	92.9%	100.0%	87.1%	84.3%
June													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.77	4.64	5.6	3.83	1.93	0.96	1.50	-	1.87	3.53	1.00	0.87	31.00
Monthly % Occupancy	96.1%	77.4%	93.3%	76.6%	96.7%	48.2%	75.0%	-	93.3%	88.3%	100.0%	86.7%	85.4%
July													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.94	5.00	4.71	3.45	1.94	1.19	1.45	-	1.87	2.97	1.00	0.81	29.61
Monthly % Occupancy	98.9%	83.3%	78.5%	69.0%	96.8%	59.7%	72.6%	-	93.3%	74.2%	100.0%	80.6%	81.9%
August													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.65	4.80	3.81	4.16	1.83	1.29	1.94	0.68	1.94	3.74	1.00	0.65	31.23
Monthly % Occupancy	94.1%	80.0%	63.4%	83.2%	91.7%	64.5%	96.8%	33.9%	96.8%	93.5%	100.0%	64.5%	80.7%
September													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.87	4.72	3.45	2.60	1.83	1.43	1.97	1.40	2.00	3.73	1.00	0.80	30.50
Monthly % Occupancy	97.8%	78.7%	57.5%	52.0%	91.7%	71.7%	98.3%	70.0%	100.0%	93.3%	100.0%	80.0%	79.1%
October													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	6.00	4.73	3.61	3.52	2.00	1.18	1.74	1.13	1.97	3.68	1.00	0.94	31.23
Monthly % Occupancy	100.0%	78.9%	60.2%	70.3%	100.0%	58.9%	87.1%	56.5%	98.4%	91.9%	100.0%	93.5%	80.9%
November													
Total Beds	6	6	6	5	2	2	2	2	2	4	1	1	39
Monthly Avg.	5.97	4.55	5.07	3.60	1.90	0.41	1.67	1.13	1.53	4.00	1.00	1.00	31.57
Monthly % Occupancy	99.4%	75.9%	84.4%	72.0%	95.0%	20.5%	83.3%	56.7%	76.7%	100.0%	100.0%	100.0%	82.5%

Based on data reported to the Vermont Department of Mental Health (DMH) by crisis bed programs for adult care using the electronic bed boards system. Programs are expected to report to electronic bed boards a minimum of once per day to update their census. State averages are adjusted to exclude programs on days where there were no updates submitted to the bed board.
The Second Spring - Williamstown program is based upon two beds that can be reallocated to intensive residential services as needed.

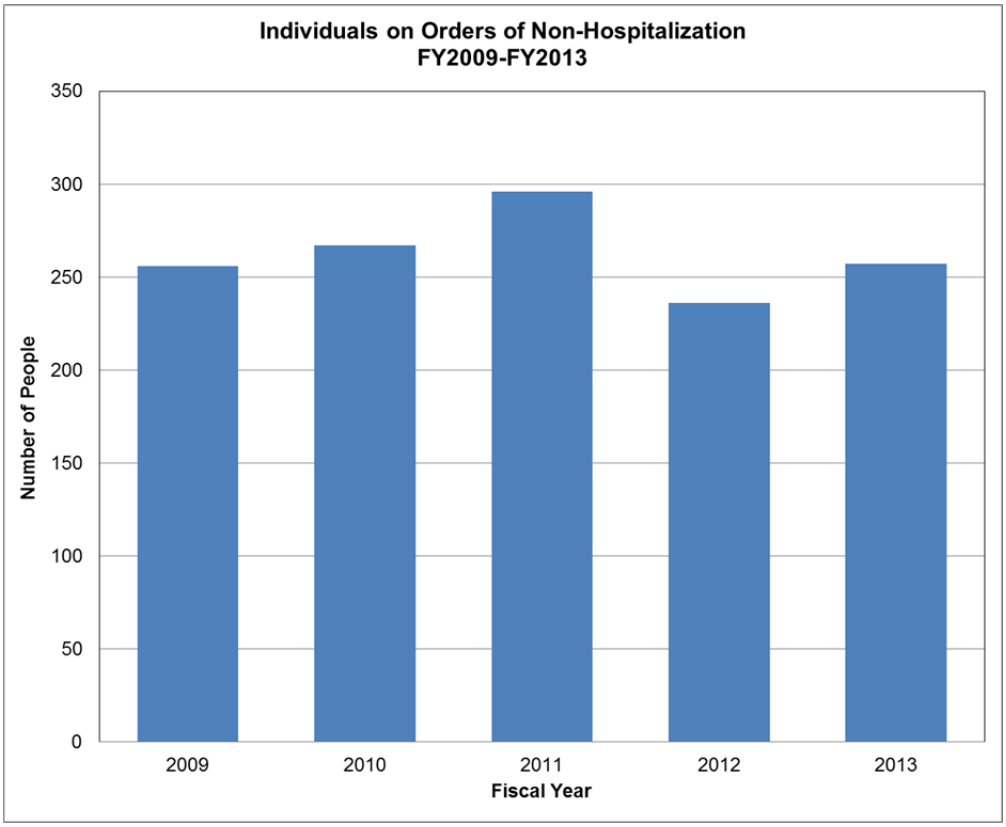
Chart Twenty-Nine: Non-Categorical Case Management



The support of non-categorical case management has led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for CRT services.

Each DA is also developing mobile crisis teams to better respond to individuals experiencing psychiatric crisis and the majority of programs have begun to perform crisis assessments and interventions in the community, as well as providing law-enforcement related crisis response and ED and hospital diversion. While DMH is still in the process of refining and standardizing data collection regarding the expansion of mobile crisis response, Designated Agencies have reported providing over 6,651 crisis assessments in the community during the state fiscal year 2013. Enhanced outpatient services are described more fully in a later section of this report.

Chart Thirty: Orders for Non-Hospitalizations



DMH Orders of Non-Hospitalization (ONH's) showed an upward trend through FY 2011, approaching nearly 300, dipping to below 250 in FY 2012 and rising slightly above 250 in FY 2013. DMH legal staffs work closely with DMH clinical staff and DA clinicians to monitor treatment compliance and maintain communication with providers. Through this process, community service providers are required to provide clinical justification of the ongoing need and their efforts to engage individuals in the treatment planning process and in understanding and complying with community conditions. DMH plans to continue providing oversight through the care management team. It is important to note that the percentage of ONH's is still extremely low when compared to the enrolled CRT Program numbers, approximately 7.5%.

Law Enforcement and Mobile Crisis

Act 79 also calls for a reduction of law-enforcement intervention for people in mental health crisis. The primary vehicle for this reduction is through mobile crisis outreach. Outreach to people in mental health crisis is essential to recognition of the pressure points in the lives of individuals. Proactive mobile teams that include peers in some areas, perform outreach through DMH grant initiatives, providing support in homes and in emergency departments. Joint interventions between law enforcement and mobile crisis teams have the potential benefit for service recipients in modeling de-escalation techniques. Increased communications between these two responder entities should also support mobile crisis teams to do outreach without police being present.

To continue these efforts successfully, standards and training for law enforcement personnel and crisis teams have been established. Law enforcement staffs from local and statewide jurisdictions have participated in the trainings that will continue into 2014. Over the past year, a statewide communications protocol for deployment and safety between mobile teams and law enforcement has been established. An interdisciplinary training model has been developed by DMH and Public Safety and has been delivered regionally through a train-the-trainers model referred to as "Team Two" Training. "Team Two" teams have been established in the 5 regions of the State:

- Central Team – Washington County, Orange County
- Southeast Team – Windham and Windsor Counties
- Southwest Team – Bennington, Rutland and Addison
- Northwest Team – Chittenden, Franklin Counties
- Northeast Team – Lamoille, Orleans and Caledonia Counties

The philosophy behind the Team Two training is one of collaboration, information sharing and resource management for law enforcement and mental health crisis teams when responding to a situation from the legal, clinical and safety perspectives. Training provides responders a clear understanding of the limitations and expectations of their fellow responders and evaluates the legal, clinical and safety aspects of the situation. "Train the Trainer" trainings have also been held to build capacity to maintain the learning and assure responders have the same interpretation of statutory issues.

Peer Services

Over the past year, DMH has expanded the availability of services provided by individuals with the lived experience of mental illness (peers). These services include: community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. DMH also funds family-to-family peer support for people who have a family member with severe mental illness.

Chart Thirty-One: Peer Supported Programming

Organization	**Services Provided**
Another Way	Community center providing outreach, community and network building, support groups, service linkages, crisis prevention, and employment supports.
Alyssum	Two-bed program providing crisis respite and hospital diversion and step-down.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups.
Northeast Kingdom Youth Services	Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization.
Pathways – Peer Support Line	Statewide telephone peer support to prevent crisis and provide wellness coaching.
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings.
Vermont Vet-to-Vet	Community outreach, support groups and crisis intervention for veterans at risk of hospitalization due to mental health and substance use challenges.

DMH is also piloting the use of individual recovery outcomes tools at contracted peer-run programs through a federal Mental Health Transformation grant. Two programs are currently collecting National Outcome Measures (NOMS) and the Peer-Operated Protocol (POP), and outcome data will be available in the coming months.

DMH has also contracted with the Vermont Center for Independent Living (VCIL) to coordinate and support the development of a Wellness Workforce Coalition (WWC) for organizations and individuals offering peer-based services and supports to individuals with mental health and other

co-occurring challenges. This network will support the expansion, coordination, and quality improvement of peer services in the state, including:

- Coordinating core training (Intentional Peer Support, Wellness Recovery Action Planning)
- Workforce development (e.g. recruitment, retention, career development)
- Mentoring
- Quality improvement
- Coordination of peer services
- Communication and networking
- Systems advocacy.

Individual Experience and Recovery

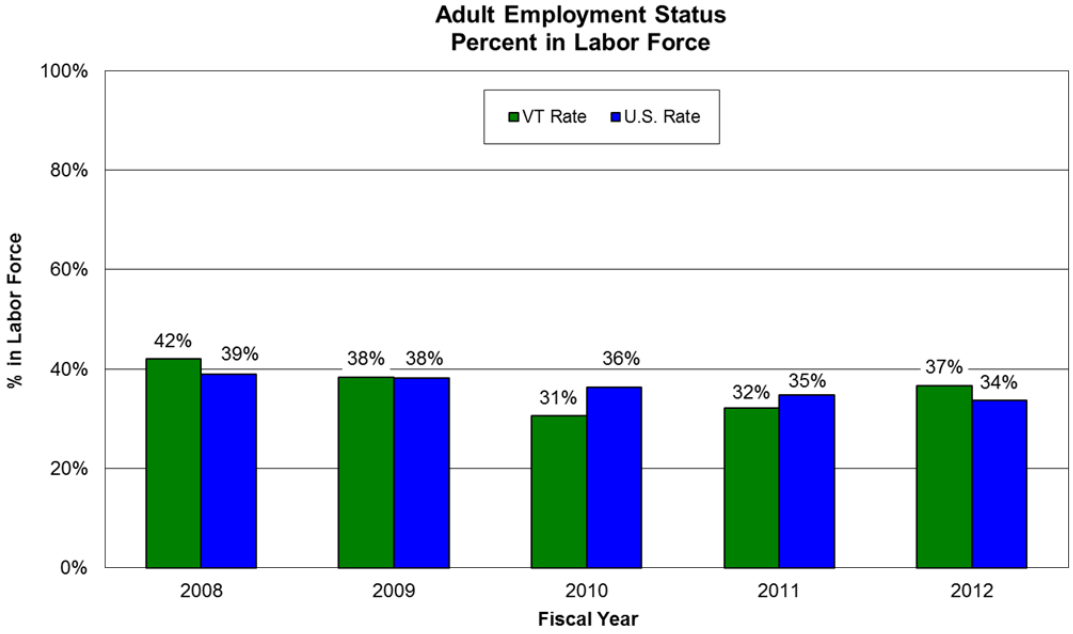
A significant aspect of the intent of Act 79 was to improve the care and the experiences of those receiving mental health services in the State of Vermont. The DMH routinely surveys consumers of mental health care, and staff who provide the treatment, as part of its Agency Review process. These surveys are one measure of individual experience and recovery, and the results are summarized in Charts 34 and 35.

Person centered care is focused upon the individual needs and movement towards stabilization and recovery. The individual needs of clients are the focal point at all of the levels of care in the system. DMH tracks clinical, social and legal measures to assess experience and recovery. There are a number of measures used to quantify individual experience and recovery including employment information, consumer surveys, housing, and other metrics.

Employment

Employment is an essential part of recovery for many individuals living with a mental illness. National data has shown that employment leads to decreased involvement with corrections, decreased hospitalizations, improved physical health outcomes, decreased substance use, and better community integration. Employment reduces a person's dependence on Social Security and has the potential to create significant savings to the system of care over time.

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

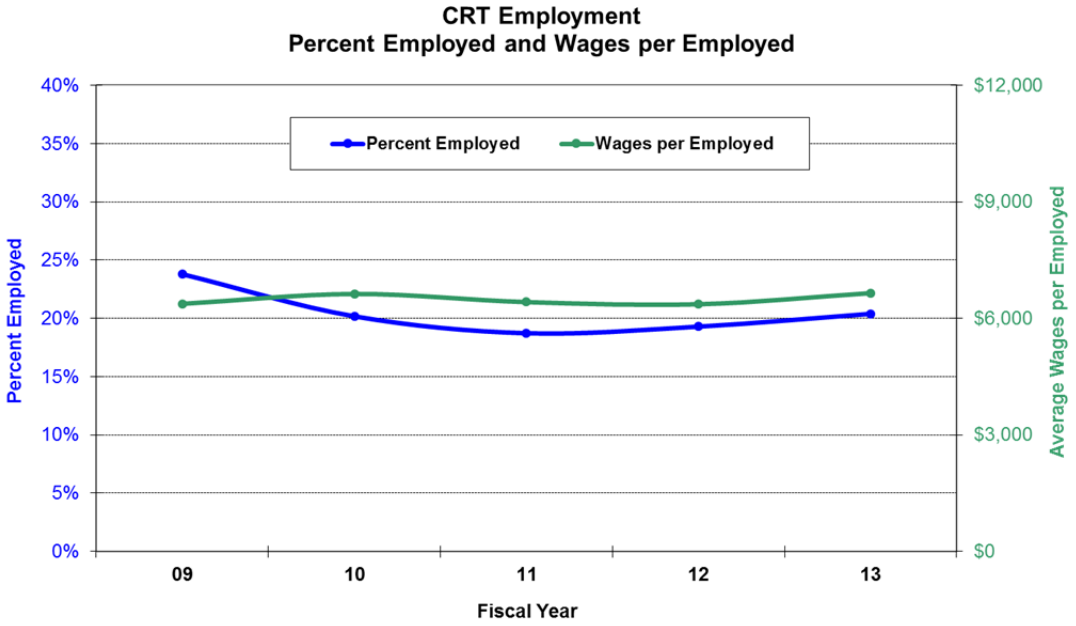


Employment status for adults (18-64) with Serious Mental Illness (SMI) is based on data linkage with the state Department of Labor for FY2008 - FY2012. Employment status for other mental health clients is based on case manager monthly service reports.
Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2012.
US totals are calculated uniquely based on those states who reported.

Chart 32 shows the employment rate for all people with mental illness has **increased 5%** in Vermont while across the nation it continues to decrease. Reasons for this increase may include:

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

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



Analysis includes Community Rehabilitation and Treatment clients aged 18 - 64 who were active during any part of the annual reporting periods and includes all employment reported for the annual reporting periods.This report is based on analysis of the Department of Mental Health (DMH) and the Department of Labor (DOL) databases. DMH client data are submitted by Community Rehabilitation and Treatment Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal unemployment laws. Workers who are excluded from DOL reporting are the self-employed, firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals who work out of state.

Chart 33 indicates a 1% increase in CRT employment outcomes between FY12 and FY13. CRT programs continued to support individuals with their employment goals despite continued challenges within the system of care.

- Individuals, on average, earned $6,650 per year (*16 hours per week for full year at minimum wage*).
- Total wages earned in FY 13 were $3,497,779, an increase of 5% from FY12.

Consumer Ratings and Experience

DMH conducts consumer surveys to evaluate Community Rehabilitation and Treatment Services and Children and Family Services provided by the 10 designated agencies in Vermont. (The survey for children and families includes parents of children and adolescents with a severe emotional disturbance as well as youth in services.) The full survey reports can be found online at: http://mentalhealth.vermnt.gov/report/survey. The surveys focus on 5 areas with a resulting overall score constructed from responses to the 44 survey questions, and 5 additional sub-scales. These are represented in charts 34 and 35.

Overall satisfaction has generally remained the same over the years, with a slight increase for parents of children in child and adolescent programs in Vermont.

Survey results vary widely by DA. Information from surveys is used in the designation process and when working with designated agencies to improve care.

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

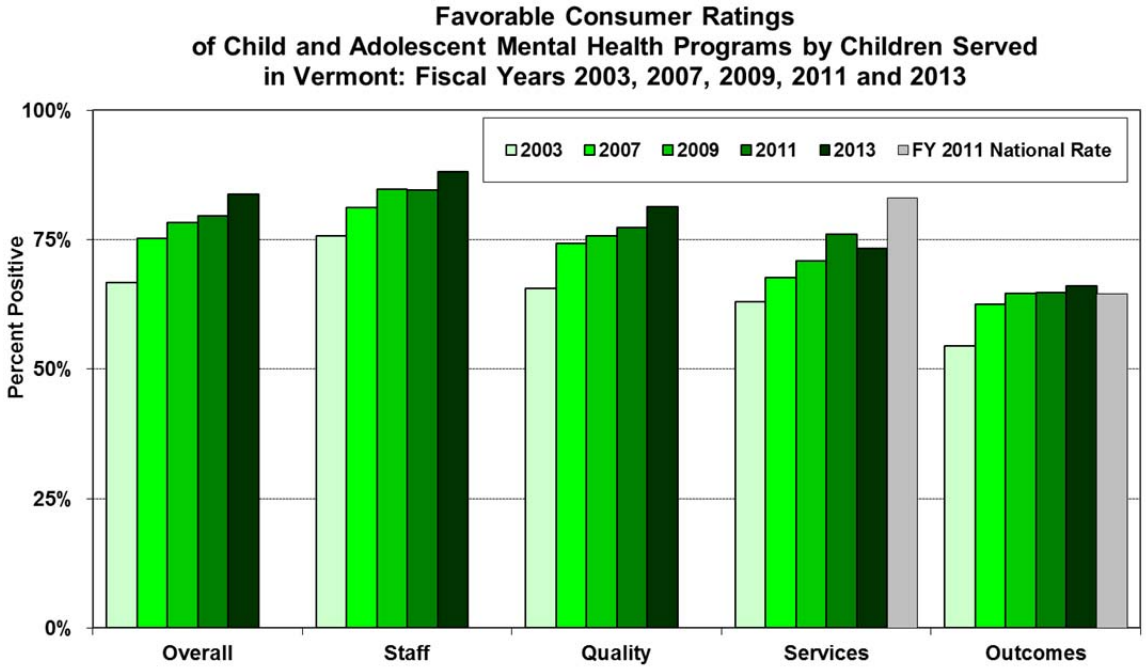
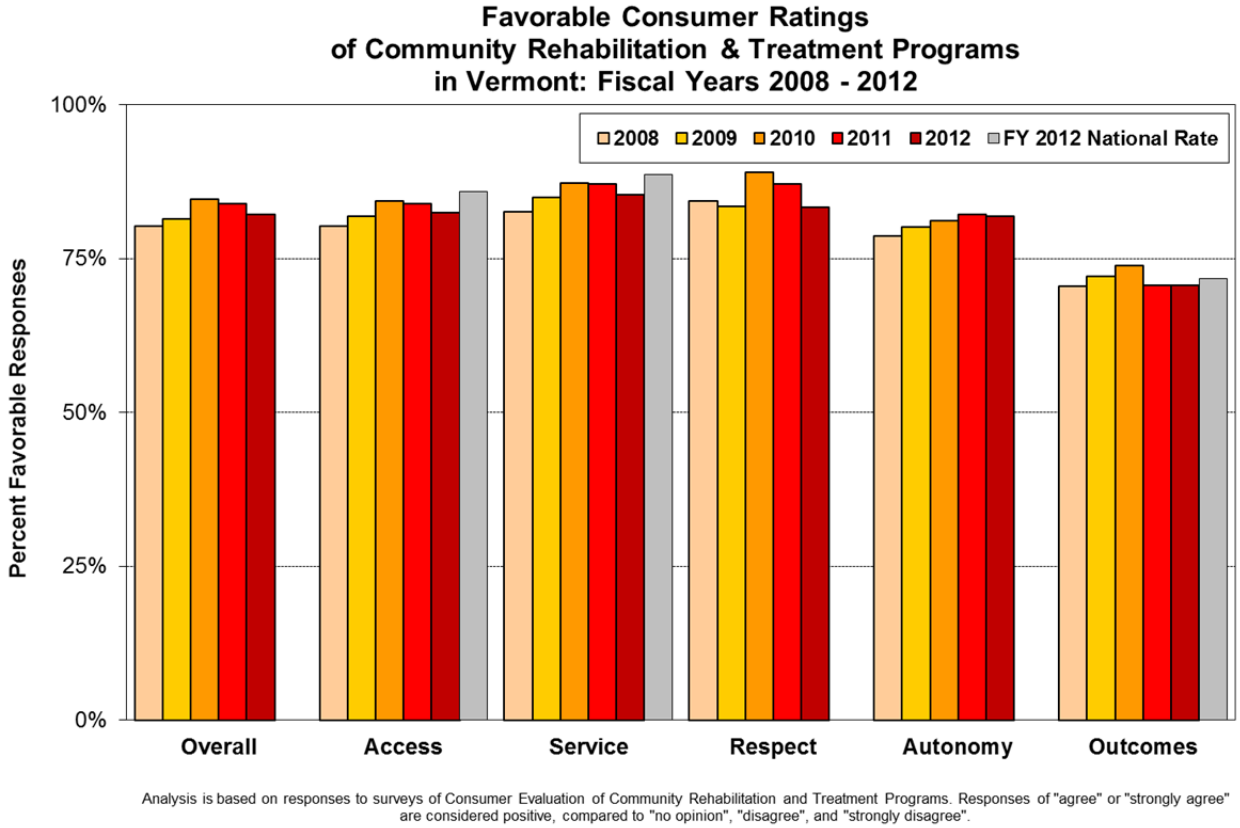
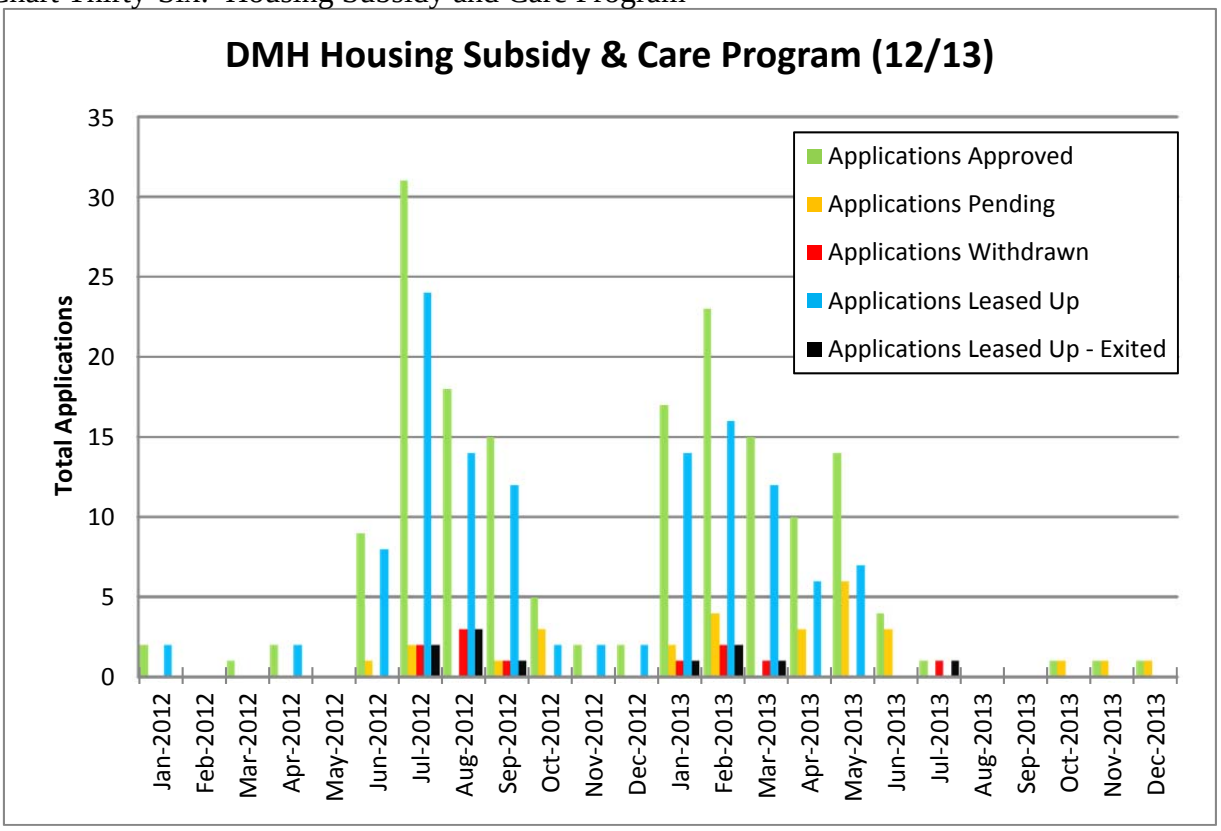


Chart Thirty-Five: Favorable Outcomes Percentage for CRT



Housing

Chart Thirty-Six: Housing Subsidy and Care Program



- A total of 123 persons who were homeless, mentally ill and needing an acute care bed have been allocated a subsidy and have subsequently been housed with community supportive services by the DMH HS&C program. Vermont State Housing Authority (VSHA) remains the DMH collaborating partner verifying income, setting rent payments, and working with landlords.

- A total of 172 applications have been approved, of that number 28 approved applications are pending (seeking a unit to lease) and 11 applicants have withdrawn. Lastly, there have been 10 exits.

- All 12 of our local participating partner agencies have provided essential supportive services and have documented the work they do to assist in housing retention.

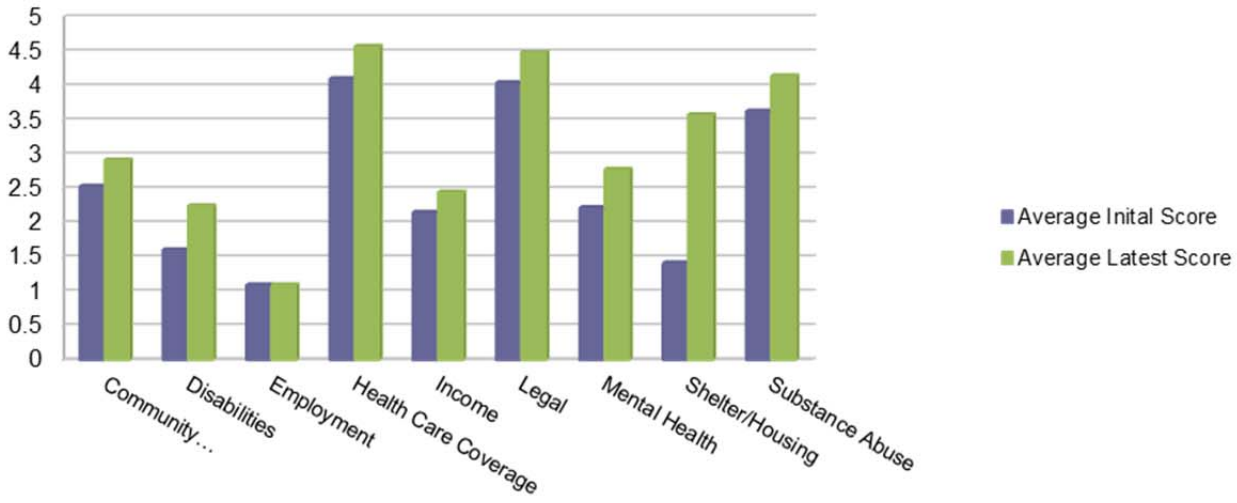
- Of the 123 persons housed since the program began 3 have exited for a legal matter, a substance abuse issue, others exited moved out of state, or passed away.

- The lengths of stay in housing since the program began range from 30 to 713 days. With over 50% length of stay greater than one year. The performance indicator we seek to achieve is a *one year* housing retention.

- An equal number of male and female were served and three children continue to be assisted with their mothers.

- Of the 123 served, more than 73% were literally homeless or homeless in an acute care bed. Less than 9% of those assisted were at serious risk of losing housing and going to an acute care bed.

Chart Thirty-Seven: Self Sufficiency Matrix



Eight of the nine self-sufficiency outcome measures recorded demonstrated improvement for the individuals participating in the housing subsidy & care program. Most notable was the improvement in community involvement, improvement in disability, income, housing, health care mental health, and substance abuse outcome measures.

Conducting Quality Management

The Vermont Department of Mental Health (DMH) endorses principles of recovery, integrated evidence based health, mental health and substance abuse care through flexible, person-centered care offered in the least restrictive environment. The DMH is committed to the following Quality Domain Measures: Access, Practice Patterns, Outcomes/Results of Treatment, and Administration of fully functional agencies providing care, as delineated in the *DMH System of Care 3-Year Plan FY2012-2014.*

The goal of the Quality Management Unit is assure that all programs and services funded by the state are in compliance with state and federal laws and regulations, while achieving desired outcomes through the provision of high-quality services and supports. In addition, the QM Unit contributes to policy development through the generation of accurate, valid and reliable data and ongoing continuous quality improvement activities including the development and ongoing modification of DMH dashboards and reporting, for the leadership team and stakeholders.

The DMH Quality Director is a member of the Agency of Human Services (AHS) Performance Accountability Committee (PAC) that has been convened with the Charter to "contribute to the delivery of services, consumer outcomes, and the overall health and well-being of those we serve." The PAC has supplanted the committee previously known as QAPI. In addition, the Quality Management Unit is a steering committee member on the Agency Improvement Model (AIM), which oversees and supports training for AHS staff in Quality Improvement methodology. The Quality Director meets monthly with the Mental Health and Substance Abuse Council's Outcomes Work group.

The Quality Management Unit is now fully staffed, adding a RN Coordinator and a licensed psychologist that enables DMH to implement the responsibilities it is delegated to enact and as recommended in the *Act 79*. In addition, the Quality Management Unit is inclusive of Clinical Care Management, Research and Statistics, and Change Management processes. The primary responsibilities are listed below and addressed in the narrative that follows.

1. Create and monitor systems to assess, evaluate and report on clinical services provided by the Department
2. Address gaps in reporting that require immediate attention and to serve as an Intergovernmental Agency (IGA) of DVHA for the Managed Care Entity (MCE) as described below.
3. Designate both Hospitals and Community Mental Health Agencies through systematic assessment and evaluation activities.
    a. These include updates to the Administrative rules and Minimum Standards as well as other Manuals for standardization of care.

DMH utilizes an Executive Dashboard titled *DMH Monthly Snapshot* to monitor point in time utilization of resources and track movement of individuals on a monthly basis across the continuum of care. The Snapshot is also provided to the Legislative Mental Health Oversight Committee on a scheduled periodic and as requested basis and is posted to the DMH website on a monthly basis. Leadership at DMH, in concert with stakeholders, has identified the variables

for ongoing reporting which are listed on the DMH Snapshot. The Department, through its Quality Management and Research and Statistics Units will continue to analyze and report on measures of our system of care on an annual basis, as this information is a cornerstone to our ongoing quality improvement process.

Electronic Bed Board

An electronic bed board was established in August 2012 as a means to track availability of inpatient, residential and crisis bed capacity for placement of patients in need of inpatient treatment and/or placement upon discharge from a designated hospital. The new system has now been in operation for 16 months, providing useful data for utilization review across the various levels of care. Emergency services screeners are able to see where potential openings exist for placement of individuals in need of treatment in a hospital, crisis, or residential setting. This database was developed to provide as close to 'real time' use as possible to facilitate timely location of placements for those in crisis. Each weekday morning DMH leadership and care management team staff meet to discuss individuals in need of or in the process of hospital placement. The staff works collaboratively with the DAs, the hospital staff, law enforcement, Corrections and other involved agency personnel. DMH provides 24/7 admissions information and support services through DMH Admissions Unit staff and after-hours clinical and administrative staff availability to community providers.

Clinical Care Management

The Clinical Care Management Team was convened following enactment of Act 79 has been in operation for approximately 18 months. The team is comprised of five DMH care managers, and a Care Management Director. A component of the clinical care management system is the Technical Support Team, as described earlier in this report. Clinical care managers meet weekly with staff from BR, FAHC, and RRMC and also with CVMC and Windham Center staff when psychiatric patients are admitted to those inpatient units. The team works with hospital and community DA staff to support and provide resources to assist in transitioning patients between levels of care and to facilitate placement when needed, within a system of limited capacity. Individuals served are primarily those who are involuntarily hospitalized and/or on Orders of Non-Hospitalization (ONH).

The Care Management Team and staff of the Commissioner's Office also work directly with DHs, DAs, Alyssum, hospital emergency departments, Department of Corrections, Law Enforcement, Pathways to Housing, AHS Field Directors and others to ensure access to services for individuals needing them. The care management and utilization review managers monitor the flow in and out of acute-care inpatient services using the electronic bed board. Care management staffs are also working closely with DVHA care managers to provide oversight to all Medicaid inpatient psychiatric hospitalization. These review processes closely align between the two departments for consistency with inpatient providers as well. A multi-disciplinary, intra-organizational workgroup to review and make recommendations for enhancement of the clinical resource management system has helped to shift the change in care management to focus more on transitions of care between community and hospital resources.

Oversight of Regulatory Requirements for DHs and DAs Receiving Funding

DMH quality staff collaborates formally with Designated Hospital administration and Quality Managers on a monthly basis, and as needed, to facilitate policies and procedures pertaining to quality assurance and improvement and to implement changes as they are identified through and for the system of care that is evolving. In this forum, the group has reviewed and revised critical incident reporting, core measures of performance, patients' experience of care, use of seclusion and restraint, and to interface with DMH, law enforcement and to address legal issues. In particular, hospitals are required to maintain CMS and JCAHO accreditation. Other quality measures including HBIPS are also a subject of quality review by the DMH.

Quality coordinators are involved with and manage the re-designation processes for both the DHs, and the DAs. During the summer and fall of this year, DMH completed re-designation for all of the five hospitals that accept involuntary patients. The Designated Agencies are in a cycle of re-designation that involves a four- year process. The Minimum Standards elements have been revised and are now being utilized in quality assurance activities, in concert with a recent revision of the 2004 CRT Manual. This revision is currently in draft form, while DMH works closely with the DAs and the Vermont Council for Developmental and Mental Health Services to finalize it. Other projects accomplished this year are a much streamlined and integrated Grievance reporting system and ongoing refinement of transportation and supervision processes provided to involuntary patients by Sheriff's Departments, a revised protocol for DMH response to a critical incidents reported by either DH or DA, enhanced analysis of data generated through the Bed Board, revision of the *Statewide System of Care Plans*, and ongoing work to align performance measures across a range of health care reform initiatives system and state-wide.

Enhanced Outpatient Services

The impact of the enhancements allocated by the legislature in Act 79 is in its initial phases of assessment. Many of the agencies that received this funding were able to activate their respective programs well into FY 13, providing less than a year to six months for evaluating the impact these services have had on the system of care and those it serves. All of the designated agencies participated in developing additional services and enhancing services already in place, in order to provide more timely access to and response for those in crisis.

The funds were disbursed as services were developed and implemented. The list of enhancements is fairly broad, with common themes and best practices identified and implemented across all of the DA's. Due to the fact that all of the agencies implemented their programs to meet the individual needs of their catchment areas, and to differences in how outcomes and delivery of services were measured, the quantitative data is not conclusive at this point. A baseline of relevant themes reported by each of the agencies and rough estimates of numbers of persons served in several categories are presented.

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

- Enhancements to the Emergency Services through additional staff and implementation of mobile/community crisis and assessment capacity.

- Adding Peer supports in either crisis settings, or in some areas, hospital emergency rooms.
- Diversion from Emergency Departments
- Collaboration with Law enforcement and participation with law enforcement training
- Emergency respite and crisis beds
- Non-categorical case management (in all but one DA)
- Special services such as new programs developed to manage more complex clients in the community, extending services to those not previously covered through CRT and/or AOP, and additional psychiatrist/Nurse Practitioner time for medication evaluation and administration.

Quantitative Data The DA's receiving enhancement funding, sent quarterly reports of persons and/or services provided, when data was available. Due to differences in definitions and in services provided, it is difficult to capture quantitative outcomes. The primary outcome measures to be reported were mainly descriptive:

- # Assessed in Emergency Department
- # Assessed in the Community
- # Total Assessments
- # Diverted from ED
- # Diverted from Hospitalization
- # Voluntarily hospitalized
- # Involuntarily hospitalized

# Assessed in ED	# Assessed in Comm	# Total Assessments	Diverted from ED	Diverted from Hospital	Vol hospital	Invol hospital
3185	2972	6651	4267	1129	972	462

This summarized data from all of the Agencies, is more of an estimate, as data was not consistently reported and /or was missing for some quarters. In those instances, the data was annualized in order to provide an estimated snapshot. It is for this reason, that qualitative data was determined to be the more appropriate format for evaluation of the outcomes of this funding. It can be said that the funding provided for a host of services that were either not in existence or were not adequate prior to the allocation. Below are some excerpts from actual reports submitted to DMH from the Designated Agencies that implemented enhanced programming.

Qualitative Themes

- ***Increased Access***:
  Several of the DA's reported that the numbers of persons served through their emergency and crisis services, as well as in the Adult Outpatient services increased between FY12 and FY 13. This was also impacted in some areas, by the time required to bring services up to speed.

- ***Diversion from hospitalization****:*

DA staff report that through diversion case managers, services are being provided to those at risk for hospitalization in community settings, such as in motels or other services for those who may be homeless.

Increased home-based services through increasing the number of case managers for those who fail to meet criteria for CRT and/or DS programs.

- ***More crisis intervention capacity****:*
  "We have been able to have staff respond to many different situations where clients and non-clients were at risk for hospitalization and been able to provide the support needed to divert these higher level care needs. In addition, "these resources have made….this shift possible", to "changing the approach of staff and their response to the person in need through adopting a prevention philosophy of recovery and resiliency". (CMC)

- ***Collaboration with Law Enforcement has resulted in increased capacity to manage complex clients in the community****.*

Emergency team clinicians are screening, assessing and providing case management services through police departments, primary care providers and others to prevent escalating crises and further decompensation for persons in need.

- ***Expanded capacity to provide higher levels of support and supervision in the community as a way to prevent higher cost institutional services.***

  Utilization of an interagency team approach to serving persons who repeatedly utilize costly institutional services has provided the structure and support to reduce hospitalizations.

  The ability to provide outreach and home based services to fragile people who might otherwise have been admitted to higher level of care.

Challenges to implementation of enhanced programs

- Challenges in hiring qualified staff
- Difficulty siting programs in communities that are sensitive to having programs for persons with mental health problems in their neighborhoods

Quality Management Unit Processes for DMH

The formation of a DMH Quality Council was convened by former Commissioner, Mary D. Moulton and meets bi-monthly. Membership of the Council is comprised of the Director of Quality Management (lead), DMH Medical Director, the Directors of services for adult mental health and for children, adolescents and their families, the Director of Mental Health Services, the Deputy Commissioner, and the Executive Director of the GMPCC. Others may be invited to participate when discussion of specific issues requires their attendance.

The Quality Management Unit provides oversight and facilitates development of standardized definitions and standards of practice to be implemented by the DAs and DHs providing care. As mentioned above, data reporting and analysis in collaboration with partners at AHS and the community have an ongoing focus on performance measures that support the intent of Act 79. These include integration with health care services, integration of mental health and substance abuse services and involvement of peers and other stakeholders in policy development.

Quality Management Unit Goals

As noted above, the Quality Management Unit is newly reconstituted. It is working with both internal and external stakeholders to determine priorities and time lines for its goals and objectives for the next one to three years and beyond. The following list presents top-priority goals identified by DMH leadership.

- Update of major documents to include *Administrative Rules* pertaining to agency designation, mission/vision statements and coordination with other mission/vision statements within AHS
- Continue to develop the role of the Quality Council
- Monitor the results of data provided through the utilization review process for inpatient psychiatric hospitalization of Level 1 patients
- Determine performance measures for the Care Management Team functions to assess efficacy of the interventions DMH is using to facilitate transitions across elements of the system of care
- Perception of Care Surveys will be reviewed and revised as determined necessary; to include an expanded population of consumers
- Work closely with the newly established workforce development and practice-improvement cooperative (Vermont Cooperative for Practice Improvement and Innovation – VCPI) to support the implementation of promising, evidence-based, and recovery-oriented practices within the state's treatment and support system.
- Tie performance measures in with AHS Master Grant goals

Planning for the Future

The landscape of the Mental Health System of Care continues to change and evolve as new system resources come on line and are deployed to community based care or inpatient care settings. Since last year's report we have seen an ongoing demand for the limited number of inpatient beds to serve individuals with mental health needs. The increase in intensive residential recovery, secure, and crisis beds has continued to buoy a system treading water while new hospital bed construction was underway. At all times, the Department's daily work continues to be one of assuring that patients are cared for in the least restrictive setting, that wait times for admissions continue to be actively managed, and that services throughout the system are of high quality.

DMH continues to work diligently with the DHs and DAs to develop the capacity to care for this vulnerable population of Vermonters, implement process and outcome measures to assure value to the system of care in terms of quality and cost, and collaborate with partners including the DHs, DAs, Courts, Law Enforcement, Disability Rights Vermont, Department of Correction, DVHA, and the Blueprint for Health. DMH will continue with these efforts in the coming year.

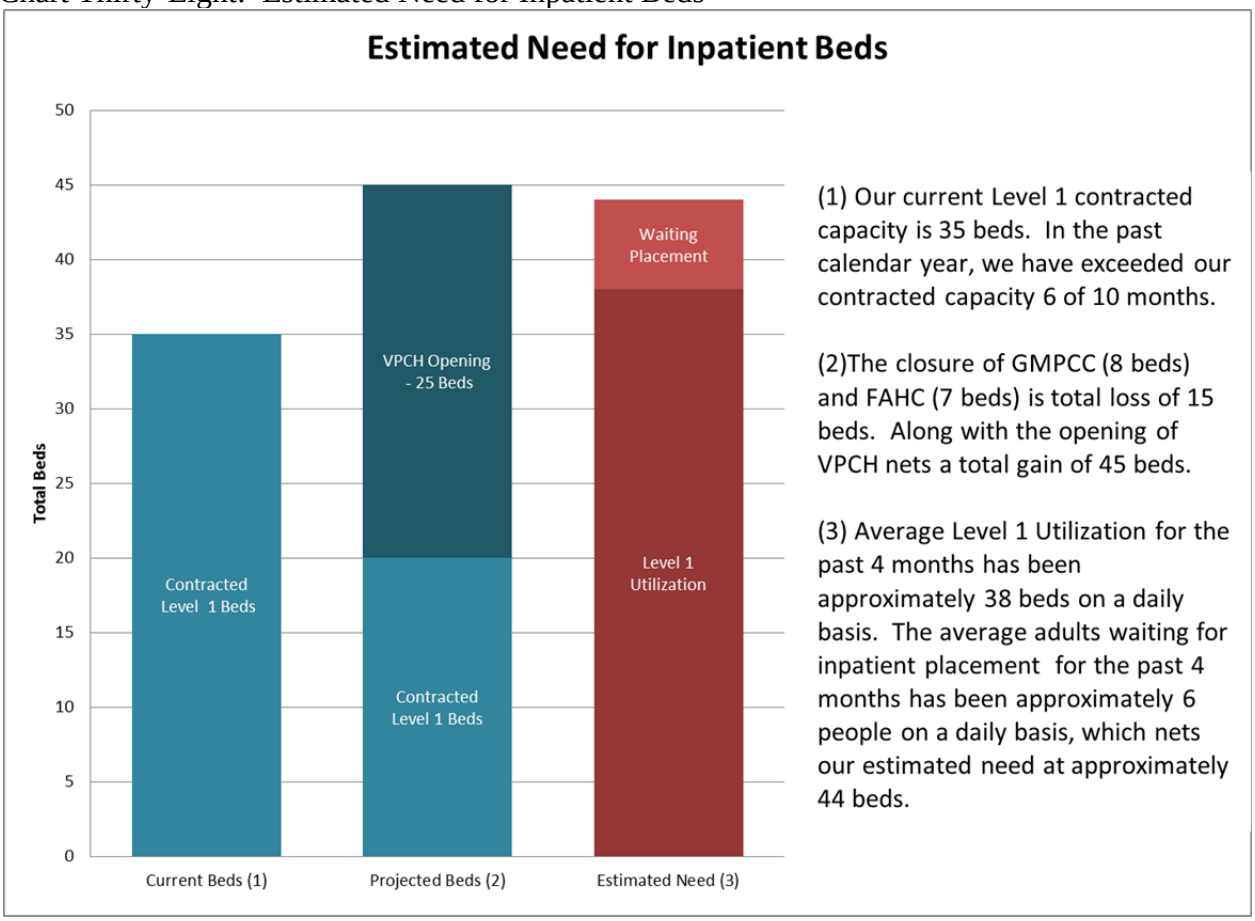
Building and Maintaining Capacity

DMH's top priority for this coming year is the completion and opening of the Vermont Psychiatric Care Hospital suitable for both CMS certification and JCAHO accreditation. The addition of this twenty-five bed state-operated hospital will add additional bed capacity to our struggling system of involuntary Level 1 inpatient capacity. The addition of high acuity beds to the existing system capacity will also enable the state's psychiatric inpatient hospitals to again more adequately serve voluntary individuals with mental health needs who must also compete for inpatient treatment beds. In combination with enhanced community-based treatment and support programs a fundamentally essential underpinning of our public mental health system of care will be complete as signaled by a new state-run hospital. First envisioned as part of the Future's initiative, the array of system treatment capacities undertaken and achieved to date will only be completed with additional underpinnings marked by both access across care and service settings and fully integrated care delivery environments. Much work remains to ensure a broader mission continues to assure mental health services for all Vermonters regardless of setting and as an integral component to overall health needs.

In moving this ideal forward, DMH's next priority is the ongoing evolution of the clinical care management system outlined in Act 79. Building and maintaining both inpatient and outpatient capacity is critical to the future of the system of care. As referenced earlier, in April 2013 the BR completed its renovations of the Tyler 4 Unit and RRMC added six beds in its renovated Unit. The increase in Level 1 capacity by 14 beds supports the system of inpatient care, while the Vermont State Psychiatric Hospital is being built in Berlin. Once opened, the GMPCC beds will be included in Berlin, providing a total inpatient capacity of 45 Level 1 beds. The Graph below illustrates the estimated need for inpatient beds.

Lastly, DMH continues to prioritize mental health as an integral component of overall health and opportunities to further embed and develop this expectation in current health reform efforts. DMH staff are involved in a number of steering committee activities including AHS health integration, health reform, and grant supported health care workgroup initiatives (S.I.M. Grant, Dual Eligible, and Green Mountain Care Board).

Chart Thirty-Eight: Estimated Need for Inpatient Beds

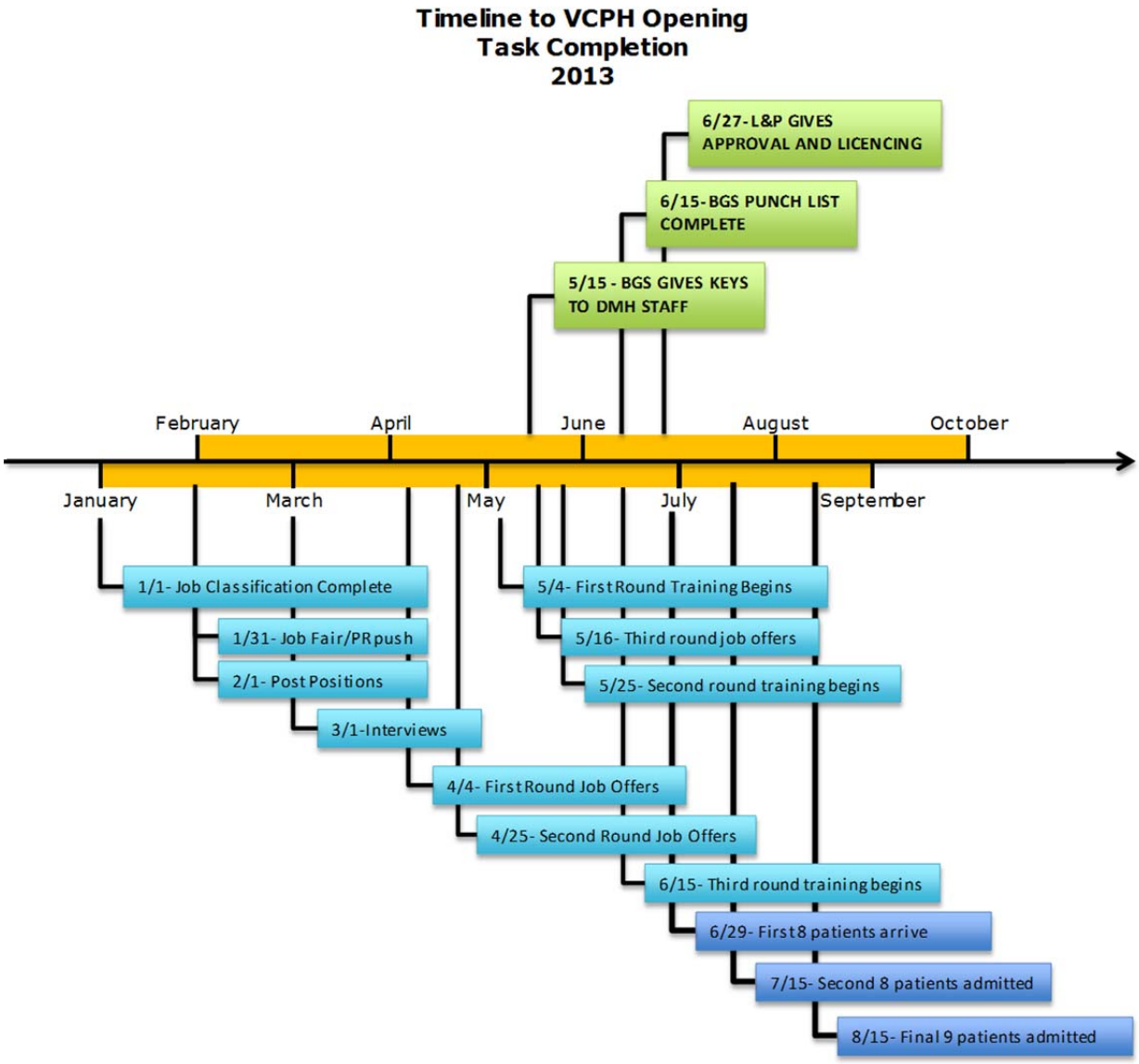


This is still below the pre-Irene number of inpatient psychiatric beds. Continued work to build and maintain capacity will include:

- Completion of the Vermont Psychiatric Care Center
- Continued support at the points of transition of care through clinical care management
- Continued work of the Technical Assistance Team to support DHs and DAs in caring for intensive need clients, and their ongoing support of high utilization clients
- Consideration of out of state options for a small number of committed individuals
- Ongoing evaluation of services

The proposed timeline for opening and accepting patients to its full capacity at Vermont Psychiatric Care Center in Berlin is impacted by a number of both clinical and logistical factors. The illustration below shows the progression of events.

Chart Thirty-Nine: Timeline for Completion of Vermont Psychiatric Care Center



Evaluation of Services

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

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

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

Collaboration

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

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

Appendices

Appendix A: DMH Snapshot
Appendix B: NOMS (National Outcome Measures) Data Sheet
Appendix C: Clinical Resource Management System Work Group FY13 Report

APPENDIX A: DMH MONTHLY SNAPSHOT

VERMONT

Vermont Department of Mental Health
System Snapshot (November 13, 2013)

*data forthcoming

Reporting Category	2013 FY13 Q3 Jan	Feb	Mar	FY13 Q4 Apr	May	Jun	FY14 Q1 Jul	Aug	Sep	FY14 Q2 Oct	Nov	Dec
Adult Inpatient Hospital												
% Occupancy	94%	91%	92%	84%	87%	93%	88%	89%	89%	89%		
Avg. Daily Census	137	132	136	134	135	146	138	139	139	143		
% Occupancy at No Refusal Units							100%	96%	99%	99%		
Avg. Daily Census							28	27	28	28		
Adult Crisis Beds												
% Occupancy	77%	79%	83%	82%	84%	85%	82%	81%	79%	81%		
Avg. Daily Census	27	28	29	29	31	31	30	31	31	31		
Applications for Involuntary Hospitalizations (EE)												
Youth (0-17)	-	-	-	9	10	6	9	7	15	6		
Adults	50	32	55	41	55	39	65	32	43	43		
Total adults admitted with CRT	13	13	27	19	14	11	15	12	9	7		
Designation (% of Total applications)	26%	41%	49%	46%	25%	28%	23%	38%	21%	16%		
Total Level 1 Admissions	22	13	20	22	26	10	19	18	11	9		
Instances when Placement Unavailable & Adult Client Held in ED	27	21	43	27	38	24	38	16	34	29		
Adult Involuntary Medications												
# Applications	2	3	3	2	9	4	5	7	5	10		
# Granted Orders	2	3	2	2	5	3	5	6	3	4		
Mean time to decision (days)	22	12	20	27	19	17	20	14	12	17		
Court Ordered Forensic Observation Screenings												
# Requested	11	13	9	10	11	11	22	20	19	16		
# Inpatient Ordered	3	7	5	5	6	6	11	8	7	5		
VT Resident Suicides												
Youth (0-17)												
Total	0	0	0	0	0	2	0	0	0	*		
# with DA contact within previous year	-	-	-	-	-	1	-	-	-	*		
Adults (18+)												
Total	4	6	10	8	10	5	8	10	7	*		
# with DA contact within previous year	0	3	2	2	1	0	2	1	1	*		
Housing												
# Clients permanently housed as a result of new Act79 housing funding	18	21	14	11	14	5	0	5	0	2		
Total # enrolled to date	98	119	133	144	158	169	169	176	176	168		
Involuntary Transportation Adults (total transports)												
# of Transports	19	17	18	11	18	13	18	12	18	*		
% Non-Restrained	58%	94%	61%	82%	78%	85%	72%	75%	83%	*		
% Restrained	42%	6%	39%	18%	22%	15%	28%	25%	17%	*		
% all transports using metal restraints	16%	6%	6%	9%	6%	8%	17%	25%	17%	*		
% all transports using soft restraints	26%	0%	33%	9%	17%	8%	11%	0%	0%	*		
Youth Under 10 (total transports)												
# of Transports	3	3	0	0	0	0	0	0	2	*		
% Non-Restrained	100%	100%	-	-	-	-	-	-	100%	*		
% Restrained	0%	0%	-	-	-	-	-	-	0%	*		
% all transports using metal restraints	0%	0%	-	-	-	-	-	-	0%	*		
% all transports using soft restraints	0%	0%	-	-	-	-	-	-	0%	*		
CRT Employment												
% Employed		15%										
Wages per employed client		$2,318										

APPENDIX B: NOMS

Vermont 2012 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per1,000 population	7,161,659	39.12	22.67	59
Community Utilization per 1,000 population	6,843,786	38.98	21.67	59
State Hospital Utilization per 1,000 population	151,069	0.14	0.48	53
Other Psychiatric Inpatient Utilization per 1,000 population	380,211	0.64	1.47	40

Adult Employment Status	U.S.	State	U.S. Rate	States
Employed (Percent in Labor Force)*	528,515	36.7%	33.7%	58
Employed (percent with Employment Data)**	528,515	25.3%	16.9%	58

Adult Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	68.3%	71.8%	52

Child/Family Consumer Survey Measures	State	U.S. Rate	States
Positive About Outcome	61.1%	66.3%	50

Readmission Rates:(Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	10,468	8.4%	8.9%	51
State Hospital Readmissions: 180 Days	22,902	13.6%	19.6%	51
State Hospital Readmissions: 30 Days: Adults	9,696	8.4%	9.1%	51
State Hospital Readmissions: 180 Days: Adults	21,211	13.6%	20.0%	51
State Hospital Readmissions: 30 Days: Children	754	0.0%	7.1%	21
State Hospital Readmissions: 180 Days: Children	1,646	0.0%	15.4%	25

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	3,935,855	86.7%	80.7%	57
Homeless/Shelter	150,557	2.4%	3.1%	55
Jail/Correctional Facility	95,668	0.2%	2.0%	51

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	73,212	-	2.6%	38
Supported Employment	48,880	32.7%	1.7%	42
Assertive Community Treatment	65,383	-	2.0%	40
Family Psychoeducation	13,045	-	0.9%	16
Dual Diagnosis Treatment	61,808	-	4.0%	22
Illness Self Management	162,725	-	12.7%	21
Medications Management	267,702	83.6%	22.8%	16

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	15,777	-	1.5%	28
Multisystemic Therapy	9,155	-	1.2%	19
Functional Family Therapy	10,480	-	1.8%	14

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	66.0%	72.1%	52
Child/Family Improved Social Connectedness	-	86.9%	48

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

CMHS Uniform Reporting System - 2012 State Mental Health Measures

STATE: Vermont

Utilization	State Number	State Rate	U.S.	U.S. Rate	States
Penetration Rate per 1,000 population	24,490	39.12	7,161,659	22.67	59
Community Utilization per 1,000 population	24,403	38.98	6,843,786	21.67	59
State Hospital Utilization per 1,000 population	87	0.14	151,069	0.48	53
Medicaid Funding Status	15,127	66%	4,344,739	63%	57
Employment Status (percent employed)	2,536	25%	528,515	17%	58
State Hospital Adult Admissions	38	0.44	125,321	0.90	53
Community Adult Admissions	6,647	0.46	10,102,079	2.28	53
Percent Adults with SMI and Children with SED	8,714	36%	4,989,352	70%	58

Utilization	State Rate	U.S. Rate	States
State Hospital LOS Discharged Adult patients (Median)	46.00 Days	63 Days	50
State Hospital LOS for Adult Resident patients in facility <1 year (Median)	340.00 Days	69 Days	48
Percent of Client who meet Federal SMI definition	20%	72%	54
Adults with Co-occurring MH/SA Disorders	18%	22%	50
Children with Co-occurring MH/SA Disorders	2%	5%	48

Adult Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	82%	85.8%	51
Quality/Appropriateness of Services	85%	88.9%	51
Outcome from Services	68%	71.8%	52
Participation in Treatment Planning	78%	81.9%	51
General Satisfaction with Care	86%	88.7%	51

Child/Family Consumer Survey Measures	State Rate	U.S. Rate	States
Access to Services	85%	85.7%	49
General Satisfaction with Care	74%	86.1%	50
Outcome from Services	61%	66.3%	50
Participation in Treatment Planning	83%	87.6%	50
Cultural Sensitivity of Providers	89%	92.8%	49

Consumer Living Situations	State Number	State Rate	U.S.	U.S. Rate	States
Private Residence	18,033	86.7%	3,935,855	80.7%	57
Jail/Correctional Facility	41	0.2%	95,668	2.0%	51
Homeless or Shelter	500	2.4%	150,557	3.1%	55

Hospital Readmissions	State Number	State Rate	U.S.	U.S. Rate	States
State Hospital Readmissions: 30 Days	13	8.4%	10,468	8.9%	51
State Hospital Readmissions: 180 Days	21	13.6%	22,902	19.6%	51
Readmission to any psychiatric hospital: 30 Days	-	-	33,073	12.3%	32

State Mental Health Finance (FY2010)	State Number	State Rate	U.S.	U.S. Rate	States
SMHA Expenditures for Community MH *	$121,600,000	81.1%	$27,363,258,758	72.8%	52
SMHA Revenues from State Sources **	$22,200,000	15.4%	$15,175,923,104	40.9%	52
Total SMHA Expenditures	$150,000,000	-	$37,608,180,077	-	52

Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Assertive Community Treatment	-	-	65,383	2.0%	40
Supported Housing	-	-	73,212	2.6%	38
Supported Employment	904	32.7%	48,880	1.7%	42
Family Psychoeducation	-	-	13,045	0.9%	16
Integrated Dual Diagnosis Treatment	-	-	61,808	4.0%	22
Illness Self-Management and Recovery	-	-	162,725	12.7%	21
Medications Management	2,314	83.6%	267,702	22.8%	16

Child Evidence Based Practices	State Number	State Rate	U.S.	U.S. Rate	States
Therapeutic Foster Care	-	-	15,777	1.5%	28
Multisystemic Therapy	-	-	9,155	1.2%	19
Functional Family Therapy	-	-	10,480	1.8%	14

Outcome	State Number	State Rate	U.S.	U.S. Rate	States
Adult Criminal Justice Contacts	164	6.0%	25,453	5.4%	44
Juvenile Justice Contacts	494	4.5%	8,933	7.7%	42
School Attendance (Improved)	126	34.5%	11,398	27.3%	34

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

Appendix C:

Vermont Department of Mental Health
Clinical Resource Management System (CRMS) Work Group

FY 2013 Report

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

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

The goals are:

1. Ensure all individuals in the care and custody of the commissioner receive the highest quality and least restrictive care necessary.
2. Develop a process for receiving direct patient input on treatment opportunities and location of services.
3. Work collaboratively with community partners, including DAs, DHs, and individuals with mental health conditions, and peer groups to ensure access to services for individuals as needed.
4. Use an electronic, web-based bed board to track in real time the availability of bed resources across the continuum of care.
5. Use specific level-of-care descriptions, including admission, continuing stay and discharge criteria and mechanisms for ongoing assessment of service needs at all levels of care.
6. Specify protocols for medical clearance, bed location, transportation, information sharing, census management, and discharge or transition planning.

7. Coordinate transportation resources so that individuals may access the least restrictive mode of transport consistent with safety needs.
8. Ensure that to the extent patient's protected health information pertaining to any identifiable person that is otherwise confidential by state or federal law is used within the clinical resource management system, the health information exchange privacy standards and protocols as described in subsection 9351(e) of this title shall be followed.
9. Ensure that individuals under the custody of the commissioner being served in designated hospitals, intensive residential recovery facilities, and the secure residential recovery facility shall have access to a mental health patient representative.
10. Maintain the integrity and effectiveness of the clinical resource management system. Require a designated team of clinical staff to review the treatment received and clinical progress made by individuals within the commissioner's custody.
11. Coordinate care across the mental and physical health care systems as well as ensure coordination within the Agency of Human Services, particularly the Department of Corrections, the Department of Health's Alcohol and Drug Abuse Programs, and the Department of Disabilities, Aging, and Independent Living. Coordinate service delivery with Vermont's Blueprint for Health and health care reform initiatives, including the health information exchange.

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

Coordination and Care Management

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

Ensuring access to services is a broad based objective for the DMH. This is accomplished through multiple activities that are supported through state funding and guidelines. The DMH

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

Effectiveness of the collaborative relationships is addressed during the hospital re-designation process. Through this process, DMH Quality Management evaluates relationships between the designated hospital and designated agencies and community providers. Opportunities for improved collaboration and communication are addressed in order to improve patient transitions between different levels of care and facilitate referrals within the system of care.

Collaboration with the Department of Corrections

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

Quality Management

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

DMH is working with AHS and other stakeholders to align quality measures with national standards and benchmarks where available.

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

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

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

Community Services performance measures:

- Placement in least restrictive environments;
- Hospital diversion when appropriate;
- Clients in CRT programs will achieve the highest level of independence possible;
    - Permanent housing (tenure in community),
    - Rates of employment,
    - Receive medical health care services.

Designated Hospitals performance measures:

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

Hospital Designation Process

Access to services and treatment in the designated hospitals is reviewed during the bi-annual designation process. The designation review allows DMH to maintain oversight over hospitals' policies, procedures, treatment program, and quality initiatives. DMH Quality Management

ensures patients have access to legal representation and patient advocates (including Vermont Psychiatric Survivors and Disability Rights Vermont). The DMH collects information about involuntary treatment and care as part of its continuing monitoring activities of inpatient hospital-level care.

Agency Designation Process

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

Levels of Care

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

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

Level 1 and Involuntary Criteria for Psychiatric Admission to a DH

- Criteria and procedures described in memo ‘Psychiatric Inpatient Billings Procedures’, effective July 2012.
- DMH UR staff review Level 1 eligibility of all involuntary admissions at FAHC, GMPCC, BR and RRMC.

Level of Care Utilization System (LOCUS)

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

Hospital level of care

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

Intensive Residential Programs

- Care management team will review annual reports, discuss findings with the residential staff, and make recommendations regarding admission, continuing stay, and discharge criteria, as well continued use of LOCUS or other tools. To be completed by April 2014.
- Meeting with staff from Second Spring, Hilltop and Meadowview is scheduled 1/17/14 to review current use of LOCUS and GAF.

Crisis beds

- Care management team will review annual crisis bed reports, discuss findings with DA emergency services staff, and make recommendations regarding utilization of these beds, including continued use of LOCUS. To be completed by April 2014.
- Universal referral form for crisis beds was developed and put in use in May, 2013

Middlesex Therapeutic Recovery Program

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

Intensive Residential Services

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

Medical Clearance Guidelines

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

Medical clearance guidelines

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

Bed location

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

Transportation

- Protocols have been established and implemented (further information below)

Census management

- Census management is conducted at many levels of the DMH, using the electronic bed board as a primary resource.
- DMH sent out a protocol for communication and responsibilities between Emergency Rooms, DMH and Designated Agencies to help clarify roles when individuals are held involuntarily in an Emergency Room due to lack of psychiatric bed availability.

Discharge or transition planning

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

Existing guidelines in use

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

Patient Care: Transportation

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

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

In December 2011 DMH formed the Involuntary Transport Work Group with members from DMH, law enforcement, peer community, mental health, advocates/Disability Rights Vermont (DRVT) and one representative from the Legislature, and began meeting on a regular basis. The definitions listed below were the result of successful field work and reports back to work group including monthly data demonstrating a striking decrease in application of metal handcuffs during involuntary care. As a result the work group ended having its last meeting in November 2012. The following are the current definitions of secure and non-secure transportation from the Protocol:

Secure Transport:
Secure transport is defined as involving the application of mechanical restraints depending on which is least restrictive under the circumstances of the individual being transported. As the system of less restrictive transport evolves and other creative entities share in involuntary transports it becomes necessary to revisit and redefine 'Secure'. When the clinical team requests mechanical restraint, sheriffs will be ordered.
Non-Secure Transport:
Persons on involuntary status who are deemed safe for non-secure transport in collaboration with their clinical team shall have a broader range of transportation alternatives including but not limited to:

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

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

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

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

- There are two pilot programs with law enforcement: North (Lamoille County Sheriff,) and South (Windham County Sheriff). The demarcation of territory for pilot participants is generally north and south of I-89 respectively. The two pilot programs have alternative

modes of transport, dress and mechanical restraints and their mission is to use the least restriction.

- Involuntary transports out of Rutland Regional Emergency Department are transported exclusively by ambulance with Sheriff ride-along. It should be noted as a practice pattern that these transports occur without mechanical restraint other than the usual and customary gurney that is based on safety and ambulance policy—not mental health involuntary status.
- To transport a child under the age of nine in metal handcuffs, it is required that the Commissioner of Mental Health or Designee be contacted through GMPCC admission 24 hours a day-state wide (Hartmann, 2007, Oliver 2011, rev. Dupre 2013).
- Regional humane transport teams that have been supported by DMH grants since the beginning of humane transport initiative (2007) serve various purposes. These teams include Howard Center, CSCORP Flex team out of Second Spring in Williamstown and HCRS Transport Team serving Points South. All three of these teams use trained experienced mental health staff and Howard Center will sometimes use paid, experienced peers, in recovery when appropriate.
- Data on ambulance use is reliant on the statewide Transportation checklist, which is reconciled to the monthly list of involuntary examinations and sheriffs and provider invoices. The process is under review to enhance efficiency and accuracy of information gathering.
- All Sheriff's Departments have had soft restraints purchased by DMH and training provided on using them. There have been multiple regional and statewide trainings and presentations at conferences, meetings and small groups by different members of DMH's legal, care management and leadership staff. Delivery of training for sheriffs regarding "Building Rapport with People in Mental Health Crisis" and "Safe Transport Strategies".
- DMH has supported a pilot program with sheriffs in Lamoille County using a least-restrictive approach by deputies in plain clothes with an unmarked van. Progression to some type of restraint is utilized only when a no-restraint approach fails.

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

Electronic Bed Board

DMH E-Bed Board has been fully functional and accessible as a public website since 08/2012. As designed, the bed board tracks bed availability for:

- In-patient units at designated hospitals
- DA crisis beds

- Intensive Residential facilities
- DA residential facilities

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

- In-patient units: every 8 hours
- DA crisis beds: every 8 hours
- Intensive Residential facilities: every 8 hours
- DA residential facilities: every 168 hours (weekly)

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

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

At the request of DVHA, the vendor for the bed board has added “click count” functionality. This function will document the number of times the bed board is accessed for information. The designated DMH administrator has met with representatives of the crisis programs to answer questions regarding bed board functionality and to hear recommendations for changes to the bed board. One of the changes requested, and implemented, was the formula used to calculate daily census. The census is now reported by the highest bed occupancy for the reporting day.

Peer Services

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

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

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

Access to Patient Representatives

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

representative, methods for communication (including a primary contact from the facility), and ways for patients to access the patient representative at the facility.

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

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

Protection of Health Information:

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

Summary and Next Steps

Extensive groundwork has now been laid for the functioning of a system of care based on decentralized psychiatric hospital and outpatient organizations. The input and collaborative participation by all of the identified stakeholders has been invaluable and we are beginning

calendar year 2014 with a well-established E-Bed Board, Utilization Review process and clarity of admission/discharge criteria, additional resources for providing community based services to divert individuals from hospitalization, where appropriate, and for placement in the level of care that is warranted. DMH staff is working collaboratively with DA representatives to continue the process of streamlining communication protocols, developing core quality measures, enhancing efficiency of service delivery and maximizing resources across the state. An example of this is the development of the Universal Referral form for Crisis Bed Program admission. This form is now available for each hospital and other settings, to make a referral to a crisis bed for either step down or diversion purposes.

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

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