VERMONT2019

Evaluation of the Overarching Structure for the Delivery of Mental Health Services

REPORT TO THE LEGISLATURE

As required by Act 82, Section 3(c) of the 2017 legislative session and as amended by Act 200, Section 9 of the 2018 legislative session

January 15, 2019

VERMONT

AGENCY OF HUMAN SERVICES
Department of Mental Health
280 State Drive, NOB-2 North
Waterbury, VT 05671
www.mentalhealth.vermont.gov

CONTENTS

1. STATUTORY REQUIREMENT:

Sec. 9. 2017 Acts and Resolves No. 82, Sec. 3(c) is amended to read:

(c) On or before January 15, 2019, the Secretary shall submit a comprehensive evaluation of the overarching structure for the delivery of mental health services within a sustainable, holistic health care system in Vermont to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services. The Secretary shall ensure that the evaluation process provides for input from persons who identify as psychiatric survivors, consumers, or peers; family members of such persons; providers of mental health services; and providers of services within the broader health care system. The evaluation process shall include such stakeholder involvement in working toward an articulation of a common, long-term vision of full integration of mental health services within a comprehensive and holistic health care system. The evaluation shall include:

(1) whether the current structure is succeeding in serving Vermonters with mental health needs and meeting the goals of access, quality, and integration of services;

(2) whether quality and access to mental health services are equitable throughout Vermont;

(3) whether the current structure advances the long-term vision of an integrated, holistic health care system;

(4) how the designated and specialized service agency structure contributes to the realization of that long-term vision;

(5) how mental health care is being fully integrated into health care payment reform;

(6) any recommendations for structural changes to the mental health system that would assist in achieving the vision of an integrated, holistic health care system;

(7) how Vermont's mental health system currently addresses, or should be revised better to address, the goals articulated in 18 V.S.A. § 7629 of achieving "high-quality, patient-centered health care, which the Institute of Medicine defines as 'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions'" and of achieving a mental health system that does not require coercion;

(8) recommendations for encouraging regulators and policymakers to account for mental health care spending growth as part of overall cost growth within the health care system rather than singled out and capped by the State's budget; and

(9) recommendations for ensuring parity between providers with similar job descriptions regardless of whether they are public employees or are employed by a State-financed agency.

2. EXECUTIVE SUMMARY

Act 82 (2017) requires the Secretary of the Agency of Human Services (AHS) to "… submit a comprehensive evaluation of the overarching structure for the delivery of mental health services within a sustainable, holistic health care system in Vermont…".

In order to prepare this report, AHS reviewed and analyzed information, definitions, standards and practices across the mental health system of care and across payers in ways that have not been done in recent Agency memory. As such, the activity of accumulating and organizing available information into a single repository was a significant effort and is an appreciated outcome of conducting this report.

The primary desired result of this report is the outline of a 10-year vision for the mental health system of care spanning children, youth, families and adults, accompanied by clear action steps for achievement. AHS found that the process of creating this report was a first and significant step in this direction and that the scope and complexity of the work that the Department of Mental Health leads requires more time and engagement to then create such a plan. The report includes recommended action steps throughout and includes the foundational premise of a 10-year plan at section 11. The plan is provided as an illustration that is aligned with the Agency's values, builds off out stakeholder input, and is a springboard for the Agency, the Department of Mental Health (DMH), and their many partners in the health care system to move into the next phases of engagement, planning and development.

To that point, a second important outcome of the report is the Agency's intent, through the Department of Mental Health, to engage in a second phase of stakeholder engagement subsequent to the 2019 legislative session. This engagement process will inform a shared vision, shared commitment, and shared accountability for the long-term vision of an integrated, holistic health care system. The engagement process will consider implementation of current system changes resulting from healthcare reform, planned changes in inpatient capacity and other commitments of the Department of Mental Health, the Agency of Human Services, and the many partners, providers and payers who are responsible for the State's mental health system of care. The resulting vision will be used to create a framework for implementation strategies and a process to achieve a comprehensive continuum of integrated care.

Finally, the Agency of Human Services notes here that it is a payer of Medicaid mental health services but does not oversee mental health services paid for through other means such as Medicare or commercial insurance plans. The Agency considers that there may be additional opportunity to review practices, performance and requirements of other payers beyond what is immediately available to staff of AHS and as presented in this report.

2.1 RESULTS OF THE EVALUATION

This evaluation demonstrates that the Agency of Human Services, Department of Mental Health, has significant concrete work planned or underway as a result of previous stakeholder engagement and legislative charges. The process of the evaluation also made clear, however, that to build a 10-year plan on the foundation of a thorough process of stakeholder engagement and collaboration, requires more time. For that reason, this report includes the draft outline of a plan in section 11, informed by previous input and statutes, rather than a final vision and action plan with concrete steps. The Agency proposes to present a complete plan at the beginning of the second biennium of the 2019-2020 legislative session, following a series of stakeholder engagement meetings.

The work that we are already embarked on includes; responding to the immediate mental health crisis by adding inpatient capacity, mirroring that increased capacity with increased community resources to support transitions from care back into the community, supporting full integration of services across all providers, supporting prevention and health promotion activities through initiatives such as Building Flourishing Communities, a public health campaign that gets the information about the effects of early childhood adversity on developing brains, and how to prevent adversity, build resilience and achieve flourishing for all Vermonters.

2.2 NEXT STEPS

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

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

Next steps from this report include:

- Initiation of a second phase of stakeholder engagement process during the summer of 2019 to develop a comprehensive 10-year collective vision for the future of our mental health system.
- An inclusive process to share findings and recommendations for additional feedback and collaboration, and the articulation of the policy, legislative and administrative action required to move the recommendations forward.
- The development of short-term, mid-term and long-term implementation strategies, process and timeline to achieve a comprehensive continuum of integrated care for the mental health system of care in Vermont.

2.3 RECCOMENDATIONS

Specific recommendations for the mental health system of care are included throughout the report and excerpted for the reader's convenience in this section.

Role of Non-Designated Hospitals

- The Agency considers that expanded capacity at non-designated hospitals could be developed to support appropriate care and treatment services closer to home. While all current capacity for inpatient psychiatric care exists at designated hospitals, there is a remaining inpatient system and/or beds that could be developed and utilized to meet local needs.
- Voluntary mental health admissions occur at only a few select hospitals versus routine statewide healthcare access and is another access gap area for possible development. Just as other customary hospital health care services are available to any individual presenting to an ED for triage, stabilization, and transfer to specialized care if needed, involuntary inpatient psychiatric care services should be comparable to other specialized, physical inpatient services paralleling such specializations as cardiac care, dialysis, and physiatry (acute rehabilitation) services.

Role of Community-Based Care

- The absence or limitations of a local community to respond to individual needs when inpatient care isn't necessary compounds the difficulty in transfer from hospitals to more appropriate resources or levels of care. Current options such as MyPad housing in Chittenden County, the Soteria and Alyssum peer-supported crisis and transitional residential programs, crisis beds, and current Intensive and Secure Residential Recovery

programs provide more individually focused levels of care options for community re-entry and recovery; this array of services, however, is not provided in every region. Despite the existing services array that has been enhanced since 2012, there is a continuing need and opportunity to provide increased community capacity to offset unnecessary ER wait times or inpatient admissions.

- Consistent with a collaborative network approach between hospitals and community-based programs, the gap in bed capacity could potentially be addressed through more robust investments in an expansion of the array of residential support models in the community. Expansion of step-down regional residential support programs could be a cost-effective, less restrictive option for individuals who are ready for transition from inpatient beds to some form of community residential treatment and support. The pairing of both some growth in inpatient capacity and investments in community-based services provides capacity for local communities to timely receive back individuals who do not need hospitalization.

Mobile Response and Support Systems

- The Agency of Human Services is working across multiple Departments to explore Mobile Response and Support Services (MRSS) for the child, youth and family system of care.
- In 2013 the Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicaid and CHIP Services (CMCS) recognized Mobile Crisis Response and Stabilization Services as "not only clinically effective but cost effective as well."
- MRSS differs from traditional crisis services in that it's more upstream. A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention earlier for a child or youth and family before emotional and behavioral difficulties escalate. An MRSS response has been shown in other states to "avert unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, or residential treatment (NASMHPD 2018).

Other recommendations:

- Additional analysis is recommended to review commercial rates of payment to mental health providers as compared to physical health.

2.4 REPORT SECTION SUMMARIES

ACCESS OVERVIEW

- In CY 2017, mental health spending on behalf of Vermont residents with a primary mental health diagnosis represents $372,400,000 of a total health care spend of $3.8B, or 9.8% of total health care costs.
- In CY 2017, mental health spending on behalf of Vermont residents with mental health diagnosis any place on the claim represents $854,200,000 of a total health care spend of $3.8B, or 22% of total health care costs.
- Compared to national averages, more people in the state of Vermont have mental health needs, but more are also using mental health services.
- Access in the state of Vermont meets federal Medicaid requirements, however, some areas of Vermont—particularly more rural counties—may have significantly fewer providers relative to their population than other regions.

ACCESS AND FLOW ACROSS THE SYSTEM OF CARE

- Stakeholders would like more access to mental health services in Vermont but are satisfied with service quality once accessed.
- Emergency department length of stay increased significantly over the past year, and approximately three percent of visits accounted for approximately 40% of bed day utilization.
- More voluntary inpatient admissions contributed to more incidents of increased length of stay than anticipated.
- Emergency department services should routinely include acute mental health treatment. If needed, expanded capacity at non-designated hospitals could be developed to support appropriate care and treatment services closer to home. Services and beds in the current inpatient system could also be developed to meet local needs.
- A broader range of community-based services must be developed statewide.
- Child and youth services have been expanded through a new 6-bed hospital diversion program; DMH is exploring development of a mobile face-to-face response program that provides support and intervention earlier for a child/youth and family before emotional and behavioral difficulties escalate.
- Vermont has 201 adult inpatient psychiatric care beds to serve both voluntary and involuntary treatment needs. As many as 35 new beds are being planned by the University of Vermont Medical Center. Under federal law, however, Vermont Psychiatric

Care Hospital could lose 9 beds by 2026 in order to remain eligible for Medicaid reimbursement.
- DMH initiated several new collaborative efforts to address delays in access and flow.

QUALITY

- Across payers, there is not a consistent approach to quality review of mental health providers and organizations and levels of oversight may vary.
- The Department of Mental Health has robust and comprehensive oversight and compliance review processes of Designated and Specialized Services Agencies that appear to be more intensive than those of other outpatient mental health providers.

PERSON-CENTERED CARE

- Rules, regulations, governance and oversight of mental health services all serve to build a system of care that is driven by and centered around the individual at the center of every interaction.
- Vermont's mental health system of care has a long history of building a system based on person-centered care.

COERCION

- Vermont's mental health system of care is based on respectful treatment of every patient.
- The goal is for a system with the least use of coercion possible, which is always guided by the patient's welfare.
- Involuntary medication, restraint, commitment or other limiting of the patient's choice may be sought or administered only when a patient is in danger of self-harm or of harming others.
- Coercion must be carried out in a trauma-informed manner.
- Every attempt is made to follow an informed-consent process, so that the patient understands why the procedure is necessary.

VISION OF AN INTEGRATED, HOLISTIC HEALTH CARE SYSTEM

- The Department of Mental Health is committed to integrated care based in the continuum of health promotion, disease prevention and life-span pro-active care and rehabilitation as defined by the World Health Organization.
- Through carefully designed collaborative pilots, wellness-focused projects and a guiding principle of supporting whole-person health, DMH continues to build a system of care

that strives for the triple aim of health care reform; better care that results in improved health and reduced cost.

MENTAL HEALTH AND PAYMENT REFORM

- With the advent of the mental health payment reform in January 2019, limitations of fee for service payment models will be significantly reduced.
- Designated Agency staff express strong anticipation of the change to more population-based payments.
- DA staff look forward to being able to provide the services Vermonters need, rather than only those services the client is eligible for.

STRUCTURAL CHANGES

- More work is needed to achieve an integrated and holistic health care system.
- Resources must be directed to services delivered in the community, and those services must be delivered in a coordinated and integrated continuum of care.
- While inpatient capacity must grow initially, additional capacity in community residential levels of care, expansion of integrated care and prevention and health promotion activities should help decrease the number of Vermonters who find themselves in need of such levels of care.

MENTAL HEALTH SPENDING

- Recent increases to Medicaid rates paid to Designated and Specialized Services Agencies appear to be positively impacting provider capacity and employee retention.
- Additional analysis is recommended to review commercial rates of payment to mental health providers as compared to physical health.
- The All-Payer Model requires a plan to account for mental health services as a part of the All-Payer Financial Target Services in a future All-Payer Model Agreement. This approach presents a natural opportunity to analyze rates of payment for mental health providers outside of their current payment environments and to consider what their reasonable growth trend should be as compared with expectations of overall cost containment for the primarily physical health services currently included in the All-Payer ACO Model Agreement.

PROVIDER WORKFORCE PARITY

- Recent increases to Medicaid rates paid to Designated and Specialized Services Agencies appear to be positively impacting provider capacity and employee retention.

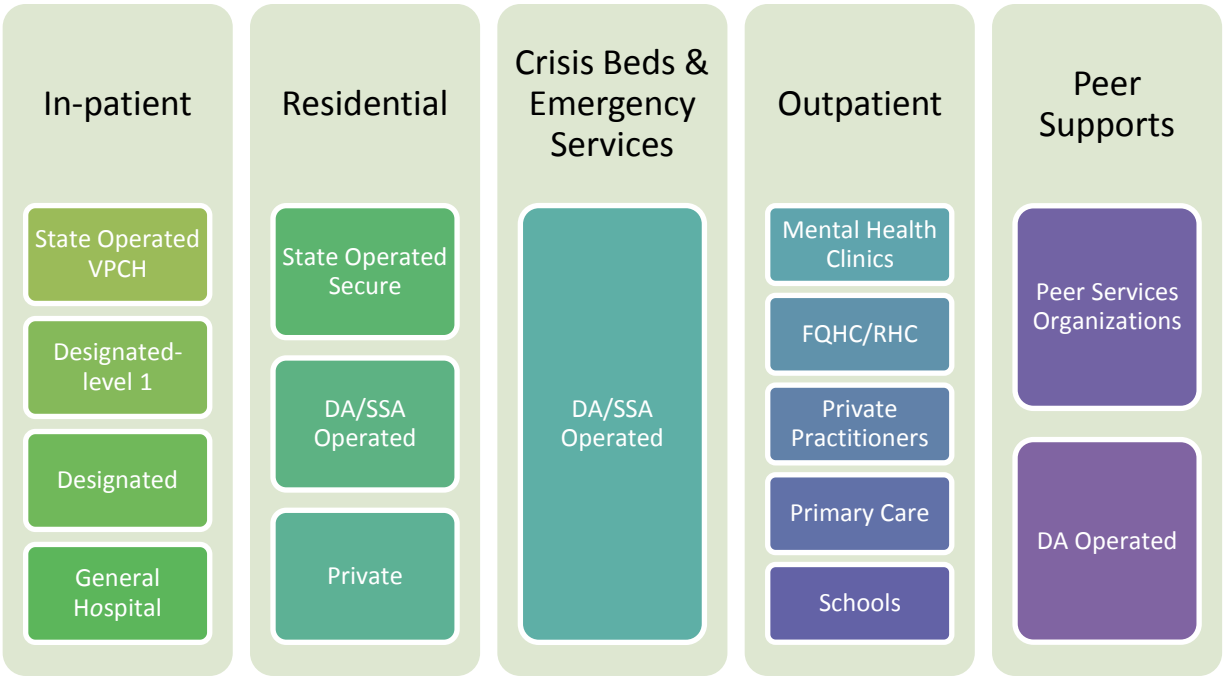
- Additional analysis is recommended to review commercial rates of payment to mental health providers as compared to physical health.
- As stated in the prior section, the All-Payer Model requires a plan to account for mental health services as a part of the All-Payer Financial Target Services in a future All-Payer Model Agreement. This approach presents a natural opportunity to analyze rates of payment for mental health providers outside of their current payment environments and to consider what their reasonable growth trend should be.

2.5 MENTAL HEALTH SYSTEM OF CARE OVERVIEW

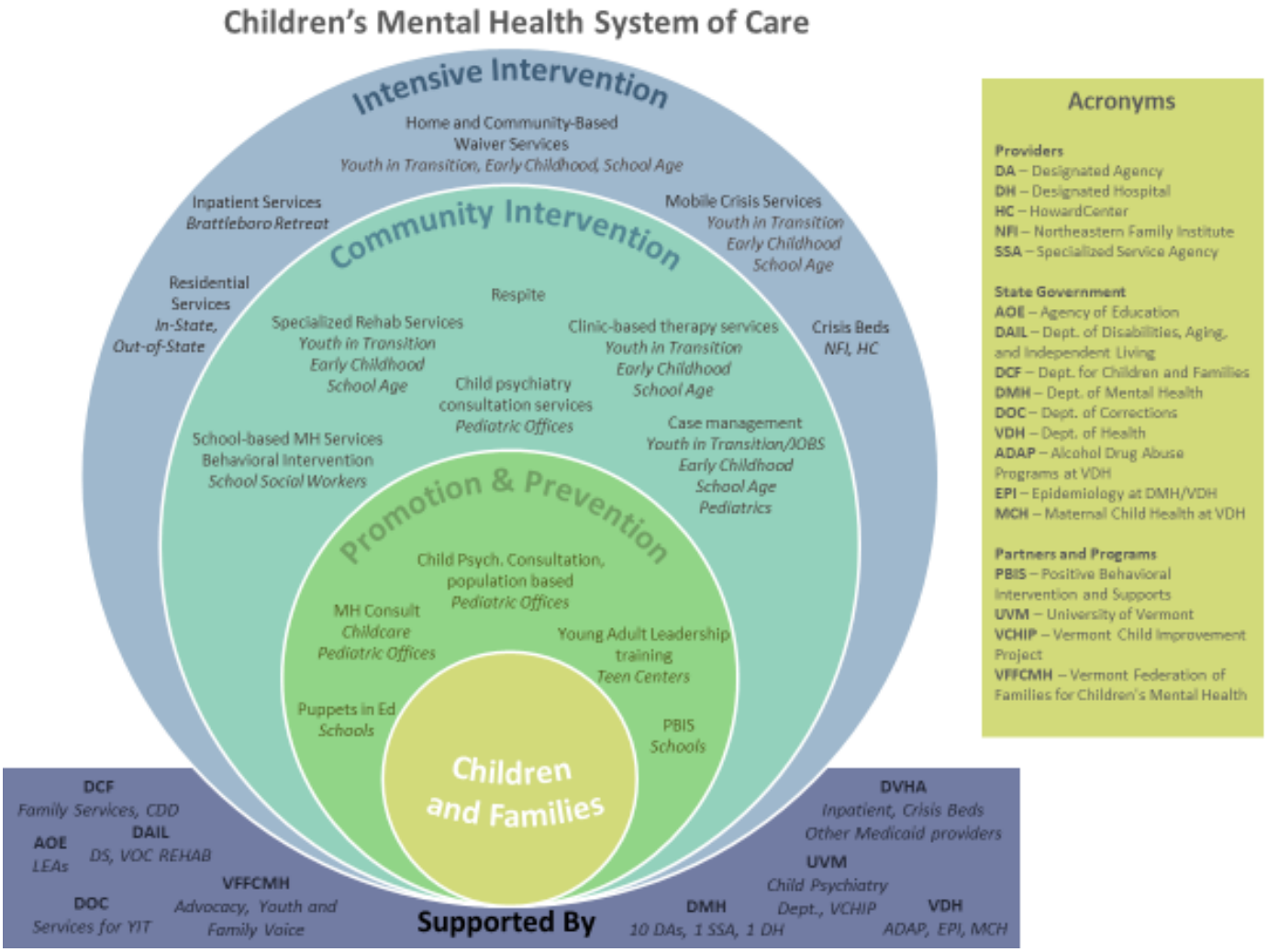
This section provides an overview of the current structure of the mental health system of care. It provides an orientation to mental health provider organizations at all levels of care, describes types of mental health providers, characteristics of mental health services, and then primary payers of mental health services in the State of Vermont.

STRUCTURE OF MENTAL HEALTH PROVIDER ORGANIZATIONS

Mental health providers may provide services at all levels of care. Mental health providers may be employed independently, by the state, or through provider organizations such as hospitals, clinics or schools.



The graphic below represents the array of supports in the child, youth and family mental health system of care across promotion and prevention activities, early intervention, and intensive intervention as well as the key partners in that system.



In-Patient- 7 designated psychiatric facilities (201 beds in total)

General Hospital

There are seventeen hospitals in the state of Vermont: two specialized facilities that serve those with mental health needs only, one specific to the needs of Veterans, and fourteen that serve community health more generally. Community hospitals screen for mental health needs and refer internally or externally as needed.

Designated Hospitals – 201 beds (45 Level I beds, 156 Non-Level I and Voluntary beds)

Seven hospitals in the state have achieved designation status with the Department of Mental Health: Brattleboro Retreat, Central Vermont Medical Center, University of Vermont Medical

Center, Rutland Regional Medical Center, Windham Center at Springfield Hospital, Vermont Psychiatric Care Hospital, and the White River Junction VA Medical Center.

Designated Hospitals must maintain standards to keep beds open to support those with mental health needs. Two hospitals (Vermont Psychiatric Care Hospital and Brattleboro Retreat) focus solely on providing mental health treatment and services. All seven hospitals support adults, one hospital specializes in supporting children, youth, and families, and one hospital specializes in supporting veterans.

Designated Level I – 45 beds
When individuals with mental health needs are acutely distressed and require additional services, they meet criteria for 'level one' care. At hospitals with level one beds, these individuals are served on a primarily involuntary basis. These beds are located at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Vermont Psychiatric Care Hospital (25 beds).

State Operated: the Vermont Psychiatric Care Hospital
The Vermont Psychiatric Care Hospital is a 25-bed acute care hospital, serving adults on an involuntary basis, regardless of whether or not they meet requirements for level-one acute status, located in Central Vermont.

Residential
State Operated Secure: Middlesex Therapeutic Community Residence
The Middlesex Therapeutic Community Residence (MTCR) is a 7-bed secure residential facility designed to provide a community-based aftercare option for people who are ready to discharge from a psychiatric hospital but still require considerable support in their recovery process.

DA/SSA Operated
The Department of Mental Health designates one Designated Agency (DA) in each geographic region of the state. Designated Agencies are non-profit service providers that are responsible for ensuring the delivery of mental health programs for adults and children. There are presently ten designated agencies: Clara Martin Center (CMC), Counseling Services of Addison County (CSAC), Howard Center (HC), Lamoille County Mental Health (LCMH), Northeast Kingdom Human Services (NKHS), Northwestern Counseling Service and Support (NCSS), Rutland Mental Health Services (RMHS), United Counseling Services (UCS), Washington County Mental Health (WCMH), and Healthcare and Rehabilitation Services (HCRS).

Specialized Service Agencies (SSAs) may operate in more than one geographic region of the state and provide a distinctive approach to service delivery and coordination that meet distinctive needs of individuals. Vermont presently has two specialized mental health service agencies: Northeast Family Institute (NFI) serving children, youth and families and Pathways Vermont (PVT) serving adults.

The ten designated and two specialized services agencies in the state operate a variety of residential options for adults including supported independent living, nineteen group homes (151 beds), and six intensive residential recovery spaces (47 beds). They support individuals in the least restrictive environment possible. One DA and the one children's SSA operate residential programming for children and youth, including 8 community-based group homes (ranging in capacity from 3-6 youth each for a total of 30 beds) and 2 residential treatment programs (18 beds) used by DMH. One DA provides another residential treatment program that is solely used by DCF-Family Services.

Private

Privately owned and reimbursed residential programs also serve the needs of Vermonters. For children, the Private Non-Medical Institutions in Vermont are residential treatment programs licensed by DCF-Family Services. DMH uses 7 non-DA/SSA run PNMI programs, with capacity to serve 75 youth; however, this capacity is accessed by both DCF-Family Services and DMH. There has been a significant reduction in the number of licensed residential beds available to children and youth in Vermont since 2010. This reduction of in-state capacity, as well as the clinical need of individual children/youth who require specialized treatment that is not available in Vermont, means that some children and youth are referred out-of-state for residential treatment.

Crisis Beds & Emergency Services

Emergency Services are provided by designated agencies and include mobile crisis teams to respond to needs in the community as well as phone support and prevention services. When needed, clients are referred to crisis beds, which are part of a community-based hospital diversionary program that offers emergency, short-term, 24-hour residential supports in a setting other than the person's home. They are operated by the designated and specialized services agencies. There is also a peer-run crisis bed program called Alyssum. The total crisis bed count in the state is 38 for adult mental health and 18 for children and youth.

Outpatient

Mental Health Clinics

All ten designated agencies offer outpatient services at their clinics including individual therapy, group and family therapy, case management services, and safety planning. If needed, they refer internally or externally to higher levels of care.

FQHC/RHC

Federally Qualified Health Centers (FQHCs) are community health care practices that offer primary care and preventative and emergency services, regardless of the person's ability to pay. There are forty-four FQHCs in Vermont. Additionally, there are twelve Rural Health Clinics (RHCs) in Vermont certified through the Department of Disabilities, Aging, and Independent Living to provide primary care services in rural areas of Vermont. These organizations screen for mental health needs, refer when appropriate, and have providers on staff who can prescribe medication if indicated.

Private Practitioners

Throughout the state, independent practitioners provide outpatient therapy, screening and assessment, medication management, and case management services to Vermonters in need. They fall under the wide range of mental health professionals outlined above.

Primary Care

Like the role of FQHCs/RHCs, primary care practices throughout the state house health professionals trained to screen for mental health needs, refer when appropriate, and prescribe medication if indicated.

Pediatric primary care providers can benefit from access to child psychiatric consultation which can expand their ability and comfort to assess and manage appropriately more complex and co-morbid mental health needs.

Schools

Within schools, a variety of supports exist for students to promote healthy social-emotional development for all students, identify and provide support for students at risk, and provide intervention for those students with identified mental health needs. Schools supports include Positive Behavioral Intervention and Supports or other Multi-Tiered Systems of Support, Individualized Education Plans and 504 Plans to protect modifications to learning environment and supports and Educational Support Teams. Mental health services in schools may include school-based clinicians, behavior interventionists, and other mental health professionals. Mental health services in schools can include individual and group therapy, mental health screenings, case management services, consultation by a mental health professional on school-wide efforts as well as individual student plans, and school support and advocacy, which can be

provided by school staff, private clinicians, or staff provided by designated agencies through partnership with the school/district.

Peer Supports

Peer Service Organizations

Eleven organizations in Vermont are run by and for people who have experienced mental health needs, self-labeled as peers. Our current peer organizations are Another Way, Alyssum, College Steps, Friends of Recovery-VT, Green Mountain Self-Advocates, NAMI Vermont, Pathways, Vermont Center for Independent Living, Vermont Federation of Families for Children's Mental Health, Vermont Foundation of Recovery, and Vermont Psychiatric Survivors. These organizations provide services including 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.

Peers are also working within some Designated Agencies to provide supports to individuals awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services.

MENTAL HEALTH SERVICES AND QUALIFIED PROVIDERS

This section of the overview provides an orientation to types of mental health services available in Vermont and the health care professionals qualified to provide them. Information for this section was sourced from the National Association for Mental Illness[i], the Vermont Office of Professional Regulation[ii] as well as the Vermont Department of Mental Health Provider Manual[iii]. Services described at A) through C) are generally covered by insurance plans that include mental health coverage. Services described at D) through Q) are covered by Vermont Medicaid and are not consistently covered by other insurance plans.

A) Assessment and Therapy

Clinical assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments. A clinical assessment is a service related to creating an accurate picture of an individual's needs and strengths, and it is the process by which a mental health professional may diagnose a mental health condition.

Clinical therapy services are specialized, formal interactions between a mental health provider and a client, family, or group of clients to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder,

psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Psychologists

Doctoral Level Psychologists hold a doctoral degree in clinical psychology or another specialty such as counseling or education. They are trained to evaluate a person's mental health using clinical interviews, psychological evaluations and testing. They can make diagnoses and provide individual and group therapy.

Degree requirements: Doctor of Philosophy (Ph.D.) in a field of psychology or Doctor of Psychology (Psy.D.).
Licensure & credentials: Psychologists are licensed by The Vermont Office of Professional Regulation.

Master's level Psychologist hold a Master's degree in Psychology. They are trained in the provision of treatment, diagnosis, evaluation, or counseling services to individuals or groups.

Degree requirements: Master's degree in Psychology from a program that is a full member of the Council of Applied Master's Programs in Psychology (CAMPP)

Licensure & credentials: Master's level Psychologists are able to be licensed by The Vermont Office of Professional Regulation.

Counselors, Clinicians, Therapists

The practice of clinical mental health counseling includes diagnosis and treatment of mental conditions or psychiatric disabilities and emotional disorders, psychoeducational techniques aimed at the prevention of such conditions or disabilities, consultations to individuals, couples, families, groups, organizations, and communities, and clinical research into more effective psychotherapeutic treatment modalities.

Degree requirements: master's degree (M.S. or M.A.) in a mental health-related field such as psychology, counseling psychology, marriage or family therapy, among others.
Licensure & Certification: Counselors, Clinicians, and Therapists can be licensed through The Vermont Office of Professional Regulation.

Examples of licensure in Vermont include:

- LCMHC, Licensed Clinical Mental Health Counselor
- LMFT, Licensed Marriage and Family Therapist

Clinical and Master's Level Social Workers

Clinical and Master's Level social workers are trained in social work theory, knowledge, methods, ethics, and practice in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions, and addictions.

Degree requirements: master's degree in social work (MSW), master's degree in social administration (MSSA).
Licensure & credentials: Licensure in Vermont is called:

- LICSW, Licensed Independent Clinical Social Worker through the Vermont Office of Professional regulation
- LMSW, Licensed Master's Social Worker, provides social work services and must complete 10 hours every two years of continuing education.

Licensed Alcohol & Drug Counselor (LADC)

Licensed Alcohol and Drug Counselors provide services that assist an individual or group to develop an understanding of alcohol and drug abuse dependency problems and to define goals and plan actions reflecting the individual's or group's interests, abilities, and needs as affected by alcohol and drug abuse dependency problems and comorbid conditions.

Degree Requirements: Master's Degree or Doctorate in a human services field from an accredited educational institution.

Licensure and credentials: LADC, Licensed Alcohol and Drug Counselor Licensure by the Vermont State Office of Professional Regulation

B) Medication Evaluation, Management and Consultation Services

Medication Management and Consultation Services include evaluating the need for medication, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's mental health care in coordination with other medical providers.

The following health care professionals can prescribe medication. They may also offer assessments, diagnoses and therapy.

Psychiatrists

Psychiatrists are licensed medical doctors who have completed psychiatric training. They can diagnose mental health conditions, prescribe and monitor medications and provide therapy. Some have completed additional training in child and adolescent mental health, substance use disorders or geriatric psychiatry.

Degree requirements: Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO), plus completion of residency training in psychiatry.
Licensure & credentials: Licensed physician in Vermont through the Office of

Professional Regulation; may also be "Board Certified" by the Board of Neurology and Psychiatry.

Primary Care Physicians

Primary care physicians and pediatricians can prescribe medication, but primary care and mental health professionals should work together to determine an individual's best treatment plan.

Degree requirements: Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (DO).
Licensure & credentials: Licensed physician through the Vermont Office of Professional Regulation.

Advanced Practice Registered Nurse

A licensed registered nurse authorized to practice in this state who, because of specialized education and experience, is endorsed to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under administrative rules adopted by the board. Included in the APRN scope of work is Psychiatric/ Mental health as well as prescribing medication and prescribing medical, therapeutic, or corrective measures.

Degree Requirements: Master of Science (M.S.) or Doctor of Philosophy (Ph.D.) in nursing with specialized focus of Psychiatry.

Licensure & credentials: APRN Licensing through the Vermont Office of Professional Regulation. Examples of ARPN Licensing include:

- Nurse Practitioner
- Clinical Nurse Specialist in Psychiatric and Mental Health Nursing.

Examples of Credentials include:

- NCLEX, National Council Licensure Examination
- PMHNP-BC, Board Certification in psychiatric nursing through the American Academy of Nurses Credentialing Center

C) Emergency care and assessment services/mobile crisis services

Emergency Care and Assessment Services (Emergency Services, ES) are time-limited, intensive supports intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources[iv].

Services include:

- Crisis Response – screening and assessment
- Inpatient Screening – voluntary and involuntary
- Court Screenings
- Community Emergencies – disaster response, public education, outreach and referral
- Reassessment – for individuals on Involuntary Status awaiting an inpatient hospital bed
- Mobile Outreach – Community outreach, in tandem with law enforcement as necessary

The following health care professionals may provide Emergency Care and Assessment Services:

Bachelor degree level staff who based on their education, training, or experience, is authorized by a Designated Agency's or Specialized Services Agency's Medical Director as competent to provide the service.

Only Qualified Mental Health Professionals (QMHP) may screen and refer an individual for involuntary psychiatric admission.

Qualified Mental Health Professional [2]

A Qualified mental health Professional is a person with professional training, experience, and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse, or other qualified person designated by the Commissioner. A Qualified Mental Health Professional is designated by the Commissioner to serve and the applicant for involuntary psychiatric admissions.

Degree Requirement: Degree requirements vary based on the applicant's level of experience in crisis services

Credentials: Commissioner designated QMHP's must participate in QMHP- specific training by DMH every two years in order to retain their designation.

The following services at D) through R) are covered by Vermont Medicaid for some Vermonters with additional mental health needs and may be provided by any of the previously described licensed professionals in this section who are operating within their scope of practice, **or** by:

Mental Health Workers/ Social Workers

Bachelor's degree level staff that provide case management, inpatient discharge planning services, placement services and other community-based services to support

healthy living. These staff may be referred to as Case Managers, Community Skills Workers, Service Coordinators, Residential Counselors etc. Based on their education, training, or experience, they are authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

D) Crisis stabilization bed services

Facility-based Crisis Stabilization and Support Services provide short term services (hours to a few days) designed to stabilize people in an acute mental health crisis and to move to community-based supports as soon as possible with planned discharge and placement.

E) Service planning and coordination

Service planning and coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and supports.

F) Community supports

Community Supports are individualized and goal-oriented services to assist individuals and their families with clearly documented psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and positive growth.

G) Supported employment

Supported employment services assist individuals with developing, achieving and sustaining work, educational, and career goals.

H) Day services

Community-based services provided in a Day Service environment, where group recovery activities are provided to adults in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope.

I) Transportation

Transportation services are for the necessary transportation of individuals covered by Medicaid to and from an agency facility in order to receive Medicaid- reimbursable services.

J) Special evaluations

A specialized clinical evaluation, such as a neuropsychological, psychosexual, risk assessment or an in-depth trauma evaluation, which includes a child's current level of functioning, mental health, social, and family history, a Diagnostic Statistical Manual (DSM) diagnosis as appropriate to the evaluation type, and recommendations.

K) Family education/consultation

Education, consultation and training services provided to family members, significant others, home providers, foster families and treatment teams to increase knowledge, skills and basic understanding necessary to promote positive change.

L) Respite

In-home or community-based care for the purpose of providing a planned break for parents/guardians or foster care providers for children in foster care/therapeutic foster care.

M) Therapeutic foster care

Short-term individualized support for children in the home of a licensed and contracted foster home provider.

N) Shared living home provider

Shared-living arrangements for adults, offered within a home provider's home.

O) Staffed living

Residential living arrangements for individuals with significant mental health needs staffed full-time by employees of a provider agency.

P) Group living

Living arrangements for three or more people, designed to provide individualized, recovery-oriented treatment plan services in either transitional or longer-term residential rehabilitation settings.

Q) Intensive residential recovery

Specialized group arrangements for three or more people, staffed full-time by employees of a provider agency. These arrangements are designed to be recovery oriented and treatment focused programs for individuals frequently stepping down from hospital level of care.

R) School Based mental Health Services

Behavior Interventionist (BI)

Behavioral Interventionists are mostly Bachelor's degree educated mental health staff who provide 1:1 or small group assistance to students struggling with an emotional disability in a classroom or school setting within the context of an individualized behavior support planning process. The BI services are individualized to the student's mental health and behavioral needs to help the student access his/her academics. The BI Services include clinical training and supervision of the BI, initial and ongoing assessment by clinical professionals, and behavior interventions that are grounded in the assessment and behavior support plan as described in the BI Minimum Standards.

School Based Clinicians/ School Based Social Workers/ Home School Coordinators

The School Based Clinicians/ School Based Social Workers/ Home School Coordinators provide services in school that include assessment, development of Individual Service Plans (ISP), individual therapy, family therapy, group therapy, community supports, service planning & coordination, consultation & education/training to school personnel on mental health topics, prevention and early intervention supports, interagency service coordination, support to Positive Behavioral Interventions and Supports (PBIS) framework, referral for other services and supports. The staff that provide this service are required to have a Master's Degree as a minimum requirement. These services can also be provided by previously described Licensed providers.

Board Certified Behavioral Analyst (BCBA)

BCBA's in schools provide support and training to the Behavioral Interventionist, complete Functional Behavior Assessments and create behavioral support plans for students. In addition the BCBA provides Supervision to BI's in the application of applied behavioral analysis. BCBA's also participate on the students educations team, review's cases, documentation, and client management issues.

Degree requirements: Obtain a doctoral or master's degree from a recognized educational program accredited by the Association for Behavior Analysis International Accreditation Board, or from a program at a recognized educational institution that is approved by the Director and that substantially meets the educational standards of the Association for Behavior Analysis International Accreditation Board or the Behavior Analysis Certification Board. Any program shall include an approved course sequence of the Behavior Analyst Certification Board.

Licensure & credentials: Successfully complete a nationally recognized examination adopted from the Behavior Analyst Certification Board and approved by the Director, related to the principles and practice of applied behavior analysis. Licensure as a Board Certified Behavior Analyst through the Vermont Office of Professional Regulation.

Other Professionals

Peer Specialists

These specialists have lived experience with a mental health condition or substance use disorder. They are often trained and prepared to assist with recovery by helping a person set goals and develop strengths. They provide support, mentoring and guidance.

Pastoral Counselors

Pastoral counselors are clergy members with training in clinical pastoral education. There is currently no licensure for Pastoral Counseling in Vermont.

WHO PAYS FOR MENTAL HEALTH SERVICES

Vermonters access insurance in many different ways- from their employer, from the federal government, from state government, or by purchasing it themselves on the insurance marketplace, Vermont Health Connect. Parity laws do not apply to all plans in the same way, and not all types of health insurance are covered by the Federal Parity Law or a state parity law.

The Mental Health Parity and Addiction Equity Act was passed in 2008 and requires health insurance plans to cover mental health benefits and physical health benefits equally. The Federal Parity Law says that health insurance plans cannot have higher co-payments and other out-of-pocket expenses for mental health benefits than they do for other medical benefits; health insurance plans cannot put higher limitations on the number of visits or days of coverage for mental health care than they do for other medical care; and, health insurance plans cannot use more restrictive managed care practices for mental health benefits than they use for other medical benefits.

The Federal Parity Law does not require that all health insurance plans cover mental health care, but if they do, the coverage must be comparable to what's in place for other medical care.

Medicare

Medicare covers Inpatient Hospital (Part A), Outpatient (Part B), and Prescription Drugs (Part D) for mental health.

Inpatient Hospital (Part A) covers things like: room, meals, nursing care, therapy or other treatment, lab tests, medications, and other related services and supplies. If the

services are provided in a psychiatric hospital, Medicare only pays for up to 190 days of inpatient psychiatric hospital services during a person's lifetime.

Outpatient (Part B) covers things like: visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests ordered by a doctor. Outpatient coverage may also pay for partial hospitalization services if someone needs intensive coordinated outpatient care.

Prescription Drugs (Part D) helps cover drugs that may be needed to treat a mental health condition.

Medicare will cover mental health services if they are provided by the following types of qualified providers: psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician assistant.

Medicaid

Medicaid covers inpatient hospital, outpatient and prescription drugs for mental health. A listing of benefits and qualified providers are described in the prior section and include Inpatient Psychiatric Hospital (no limit), Outpatient, Emergency/Crisis Services, Over-the-Counter and Prescription Drugs; and Transportation.

Through the Global Commitment to Health Waiver and its Medicaid State Plan, Vermont Medicaid covers additional benefits for some Vermonters with additional mental health needs. These services are described at 2.3 D) through R), and include services such as service planning and coordination, community supports, supported employment, day services, special evaluations, family education/consultation, respite, and a variety of levels and types of residential settings.

Commercial

In the state of Vermont, every plan must provide minimum essential coverage, which is coverage of the following 10 basic health benefits, including mental health:

- Children's health services
- Emergency care
- Hospitalization
- Lab services
- Maternity and newborn care
- Mental health and substance abuse services
- Outpatient services
- Prescription drugs

- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Although the specifications of covered services under the mental health benefit will vary among different commercial plans, as described in the introduction of this section, the coverage must be comparable to what's in place for other medical care.

SUMMARY

- Mental Health services are provided at all levels of care and in just about any location.
- Mental health services are paid for by all major categories of insurers; Medicaid, Medicare and Commercial, however, benefits, provider qualifications and coverage of mental health services vary between payers.
- Medicaid coverage for mental health services and inclusion of qualified provider types is more extensive than Medicare or Commercial insurance. In particular, Medicaid pays for individuals to receive services in an inpatient hospital without life-time limits such as those imposed by Medicare and pays for residential levels of care in the community that are generally not covered by other insurers.

3. PROCESS

The following sections of the report address requirements (1) - (9) of 2017 Acts and Resolves No. 82, Sec. 3(c) as amended by 2018 Acts and Resolves No. 200, Sec. 9. Each section presents and discusses findings that address requirements of the legislation with a summary provided at the end of each major, numbered section. An attempt is made to address requirements of the report in order, however, in several sections the requirements were broken apart due to the amount of information presented or were addressed out of order so that the information could be more seamlessly connected by the reader to related information.

3.1 STAKEHOLDER FEEDBACK

Stakeholder feedback is presented in themes and broken out by topic area throughout the evaluation. To recap, stakeholders are persons who identify as psychiatric survivors, consumers, or peers; family members of such persons; providers of mental health services; and providers of services within the broader health care system.

AHS works regularly with stakeholders in planning, operating and evaluating mental health services. To initiate this evaluation, the Department of Mental Health reviewed its prior stakeholder engagement processes that addressed the topic matter required by the legislation. This included feedback received from stakeholders through the following forums:

- 2014 Children, Youth and Family Services perception of care surveys by clients/family
- 2015-2018 feedback from stakeholder organizations related to Agency Review and Agency Designation
- 2016 Community Rehabilitation and Treatment perception of care surveys by clients
- 2017- Act 82 statewide listening sessions
- 2017 - Act 82 feedback regarding Emergency Department wait times from the National Alliance on Mental Illness- Vermont, Vermont Psychiatric Survivors, and the Vermont Association of Hospitals and Health Systems
- 2017 - The State Interagency Team System of Care Plan
- 2018 - Act 264 Board recommendations for the child, youth, and family system of care

As well as reviewing prior feedback, the Department created a new Mental Health System of Care survey, specific to this legislative report, and posted it to its public website. The survey was distributed to consumer advocacy and provider trade organizations with an invitation to send the survey link to any other interested parties. The survey was open from October 8th, 2018, through October 31st, 2018 and 61 responses were received.

As noted in the executive summary and elsewhere in this report, the Department plans to initiate a second phase of stakeholder engagement subsequent to the 2019 legislative session to refine the short, mid and long-term goals for the mental health system of care and related next steps.

4. ACCESS OVERVIEW

This section of the report responds to the first two requirements of the evaluation around access.

(1) whether the current structure is succeeding in serving Vermonters with mental health needs and meeting the goals of access…;
(2) whether … access to mental health services [is] equitable throughout Vermont;

The section is organized to present information about access as follows:

- Definition of access
- Access to mental health services- Vermont in perspective
- How Vermonter's access health care
- Mental health costs according to paid claims
- Distribution of mental health professionals in Vermont
- Vermont Medicaid Access to care standards

4.1 WHAT IS "ACCESS"?

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

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

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

This report provides information about Vermonters' access to mental health services in relation to insurance status and geographic availability of mental health providers. Although Medicaid insurance coverage relates to socioeconomic status, information about most demographic statuses listed above was not immediately available to AHS.

4.2 ACCESS TO MENTAL HEALTH SERVICES- VERMONT IN PERSPECTIVE

Based on data from 2014 to 2016, Mental Health America ranked Vermont second best access to care in the United States[vi]. Vermont's high Access Ranking indicates how much access to mental health care exists within Vermont and also indicates that Vermont provides relatively more access to insurance and mental health treatment.

The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. The 9 measures that make up the Access Ranking include:

1. Adults with Any Mental Illness who Did Not Receive Treatment
2. Adults with Any Mental Illness Reporting Unmet Need
3. Adults with Any Mental Illness who are Uninsured
4. Adults with Disability who Could Not See a Doctor Due to Costs
5. Youth with Major Depressive Episode who Did Not Receive Mental Health Services
6. Youth with Severe Major Depressive Episode who Received Some Consistent Treatment
7. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
8. Students Identified with Emotional Disturbance for an Individualized Education Program
9. Mental Health Workforce Availability

Another recent national report graded Vermont as failing when assessed on the strength of mental health and substance use disorder parity statutes. The report was created by a consortium including the Kennedy-Satcher Center for Mental Health Equity and the Satcher Health Leadership Institute.

Vermont's Department of Financial Regulation analyzed the report and identified omission of several significant statues, regulations or rules that, had they been included would have resulted in a much higher grade. Given the errors in the report, we did not include its findings here. The correspondence regarding the errors is in Attachment F and G.

The two tables below inventory data from a variety of sources between 2011-2017 and show that while Vermonters have higher than national average rates of mental health needs and substance use, they are also accessing treatment at higher rates than national averages.

Data about prevalence	**National**	**Vermont**	**VT Trend (2011-15)**
Youth (12-17 years old) who report using marijuana[vii]	7.2%	10.9%	↘
Youth (12-17 years old) who report smoking[viii]	4.5%	6.2%	↘
Youth (12-17 years old) who report drinking[ix]	10.6%	13.2%	↘
Youth (12-17 years old) who were diagnosed with major depressive episodes in the past year[x]	11.9%	12.1%	↗
Youth (3-17 years old) who were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)[xi]	8.8%	9.6%	No data
Youth (3-17 years old) who were diagnosed with autism spectrum disorder (ASD) [xii]	2.8%	1.8%	No data
Persons (12+ years old) who report using heroin [xiii]	0.33%	0.77%	↗
Persons (12+ years old) diagnosed with alcohol use disorder[xiv]	6.1%	7%	→
Adults (18+ years old) who reported having suicidal thoughts in the past year[xv]	4.0%	4.6%	→
Adults (18+ years old) who were diagnosed with Serious Mental Illness (SMI) [xvi]	4.1%	4.9%	→

Data about treatment	**National**	**Vermont**	**VT Trend (2011-15)**
Infants (9-35 months old) who were screened for developmental disorders [xvii]	31.1%	37%	No data
Youth (12-17 years old) who utilized mental health care services for depression in the last year[xviii]	38.8%	55.6%	No data
Youth (0-17 years old) who report improved functioning as a result of DA/SSA treatment[xix]	71.6%	62.7%	No data

Youth (3-17 years old) who utilized mental health care for ADHD[xx]	44.8%	45.8%	No data
Youth (3-17 years old) who utilized mental health care for ASD[xxi]	57.1%	88.9%	No data
Youth with a medical home[xxii]	48.7%	60.1%	No data
Adults (18+ years old) who utilized mental health care services for any mental illness[xxiii]	42.9%	56.4%	No data
Adults (18+ years old) who report improved functioning as a result of DA/SSA treatment[xxiv]	71.8%	73.8%	No data
Adults (18+ years old) who have NOT seen a primary care physician in the past year[xxv]	34.0%	15.9%	No data

The Agency considers it probable that there is a causal relationship between identification of mental health need described in the table regarding prevalence and the data showing high rates of access to treatment as shown in the second table.

4.3 HOW VERMONTERS ACCESS HEALTH CARE

Ninety-seven percent of Vermonters have healthcare insurance, according to the latest Vermont Household Health Insurance Survey[i] (VHHIS). Fifty-three percent of those insured have private health insurance (through their employer, typically), while 22% have Medicaid and 19% Medicare. Three percent of Vermonters are insured through the military.

Among the insured, however, are the underinsured: more than a third (36%) of Vermonters under age 65 do not have the level of insurance necessary to protect them from financial stress if they become seriously ill or injured. In addition, there are the three percent, or 19,800 Vermonters with no insurance.

Not surprisingly, lack of insurance, or lack of sufficient insurance, is a barrier to accessing care for those without the private means to pay for it. For example, when considering mental health care, the VHHIS found that while 12% of Vermonters with insurance received mental health care in 2018, only two percent of uninsured Vermonters reported having accessed this type of care. This is of particular concern, given the research that indicates that there is a high rate of lack of insurance or underinsurance among people with mental illness. Nationally, data indicates that the percentage of those with mental illness who are uninsured is as high as 20%, as compared to 15% of the general population[xxvi].

Stigma regarding mental illness appears to continue to act as a barrier to getting mental health care as well.

Among Vermonters between the ages of 18 and 64, for example, the underinsured received general health care at similar rates to those who were fully insured. But fewer than one in five (15%) of those who were underinsured received mental health counseling in 2018.

"Generally, underinsured Vermonters ages 18-64 delay care at higher rates than those with adequate insurance," according to the VHHIS report. "Less than five percent of underinsured Vermonters 18-64 delayed care for … mental health care. However, those who are underinsured are statistically more likely than those who are not underinsured to delay [this type] of care."

And for those with no insurance, delaying mental health treatment was three times as likely as among the insured population (three percent vs. one percent).

The report further indicates that cost limits the amount of mental health care an individual is willing to seek. Only five percent of those with insurance paid more than $500 out of pocket for mental health care in 2018. For those without insurance, that percentage dropped to four percent. This parallels the average out-of-pocket expenditures reported by the VHHIS. The uninsured spent an average of $80 out-of-pocket for mental health care, while the insured were willing to spend, on average, $90.

For those who are underinsured, eight percent paid more than $500 out of pocket for mental health care, while only four percent of those fully insured paid more than amount for such care.

Among the more notable figures is the average amount of money paid out of pocket by underinsured Vermonters between the ages of 18 and 64 for mental health care. Those who are underinsured spent an average of $184 on mental health care last year. For those fully insured, that amount was $75.

4.4 MENTAL HEALTH COSTS ACCORDING TO PAID CLAIMS

Data provided in this section represents all claims in VHCURES for calendar year 2017 with a mental health diagnosis code. The report was run twice, once for claims where the Principal Diagnosis in the claim header was a mental health diagnosis code, and once where the mental health diagnosis code was listed anywhere in the claim, including principle diagnosis. The full set of mental health diagnosis codes considered is included for reference at Attachment E.

The VHCURES cost data were then combined with mental health costs paid through the Department of Mental Health that are not available in VHCURES, including payments made for Middlesex Therapeutic Community Residence and Vermont Psychiatric Care Hospital, and information about Medicaid Global Commitment Investments expenditures for mental health[xxvii].

Note on completeness- VHCURES only contains claims for Vermont residents for Medicare, Medicaid, and commercial submitters required to produce data (e.g. no Federal Employee Health Benefit Plans, military, uninsured). Since the self-funded commercial market is not required to submit claims to VHCURES, there is some data missing from this population.

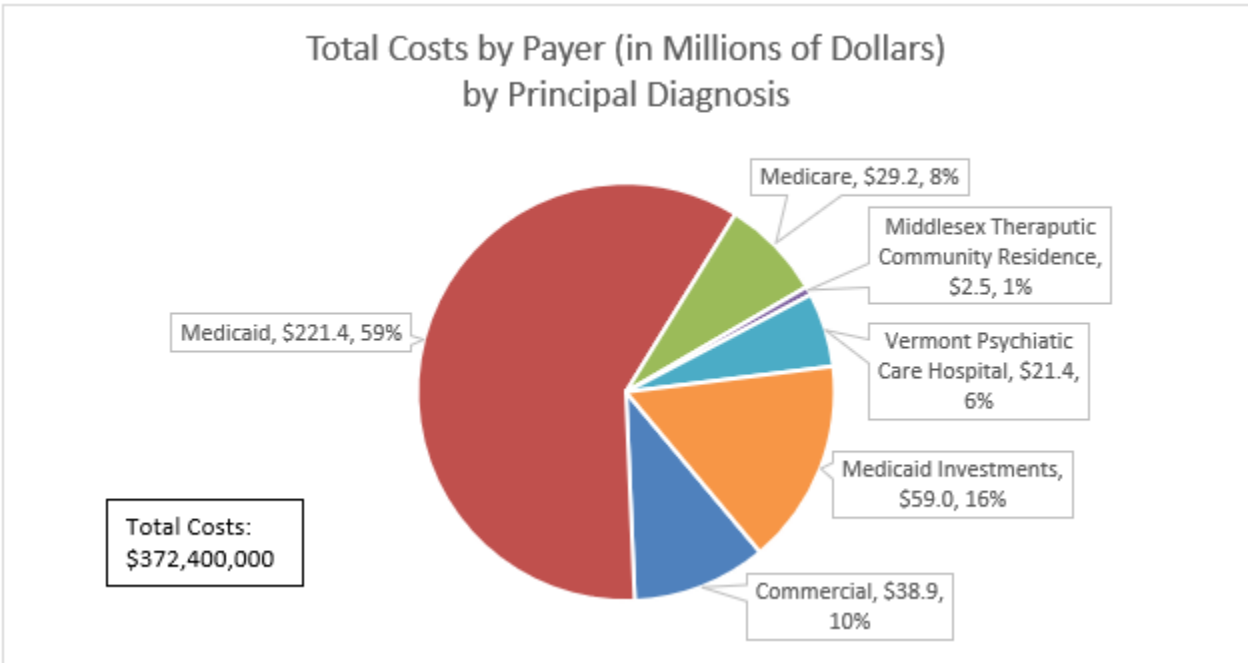
Costs are defined as the total allowed amount, including what providers are paid and what the member is responsible for. Excluded data from this set includes adjustments that can't be tied to an initial claim in the VHCURES database.

A commonly reference amount for total health care spending in 2016 is $6 Billion. The total healthcare spend of $3.8 Billion, referenced for context in the bullets below, is restricted to claims-based medical spending available in VHCURES and does not include approximately $2.2 Billion of additional health care spending which is not available through VHCURES.

According to the combined information from VHCURES and Vermont Department of Mental Health:

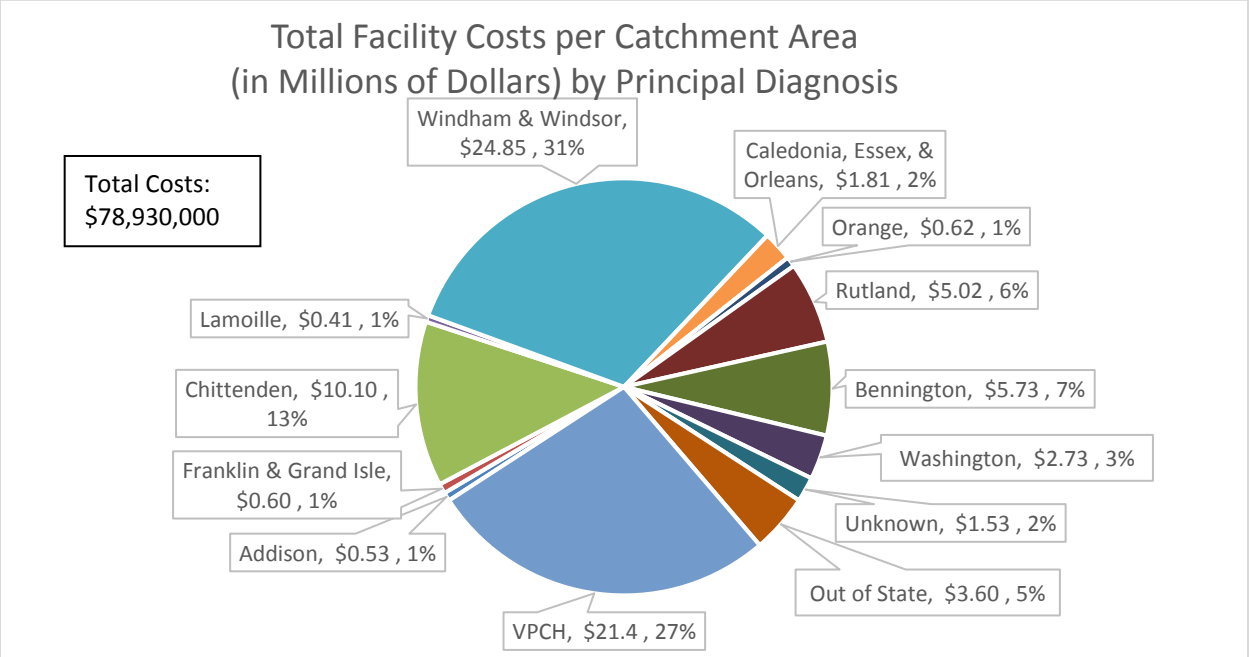
- In CY 2017, mental health spending on behalf of Vermont residents with a primary mental health diagnosis represents $372,400,000 of a total health care spend of $3.8B, or 9.8% of total health care costs.
- In CY 2017, mental health spending on behalf of Vermont residents with mental health diagnosis any place on the claim represents $854,200,000 of a total health care spend of $3.8B, or 22% of total health care costs.

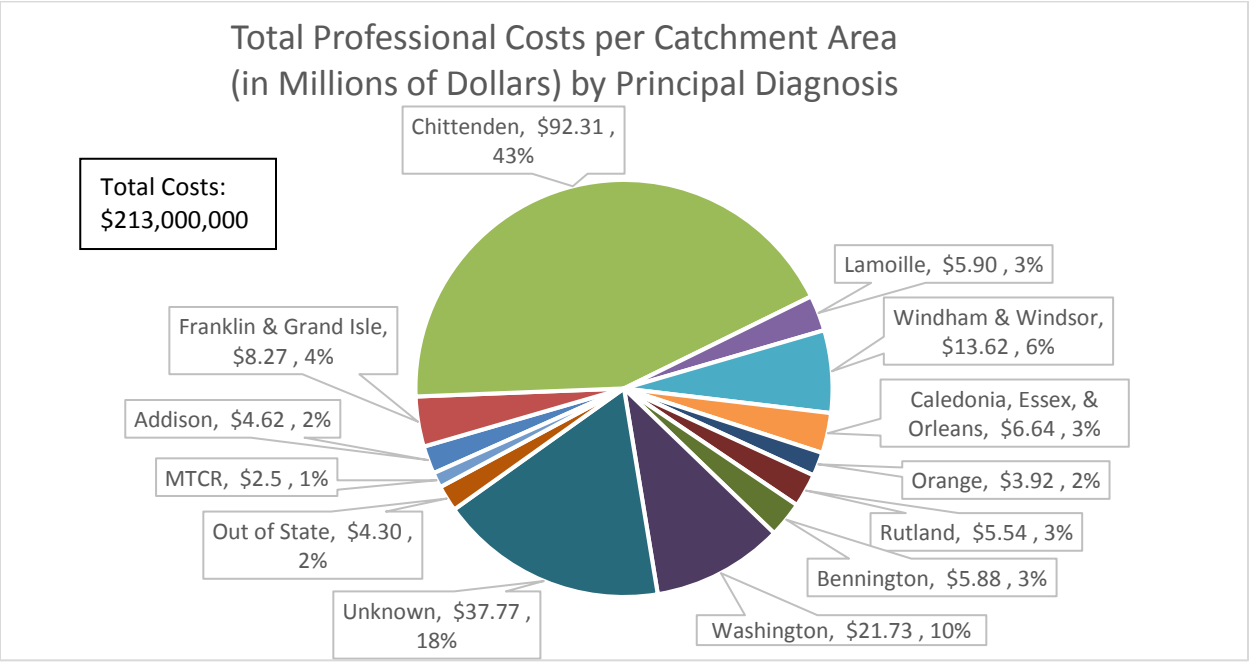
TOTAL MENTAL HEALTH COSTS BY PRINCIPLE DIAGNOSIS



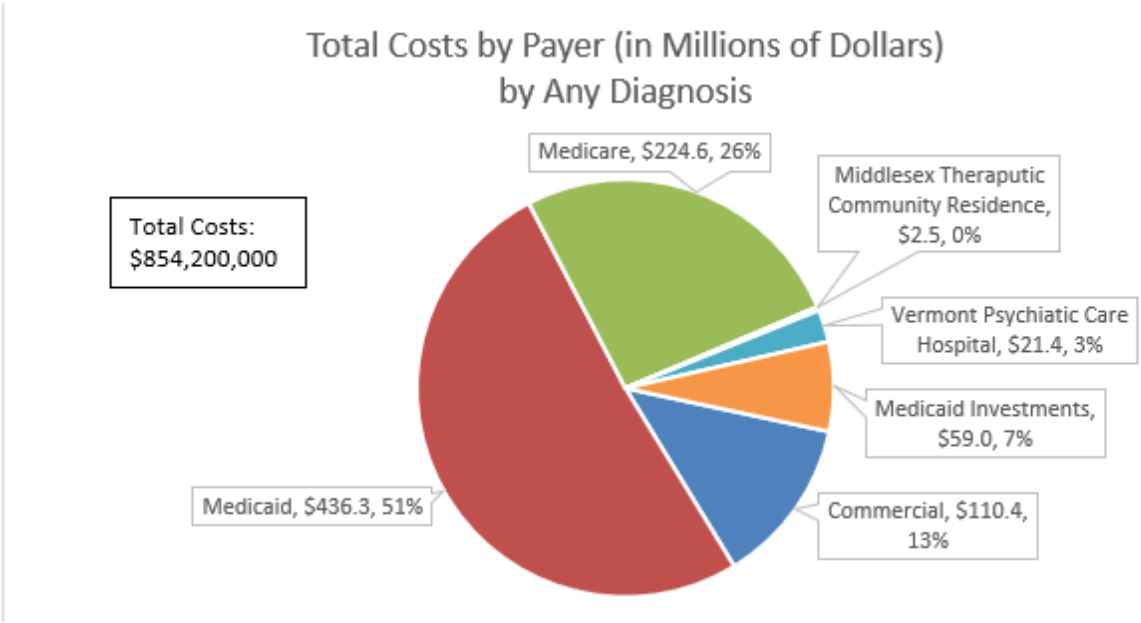
The two tables below break the Total Costs by payer into categories of facility and professional claims. Facility claims are generally defined as inpatient claims, but they may also include services provided by the facility on an outpatient basis. Professional claims are generally defined as outpatient claims.

The total costs of facility and professional breakouts do not equal the total costs by payer due to suppressed values required by the size of the data set.



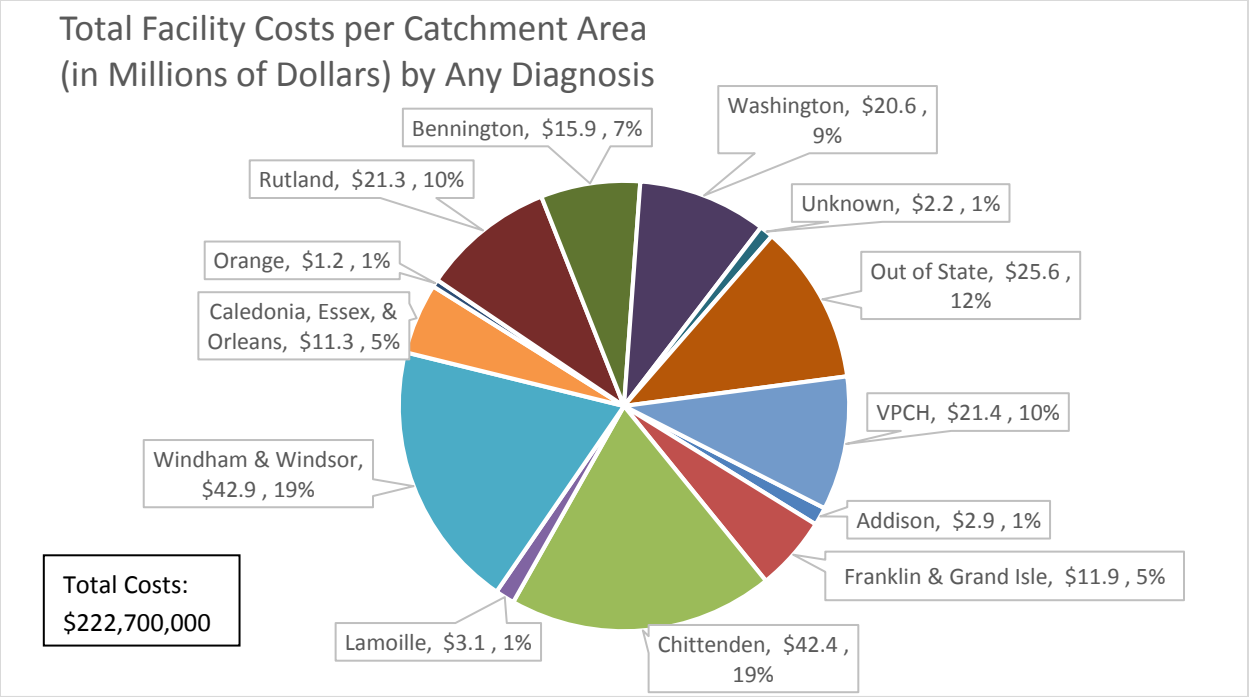


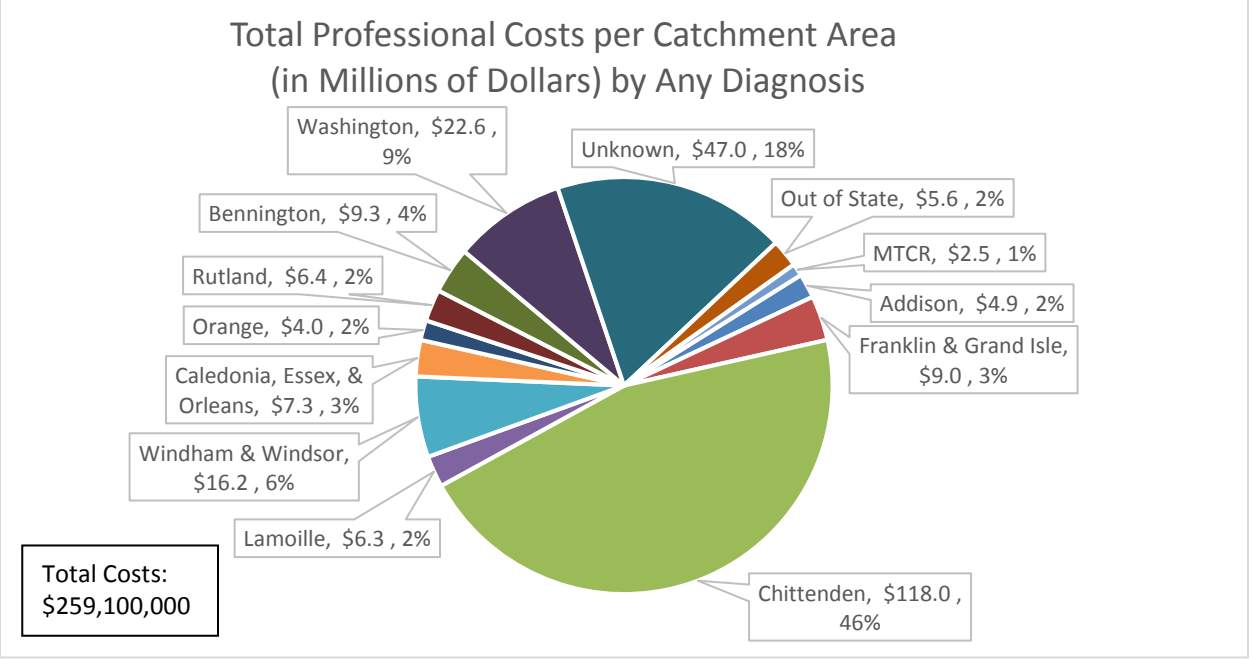
TOTAL MENTAL HEALTH COSTS BY MENTAL HEALTH DIAGNOSIS ANY PLACE ON CLAIM



The two tables below break the Total Costs by payer into categories of facility and professional claims. Facility claims are generally defined as inpatient claims, but they may also include services provided by the facility on an outpatient basis. Professional claims are generally defined as outpatient claims.

The total costs of facility and professional breakouts do not equal the total costs by payer due to suppressed values required by the size of the data set.





4.5 DISTRIBUTION OF MENTAL HEALTH PROFESSIONALS IN VERMONT

According to data provided by the Vermont Department of Health, regions vary on representation of the following health professionals[xxviii]:

- Mental health counselors (MH)
- Licensed clinical social workers (LICSW)
- Marriage and family therapists (MFT)
- Psychiatrists (Psy (MD))
- Psychologists (Psy)
- Physicians (Phys)
- Non-licensed psychotherapists (NLP)
- Alcohol and drug abuse counselors (ADAC)
- Advance practice registered nurses (APRN)
- Naturopaths (Nat)
- Pharmacists (Phm)

	MHC	LICSW	MFT	Psy (MD)	Psy	Phys	NLP	ADAC	APRN	Nat	Phm
Regions with a Designated Hospital											
Chittenden		+		+		+	+	+	+	+	+
Windham	+	+	+	+				+		+	
Washington	+		+	+			+				
Windsor		+	+					-			
Rutland	-										+
Regions without a Designated Hospital											
Addison							+			+	
Bennington					+			-			+
Lamoille	+		-					+			
Caledonia	+	-	-					+			
Orange							+				-
Orleans		-		-			-				
Franklin			-							-	
Essex	-		-	-		-	-	-	-	-	-
Grand Isle	-	-	-	-		-	-	-	-	-	-

Key:

+	Significantly more professionals of this type in this region
	Providers of this type in this region are within expected range
-	Significantly fewer professionals of this type in this region

For each profession, the VT Department of Health surveyed licensed professionals in each field. Significance was determined per each profession, for example for Mental Health Counselors, less than 30 FTEs per 100,000 population was considered below average, 30-90 FTEs per 100,000 population was average, and Greater than 90 FTEs per 100,000 population was above average. For Licensed Clinical Social Workers, the thresholds for significance were less than 35

FTEs were below average, 35-108 FTEs were average, and greater than 108 FTEs were above average per 100,000 population.

Summary of findings:

- Essex and Grand Isle Counties have fewer providers relative to their population than other regions. Of note, Essex and Grand Isle Counties have the smallest populations in the state.
- Washington, Chittenden, and Windham counties have more providers relative to their population than other areas, but these counties also have designated hospitals which cannot exist without added professionals to staff them. Chittenden also has the highest population of people in the state.
- Rutland and Windsor have about the same number of professionals as other counties relative to their population, even though they each have a designated hospital in their county[xxix].
- Franklin, Lamoille, Caledonia, Orange, Addison, Orleans, and Bennington have about the same number of health professionals as other regions in the state.

4.6 VERMONT MEDICAID ACCESS STANDARDS

Vermont Medicaid policies and practices regarding access to care are designed to ensure that the Medicaid provider network has a sufficient range and quantity of providers, is easily accessible to members, and complies with federal network adequacy requirements.

The most recent Access to Care Plan[xxx], published in 2016, describes that mental health is considered specialty care for which Vermont Medicaid expects members to be able to access care within 60 miles of their home. The statewide average miles traveled for SFY17 for mental health and substance use services was only 19 miles, and 93% of clients received services within 60 miles.[xxxi] The Access to Care Plan acknowledges that that some areas of Vermont—particularly more rural counties—may be above the access thresholds set forth in the report. On a statewide basis, it is expected that access thresholds are met by Vermont Medicaid.

4.7 SUMMARY

- In CY 2017, mental health spending on behalf of Vermont residents with a primary mental health diagnosis represents $372,400,000 of a total health care spend of $3.8B, or 9.8% of total health care costs.
- In CY 2017, mental health spending on behalf of Vermont residents with mental health diagnosis any place on the claim represents $854,200,000 of a total health care spend of $3.8B, or 22% of total health care costs.

- Compared to national averages, more people in the state of Vermont have mental health needs, but more are also using mental health services.
- Access in the state of Vermont meets federal Medicaid requirements, however, some areas of Vermont—particularly more rural counties—may have significantly fewer providers relative to their population than other regions.

5. ACCESS AND FLOW ACROSS THE SYSTEM OF CARE

5.1 EMERGENCY DEPARTMENTS

The Vermont Association of Hospitals and Health Systems' Hospital Community Assessment: Vermont's Mental Health System, January 2019 reviewed calendar years 2015 - 2017 for patients who were admitted and discharged from the emergency departments with a primary diagnosis of mental illness. Data from this review suggests that:

- The number of visits for patients with mental illness increased by a modest amount, while the length of stay increased at a much greater rate.
- Same-day discharges decreased while discharges longer than one day increased by 8.2%.
- Discharges longer than one day represented 34% of all mental health related ED visits.
- About 3% of visits accounted for approximately 40% of bed day utilization in its patient sample.
- More voluntary inpatient admissions contributed to more incidents of increased length of stay than anticipated.

The University of Vermont Health Network in its September 24, 2018 Strategic and Business Planning Analysis, used a planning assumption criteria of "admission within 8 hours of admission recommendation" for psychiatric care and used this criterion as a basis for its projected number of additional inpatient beds, citing a significant impact to current emergency department length of stay and timely access to inpatient psychiatric beds. The UVM Health Network planning analysis also assumes that there will be no reductions in statewide inpatient bed capacity from current levels and indicates consideration of forecasted growth in demand for the next 5-10 years.

Both of these assessments regarding delays in emergency rooms (ER) are supported by ProPublica's "ER Wait Watcher" that identifies the average wait times for each state in four areas: Wait time to see a doctor; time spent in (ER) before discharge; average time waiting for pain management; and for admissions, additional time spent in ER before room admission. Nationally, these indicators suggest that all states can do better in the areas of timely patient

access to health care services and disposition determinations. Vermont was ranked between 32nd and 39th in each of the four areas as of February 2018.

In early 2018, the former Executive Director of Vermont Psychiatric Survivors (VPS) produced an Addendum to Report to the Legislature on the Implementation of Act 82 – Section 5: Involuntary Treatment and Medication Review that cited prolonged wait times for mental health patients. A comparison with non-mental health admissions suggested the persons waiting for inpatient mental health care had longer lengths of stay, sometimes more than three times longer than persons presenting for other treatment needs. This purported finding of a small survey size should still be considered as a potential access and parity issue with other healthcare services when an individual is in acute need.

There are longer wait times for individuals seeking psychiatric care than emergent medical care and the Agency of Human Services has spent significant time with stakeholders discussing access to inpatient level of care for mental health services. Wait times in emergency department rooms have been identified and remain a significant access to care concern and an unresolved issue for Vermonters of all ages. At times, neither emergency room visits nor inpatient psychiatric admission are indicated, but discharge is delayed for other reasons. It should not be ignored that underscoring the ER length of stays referenced in the VPS addendum, are social determinants such as homelessness and lack of suitable alternatives in times of crisis.

ROLE OF NON-DESIGNATED HOSPITALS

The Agency of Human Services considers that the capacity of an emergency department to triage and stabilize persons presenting with any health care need should routinely include acute mental health treatment. If a gap does exist at this door to healthcare access, expanded capacity at non-designated hospitals could be developed to support appropriate care and treatment services closer to home. While all current capacity for inpatient psychiatric care exists at designated hospitals, there is a remaining inpatient system and/or beds that could be developed and utilized to meet local needs.

Voluntary mental health admissions occur at only a few select hospitals versus routine statewide healthcare access and is another access gap area for possible development. Just as other customary hospital health care services are available to any individual presenting to an ED for triage, stabilization, and transfer to specialized care if needed, involuntary inpatient psychiatric care services should be comparable to other specialized, physical inpatient services paralleling such specializations as cardiac care, dialysis, and physiatry (acute rehabilitation) services.

ROLE OF COMMUNITY-BASED CARE

The absence or limitations of a local community to respond to individual needs when inpatient care isn't necessary compounds the difficulty in transfer from hospitals to more appropriate resources or levels of care. Current options such as MyPad housing in Chittenden County, the Soteria and Alyssum peer-supported crisis and transitional residential programs, crisis beds, and current Intensive and Secure Residential Recovery programs provide more individually focused levels of care options for community re-entry and recovery; this array of services, however, is not provided in every region. Despite the existing services array that has been enhanced since 2012, there is a continuing need and opportunity to provide increased community capacity to offset unnecessary ER wait times or inpatient admissions.

The Department continues to plan for the replacement of the current Secure Residential Recovery (SRR) program, the 7-bed temporary facility in Middlesex. Prior activities have included reports on the populations to be served and needs for the program, a larger bed capacity given referrals to the program for initial step-down aftercare services, a *Request for Proposals* to assess interest among community stakeholders in developing and/or operating a permanent secure recovery program, and planning across multiple AHS departments to assess how the mental health needs of populations being served by other departments might be addressed by future permanent program/s. Allocated funding is still required to develop a such a replacement plan.

5.2 CHILDREN, YOUTH AND FAMILIES

HOSPITAL DIVERSION

In recognition that the only crisis stabilization programming for children and youth was in the northern part of the state, the Department of Mental Health and Department of Vermont Health Access recently collaborated to expand the hospital diversion programming for children and youth in the southern region. In April 2018, the Northeastern Family Institute, in collaboration with Health Care and Rehabilitation Services (HCRS), opened a 6-bed Hospital Diversion Program in Brattleboro to provide short-term psychiatric crisis stabilization serving children and youth ages 10 to 18 years old. The program opened with capacity for two youth and has increased bed capacity as staffing capacity was expanded and staff were fully trained.

RESIDENTIAL SERVICES

DMH has an ongoing pressure in PNMI (private non-medical institutions – residential treatment for children). Due to many factors, but primarily increased family challenges (including adverse family experiences such as opioid use, parental mental health, and difficulty managing a child or

youth's challenging behaviors), decreased access to community-based services due to staffing challenges, and decreased risk tolerance in communities due to threats of violence, the demand for residential has increased.

DMH has also seen an increase in the acuity of clinical need in children and their families. When the community-based array of clinical and support services are not able to adequately address clinical needs, children are referred for residential treatment. The children's clinical care management team at the Department of Mental Health uses clear procedures and guidelines with clinical criteria to determine medical necessity for residential treatment and provides technical assistance with expecting schools, communities, families and Designated Agencies (DAs) to work together to explore options to meet the needs of the child in the community.

There has also been a significant reduction in the number of licensed residential beds available to children/youth in Vermont since 2010. This reduction of in-state capacity, as well as the clinical need of individual children and youth who require specialized treatment that is not available in Vermont, means that some children and youth are referred out-of-state for residential treatment.

In order to fulfill the federal Medicaid mandate for early and periodic screening, diagnosis and treatment, which requires states to provide medically necessary services to address or ameliorate a child or youth's identified mental health needs, the Department of Mental Health funds necessary residential treatment for children in programs in-state and out-of-state. While the Department for Children and Families has seen a reduction in their residential utilization rates, the Department of Mental Health's experience is that children and their families still have very high needs that are addressed through the mental health system.

MOBILE RESPONSE AND SUPPORT SERVICES

The Agency of Human Services is working across multiple Departments to explore Mobile Response and Support Services (MRSS) for the child, youth and family system of care. Representatives from the Agency, along with representatives from a family advocate organization and a Designated Agency, participated in a state-to-state peer learning and technical assistance event in December 2018 to hear about the experience of other states who have implemented MRSS.

In the National Association of State Mental Health Program Directors report, *Making the Case for a Comprehensive Children's Crisis Continuum of Care* (2018), it notes that "[i]n 2013 the Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for

Medicaid and CHIP Services (CMCS) recognized Mobile Crisis Response and Stabilization Services as "not only clinically effective but cost effective as well.""

MRSS differs from traditional crisis services in that it's more upstream. A mobile face-to-face response is provided to a family-defined crisis to provide support and intervention earlier for a child or youth and family before emotional and behavioral difficulties escalate. An MRSS response has been shown in other states to "avert unnecessary" higher levels of care in settings such as emergency departments, inpatient psychiatric care, or residential treatment (NASMHPD 2018).

5.3 INPATIENT ACCESS

During FY 2018, involuntary inpatient lengths of stays were relatively unchanged. While Vermont's readmission trend rates continue to consistently be below the national readmission rate trends, more adults were being referred to involuntary inpatient care than in previous years. In FY 2017, the most recent National Outcomes Measures data available from the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System reports that Vermont's state hospital utilization per 1,000 people was 0.14 compared to national utilization of 0.40. Likewise, data for other psychiatric hospitalization utilization per 1,000 in Vermont is showing a slowly progressing upward trend since 2012.

The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. More information on hospital bed utilization, length of stay, and overall adult system bed capacity may be found in the 2019 Act 79 Report.

ADULTS

When hospitalization is indicated, Vermont has 201 adult inpatient psychiatric care beds (also described in section 2.4) to serve both voluntary and involuntary treatment needs. These inpatient beds are in five designated regional hospitals (BR, UVMC, CVMC, RRMC, and WC) and one publicly funded state hospital (VPCH). Nine regional hospitals have no psychiatric inpatient capacity. Level 1 Involuntary care is provided at specific units across three hospitals for a total of 45 beds. These beds require admission and concurrent review by the Department of Mental Health utilization review and care managers. These beds are located at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Vermont Psychiatric Care Hospital (25 beds). The remaining 156 beds are used for non-level 1 involuntary and voluntary inpatient stays. Approximately 80% of these bed days were used for voluntary hospitalization admissions and all operate at steadily high occupancy rates. Overall, adult inpatient bed occupancy has

decreased slightly in 2018 but does not suggest a decreasing need for inpatient capacity given the small percentage fluctuation from prior years and ongoing bed occupancy rates.

CHILDREN

Vermont has one hospital, the Brattleboro Retreat, which provides inpatient psychiatric programming for children ages 5-12 (12 beds) and adolescents ages 13-17 (18 beds). This restricts the access for children or youth with involuntary treatment needs. Children or youth who have voluntary inpatient needs may be able to access a hospital diversion program or an inpatient setting in neighboring states, such as CVPH. Concurrent review of children's inpatient beds is conducted by the Department of Vermont Health Access.

5.4 ASSESSMENT AND DEVELOPMENT OF INPATIENT CAPACITY

Act 190 of 2018 and the Big Bill (Act 11 of the 2018 Special Session) provided $4.5M in Capital Funds and $1.0M from the Tobacco Litigation Settlement Fund to the Agency of Human Services through the Department of Buildings and General Services to increase the state's Level I inpatient bed capacity at the Brattleboro Retreat. The funding provides for an additional 12 beds to increase statewide capacity by January 2020 while additional inpatient beds are further explored with the University of Vermont Health Network. A concept proposal was introduced late in the legislative session by the UVM Health Network recommending the development of additional inpatient beds on the campus of the Central Vermont Medical Center. Development of the concept proposal is ongoing and likely will be part of a longer-term inpatient bed replacement plan.

The Treatment Advocacy Center (TAC) reported in 2016 that a minimum of 50 beds per 100,000 people was the minimum number of public psychiatric beds to meet the treatment needs of individuals with severe mental illness.

Public Psychiatric Beds in Vermont

A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Like every state, Vermont fails to meet this minimum standard.

Beds in 2016	Beds in 2010	Beds lost or gained	Beds per 100,000 people	Census of forensic patients	% of all beds occupied forensic	State ranking in beds per capita
25	52	-27	4.0	10	40.0	41

(SOURCE: GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELMINATING STATE PSYCHIATRIC BEDS, Treatment Advocacy Center, 2016)

While the TAC report focuses on public psychiatric bed reductions, the bed formula for resource needs, whether it is specifically hospital beds or some other treatment environment option, is still worthy of consideration. The TAC formula suggests that Vermont's psychiatric inpatient bed capacity should be in the range of 300 inpatients beds which is higher than projected future bed capacity, even with the current concept development work undertaken by the University of Vermont Health Network in its September 24, 2018 Strategic and Business Planning Analysis.

5.5 PHASE DOWN OF MEDICAID COVERAGE OF INSTITUTIONS OF MENTAL DISEASE

In direct opposition to plans for increased inpatient capacity is the federal requirement through the State's Global Commitment to Health Waiver that federal financial participation (FFP) for Institutions of Mental Disease (IMD) must phase down over six years starting in CY 2020 through CY 2026. The Agency of Human Services submitted its required proposal of a phase down plan for receipt of FFP in December 2018[xxxii] and in that submission makes it clear that Vermont Medicaid is opposed to this requirement and its impacts on the mental health system of care, which has just under 60% of inpatient beds located in IMDs. The report describes that IMD settings are an integral part of the overall mental health treatment continuum that supports integrated care in the most clinically appropriate, least restrictive setting possible and that there are significant negative impacts of any phase down alternative. The Agency concludes that loss of IMDs would negatively impact an already stressed system with increased demand and respectfully requests that the administration reconsider the phase-down requirement in light of recent changes in the federal stance toward institutions of mental disease.

If there is no reduction of existing inpatient bed capacity, temporary capacity being developed at Brattleboro Retreat, and future projected bed development in the UVM Health Network plan should address inpatient demand over time. These additional resources also place demands on community-based providers to provide complimentary capacity to transition individuals into aftercare supports and services and must be timely to maintain system flow of individuals who do need the most acute care services.

Consistent with a collaborative network approach between hospitals and community-based programs, the gap in bed capacity could potentially be addressed through more robust investments in an expansion of the array of residential support models in the community. Expansion of step-down regional residential support programs could be a cost-effective, less restrictive option for individuals who are ready for transition from inpatient beds to some form of community residential treatment and support. The pairing of both some growth in inpatient capacity and investments in community-based services provides capacity for local communities

to timely receive back individuals who do not need hospitalization. Such planning would address the resource gap identified in the TAC report and cost avoid overdevelopment of specialized, higher cost care beds.

5.6 ACCESS – ADDRESSING DELAYS

In recent months, DMH held two meetings with designated agencies, designated hospitals, DAIL, and intensive residential programs to address the issue of difficult discharge planning. These meetings, which continue, are designed to bring all providers together to discuss the complex needs of some of the Vermonters we serve and to increase the flow that must occur to assist with decreasing emergency room wait times.

The Care Management team regularly visits all the psychiatric hospitals as well as designated hospitals. This is an effort to continue to enhance relationships and open lines of communication as well as discuss situations/barriers that DMH Care Management should be aware of. The Care Management Director regularly attends the VAHHS Designated Hospital meeting to represent the Department of Mental Health. This is an opportunity to explore common patterns and discuss barriers across the system of care.

More recently, the Care Management Director, Mental Health Director and representatives from the Department of Aging and Independent Living have begun attending the VAHHS Emergency Department Director's meeting to discuss various wait times, barriers to finding an inpatient bed as well as to ensure everyone understands the proper use of Sheriffs in Emergency Rooms.

In addition to these on-going efforts, the Qualified Mental Health Provider (QMHP) training has been redesigned to enhance the education and training of providers in the field.

5.7 ACCESS – STAKEHOLDER FEEDBACK

This section presents stakeholder feedback received by the Department of Mental Health on the topic of access to care. The process for collecting stakeholder feedback is described at section 3.1.

- Stakeholders across Adult Mental Health (AMH) and Children, Youth, and Family Services (CYFS) report that generally, core services are available to those in need in a reasonable amount of time.
- At the same time, stakeholders from across the treatment spectrum see room for improvement in capacity and staff retention at DAs/SSAs, supported through funding for salary parity and professional development opportunities. Stakeholders would like increased access to services and decreased wait times across the system of care. They would also like to see an increase in capacity of diversion alternatives beyond and including crisis services. Other services AMH stakeholders see a need for include

increased capacity and access which includes housing at all levels (long term secure residential, supervised housing, supported housing, group homes, independent apartments), peer services, and psychiatry. CYFS stakeholders share the desire for increased access to psychiatry services.

- In the Department of Mental Health's Annual Perception of Care Surveys of Adults in Community Rehabilitation and Treatment programs, participants are asked to rate their region according to access. Respondents in the most recent (2016) survey were 81% positive about access to services statewide. Stakeholders for AMH and CYFS also express the need for more services specific to vulnerable populations, including but not limited to LGBTQIA+, elders, homeless, living with substance use challenges, or living in poverty.

5.8 SUMMARY

- Stakeholders would like more access to mental health services in Vermont but are satisfied with service quality once accessed.
- Emergency department length of stay increased significantly over the past year, and approximately three percent of visits accounted for approximately 40% of bed day utilization.
- More voluntary inpatient admissions contributed to more incidents of increased length of stay than anticipated.
- Emergency department services should routinely include acute mental health treatment. If needed, expanded capacity at non-designated hospitals could be developed to support appropriate care and treatment services closer to home. Services and beds in the current inpatient system could also be developed to meet local needs.
- A broader range of community-based services must be developed statewide.
- Child and youth services have been expanded through a new 6-bed hospital diversion program; DMH is exploring development of a mobile face-to-face response program that provides support and intervention earlier for a child/youth and family before emotional and behavioral difficulties escalate.
- Vermont has 201 adult inpatient psychiatric care beds to serve both voluntary and involuntary treatment needs. As many as 35 new beds are being planned by the University of Vermont Medical Center. Under federal law, however, VPCH could lose 9 beds by 2026 in order to remain eligible for Medicaid reimbursement.
- DMH initiated several new collaborative efforts to address delays in access and flow.

6. QUALITY

This section of the report seeks to respond to the first two requirements of the evaluation as regards quality.

(1) whether the current structure is succeeding in serving Vermonters with mental health needs and meeting the goals … quality…;
(2) whether quality … [of] mental health services [is] equitable throughout Vermont;

The section is organized to present information about quality as follows:

- Definition of quality
- A review of quality oversight and findings
- Equity of quality and mental health services
- Stakeholder feedback on quality

6.1 WHAT IS "QUALITY"?

Quality is a measure of the ability of programs and services to achieve desired outcomes through the provision of services and supports that are deemed clinically appropriate. Measuring quality is integral to the delivery of services for all participants in the mental health system.

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

Within the Agency of Human Services, the Department of Mental Health uses the following Quality Domain Measures for assessing the quality of Designated and Specialized Services Agencies: Access, Practice Patterns, Outcomes/Results of Treatment, and Administration of fully functional agencies providing care.

When there is a focus on quality, the mental health system of care benefits in many ways. Quality ensures that resources are used properly, which reduces waste and may result in both time and monetary savings. Quality in services promotes the use of evidence-based practices which encourages use of the most relevant and updated interventions, with the goal of improving the lives of people engaging in services. Additionally, focusing on quality within the system of care can lead to the identification and removal of barriers, create a more effective

approach to service delivery, and produce a system that encourages transparency and inclusion with the ultimate goal of improving the lives of the people it serves.

The World Health Organization (WHO) Mental Health Policy and Service Guidance Package[xxxiii] recommends that the following steps be taken to assess quality in mental health programming:

1. Align policy for quality improvement through consultation, partnerships, legislation, funding
   and planning.
2. Design a standards document.
3. Establish accreditation procedures.
4. Monitor the mental health service by using the quality mechanisms.
5. Integrate quality improvement into the ongoing management and delivery of services.
6. Consider systematic reform for the improvement of services.
7. Review the quality mechanisms.

Through the creation and utilization of the *Administrative Rules on Agency Designation*, the Department of Mental Health incorporates and enacts each of the above steps to ensure that the quality of the services provided have a standard to be evaluated by and that quality reviews are routinely conducted within Vermont's designated agency system.

6.2 RESULTS BASED ACCOUNTABILITY

As part of the Agency of Human Services, the Department of Mental Health uses the Results Based Accountability (RBA) framework to evaluate the performance of programs and initiatives. RBA is a framework that helps programs improve the lives of children, families, and communities and their performance because RBA:

- gets from talk to action quickly;
- is a simple, common sense process that everyone can understand;
- helps groups to surface and challenge assumptions that can be barriers to innovation;
- builds collaboration and consensus; and
- uses data and transparency to ensure accountability for both the well-being of people and the performance of programs

There are two types of accountability in RBA:

> *Population accountability* is focused on the health and well-being related to entire communities, cities, counties, states, nations. It is talked about in terms of Outcomes and quantified through population-level Indicators. It is important to note that no single program, state agency, provider, or strategy can be accountable for population-level

Outcomes or Indicators. Turning the curve at the population level requires the work of many partners and many programs all working toward a common outcome.

Performance Accountability is responsible for the health and well-being related to clients enrolled or served by specific strategies or programs. It is talked about in terms of Programs or Strategies and quantified through program-level Performance Measures.

The Department of Mental Health includes performance measure requirements in Designated Agency Master Agreements, which require Quantity, Quality, and Impact metrics be recorded for the programs serving the community. Agencies report on these performance measures quarterly, or annually, depending on the measure, and the information is monitored for quality improvement purposes.

New in calendar year 2019 as a part of Mental Health Payment Reform, there are performance measures selected as a part of Value-Based Payment built around an RBA framework. They include measures generated in through a collaborative engagement with community mental health partners and serve to provide a standardized and transparent way to ensure accountability to quality outcomes across agencies. The Department of Mental Health has established a *Mental Health Payment Reform Scoring and Metrics Advisory Committee* to make recommendations on the development of new performance measures and the establishment of performance targets. The committee consists of 14 members, with equal representation from the State and provider networks. The value-based payment model is expected to reach maturity in its fifth year and the performance measures and targets are expected to evolve over time as program priorities shift and as necessary to support continuous quality improvement.

RBA CLEAR IMPACT SCORECARDS

The Department of Mental Health has several RBA scorecards[xxxiv] containing data and performance measures related to our programs and our system of care. We work toward the outcome that all Vermonters are healthy and we are one of many partners working to reduce the suicide rate in Vermont and increase the availability of mental health treatment (both indicators).

How we use RBA to guide Performance and Reporting

- Creation of a “VPCH Outcomes” scorecard to meet legislative reporting requirements
- Creation of a “DMH Scorecard” using the RBA scorecard reporting tool
- Migration of the “DMH Snapshot” and the “DMH continued reporting” report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the AHS Community profiles

6.3 INPATIENT QUALITY- ALL HOSPITALS

The Commissioner of Mental Health (Commissioner) is responsible for supervising the operations of hospitals that provide inpatient care for individuals with mental illness (*18 V.S.A. § 7401).* The Commissioner oversees the provision of care by designating hospitals and thereby ensuring that standards of care are established and maintained. Designation is the process by which the Commissioner establishes that a facility has met the standards of care for patients requiring hospitalization. Hospitals that are designated may admit patients that are under the care and custody of the Commissioner of Mental Health. The requirements are generally related to voluntary and involuntary patient care, including; patient rights; treatment provisions; hospital staffing; quality measures and outcomes; quality assurance and performance improvement; and, discharge planning.

Department of Mental Health requirements must be met for a hospital to become designated or re-designated. It is the Designated Hospital's responsibility to provide the Department of Mental Health with copies of specific documentation demonstrating compliance with each requirement. The Commissioner requires re-designation of Designated Hospitals every two years. To enable adequate oversight by the Department, Departmental staff arrange for a visit in advance of the designation expiration date. This visit includes interviews with key staff, a review of outcomes, and a review of policies and procedures. A written decision letter and feedback is provided to the Designated Hospital following the visit. The review may require the Designated Hospital to address any missing information or provide a corrective action plan.

Hospital Designation Status

HOSPITAL	DESIGNATION PERIOD	DESIGNATION TO PROVIDE	PLAN OF CORRECTION (POC)
Springfield Hospital/Windham Center	2017-2019	Inpatient, Electroconvulsive Therapy (ECT)	No
Rutland Regional Medical Center	2017-2019	Inpatient	No
Brattleboro Retreat	2017-2019	Inpatient	No
Veterans Administration Medical Center	2017-2019	Inpatient	Yes, POC provided & being implemented.
Vermont Psychiatric Hospital	2017-2019	Inpatient	No
Central Vermont Medical Center	2017-2019	Inpatient, ECT	No
University of Vermont Medical Center	2017-2019	Inpatient, ECT	No

Hospital Complaint Investigations

The Vermont Department of Disabilities, Aging, and Independent Living Division of Licensing and Protection is tasked with unannounced on-site investigation of reports that hospitals are not in compliance with federal health and safety regulations. The following tables show data from all complaints investigated in 2018[xxxv]. The first table relates to non-designated hospitals and the second table relates to designated hospitals. According to the Vermont Department of Disabilities, Aging, and Independent Living Division of Licensing and Protection, the statewide totals of federal hospital complaint investigations conducted were similar for FY 2017 and FY 2018.

Hospitals Not Designated for Mental Health Services			
Hospital	Number of complaint investigation in 2018	Investigations where violations were substantiated. Plan of Correction was developed	Percent of complaint investigations with substantiated violations
Northeastern Vermont Regional Hospital	5	5	100%
Northwestern Medical Center	4	1	25%
Copley Hospital	3	3	100%
Porter Hospital	2	1	50%
Gifford Memorial Hospital	2	1	50%
Mount Ascutney Hospital	2	1	50%
Southwestern VT Medical Center	1	0	0%
Grace Cottage Hospital	0	n/a	n/a
North Country Hospital	0	n/a	n/a
Total	19	12	63%

Designated Hospitals			
Hospital	Number of complaint investigations in 2018	Investigations where violations were substantiated. Plan of Correction was developed	Percent of complaint investigations with substantiated violations
Brattleboro Retreat	4	2	50%
University of Vermont Medical Center	4	2	50%
Windham Center at Springfield Hospital	3	1	33%
Rutland Regional Medical Center	2	0	0%
Central Vermont Medical Center	1	0	0%
Vermont Psychiatric Care Hospital	1	1	100%
Veterans Administration	DAIL does not have authority to review	n/a	n/a
Total	15	6	40%

6.4 QUALITY REVIEW OF DESIGNATED AND SPECIALIZED SERVICES AGENCIES

Compliance and quality oversight of the DA/SSAs related to designation runs on a four-year cycle and consists of three separate oversight processes

1. Minimum Standards Chart Review
2. Agency Review
3. Designation

Each quality oversight process assesses the agencies on a specific set of standards informed by state and federal requirements.

1. **Minimum Standards Chart Reviews** are conducted at each DA/SSA during the four-year cycle. Criteria used to create the review standards are based on state and federal regulations and laws. Chart reviews examine 33 different criteria in seven different sections for adults and 61 criteria over 11 sections for children/youth to assess the agency's ability to meet the standard of care and provide quality services. Agencies are given an overall score for each standard, section, and overall quality. If a section falls

below a determined threshold, the agency is required to complete a corrective action plan to come into compliance. The corrective action plan must be submitted to the Department of Mental Health (DMH) for approval and completed within 180 days of the findings.

2. Additionally, DMH completes **Agency Reviews** prior to designation, which affords the department a more in-depth programmatic review and offers the agency an opportunity to correct areas that the department anticipates being potential issues prior to designation. DMH analyzes licensure, staffing ratios, use of evidence-based practices, SWOT analysis, utilization review, internal assessment of quality, policies, trainings, and use of standardized tools. DMH also surveys agency staff, community stakeholders, and the local program standing committee to assess local opinions about the quality of care that the agency is providing.
3. Lastly, **Designation** completes the quality and compliance process in the four-year cycle. For each population served by the Department of Mental Health, the Commissioner designates one agency in each geographic area of the state to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DMH, the goals of Vermont for its citizens, the goals of the citizens themselves, and other policies, plans, regulations, and laws.

   The designation process is the most intensive of the three processes and involves a review of more than 100 standards of varying weights across 16 distinct sections. A site review is conducted at each agency undergoing re-designation so that DMH staff can interview the agency board, senior leadership, staff, the local program standing committee, stakeholders, who include clients receiving services. The department also solicits public comment and incorporates the feedback into the findings. If areas are found to be out of compliance, the agency is required to complete a corrective action plan that the department must approve. Unless extenuating circumstances exist, agencies must come into compliance within 180 days.

DESIGNATED AGENCY AND SPECIALIZED SERVICES AGENCY DESIGNATION STATUS

Agency redesignation (2016 - 2020)			
DA/SSA	Designation Time Frame	Corrective Action Plan	Status of **Current** Designation
Lamoille County Mental Health Services	5/25/18-5/25/22	Yes	Re-designated with Minor Deficiencies
Northeast Kingdom Human Services	7/25/18-7/25/22	Yes	Re-designated with Minor Deficiencies

Healthcare and Rehabilitation Services	10/19/18-10/19/22	Yes	Re-designated with Minor Deficiencies
Currently in the process of redesignation…			
DA/SSA	Designation Time Frame	Corrective Action Plan **Previous** Designation	Status of **Previous** Designation
Washington County Mental Health Services	Pending, expires 1/23/19	Yes	Re-designated with Minor Deficiencies
Northwestern Counseling and Support Services	Pending, expires 4/29/19	Yes	Re-designation with Minor deficiencies
Rutland Mental Health Services	Pending, expires 7/28/19	Yes RMHS had 180 days to work with DMH to correct deficiencies and avoid de-designation, which they completed	Provisional Redesignation with Intent to De-designate, ***Resolved***
Designation findings from previous cycle (2012-2016)			
Clara Martin Center	9/25/15-9/25/19	Yes	Re-designated with minor deficiencies
Howard Center	1/26/16-1/26/20	No	Re-designated —No Further Action Required
Northeastern Family Institute (children only)	3/27/16-3/27/20	Yes	Re-designated with Minor Deficiencies
United Counseling Service	4/29/16-4/29/20	Yes	Re-designated with Minor Deficiencies
Counseling Services of Addison County	7/29/16-7/29/20	Yes	Re-designated with Minor Deficiencies
Pathways Vermont (adult only)	10/3/16-10/3/20	Yes	Designate (initial designation)

6.5 QUALITY – MEDICAID OVERSIGHT OF ALL ENROLLED MENTAL HEALTH PROVIDERS

The Agency of Human Services, Department of Vermont Health Access Quality Unit maintains the Vermont Medicaid Quality Plan and Work Plan, that:

- Coordinates quality initiatives throughout DVHA in collaboration with AHS partners, including formal performance improvement projects as required by the Global Commitment to Health Waiver
- Coordinates the production of standard performance measure sets including *Global Commitment to Health* measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS Adult and Children's Core Quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures

6.6 QUALITY AND UTILIZATION REVIEW

The purpose of Utilization Review and Case Management is to monitor episodes in services to prevent unnecessary treatment, duplication of services, to shorten Length of Stay (LOS) when appropriate to do so, and to uncover opportunities to maximize greater outcomes. Utilization Review (UR) also known as Utilization Management is the process by which the plan, payor, or UR firm determine which services are medically appropriate and cost effective

There are three types of utilization review: prospective, concurrent and retrospective. Prospective review is review or authorization for services prior to such services being rendered. Concurrent review is review or authorization for procedures or services during the time such services are being rendered. An example of concurrent review is when a clinician calls a Managed Care Organization (MCO) and requests an initial length of stay (LOS) for a patient and then after the patient has been admitted into a residential program, the clinician calls the MCO and explains that due to extenuating circumstances the client needs to stay for a longer time and the clinician requests an extended length of stay. Retrospective review is review of services after they have been rendered, typically using client charts.

Within the Department of Mental Health, a care manager is assigned to conduct outreach, review, and systemic coordination with treatment providers on a regular basis. The DMH care manager responsibilities include being knowledgeable about the responsibilities and treatment services of the local treatment team members, ensuring a coordinated system level review of treatment progress for individuals being served, and facilitating coordination of providers locally when barriers exist that require the assistance of DMH. As such, there are expectations for collaboration between DMH and the DA personnel involved to ensure services, support, and local response are timely and effective in addressing system challenges and meeting individual needs.

The DMH care manager is in contact with designated DA personnel to compile information regarding services, individual engagement and progress, needs, and any issues of concern or barriers to treatment for individuals. Additionally, the care manager assigned to this population

can be a resource for securing technical assistance or proactive, early identification by a local DA of individuals in the community who may need mental health services or supports.

The DVHA Quality unit contains a Clinical Utilization Review (UR) team responsible for the utilization management of mental health and substance use disorder services. The team works toward the integration and coordination of services provided to Vermont Medicaid members with substance use disorder and mental health needs.

The team performs utilization management activities including concurrent review and authorization of mental health and substance use disorder services.

In SFY 2018, the UR team authorized and performed concurrent reviews for 393child/adolescent psychiatric inpatient admissions, 338 withdrawal management inpatient admissions, 1,266 adult psychiatric inpatient admissions and 1,760 residential treatment for substance use disorder admissions. In addition, the Autism Specialist within the Quality Unit prior authorized applied behavior analysis services for approximately 90 members. The team works closely with the Department of Mental Health, the Department for Children and Families, Vermont Department of Health's Division of Alcohol and Drug Abuse Program, the Care Alliance for Opioid Addiction (also referred to as "Hub and Spoke"), the Vermont Chronic Care Initiative, and the DVHA Pharmacy, Clinical Operations units and many providers.

6.7 QUALITY – STAKEHOLDER FEEDBACK

The psychiatric survivors, consumers, peers, their family members, the providers of mental health services and the providers of services within the broader health care system who provided feedback ("stakeholders), from across the mental health system of care for Adults (AMH) and Children, Youth, and Families (CYFS) report that services provided are appropriate, high quality, and align with current best practices. They have experienced that staff are dedicated to serving clients, with whom they have strong relationships, regularly seek training opportunities, and work well as members on teams as well as with supervisors. They agree that Designated Agencies and Specialized Service Agencies (DAs/SSAs) have a fully functional structure and administration, including strong working relationships with the Department of Mental Health, families, and other stakeholders.

At the same time, stakeholders from AMH and CYFS see room for improvement in capacity and staff retention at DAs/SSAs, supported through funding for salary parity and professional development opportunities. Stakeholders are concerned about the use of hospital emergency departments as the primary place to wait for inpatient services, noting that as currently configured, the facilities and procedures are not conducive to wellness.

6.8 SUMMARY

- Across payers, there is not a consistent approach to quality review of mental health providers and organizations and levels of oversight may vary.
- The Department of Mental Health has robust and comprehensive oversight and compliance review processes of Designated and Specialized Services Agencies that appear to be more intensive than those of other outpatient mental health providers.

7. PERSON-CENTERED SERVICES

This section of the report addresses the following requirement:

(7) how Vermont's mental health system currently addresses, or should be revised better to address, the goals articulated in 18 V.S.A. § 7629 of achieving "high-quality, patient-centered health care, which the Institute of Medicine defines as 'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions'"…;

The goal of all healthcare interactions is to prioritize the needs and preferences of the person seeking services in all decisions about their care. In Vermont, this is required in all components of the mental health system of care, supported by legislative requirements and designation rules, reviewed by agencies and the Department of Mental Health. This includes Individual Plans of Care for each person seeking services, Coordinated Services Plans between providers, family, and clients through Act 264, the mandate for standing committees at the state and local level covering a broad range of topics, but which center on the voices of persons with lived experience. It also includes but is not limited to education about the use of advanced directives, designation processes, and data tracking to respond to ever changing population needs.

Act 200 based its requirement for "high-quality, patient-centered health care," on the Institute of Medicine's definition that such care "is respectful of and responsive to individual patient preferences, needs, and values and [ensures] that patient values guide all clinical decisions"[xxxvi].

According to health care reform experts, while "patient"-centered' is a laudable goal, "person"-centered care requires an additional level of commitment to inviting the individual to direct their own care and inform providers how that care is best integrated in the individual's life and support them to thrive.

In order to more fully describe patient (or person) – centered care, DMH has used Health Affairs'[xxxvii] framework and guiding principles for person-centered care. The Health Affairs definition and guidance echo the IOM's definition of patient-centered health care:

> *A person-centered, value-driven health system provides safe, effective, personalized, affordable, and high-quality health care services that meet the needs of individual consumers as well as those who support their care, including family, friends, patient-authorized caregivers, and community service providers.*

The Health Affairs Task Force further considered "how best to engage patients/consumers in taking *shared responsibility* for their health and care."

> We converged on the idea that *a person-centric, value-driven health system provides both patients and their caregivers meaningful and effective ways to share in decision-making and care-planning at each point in the process.*

In addition, the Health Affairs Task Force developed "Guiding Principles and Operational Questions," to assist states in creating a value-based and person-centered health care system (see attachment A).

At least since 2012, when the Vermont General Assembly passed Act 79, An act relating to reforming Vermont's mental health system, the focus within Vermont's mental health system of care has been to achieve provision of services that meet the definition of person-centered care. Act 79 does not use the term "person-centered," but the services described and required meet the definitions provided above.

Act 79 directs the department to build a mental health system as a coordinated continuum of care in which "the individual's treatment choices shall be honored to the extent possible." Act 79 requires that mental health services are offered as close to the patient's home as possible; that all ranges of services be made available to those who need them, regardless of their ability to pay. "Adult Outpatient Services" are defined as "flexible services responsive to the individual's preferences, need and values," and "enhanced programming" as "targeted, structured and specific intensive mental health treatment and psychosocial rehabilitation services for individuals." Mobile support teams are required to respond to an individual where they are located during a crisis situation; "noncategorical case management" means service planning and support activities provided for adults by a qualified mental health provider, regardless of program eligibility criteria or insurance limitations; "recovery-oriented" means a system or services that emphasize the process of change through which individuals improved their health and wellness, live a self-directed life, and strive to reach their full potential.

Further, the Department of Mental Health is required to maintain a process for receiving direct patient input on treatment opportunities and the location of services. Transportation for those experiencing a mental health crisis must be the least restrictive mode possible consistent with safety needs; anyone under the care of the commissioner being served in a designated hospital,

intensive residential recovery facility or a secure residential facility must have access to a mental health patient representative. The department is required to designate clinical staff to review the treatment received and clinical progress made by individuals under the custody of the commissioner. In addition, the department must use quality indicators, manageable data requirements, and quality improvement processes to monitor, evaluate, and continually improve the outcomes for individuals and the performance of the clinical resource management system; and alternative treatment options must be available for individuals seeking to avoid or reduce reliance on medications.

The Department of Mental Health believes that the most significant improvement in care and services will occur when Vermont's health services are not only person-centered, but integrated. Vermonters who receive person-centered care from one provider but then have to duplicate their efforts to get services from another provider face barriers to access ranging from time constraints to travel difficulties; they may also receive contradictory, harmful or simply not receive needed care when one provider does not fully understand the care another provider has recommended.

The World Health Organization addressed this juncture in its global strategy report[xxxviii] for 2016-2026:

> Universal health coverage (UHC) will not be achieved without improvements in service delivery so that all people are able to access high quality health services that meet their needs and preferences. This strategy calls for reforms to reorient health services, shifting away from fragmented supply-oriented models, towards health services that put people and communities at their centre, and surrounds them with responsive services that are coordinated both within and beyond the health sector, irrespectively of country setting and development status.

7.1 PERSON-CENTERED CARE THROUGH THE VERMONT BLUEPRINT FOR HEALTH

Vermont's primary care practices are supported by the Blueprint in the process of achieving and maintaining recognition as Patient Centered Medical Homes under the National Committee for Quality Assurance (NCQA) standards.

NCQA standards promote excellence in 6 areas:

1. Patient-Centered Access
2. Team-Based Care
3. Population Health Management
4. Care Management and Support
5. Care Coordination and Transitions
6. Performance Measurement and Quality Improvement

7.2 FEDERAL MEDICAID PERSON-CENTERED PLANNING REQUIREMENTS

Federal Medicaid regulations at 42 CFR § 441.725 "Person-centered service plan" describe expectations for any individual receiving Medicaid home and community-based services (HCBS) (Attachment B). In the state of Vermont, the requirement for person-centered planning and an individualized plan of care is a requirement for all practitioners of mental health treatment services.

7.3 PERSON CENTERED SERVICES- DESIGNATED AND SPECIALIZED SERVICES AGENCIES

Minimum Standards Chart Review: The Department of Mental Health (DMH) is required to review services for mental health clients at Designated Agencies (DA) and Specialized Service Agencies (SSA) for coordination, continuity of care, and appropriateness and quality of care as described under the Access and Quality section of this report.

Multiple areas of the chart review examine how person-centered an agency's staff and services/policies are. Reviewers specifically look for the following:

- If the individual/family/youth's signature is present on the IPC and intake paperwork to ensure that they are aware of their rights and agree with the plan that is being created with them, not for them.
- Goals/outcomes are meaningful to and have been developed in partnership with client and family.
- The objectives have realistic, measurable action steps that clearly define the work and expectations between service provider and family.
- The Individualized Plan of Care is accessible and easy to understand for the consumer.
- Clear evidence in the progress notes that positive interventions and supports are utilized, are tied into the treatment goals, and any restrictions related to safety concerns are well documented and used only after attempting positive interventions and supports.

Designation: Ways in which the Designation process looks for person-centered approaches at the state level and in the DAs/SSAs can be found in multiple sections of the *Administrative Rules on Agency Designation.*

Section 3 of the rules, titled *State Program Standing Committee,* requires the state to have an advisory body comprised of between 9 and 15 members, a majority of whom will be disclosed consumers and family members of the group that they represent to make recommendations regarding Hiring of Key Management, Evaluation of Quality, State System of Care Plan, Department Policy, Complaints, Grievances & Appeals, and agency redesignation. In addition, sections 4.2.5 and 4.2.6 of the rules requires each DA/SSA to have a Local Program Standing

Committee to fulfill the same role at the SPSC on the local level for the DA/SSA. It ensures that individuals and families are taken into consideration and asked to provide advice on important topics and policies that affect the programs and services they engage with.

In section 4.4 *Consumer/Family Involvement and Input*, the rules state that the agency must demonstrate recognition of the importance of consumer and family involvement and input in agency and program design. The agency must obtain and monitor consumer and family satisfaction, keep written records of all of its monitoring efforts, and document use of this information through quality improvement activities. The agency must document consumer/family inclusion in program design. The agency must document inclusion of consumers/family members in reviews of, trends in types of services delivered, requests for services, monitoring of the quality of services, and evaluations of agency and program effectiveness. The agency shall involve consumers and families in the design, delivery and evaluation of training

In section 4.9 *Consumer Support, Treatment and Records,* DAs/SSAs must document consumer/family caregiver participation in support and treatment planning and assure when required that a written consumer-directed service plan for each person served is created. The consumer service plan must be in a format accessible to the consumer and the signature of the consumer, or guardian if applicable, must be included to document their knowledge of the treatment and/or support services. Plans should be family-directed for children and adolescents. Consumer support and/or treatment planning shall include written policies that allow for a consumer's request for a change in therapist, case manager, or support staff. DMH Reviews DA/SSA policies related to requesting a change in provider during the designation process, inquires with the LPSC and consumers/family members if they are aware of this right in interviews during the designation site visit, and monitors grievance and appeal patterns to ensure policy is being followed. Consumer support and/or treatment planning must ensure that consumers have the opportunity to include other persons, service agencies/systems in their network of shared information, if desired Consumer support and/or treatment planning shall be responsive to consumers' preferences for services and supports. Consumer support and/or treatment planning shall comply with practice guidelines and records standards of DMH. Consumer support and/or treatment planning shall include a periodic review of a person's eligibility, need for services and/or service plan. Consumer support and/or treatment planning will provide for or arrange for the provision of services that safeguard the health and safety of the consumer. Consumer support and/or treatment planning shall include the coordination of service delivery with other service systems and agencies within the region as needed for each consumer. Consumer support and/or treatment planning shall include communication and information sharing in accordance with Title 18, VSA 7103.

Furthermore, in section 4.13 *Rights and Responsibilities of Recipients,* the agency must have a written policy assuring the rights of all service recipients consistent with 18 VSA Section 8728 for persons with developmental disabilities, Act 264 for youth with severe emotional disturbances, and DMH Community Rehabilitation and Treatment (CRT) Guidelines for adults who are severely mentally ill. All agency programs must no less than annually inform recipients of their rights and responsibilities.

Section 4.14 *Confidentiality,* states that the agency must have established written policies and practices that protect the confidentiality of consumer information.

Lastly, section 4.15. *Complaints, Grievances and Appeals Procedures* requires the agency to have a written policy and procedures for complaints, grievances and appeals, and for the dissemination of information on dispute resolution to all recipients, consistent with AHS and DMH policies and regulations. The rights of adults seeking and receiving mental health treatment services has also been codified in these same processes as an operating requirement of managed care organizations, since Vermont operates under a Global Commitment to Health 1115b waiver. Adults with serious mental illness and children with serious emotional disturbance who receive mental health treatment services are an identified population group for access and specialized service assurances when part of a person-centered treatment plan. The process for resolution of individual complaints, grievances, and appeals follows a procedural justice framework, building on a process that conveys respect for an individual's expression of dissatisfaction, affords mechanisms to identify concerns and disagreements, and has a manualized process for communicating and arriving at a resolution based on equal opportunity to provide information from both individual and treatment provider. Further, when denial of requested service is involved, a process for resolution involving review by a fully independent body is available to make final recommendations for resolution with all parties in a manner that allows participation and understanding of the process whereby decisions are rendered to resolve service appeals.

All levels of disagreement are documented by the individual service agency and entered into a data repository within Vermont's Medicaid Authority with periodic reports of each service provider's performance in this area and resolution outcomes for each reporting period. If agencies are found to be out of compliance during a Minimum Standards Chart Review or during the Designation review, they will receive a corrective action plan that must be approved by DMH and include a timeline to rectify the issue.

7.4 PERSON CENTERED CARE- COORDINATED SERVICE PLANS

According to the Integrating Family Services page of the Vermont Official State Website, "Act 264, passed in 1988, requires that human services and public education work together, involve parents and coordinate services for better outcomes for children and families. The Act developed a coordinated system of care so that children and adolescents with SED and their families receive appropriate educational, mental health, child welfare, juvenile justice, residential, and other treatment services in accordance with an individual plan. Under the Interagency Agreement of 2005, eligibility was expanded to include all children/youth with a disability who receive services from the Agency of Education and the Agency of Human Services."[xxxix]

The State Interagency Team clarifies that "under Act 264, children and adolescents experiencing a SED who need services from multiple agencies are entitled to a coordinated services plan."[xl] A Coordinated Services Plan (CSP) is a written plan developed by a team for a child/youth who requires services from more than one agency. It is designed to meet the needs of the child within his or her family or in an out-of-home placement, and in the school and the community. A CSP is intended to be family driven and take the entire family into consideration with regard to what services would best support the identified need(s). Every DA currently has a parent rep contracted through the VT Federation of Families for Children's Mental Health (VFFCMH) to provide support to parents/guardians engaging in the CSP process to help them understand their rights, help maneuver the system, and ensure that their voice is heard.

7.5 PERSON CENTERED CARE AND SUPPORTING SYSTEMS

DMH is mandated through statute to have both a State Program Standing Committee for adults and one for children and families, and also requires the DAs/SSAs to have Local Program Standing Committees. These advisory bodies are required to be made up of a majority of people with lived experience for the demographic they represent to provide a person-centered and informed perspective on policy, the hiring of key management, grievance and appeal trends, System of Care Plans, and redesignation. Also, DMH encourages membership on the SPSC to include mental health providers, consumers, and agencies that provide peer support and/or advocacy. Currently, representatives from Pathways Vt and the VT Federation of Families for Children's Mental Health (VFFCMH) sit on both SPSCs, in an effort to expand the representation of people with lived experience and the systems that support them. DMH attends all SPSC meetings and provides administrative support to the groups and is able to ensure that they are advising the department and their feedback and perspective is incorporated whenever possible. DMH reviews the minutes of the LPSCs during the Agency Review and Designation processes and is able to assess whether or not the DA/SSA is making decisions that are informed by the LPSC, when applicable.

Also, DMH receives regular funding from the Mental Health Block Grant (MHBG), a non-competitive grant from SAMHSA. To draw down the funds, DMH is required to have a planning council to advise the department on how to best allocate the resources, identify areas of priority in the mental health system of care, and represent the perspective of people with lived experience. Like the SPSCs and LPSCs, the MHBG planning council is required to have a majority of members be people with lived experience to ensure that their voice is incorporated.

Finally, DMH contracts with the Vermont Federation of Families for Children's Mental Health (VFFCMH) to maintain or increase family involvement and representation on regional and state-level policy-making groups, working committees, and forums that impact families of children and youth who are experiencing a severe emotional disturbance. VFFCMH offers training to families and youth around the state to increase their leadership skills and their ability to advocate for themselves and their families. They also support families' access to and navigation of the System of Care, which is a critical component of families getting their needs met, especially during times of high-stress. VFFCMH participates in State and Regional Groups (LIT, SIT, SPSC, Act 264 Advisory Board) to ensure that family voice is represented. They are also contracted to recruit family members as representatives to each LIT region for Coordinated Services Plan (CSP)/Act 264 meetings.

7.6 PERSON CENTERED CARE- STAKEHOLDER FEEDBACK

Stakeholders, who may be psychiatric survivors, consumers, peers, their family members, the providers of mental health services and the providers of services within the broader health care system, report that they have experienced DA/SSA services being individualized to meet each client's needs and are often delivered in a holistic manner. They report that DAs/SSAs use data to track client and program outcomes and modify their practices in response to this data, including feedback from staff. They report that a client's quality of life (one's self, or reporting on a family member, peer or client) improves as a result of care they receive in Vermont.

Stakeholders encourage the AMH and CYFS systems of care to continue expanding practice patterns that create holistic wellness plans which are trauma-informed and prevention-oriented. They would like to see more trainings for partnered organizations of the DAs/SSAs. Stakeholders would like to see more research on mental health and best practices. They would like to see an increase in the number of children, youth and families served in community settings by transferring resources from residential settings and investing in local regions.

7.7 SUMMARY

- Rules, regulations, governance and oversight of mental health services all serve to build a system of care that is driven by and centered around the individual at the center of every interaction.
- Vermont's mental health system of care has a long history of building a system based on person-centered care.

8. COERCION

The advancement of person-centered service delivery, its philosophy and all related activities advance a system of care that by its nature must minimize and eliminate as much as possible any instances of coercion. This section provides information regarding the following requirement of the report:

(7) how Vermont's mental health system currently addresses, or should be revised better to address, the goals articulated in 18 V.S.A. § 7629 of achieving… a mental health system that does not require coercion;

The Department of Mental Health strives to have as many individuals as possible engaging in a voluntary treatment system. The current array of community-based systems of supports, greatly expanded under Act 79 (2012), introduced or further developed support options that addressed more person-centered support options. The expansion of local crisis bed alternative programs in all DA catchment areas and regional Intensive Residential Recovery Programs to provide transitionary treatment and recovery-oriented support environments was created. Peer supported crisis bed and medication-alternative residential programs were part of the continuum addressing coercion reduction in the system of care. While secure, the state-operated Middlesex Therapeutic Community Residential Program also supports step-down opportunities for individuals from more restrictive hospital-based care.

System-wide, DMH developed Administrative Rules for Agency Designation nearly 15 years ago to that required at both the state and local levels require standing advisory committees inclusive of over 50% consumer and family representation for adult, child, and developmental disability programs of Designated Agencies for the purpose of input, evaluation and oversight. Most recent evaluations from both child and adults served by DA programs reflect ongoing levels of satisfaction in areas of participation and respect afforded during the course of treatment services and is included in the Act 79 (2019) report. Also, within the Act 79 report are the Vermont comparisons of voluntary and involuntary hospitalization, which continue to reflect lower levels of inpatient utilization compared to national averages.

Stakeholders from Children, Youth, and Family Services are excited about Act 35 (VT 2017 H230) which allows youth to seek outpatient services without parental consent, allowing greater access and reducing coercion. In the current AMH system of care, stakeholders see room for improvement in the reduction of use of coercion, and say that while sometimes necessary, involuntary interventions should be used as a last resort.

Additional steps taken to reduce coercion include development and implementation of policy on trauma-informed care which influences use of involuntary restraint and seclusion. The DMH policy on the "Care of Psychological Trauma in the Mental Health System" (2010) sets forth the expectation that the mental health system and services are trauma-informed, "respectful, sensitive to the impact of trauma, actively involve the survivor, promote resiliency and recovery, and reduce and eliminate practices that have the potential for traumatization or re-traumatization". Drawing heavily from the Copeland[1] whitepaper on the vision of a public mental health system without coercion, this policy applies to the work of the Department and it's designated and contracted providers. The policy recognizes "the potential for treatment systems to contribute to trauma through the use of seclusion, restraint, involuntary medication and the comingling of survivors of interpersonal violence with perpetrators of interpersonal violence in care settings". Therefore, it sets forth the expectation that the mental health system "must be educated about trauma and effective non-coercive techniques and able to self-analyze, identify, and mitigate the ways that their service delivery may contribute to trauma".

At the most restrictive level, existing Vermont statutes do require the Department of Mental Health to assume responsibility for all individuals that courts in Vermont have determined meet the threshold for involuntary care and treatment services. These laws require a DMH Commissioner to maintain care and custody until the individual is no longer a person in need of treatment or continued treatment. Until such time as all individuals with mental health needs who are found to be a danger to themselves or others by the court and can be voluntarily served to mitigate the risks to themselves or others or the laws are changed to remove this departmental responsibility, this coercive requirement identified at the time of the Copeland Whitepaper: *"Vermont's vision of a public system for developmental and mental health services without coercion"* remains as an active legal requirement that DMH considers throughout involuntary care.

Research conducted on the topic of coercion has revealed that procedural justice is paramount to the consumers' overall perception of an experience as coercive. In other words, the level to which an event is experienced as coercive is highly correlated to the individual's belief about

the justice of the process[iii]. For example, if an individual believes that others involved acted out of genuine concern, treated the individual with respect, was allowed to share their experience, and felt that their autonomy was respected the level of experienced coercion is typically low. This is true for both voluntary and involuntary processes. Therefore, while we continue to search for alternatives to the current ONH structure, it is essential that those working in the field listen to, respect, and allow those with lived experience to fully engage in decisions about themselves. We have a responsibility to remain conscious of our interactions with those we serve and carefully assess as to whether or not coercion is present.

The Vermont mental health legal system continues to assure that individual rights and protections remain at the forefront in statute and in practice. Consistent with the intent of the 2000 Whitepaper to assure respect and transparency of procedural justice with the coercive practice of involuntary commitment, legal representation for all involuntary processes are assured and subject to close review by the courts. Disability Rights Vermont is statutorily identified as the mental health Ombudsman and has complete access to involuntary and emergency involuntary procedures that any individual may experience during the course of involuntary care. Certificates of Need for any emergency procedures document the sequential considerations for use of seclusion, restraint, or emergency medication use for individuals hospitalized. Legal processes for the administration of any non-emergency psychotropic medication are also closely scrutinized and overseen by the court prior to administration. Any use of psychotropic medication, if such medication is recommended by medical professionals for vulnerable individuals who are overseen by medical guardians, is also overseen by Family Courts.

DMH has also supported over a number of years SAMHSA's Six Core Strategies for reducing seclusion and restraint best-practice program further reducing coercion while an individual may be in involuntary care. Annually, DMH as well as an independent evaluator reports on all orders of court-ordered medication (Act 114), surveys or interviews individuals who have been subject to such orders and evaluates the state' s efforts to further reduce coercion. DMH also established an Emergency Involuntary Procedures (EIP) review committee comprised of provider, advocate, and peer stakeholders to review quarterly EIP data and trends and develop an annual report to DMH of its activities and recommendations.

In 2018, an ONH Review Committee was formed in response to directives of Act 200, Section 3 to review and evaluate existing laws, studies, reports, and data pertinent to Orders of Non-Hospitalization (ONH). The committee was tasked to make recommendations regarding areas for improvement, efficiencies, or changes to legislative Committees and Jurisdictions where

applicable. The most recent report submitted on December 1, 2018 identifies additional opportunities that might exist for reducing coercion in the use of ONHs. One recommendation was the full endorsement of pilot programs for voluntary intensive and readily available engagement teams for individuals who would otherwise be placed on ONHs. New resources to support this concept service capacity would need to be allocated. A second recommendation that was almost unanimously endorsed by the Study Committee was revision of criminal statutes to either require that DMH and Mental Health Law Project have party status in legal proceedings or be transferred out of criminal courts altogether.

8.1 SUMMARY

- Vermont's mental health system of care is based on respectful treatment of every patient.
- The goal is for a system with the least use of coercion possible, which is always guided by the patient's welfare.
- Involuntary medication, restraint, commitment or other limiting of the patient's choice may be sought or administered only when a patient is in danger of self-harm or of harming others.
- Coercion must be carried out in a trauma-informed manner.
- Every attempt is made to follow an informed-consent process, so that the patient understands why the procedure is necessary.

9. VISION OF AN INTEGRATED, HOLISTIC HEALTH CARE SYSTEM

This section discusses the following two requirements of the evaluation:

(3) whether the current structure advances the long-term vision of an integrated, holistic health care system;

(4) how the designated and specialized service agency structure contributes to the realization of that long-term vision;

9.1 VISION OF INTEGRATION

What is Integrated Care?

Integrated mental health care describes any situation in which mental health and medical providers work together. It is the care a person experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. The Department of Mental Health considers "integrated care" as care that

addresses the needs of the whole person, rather than being limited to treatment for specific illnesses. This means that the client/patient's needs are considered in the context of that person's comprehensive needs and includes a foundational focus on wellness and prevention.

Integrated health care teams and services do not have to be present or delivered in the same physical location to meet the definition of integrated care. While there appear to be advantages to bringing mental health services on site in primary care settings, such as increased likelihood that individuals referred for services will follow through and the opportunity for medical and mental health providers to build their relationships and skills through informal interactions, increased integration can occur between clinicians and organizations that are physically separate but use shared care plans and workflows that achieve integration of care. This is considered an acceptable variation as long as the care team can fulfill the required functions of integrated mental health care from separate locations.

One notable integration opportunity exists around the issue of primary care providers who sometimes have to manage mental health issues beyond their optimum scope of practice due to the limited access to the specialty mental health system. Psychiatric consultation delivered through integrated and coordinated care approaches can allow primary care providers to fulfill this added expectation much more effectively and thus their patients are much more likely to receive effective care.

A good example of an integrated care model is the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant. In 2017, DMH was one of three states awarded a grant from the Substance Abuse and Mental Health Administration (SAMHSA). The project, named the Children's Health Integration, Linkage, and Detection (CHILD) grant in Vermont, aims to:

1. Promote full integration and collaboration in clinical practice between primary care and mental health providers and organizations;
2. Support the enhancement of integrated care models for primary care and mental health care to improve the overall wellness and physical health status of children with or at risk for a serious emotional disturbance (SED) diagnosis; and
3. Promote and offer integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, and co-occurring physical health conditions and chronic diseases.

The CHILD grant focuses on providing coordinated mental and physical health care, wellness promotion, and prevention activities to children and families by integrating care at the local Federally Qualified Health Center (FQHC) and Designated Agency (DA). Children enrolled in the pilot benefit from enhanced care coordination of their services and supports, mental and physical health care, and family-focused community activities. For purposes of this grant,

integration refers to collocation of staff, integrated assessment and referral workflows, as well as coordinated treatment and plans of care. Integrated services also include access to wellness activities and prevention and health promotion services such as parent coaching, health coaching, programs that increase physical activity for the whole family, and mindfulness practices such as yoga.

DMH will use lessons learned from the first two regions selected for the grant, Springfield and Franklin/Grand Isle counties, to inform the system of care for the state. A planned expansion of the grant will occur in fall, 2019, with the addition of two more regions. Currently participating agencies and practices are:

- Springfield Medical Care Systems (FQHC)
- Health Care & Rehabilitation Services (DA)
- Northern Tier Center for Health (FQHC)
- Northwestern Counseling & Support Services (DA)

9.2 INTEGRATED PRACTICES

Designated Agencies

Designated Agencies (DAs) are critical providers of mental health services to Vermonters and for many services, are the only authorized providers. Designated Agencies use a whole person approach to services, ensuring that children, youth and adults served are supported by case managers to access primary and specialty care and by nursing staff to provide support to address medical conditions and achieve wellness, often in collaboration with medical providers. All DAs are engaging in integrated care approaches and collaboration with their local federally qualified health care centers, hospitals and/or other primary care organizations to provide mental health services. While there is not a standardized format for integrated care delivery, there are many examples of work related to DA physical health integration and collaboration throughout the state. The following are examples and are in no way an exhaustive list.

- Co-location of DA clinicians in primary care offices, including pediatric offices, providing brief mental health interventions, referrals, case management, care coordination, and more.
- DA clinicians embedded directly within schools providing direct 1:1 supportive counseling as well as home/school coordination.
- DA collaborations with hospitals to include: wellness coaching, embedded clinicians in emergency rooms, crisis services in emergency rooms, provision of mental health assessments, identification of high utilizers and high-risk individuals and wrapping them with services to avoid unnecessary ER and hospital utilization, and more.

- Implementation of bi-directional integration, including primary care co-location with FQHCs both independently through partnerships and through the Vermont CHILD grant.
- Education of primary care providers, CHT members, and others to decrease stigma and to enhance collaborative care efforts. These include trainings on trauma informed care, Mental Health First Aid, suicide prevention and more.
- Participation on numerous local and regional teams engaging in community care planning for people with complex health, mental health, and/or substance use challenges. These include Community Health Teams, Unified Community Collaboratives, Local Interagency Teams, Children's Integrated Services, SASH, VCCI (VT Chronic Care Initiative), and more.
- More formalized care coordination with providers through electronic shared care plans such as Care Navigator.

Additional examples provided by Vermont Care Partners are located at Attachment C.

FQHCs

According to a memorandum from Bi-State Primary Care Association, included at attachment D Vermont's Federally-Qualified Health Centers (FQHCs) participate in numerous mental health, substance use disorder and primary care integration projects. Like other parts of the mental health system of care, and as stated in the prior section regarding Designated Agencies, there is not a commonly held standard or approach toward integration, however, there continues to be frequent exploration and testing of integrated care delivery models. As providers of primary care in Vermont's rural communities, FQHCs work collaboratively with designated agencies and other health care providers to ensure the Vermonters in their service area receive the necessary mental health and substance use disorder treatment services.

One good example of an FQHC exploring integrated service delivery is the Community Health Center of Burlington, which has been exploring innovative approaches to coordinated care including:

- A partnership with the Visiting Nurse Association to pilot a Psychiatric Home Visit Program. The first of its kind in the Burlington area, this now expands psychiatric access to 20 homebound individuals; and,
- Piloting a 10-week Trauma-Sensitive Yoga class for patients experiencing PTSD.

The attached memorandum provides some additional examples of integration activities provided by Vermont's FQHCs.

Other Primary Care & Mental Health Integration Efforts

In addition to the work of FQHCs, on the primary care side, the most recent data we have is from the Area Health Education Center's (AHEC) St. Johnsbury office. In 2015, that office worked with the southern Vermont AHEC office and collected information from 73 primary care practices. Of those, 36 offices (48%) reported having some type of mental health clinician on site. Most clinicians were at the practices part-time and rotated through different primary care office sites through the week. Their credentials vary and include: licensed drug & alcohol counselor, Master's level; licensed mental health clinician; psychiatrist, psychologist, behavioral neurologist, Master of Social Work, behavioral health; substance abuse nurse.

9.3 INTEGRATION OPPORTUNITIES

Integration requires a relationship, trust, and common vision between providers so that structural and cultural differences may be understood and overcome for mental and physical health treatment to be provided in a more holistic and seamless continuum. The system of care is currently in a state of transition, in which integrated and coordinated care models are being tested and increasingly proliferated. Striking examples are the All-Payer Accountable Care Organization Model Agreement discussed as section 10 and the BluePrint for Health Community Health Team approach.

The Agency of Human Services perceives that a new, common culture is emerging around integrated care delivery and that new, cross-cutting cultures of coordinated care delivery will soon be able to inform a more formalized understanding of evidence-based models of integrated mental health service delivery. A clear next step in the integration conversation is adoption of a common definition of "integration,". One proposed definition of integrated care comes from the World Health Organization:

> Integrated health services: the management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.[xli]

9.4 SUMMARY

- The Department of Mental Health is committed to integrated care based in the continuum of health promotion, disease prevention and life-span pro-active care and rehabilitation as defined by the World Health Organization.
- Through carefully designed collaborative pilots, wellness-focused projects and a guiding principle of supporting whole-person health, DMH continues to build a system of care

that strives for the triple aim of health care reform; better care that results in improved health and reduced cost.

10. MENTAL HEALTH AND PAYMENT REFORM

(5) how mental health care is being fully integrated into health care payment reform;

In 2016, Vermont entered into the *Vermont All-Payer Accountable Care Organization (ACO) Model Agreement*, an agreement between the Centers for Medicare & Medicaid Services and the Governor of Vermont, the Green Mountain Care Board, and the Vermont Agency of Human Services to test whether the health of, and care delivery for, Vermont residents improve and healthcare expenditures for beneficiaries across payers decrease if: 1) these payers offer Vermont ACOs aligned risk-based arrangements tied to health outcomes and healthcare expenditures; b) the majority of Vermont providers and suppliers participate under such risk-based arrangements; and c) the majority of Vermont residents across payers are attributed to an ACO bound by such arrangements. The All-Payer Model agreement requires the state to plan for the future inclusion of specific Medicaid services:

11. *Medicaid Behavioral Health and Long-Term Services and Supports. By the end of Performance Year 3, AHS, in collaboration with the GMCB, shall submit to CMS a plan to coordinate the financing and delivery of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services with the All-payer Financial Target Services. The plan shall describe a strategy for including Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the State's delivery system reform efforts and for supporting the inclusion of such Medicaid services in the definition of All-payer Financial Target Services in a subsequent agreement, as described in Section 2.*

During the term of the Vermont All-Payer ACO Model agreement, the State will evolve and expand ACO-based reform and develop payment reform projects that impact other Medicaid-enrolled providers and other Medicaid-covered services (including, but not limited to, mental health services, substance use disorder treatment services, and long-term services and supports) through partnerships between departments in the Agency of Human Services. The State is placing emphasis on program evolution or development that ensures State compliance with the provisions of the All-Payer ACO Model related to achieving scale targets and on planning for the expansion of value-based payment arrangements to include providers and suppliers of additional Medicaid services beyond 2020. In addition to the Vermont All-Payer ACO Model agreement, Vermont's Global Commitment to Health 1115 Waiver further supports the development of alternative payments for Medicaid providers and services. One of Vermont's key strategies for improving the health status of all Vermonters through

implementation of the waiver is "promoting delivery system reform through value-based payment models and alignment across public payers."

As part of the State's efforts to develop health care payment reform models that align with Vermont's All-Payer ACO Model agreement and advance implementation of Vermont's Global Commitment to Health waiver, the Department of Mental Health has worked with other departments in the Agency of Human Services and with provider stakeholders to design and implement a payment model for children's and adult mental health services provided by Designated and Specialized Services Agencies. The mental health payment reform was implemented effective January 1st, 2019.

This alternative payment model is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve. The new model places additional focus on quality—at first by providing an incentive for providers to report complete, accurate, and timely information, and in future by linking a portion of payments to providers' performance on certain quality measures. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment should contribute to both State and provider readiness for an increasingly integrated health care delivery system over time, and should aid the State in developing a strategy for inclusion of additional services in All-Payer financial targets in the future.

10.1 SUMMARY

- With the advent of the mental health payment reform in January 2019, limitations of fee for service payment models will be significantly reduced.
- Designated Agency staff express strong anticipation of the change to more population-based payments.
- DA staff look forward to being able to provide the services Vermonters need, rather than only those services the client is eligible for.

11. STRUCTURAL CHANGES

This section discusses the structure of the mental health system of care and next steps to ensure that the mental health system of care is balanced between inpatient and community-based levels of care with a focus on expansion of integrated practices.

(6) any recommendations for structural changes to the mental health system that would assist in achieving the vision of an integrated, holistic health care system;

11.1 ADULTS

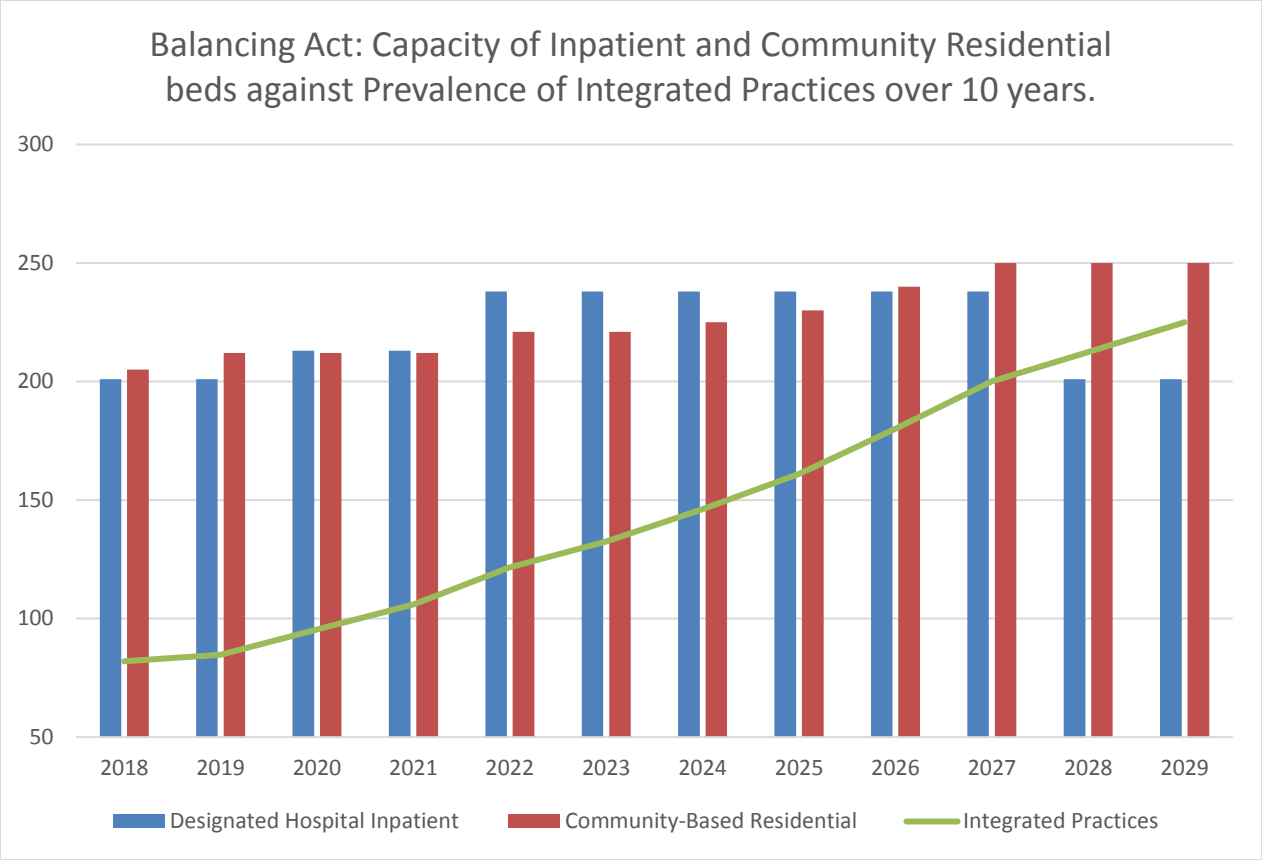
Recent efforts through the Vermont State Legislature, Agency of Human Services and provider organizations have resulted in plans to increase inpatient mental health bed capacity from 2019-2020 in order to meet emergent needs for access to inpatient mental health treatment. The Agency of Human Services regards these investments as essential and foundational steps to stabilize the current mental health system of care.

Subsequent to the 2019 legislative session, the Agency of Human Services will engage in a second phase of stakeholder engagement around an emerging vision of how integrated practices, inpatient and community residential capacity should be balanced. This engagement process will inform emerging concepts and framing necessary to finalize a long term vision of an integrated, holistic health care system and a 10-year plan for the system of care that considers implementation of reforms by the Department of Mental Health, the Agency of Human Services, and the many partners and payers who are responsible for the State's mental health system of care.

Stakeholder feedback received to date and the many significant efforts being made by partners across the continuum of care, indicates that Vermont must make additional efforts to achieve an integrated and holistic health care system. AHS firmly believes that an essential element of this vision is to shift the balance between mental health services provided in the hospital toward services delivered in the community, and that services delivered in the community must be delivered in a coordinated and integrated continuum of care, as described in Section 9 of this report regarding integration.

A visual of this concept is provided below for illustration and discussion purposes. The premise is that inpatient capacity must grow initially, but that additional capacity in community residential levels of care and expansion of integrated care approaches may alleviate the need for inpatient level of care over time. Prevention and health promotion activities should also help decrease the number of Vermonters who find themselves in need of such levels of care.

Inpatient levels of care are illustrated to be stable for several years while the growth and impacts of improved community capacity, integrated care approaches and prevention activities are evaluated for impact. For purposes of this illustration, the projected outcome is that changes in community residential and integrated care delivery are impactful such that inpatient capacity may be reduced to 2018 levels after 10 years. This is not a foregone assumption of the Agency but is proposed as the framework of a vision that is worth further exploration.



11.2 CHILDREN, YOUTH AND FAMILIES

The child, youth and family system of care requires effective relationships across mental health, child welfare, developmental disability services, early childhood, education, family organizations, primary care, and a wide range of other stakeholders. A strong system of care requires services and supports across the spectrum of health promotion and prevention, early intervention, and intensive intervention in settings where children and families spend their time.

The following are the 2019 recommendations from the State Interagency Team under Act 264, with representation of the DMH Child, Adolescent and Family Unit.

1. Support statewide integration of services to streamline and better coordinate the provision of services provided through Act 264 and as outlined in S.261 (passed by the Senate 2018, https://legislature.vermont.gov/bill/status/2018/S.261).
2. Increase the number of children, youth and families served in community settings by transferring resources from higher levels of care, investing in local regions, and focusing on mobile response efforts in Vermont.

3. Support payment reform efforts that move the System of Care away from fee-for-service and toward accountability focused on performance outcomes.
4. Support funding for family and youth partnership to be a shared responsibility of all AHS departments and the Agency of Education.
5. Increase collaboration with early childhood service providers and community supports to address the high rate of young children being placed into DCF custody, young children being expelled from childcare, young children being placed in residential settings, and the impacts of trauma on child development.

The Department is leveraging federally funded initiatives to 1) support system improvements for school based mental health services; 2) identify best approaches for integrated primary care and mental health services for children, youth and families; and 3) establish a coordinated system of mental health supports for pregnant and postpartum women through screening for maternal depression and related mental health challenges during obstetric and pediatric visits and creating pathways for assessment, brief intervention, and referral to treatment and other support services. As noted earlier, the Department is working with partners across AHS and with representatives from a DA and family organization to explore strategies to strengthen mobile response and support services for the child, youth and family system. Additionally, a team from DMH and DCF-Child Development Division are reviewing and analyzing the effectiveness and service delivery of Early Child and Family Mental Health across the state to determine what is working well, what challenges exist and what can be done to make the delivery of this service work as well as possible for children and their families.

11.3 STAKEHOLDER FEEDBACK

Stakeholders from CYFS and AMH have reported that the structure and administration of DAs/SSAs is fully functional and that the agencies have strong working relationships with stakeholders, within and beyond the Department of Mental Health, clients, and families. In most cases, feedback states that services are individualized to meet each client's needs, and attempts are made to be holistic. They appreciate the efforts being made by all stakeholders in supporting payment reform efforts that move the System of Care away from fee-for-service and toward accountability focused on performance outcomes.

11.4 SUMMARY

- More work is needed to achieve an integrated and holistic health care system.
- Resources must be directed to services delivered in the community, and those services must be delivered in a coordinated and integrated continuum of care.
- While inpatient capacity must grow initially, additional capacity in community residential levels of care, expansion of integrated care and prevention and health

promotion activities should help decrease the number of Vermonters who find themselves in need of such levels of care.

12. MENTAL HEALTH SPENDING

(8) recommendations for encouraging regulators and policymakers to account for mental health care spending growth as part of overall cost growth within the health care system rather than singled out and capped by the State's budget; and

The Agency of Human Services believes that the most effective way to work toward a holistic view of health care spending and cost growth that is inclusive of mental health care, is by using the required framework of the All-Payer Model. Absent the All-Payer Model framework, the state risks creating multiple approaches toward the same end of evaluating and understanding mental health spending growth.

As described in this report at section 10, the All-Payer Model requires a plan to account for mental health services as a part of the All-Payer Financial Target Services in a future All-Payer Model Agreement. This approach requires a review of mental health spending and an analysis of expected growth across Medicare, Medicaid and commercial payers and is of necessity compared with expectations of overall cost containment for the primarily physical health services currently included in the All-Payer Model Accountable Care Organization Agreement.

13. PROVIDER WORKFORCE PARITY

This section considers the expectations of the report in regard to Designated and Specialized Services Agencies' rates of payment. It also considers differences in rates of payment across payers to providers of mental health services in comparison to specialty and physical health services.

(9) recommendations for ensuring parity between providers with similar job descriptions regardless of whether they are public employees or are employed by a State-financed agency.

Act 85 (2017) appropriated $8.37 million in Fiscal Year 2018 for increased payment to Designated Agencies (DA) and Specialized Service Agencies (SSA). This payment increased the hourly wages of employees to $14 per hour and funded salary increases for crisis response and crisis bed personnel.

As a result of this increase, AHS noted that for the impacted workers, retention rates were showing improvement, but as a result, positions at the median compensation levels that did not receive additional funding became more difficult to fill. Each of the Designated agencies faced

slightly different employment, demographic and service level challenges and feedback from the field was mixed regarding the imperative to focus on one workforce component.

A second investment into the Designated Agency network came as a result of Act 11, Section E.314 of the 2018 Special Session, which allocated approximately $4.33M in FY 2019 to further address the compensation gap between the Designated Agency system and other providers in the health care delivery system. The Department was permitted to allocate up to 20 percent of the funds through value-based incentive payments focusing on quality and outcomes and has allocated the remaining funds through base rates to providers. Designated Agencies were directed by the legislation to allocate up to 50 percent to direct services that are provided by master's level clinicians and other staff with high levels of credentials and experience in order to reduce the compensation gap for this staff and to increase recruitment and retention of these levels of professional staff.

A complicating factor regarding this goal as written is the role of AHS as the Single State Medicaid Agency. Vermont Medicaid, with a few exceptions, does not employ health care providers directly and so does not set most health care provider salaries. When setting rates of payment, Vermont Medicaid, as with other insurers, analyzes a variety of factors that relate to the costs of delivering the service, such as the required qualifications and availability of staff, but does not generally consider salaries as the single guiding principle for setting rates. Medicaid also does not control the salaries that are set by Medicaid-enrolled provider organizations. Insurers, including Vermont Medicaid, strive to understand historic, current and future demand for services and to set rates that will meet the demand while also working within a budget and available revenue to pay for services.

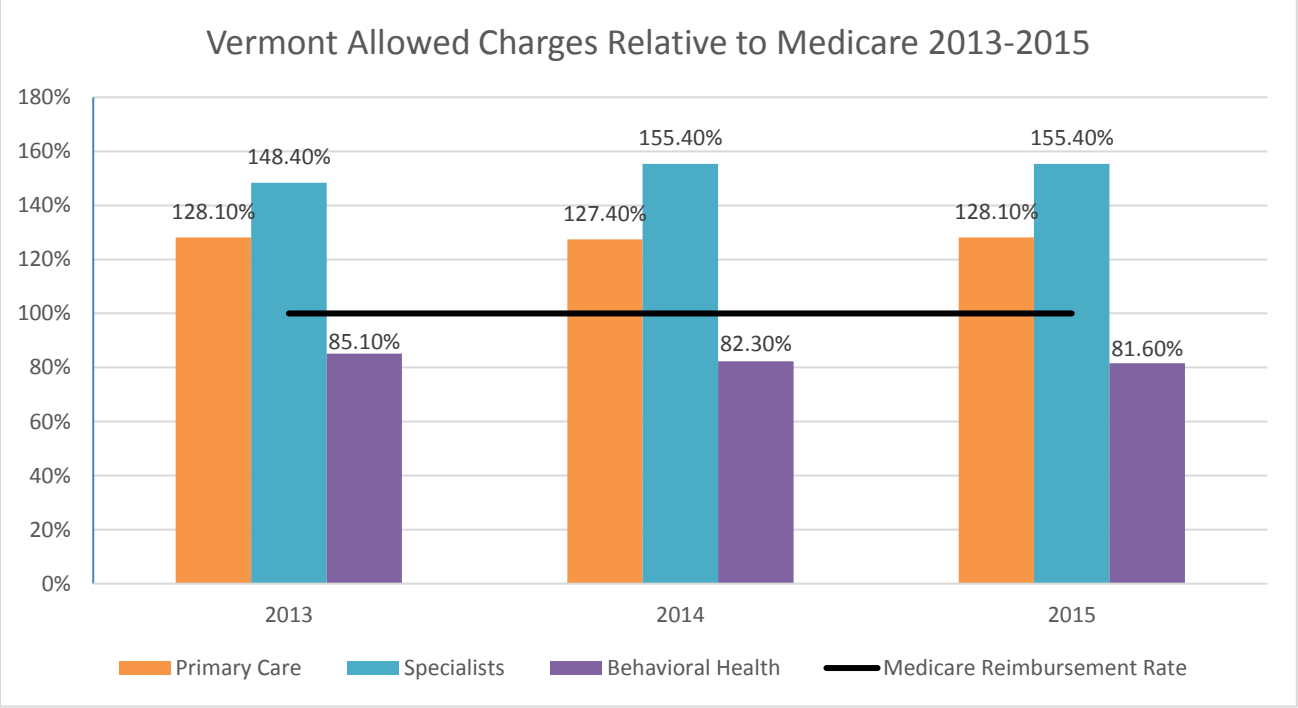
Unique perhaps to Medicaid and to Designated and Specialized Services Agencies, funds allocated for mental health services in these settings are capped. When State policy makers set annual budget allocations, they may or may not be able to respond to the history, current and projected rates or demand for these mental health services. However, as mentioned in the prior section about mental health spending, AHS considers that the All-Payer Model requirement to create a plan to account for mental health spending by the end of 2020 creates a natural opportunity to analyze rates of payment for mental health providers outside of their current payment environments and to consider what their reasonable growth trend should be as a part of the All-Payer Financial Target Services.

13.1 DISPARITIES IN PROVIDER REIMBURSEMENT RATES

In addition to disparities between salaries of state and non-profit employees, there are disparities between rates of payment to mental health professionals and other health

professionals, even when they have the same level of education. In the Milliman Research Report (2017), the following statistics are given to describe how PPO Plans reimburse compared to Medicare for different professions[xlii]:

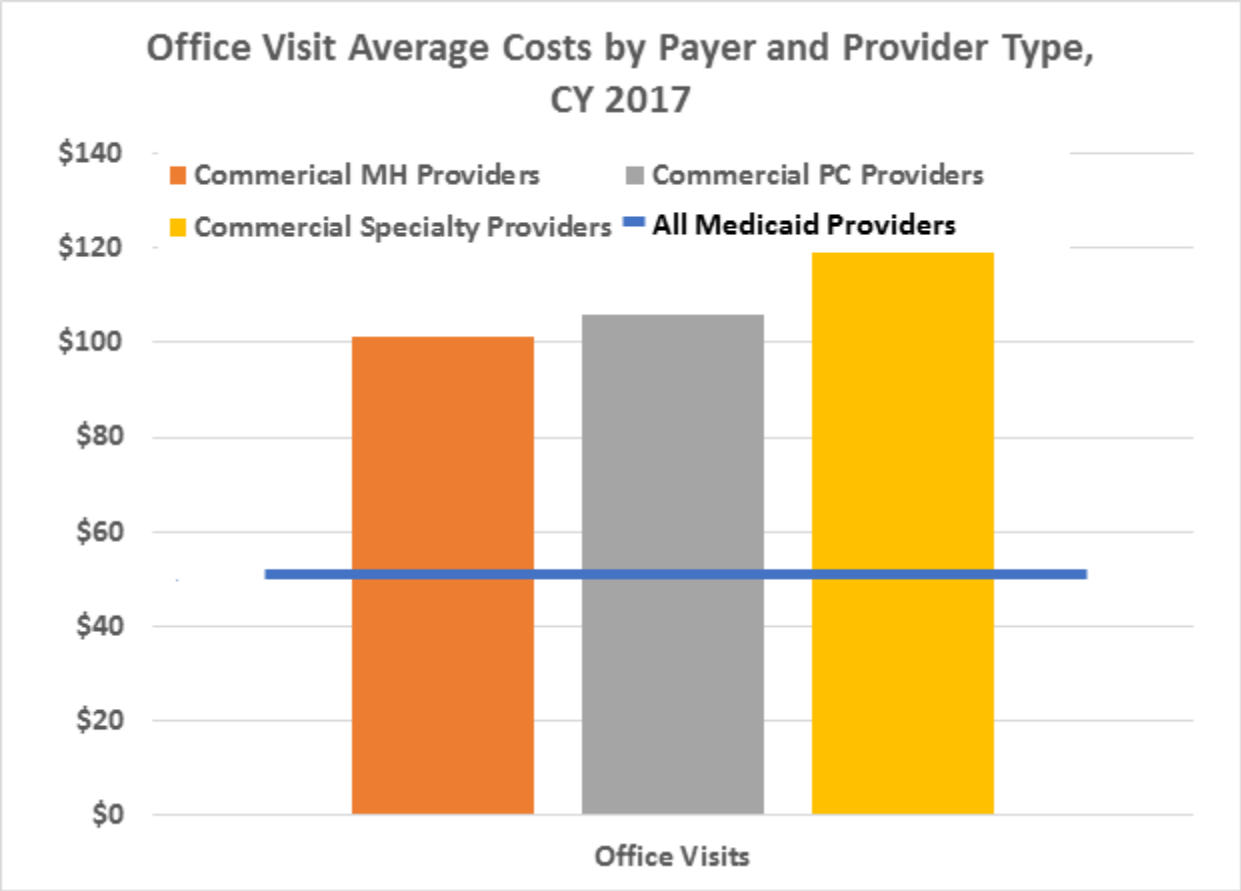
		Allowed charges relative to Medicare			Higher PCP payment levels compared to MH	Higher specialist payment levels compared to MH
		Primary Care	Specialists (not MH)	Behavioral (MH)		
Vermont	2013	128.1%	148.4%	85.1%	50.5%	74.3%
	2014	127.4%	155.4%	82.3%	54.9%	88.8%
	2015	128.1%	155.4%	81.6%	56.9%	90.4%
All States	2013	112.1%	110.1%	92.8%	20.7%	18.5%
	2014	114.6%	111.9%	94%	22%	19.1%
	2015	115.2%	111.3%	95.1%	21.2%	17.1%



The above graph and table show how private insurance consistently reimburses at lower than Medicare allowed rates for mental health professionals, while doing the opposite for primary care providers and more so for specialists.

It is the opinion of the Vermont Department of Mental Health that mental health professionals deserve to receive comparable compensation to professionals with comparable levels of education, specifically those in other health care specializations.

An attempt to mirror the Milliman analysis using Medicaid claims as compared to commercial claims from the VHCURES database appears to corroborate the results by Milliman, although less dramatically. The table below shows average payment across all evaluation and management office visits. This table is showing that, although Medicaid rates are lower, they are paid with parity across primary care and mental health providers, whereas commercial rates of payment appear to differ more greatly based on whether the provider is of mental health or physical health. Neither this analysis, nor the Milliman analysis, consider additional or enhanced payments to any of the provider types that may be made based on value or quality.



13.2 SUMMARY

- Recent increases to Medicaid rates paid to Designated and Specialized Services Agencies appear to be positively impacting provider capacity and employee retention.

- Additional analysis is recommended to review commercial rates of payment to mental health providers as compared to physical health.
- The All-Payer ACO Model Agreement requirement to review mental health spending as a part of the All-Payer Financial Target Services presents a natural opportunity to analyze rates of payment for mental health providers outside of their current payment environments and to consider what their reasonable growth trend should be.

ATTACHMENT A

The Health Affairs Task Force developed the following "Guiding Principles and Operational Questions," to assist states in creating a value-based and person-centered health care system.

Guiding Principles and Operational Questions

This principles-based framework is action-oriented and designed to be a hands-on tool that facilitates change. It provides six guiding principles accompanied by operational questions to aid a health care organization in becoming more person-centered. Organizational leaders can use these questions to identify concrete ways to foster partnership, set benchmarks, and evaluate progress toward integration of the principles into their organization's culture and transformation to value-based, person-centered care.

The principles and accompanying questions are available online and outlined below.

1. Include patients/consumers as partners in decision-making at all levels of care

- Are patients/consumers included as integral partners in all aspects of health care decision-making at every level, from system-level reform and design to point-of-care decisions?
- Are patients/consumers meaningfully engaged in governance and oversight?
- Are consumers meaningfully included in program design and implementation?
- Are person-centered performance measures included?
- Is leadership committed to supporting and cultivating changes in culture required to foster true partnerships with patients at all levels of care?
- Does the system's design strengthen consumer engagement in design-making relating to their own health and wellness?
- Are appropriate mechanisms for helping consumers take responsibility for their care considered?

2. Deliver person-centered care

Are patients/consumers and those who support them at the center of the care team?

- Is a clear and accessible point of contact available to support patients in health-related decision-making no matter where they go for care?
- Are evidence-based clinical care models used that support effective care coordination across the patient's care network?
- Are patient-centered workflows supported?
- Are appropriate consumer disclosure and transparency mechanisms supported?
- Is the capacity to provide care to consumers in a safe, effective, coordinated, and comprehensive manner being put at risk?
- Are patients protected from "narrow network" limitations?

3. Design Alternative Payment Models (APMs) that benefit consumers

Do APMs achieve cost-saving only through improvements in health and health care and do they ensure beneficiary rights and protections?

- Do consumers benefit?
- Are consumers' rights safeguarded and disclosed?
- Are vulnerable populations protected?
- Do high-priority populations benefit greatly?
- Do consumers have choice?
- Is transparent quality performance data accessible to consumers for evaluation?

4. Drive continuous quality improvement
Do the health care transformation policies and practices generate meaningful feedback and information; do they drive continuous quality improvement?

- Are patients and their authorized caregivers meaningfully engaged in quality improvement efforts?
- Have all the types of data needed to evaluate efficacy for consumers been considered?
- Are quality improvement structures and processes supported?
- Are quality improvement requirements supported?
- Are up-to-date quality measures being used?

5. Accelerate use of person-centered health information technology
Do alternative payment and care delivery models accelerate the effective use of person-centered health information technology (Health IT)? Do they enable people to better participate in their care and manage their health?

- Is use of person-centered Health IT supported?
- Does the effort incorporate strong consumer health data access, privacy, and security provisions?
- Does the effort encourage interoperable health information exchange with all parties in the care network?
- Are all parties in the care network able to gather and share appropriate electronic health data for this effort with consumers and one another?
- Have all relevant types of data needed for this effort been considered?
- Are consumers able to use patient portals, apps, and telemedicine systems to exchange information and communicate about the program?

6. Promote health equity for all
Does the health care delivery system and payment reform model promote health equity and seek to reduce disparities in access to care and in health outcomes for all?

- Does the effort support links to community-based services and supports and to other programs that address the social determinants of health, such as housing or food and nutrition programs?
- Does the effort support the use of a diverse health care workforce, including the use of community health workers?

- Does the effort support special health care services for at-risk populations?
- Does the effort support access to data needed to assess health equity-related impacts?
- Does the effort support formal structures for identifying and addressing disparities?
- Does the model's payment policy support risk adjustments, where appropriate, based on socioeconomic status and demographic factors, while at the same time ensuring that non-risk-adjusted data is publicly available?

§ 441.725 Person-centered service plan.

(a) *Person-centered planning process.*

Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(3) Is timely and occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

(6) Offers choices to the individual regarding the services and supports the individual receives and from whom.

(7) Includes a method for the individual to request updates to the plan, as needed.

(8) Records the alternative home and community-based settings that were considered by the individual.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

(2) Reflect the individual's strengths and preferences.

(3) Reflect clinical and support needs as identified through an assessment of functional need.

(4) Include individually identified goals and desired outcomes.

(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.

(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(8) Identify the individual and/or entity responsible for monitoring the plan.

(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(10) Be distributed to the individual and other people involved in the plan.

(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740.

(12) Prevent the provision of unnecessary or inappropriate services and supports.

(13) Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the

person-centered service plan. The following requirements must be documented in the person-centered service plan:

(i) Identify a specific and individualized assessed need.

(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(iii) Document less intrusive methods of meeting the need that have been tried but did not work.

(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(vii) Include informed consent of the individual; and

(viii) Include an assurance that the interventions and supports will cause no harm to the individual.

(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

ATTACHMENT C

EXAMPLES OF HEALTH CARE PARTNERSHIPS THROUGHOUT THE VCP NETWORK

Clara Martin Center: The goal is to coordinate and streamline care and services for individuals in the community and to decrease confusion and duplication of services. CMC has monthly meetings with Little Rivers Health Care (LRHC) care coordinators to discuss shared clients. They also provide psychiatric consultations to LRHC. CMC also has monthly meetings with Upper Valley Pediatrics to discuss shared clients. CMC also attends the monthly UCC, CHT and SASH meetings. With Gifford Health Center, CMC has taken part in a monthly meeting with care coordinators and coordinates on shared care plans for shared clients. Gifford attends the UCC meetings, CHT meetings, Learning Collaborative meetings, SASH meetings, VCCI (VT Chronic Care Initiative) Coordination meetings and GARP meetings all of which CMC attends as well. CMC is co-located with Gifford Health Center Staff at the Chelsea Health Center. Clara Martin Center staff provides counseling services to individuals in Chelsea and the surrounding towns in Orange County. Clara Martin Center provides co-located care coordination services one day per week at White River Family Practice which includes short term counseling and referrals.

With regard to substance abuse and criminal justice programs, CMC has a quarterly DOC/SRR Case Management meeting; attends the Monthly Adult LIT (local interagency team meeting) which focuses on coordination of care for moderate to high risk offenders reentering into the community, as well as other community high need cases who need interagency coordination; has monthly SOT coordination meeting with local probation and parole office and a monthly DVAP coordination meeting with local probation and parole office as well as a quarterly blueprint MAT meeting. In addition, CMC attends the monthly Balance of State Continuum of Care meeting in Hartford to coordinate housing resources for clients. CMC also attends the quarterly meetings for the non-categorical services (the services for those affected by the personal care changes) with UVS, Hope Charkins from Children with Special Needs, a state representative from CDD, and ourselves; and LIT meetings with DCF, education, voc. Rehab, Easter Seals, and HCRS.

Clara Martin Center attends several community integration meetings for children's services. On a monthly basis, Child and Family management staff participate in coordination and planning meetings with Upper Valley Services, Orange County Parent Child Center, and the Hartford region Local Interagency Team. In addition, we participate in weekly referral and

collaboration meetings for Children's Integrated Services, and Monthly administrative meetings for the CIS providers. Clara Martin Center has also participated regularly in the movement towards community readiness for Integrated Family Services, now known as Integrated Services (IS). These meetings take place monthly, and aim to support the community and providers in the creation of a fully integrated services system. These IS meetings include participants from physical health, mental health, community support providers, parent child centers and early intervention, as well as larger system stakeholders such as The Haven and Vermont Community Action.

Counseling Services of Addison County (CSAC): CSAC clinicians serve part time (typically 1-2 days per week) and work closely with Primary Care Physicians to provide brief mental health interventions, referrals, and care coordination within the primary care offices. They currently have seven clinicians contracted via either Blueprint or Integrated Family Services (IFS) funding in nine (9) different primary care practices in Addison County. Mental Health Clinicians are embedded directly within 22 schools in three (3) different school districts in Addison County. Services include direct 1:1 supportive counseling as well as home/school coordination. CSAC staff (typically a RN from our Community Rehabilitation and Treatment (CRT) Program) participate in a weekly learning collaborative that includes case presentations. Learning collaboration members include: Blueprint/Porter Hospital and Porter Practices/Other Private Primary Care Providers/Sash/Home Health/CSAC.

With regard to VMNG, seven CSAC staff members have received Care Navigator Orientation and Training. Approximately 20 cases have been assigned to CSAC staff members (not including the Care Navigator work being done by CSAC staff on contract through the Blueprint in Primary Care Practices-see above). CSAC staff have begun entering information in Care Navigator and staff are active participants in the VMNG monthly meetings as well as subgroups. The Addison County Collaborative Steering Committee has delegated decision making authority regarding ONE CARE VMNG collaborative dollars to a small group comprised of representatives from: Porter Hospital/Practices, Age Well, Home Health, and CSAC.

Health Care and Rehabilitation Services (HCRS): HCRS partners with the Brattleboro Retreat and Brattleboro Memorial Hospital to discuss systemic issues and challenging situations that impact our system of care. We meet regularly to address issues and seek solutions to improve our systems. HCRS psychiatrists also provide phone consultation to primary care physicians around shared clients. Collaborations with Brattleboro Memorial Hospital also include a health coach who works with the Community Health Team. HCRS also has embedded clinicians in primary health care offices in Brattleboro to support children, youth, and families.

HCRS has had a close collaborative relationship for many years with Mt Ascutney Hospital, which includes behavioral health specialists co-located at the hospital as part of their Community Health Team, providing screening, brief intervention, and referral to treatment. HCRS has worked closely with Springfield Medical Care Systems, coordinating with primary care and the Community Health Team. In addition, HCRS has recently subcontracted a care coordinator with the Springfield Community Health Team in collaboration with Springfield Medical Care Systems' FQHC. HCRS will also be working more closely with the FQHC to provide integrated services to high risk children. At Brattleboro Memorial Hospital, HCRS staff are contracted by the Community Health Team including a health coach who supports wellness activities. HCRS also has an embedded counselor at GroundWorks Collaborative and a community based perinatal wellness specialist.

As part of a collaborative SAMHSA grant in Springfield, HCRS and Springfield Medical Care Systems have established the CHILD team, consisting of case management, clinical, and wellness staff from HCRS and nursing and wellness staff from Springfield Medical Center. This team works to ensure seamless bi-directional care for all children and youth and includes consultation and regular team meetings with the additional participation from a pediatrician from Springfield Medical Center and HCRS' Child Psychiatrist. This collaboration also provides co-location of basic medical pediatric services.

HCRS' Developmental Services (DS) program partners with medical staff on a regular basis to support their clients. The DS program collaborates with VNA services to support individuals with complex medical needs. DS nurses interface with primary care physicians, specialty medical services, and hospital medical staff to help facilitate care.

Howard Center (HC): Howard Center has a contract with UVMMC to provide crisis services in UVMMC's Emergency Dept. Most recently, we have expanded our presence in the Emergency Department with an additional two FTEs through

UVMMC investment funds. HC has a long standing position imbedded in the Milton Family Practice. Most recently,

HC started a pilot project in collaboration with UVMMC to attach a Medical Home Early Childhood Clinician to a

UVMMC pediatric practice. The second pilot also with UVMMC will place a licensed clinician focused on serving New American families in a targeted UVMMC Primary Care Office. Howard Center continues a collaboration with the Burlington Community Health Center (FQHC) for the

provision of primary care for adults in our Community Support Program. In addition, HC recently expanded eldercare services through a partnership with SASH and funded by One Care to create an eldercare clinician position focused on targeted senior housing settings with a SASH site.

The Chittenden Clinic, HC's OTP (Hub) has expanded work with local spokes to form a local triage team that is charged with facilitating access to MAT across the Hub and Spoke model in Chittenden County. The growing partnership for the provision of Medication Assisted Treatment has resulted in the elimination of a wait list for MAT services. HC stepped up to create a new Spoke in the community to address the void when Maple Leaf Treatment Associates when out of business which is now providing MAT to 125 individuals.

The Burlington Street Outreach Program is a 17 year old partnership with the City, Downtown Merchants, UVMMC and State funding to deliver outreach services to individuals who are not connected with services and exhibit problematic behaviors. The Street Outreach Program served as an inspiration to create a Community Outreach Team that will serve 6 surrounding Chittenden County communities with outreach clinicians imbedded in local law enforcement with a targeted start date of January 2018.

Lamoille County Mental Health Services (LCMHS): The programs of LCMHS regularly partner with a variety of healthcare providers. Most prominent is the daily engagement with the Copley Hospital Emergency Department regarding persons needing behavioral health assessment. This is primarily through the Mobile Crisis Team and ASAP, our PIP program. It also includes LCMHS Behavioral Health collaborating with the ED social worker position in identifying high utilizing patients and prioritizes getting them into a healthcare provider for health and for behavioral health as needed. Additionally, the LCMHS AOP and CRT programs participate in the Blueprint and ACO related Unified Community Collaborative and local Learning Collaborative both of which create community care planning to persons with complex health and behavioral health challenges. This relationship extends to regular consultation between LCMHS psychiatric and clinical staff and the local FQHC primary care providers. LCMHS has also worked with the VT Department. of Health to become a distribution point for the CDC Strategic National Stockpile of medications related to a severe health emergency. Most recently LCMHS has also joined with the VT Farm Health and Safety Coalition on a pilot project with the Employee Assistance Program to help implement a farm health outreach program to increase knowledge and understanding regarding physical and behavioral health for farmers, their families and workers. Since Fall of 2018 this has also included a dedicated LNA position, the Medical Care Coordinator, who collaborates with Case Managers to facilitate

PCP contacts and visits to ensure optimal information sharing occurs between our agency and the medical provider community.

Northeast Kingdom Human Services (NKHS): NKHS was one of the first agencies to take advantage of EPSDT

Medicaid for children to create a social work position within Newport Pediatrics. This position is housed full-time at Newport Pediatrics and provides a wide variety of services including referral, case management and treatment. NKHS has a psychiatrist that spends time in one hospital, another on the way to another hospital and they currently have a contractual relationship with the local FQHC to provide mental health services in their offices. NKHS has numerous plans for future integration efforts.

Northeastern Family Institute of Vermont (NFI): NFI believes that prevention and early intervention of childhood trauma (ACES) are the most humanely and financially important issues for today's healthcare systems to effectively address. NFI has extensive expertise in the area of assessing and treating youth and adults who have experienced Complex Trauma. NFI currently presents about and provides consultation about Complex Trauma to primary care providers, school systems, judicial authorities, child welfare experts, and other service providing organizations across Vermont, the U.S., and British Columbia, Canada. They work with state agencies and organizations to increase adoption of trauma informed practices and policies. NFI hosts internationally renowned trauma researchers and thought leaders to present in Vermont. NFI recently facilitated conversations on trauma and health care between state policymakers (AHS & DCF leaders) and the international experts on developmental trauma, Allan Schore, Ph.D. and Bessel van der Kolk, M.D., while they were in Vermont doing workshops. NFI coordinates with PCP's, especially pediatric groups around individualized care for consumers.

Northwest Counseling and Support Services (NCSS): Within the Blueprint, NCSS and Primary Care have formed strong partnerships with Primary Care. There is an NCSS Social Worker embedded in 100% of local Patient Centered Medical Homes. These partnerships have improved care coordination through an integrated approach in which PCP can make direct referrals to NCSS. These NCSS Social Workers assure integrated coordination of care by acting as a liaison between Primary Care offices and NCSS. In the event of a behavioral health crisis, NCSS partners with primary care to provide mobile crisis outreach directly to the PCP's facility. NCSS has one Crisis Clinician embedded directly within our local NMC Emergency Department. This collaboration has allowed them to identify high Emergency Department utilizers and provide targeted home and community based care coordination resulting in a significant decrease in Emergency Department utilization. The NOTCH (FQHC) contracts with NCSS for

social workers at their 5 sites. Through this relationship, NCSS has developed a direct referral process with all PCP offices. NCSS provides some one-time consultations at the nursing home. NCSS also utilizes telemedicine services for medicine checks between the NOTCH and NCSS. Lastly, NCSS and the NOTCH (local FQHC) have teamed up to secure the SAMHSA Grant *Vermont FamilyCentered Health Care Home Project*. This 5 year grant will help to strengthen partnerships and promote a holistic approach to promoting wellness within children, their families, and their communities.

NCSS collaborates with NMC Primary Care Physicians to provide adolescent substance abuse treatment directly within the primary care setting. In addition to their local partnerships with Primary Care, NCSS also has partnerships with 92% of the local schools. NCSS also has two Crisis Clinicians embedded directly within local and state law enforcement. This partnership has allowed law enforcement to better manage volatile situations and improve outcomes.

Rutland Mental Health Services (RMHS): Rutland Mental Health Services (RMHS): RMHS has partnered with Community Health Centers of the Rutland Region and has placed a clinical case manager in CHCRR's offices; CHCRR is the local FQHC. The role of this position is to reach people who are struggling with chronic mental health issues and who consequently have a hard time making or keeping primary care appointments, and receiving care. The RMHS Master's-level clinician sees patients who are referred by CHCRR primary care providers and nurse managers. The clinician spends much of her time spent visiting people in remote, rural locations and doing in-home assessments. The clinician can provide therapy, assessment, coping skills, and has a better understanding of an individual's mental health condition. By building relationships with her clients, the clinician has greater success connecting them to the right services. CHCRR and RMHS are in discussions about placing another clinical case manager in a CHCRR location due to the success of this new model. In addition, RMHS's Crisis Team has an office in the local emergency room. They also have an integrated crisis worker at the Rutland City Police Department and are connected with many local schools.

United Counseling Service of Bennington County (UCS): UCS has clinical staff in 13 spoke and primary care offices throughout the county as part of the Blueprint for Health model. Included in those numbers is staff in four pediatric offices. Clinicians placed in pediatric offices are trauma informed and provide consultation and education to the community health team. In addition to training such as ACEs and trauma informed practices, Blueprint clinicians have provided additional training, most recently a presentation to physicians on the use of Cognitive Behavior Therapy for Insomnia rather than medications.

UCS and Southwestern Vermont Medical Center (SVMC) have entered into their second year of collaboration in offering an "Intensive Medication Assisted Treatment" (IMAT) program which provides treatment including observed daily dosing. Within the IMAT program are nursing, case management and physician staff through the Blueprint who are fully integrated with the clinical, management and administrative staff from UCS who share office space and documentation systems. In addition, the Rocking Horse program is also held within the IMAT office. UCS partnered with SVMC to improve patient access to mental health services by embedding psychiatry and nurse practitioner services within the Emergency Department as well as to those hospitalized at SVMC who have a primary or secondary mental health diagnosis. Given that approximately 40% of all patients being treated at SVMC have a behavioral health diagnosis it is essential to assist with policy and development, attend to providers during rounds and conduct educational sessions for staff. The psychiatry and NP staffing are available to SVMC staff and patients 20 hours per week, on-site. UCS contracts with SVMC to provide crisis clinical services within the Emergency Department. UCS and SVMC continue to discuss ways to increase integration of health care including but not limited to the development of an Atypical Behavior Unit at the Center for Living and Rehabilitation.

UCS staff is active members of the Bennington Community Care Team in order to prioritize support for high users of the ED. The Executive Director is a member of the United Health Alliance (UHA) Board, the Bennington Community Collaborative, and the Alliance for Community Health (ACH) Team.

UCS also employs a Wellness Nurse who provides Wellness care and health screenings for staff and occasionally for clients at UCS facilities. UCS provides EAP services to the Bennington Rescue Squad and SVMC.

Washington County Mental Health Services (WCMHS): WCMHS has therapists in five doctor's offices through CVMC Community Health Teams for adults and has created a trauma screening for all patients. They provide clinical supervision for SBIRT clinicians working in the CVMC Emergency Room. With the local FQHC, WCMHS provides outreach and case management for common clients. With two pediatrics offices, WCMHS has initiated a pediatric information exchange project to systemize a process for information exchange to improve health and mental health. In addition, an Adverse Childhood Experiences (ACEs) project has recently been initiated with Central Vermont Pediatric Primary Care, which embeds a collaborative position held jointly by WCMHS and the Family Center of Washington County for a family support specialist within the practice to accept up to 100 child and family referrals the first year, tracking pre and post intervention results.

The WCMHS Wellness Collaborative offers complementary approaches to traditional psychotherapy through mindfulness-focused groups, with improved outcomes on decreasing stress and increasing coping strategies. Medical practices refer patients to these programs. WellSpace in Barre, Vermont is a physical space specifically created for focus on alternatives to traditional treatment to broaden options for individuals who would not otherwise access such programs due to income, transportation, or social barriers. Programs are trauma-informed and include: open art studio, life skills programming, Jobs for transitional youth, Wellness Collaborative programming and other groups, kettle bells, cross fit, boot camp (for staff and clients); and a Doula program in collaboration with Central Vermont Medical Center, specifically for women who have experienced Adverse Childhood Events.

WCMHS also has a contract with CVMC for crisis response to the Emergency Room and the Psychiatric Unit, where over 60% of individuals screened are diverted from hospitalization. WCMHS is working with CVMC on the development of a Regional Referral Hub model that would accept referrals of individuals who do not have established follow-up treatment from primary care, emergency rooms, and psychiatric units. The purpose will be to enhance access through a single point of contact, which will include information on both public and private resources. In the past year, WCMHS has cross trained with the Emergency Room to offer a co-occurring social de-tox bed for brief support, assessment, and treatment, accepting referrals directly from the Emergency Room with immediate response.

WCMHS has worked collaboratively with CVMC to create an Integrated Health Home within the Granite City Primary Care Practice. This model assists individuals with extreme health challenges, who were not able to maintain a primary care provider, to connect through intensive case management, nursing, and psychiatric supports with the practice. The results of this model have been extremely positive with 87% success rate in successful and enduring engagement over one year for those participating.

Recently the Children, Youth, and Family Division has added one emergency room diversion bed for those Medicaid eligible children who are awaiting, or diverting from, a hospital bed. 24/7 staff provides assessment, treatment and support during a brief stay. WCMHS has also been leading its risk-bearing community with trainings and implementation of the Patient Care Navigation system through One Care Vermont. This process assigns a lead care coordinator with the goal of bringing together multi-disciplinary teams to assist individuals who have high risk health issues in accessing appropriate care and receiving at-home supports to reduce costs and improve outcomes. WCMHS also facilitates the regions monthly care coordination meeting for all community providers and the Community Health Team.

Champlain Community Services, Upper Valley Services, Families First in Southern Vermont, Green Mountain Support Services and Lincoln Street are all developmental disability agencies. Each agency coordinates with primary care and other medical teams. Developmental disability agencies take a person centered, team based approach in supporting individuals with developmental and intellectual disabilities to lead satisfying lives. This includes coordinated supported employment, home and shared living, school to career transition and community supports. In addition, the developmental disability agencies provide mental health and other clinical services as well as specialized medical care services for those who need such supports.

ATTACHMENT D

525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464

BI-STATE PRIMARY CARE ASSOCIATION
SERVING VERMONT & NEW HAMPSHIRE
Improving Access to Health Care for 30 Years
bistatepca.org

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

To: Kathy Hentcy, Department of Mental Health

Fr: Georgia Maheras, Bi-State Primary Care Association

Date: December 21, 2018

Re: Section 9 of Act 200 of that Acts of 2018

Vermont's Federally-Qualified Health Centers (FQHCs) participate in numerous mental health/substance use disorder and primary care integration projects. As providers of comprehensive primary care services, all of Vermont's FQHCs provide mental health and medication-assisted treatment services and are certified as patient-centered medical homes. Additionally, as providers of primary care in Vermont's rural communities, FQHCs work collaboratively with designated agencies and other health care providers to ensure the Vermonters in their service area receive the necessary mental health and substance use disorder treatment services.

This memo provides some of the examples of integration activities provided by Vermont's FQHCs and is not an exhaustive list. Each of these integration activities reflects the FQHCs unique community needs:

- Referral agreements and other partnerships with between designated agencies and FQHCs.
    - For example, Little Rivers Health Care has clinicians that that go to Clara Martin to visit patients.
    - Another example is that NOTCH hires social workers from NCSS to work with NOTCH patients.
- Training in trauma-informed care. FQHCs around the state are training their staff in this work and collaborative with other area providers to ensure there are appropriate referrals to services.

- School-based work. The Health Center in Plainfield provides services in the regional schools that focus on mental health, substance use disorder treatment, as well as primary care. Additionally, both the Health Center and Battenkill Valley Health Care have clinical staff that serve as guest teachers in the schools.
- Additional screening. The majority of FQHCs are using the PHQ2 and PHQ9, standard mental health and substance use disorder screening tools, to ensure their patients receive necessary services. More recently, FQHCs are expanding their tools to include screening for anxiety, trauma, and autism.

ATTACHMENT E

Mental Health Diagnosis Codes

ICD-9-CM	ICD-10-CM	Disorder, condition, or problem
Schizophrenia Spectrum and Other Psychotic Disorders (including Catatonia)		
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.4	F20.81	Schizophreniform Disorder
295.9	F20.9	Schizophrenia
295.7	F25.0	Schizoaffective disorder, bipolar type
295.7	F25.1	Schizoaffective disorder, Depressive type
293.81	F06.2	Psychotic Disorder due to Another Medical Condition, With delusions
293.82	F06.0	Psychotic Disorder due to Another Medical Condition, With hallucinations
293.89	F06.1	Catatonia Associated with Another Mental Disorder (Catatonia Specifier)
293.89	F06.1	Catatonic Disorder Due to Another Medical Condition
293.89	F06.1	Unspecified Catatonia
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia and Other Psychotic Disorder
		Bipolar and Related Disorders
296.56	F31.76	Bipolar I Disorder, Current or most recent episode depressed, in full remission
296.55	F31.75	Bipolar I Disorder, Current or most recent episode depressed, in partial remission
296.51	F31.31	Bipolar I Disorder, Current or most recent episode depressed, Mild
296.52	F31.32	Bipolar I Disorder, Current or most recent episode depressed, Moderate
296.53	F31.4	Bipolar I Disorder, Current or most recent episode depressed, Severe
296.5	F31.9	Bipolar I Disorder, Current or most recent episode depressed, Unspecified
296.54	F31.5	Bipolar I Disorder, Current or most recent episode depressed, with psychotic features
296.4	F31.0	Bipolar I Disorder, Current or most recent episode hypomanic
296.46	F31.74	Bipolar I Disorder, Current or most recent episode hypomanic, in full remission
296.45	F31.73	Bipolar I Disorder, Current or most recent episode hypomanic, in partial remission
296.4	F31.9	Bipolar Disorder I, Current or most recent episode hypomanic, Unspecified
296.46	F31.74	Bipolar I Disorder, Current or most recent episode manic, in full remission
296.45	F31.73	Bipolar I disorder, Current or most recent episode manic, in partial remission
296.41	F31.11	Bipolar I Disorder, Current or most recent episode manic, Mild
296.42	F31.12	Bipolar I Disorder, Current or most recent episode manic, Moderate
296.43	F31.13	Bipolar I Disorder, Current or most recent episode, Severe
296.4	F31.9	Bipolar I Disorder, Current or most recent episode manic, Unspecified

296.44	F31.2	Bipolar I Disorder, Current or most recent episode manic, With psychotic features
296.7	F31.9	Bipolar I Disorder, Current or most recent episode unspecified
296.89	F31.81	Bipolar II Disorder
293.83		Bipolar and related disorder due to another medical condition
293.83	F06.33	Bipolar and related disorder due to another medical condition, with manic features
293.83	F06.33	Bipolar and related disorder due to another medical condition, with manic- or hypomanic-like episodes
293.83	F06.34	Bipolar and related disorder due to another medical condition, with mixed features
301.13	F34.0	Cyclothymic Disorder
296.89	F31.89	Other Specified Bipolar and Related Disorder
296.8	F31.9	Unspecified Bipolar and Related Disorder
		Depressive Disorders
296.99	F34.8	Disruptive Mood Dysregulation Disorder
296.36	F33.42	Major Depressive Disorder, Recurrent episode, in full remission
296.35	F33.41	Major Depressive Disorder, Recurrent episode, in partial remission
296.31	F33.0	Major Depressive Disorder, Recurrent episode, mild
296.32	F33.1	Major Depressive Disorder, Recurrent episode, moderate
296.33	F33.2	Major Depressive Disorder, Recurrent episode, severe
296.3	F33.9	Major Depressive Disorder, Recurrent episode, unspecified
296.34	F33.3	Major Depressive Disorder, Recurrent episode, with psychotic features
296.26	F32.5	Major Depressive Disorder, Single episode, in full remission
296.25	F32.4	Major Depressive Disorder, Single episode, in partial remission
296.21	F32.0	Major Depressive Disorder, Single episode, mild
296.22	F32.1	Major Depressive Disorder, Single episode, moderate
296.23	F32.3	Major Depressive Disorder, Single episode, severe
296.2	F32.9	Major Depressive Disorder, Single episode, unspecified
296.24	F32.3	Major Depressive Disorder, Single episode, with psychotic features
300.4	F34.1	Persistent Depressive Disorder (Dysthymia)
625.4	N94.3	Premenstrual Dysphoric Disorder
293.83	F06.31	Depressive Disorder Due to Another Medical Condition, with depressive features
293.83	F06.32	Depressive Disorder Due to Another Medical Condition, with major depressive-like episode
293.83	F06.34	Depressive Disorder Due to Another Medical Condition, with mixed features
311	F32.8	Other Specified Depressive Disorder
311	F32.9	Unspecified Depressive Disorder
		Anxiety Disorders
309.21	F93.0	Separation Anxiety Disorder

313.23	F94.0	Selective Mutism
300.29	F40.218	Specific Phobia, Animal
300.29	F40.230	Specific Phobia, Fear of blood
300.29	F40.231	Specific Phobia, Fear of injection and transfusions
300.29	F40.233	Specific Phobia, Fear of injury
300.29	F40.232	Specific Phobia, Fear of other medical care
300.29	F40.228	Specific phobia, Natural environment
300.23	F40.10	Social Anxiety Disorder (Social Phobia)
300.01	F41.0	Panic Disorder
		Panic Attack (Specifier)
300.22	F40.00	Agoraphobia
300.02	F41.1	Generalized Anxiety Disorder
293.84	F06.4	Anxiety Disorder Due to Another Medical Condition
300.9	F41.8	Other Specified Anxiety Disorder
300	F41.9	Unspecified Anxiety Disorder
		Obsessive-Compulsive and Related Disorders
300.3	F42	Obsessive-Compulsive Disorder
300.7	F45.22	Body Dysmorphic Disorder
300.3	F42	Hoarding Disorder
312.39	F63.3	Trichotillomania (Hair-Pulling) Disorder
698.4	L98.1	Excoriation (Skin-Picking) Disorder
294.8	F06.8	Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
300.3	F42	Other Specified Obsessive-Compulsive and Related Disorders
300.3	F42	Unspecified Obsessive-Compulsive and Related Disorders
		Trauma and Stressor-Related Disorders
313.89	F94.1	Reactive Attachment Disorder
313.89	F94.2	Disinhibited Social Engagement Disorder
309.81	F43.10	Posttraumatic Stress Disorder
308.3	F43.0	Acute Stress Disorder
309.9	F43.20	Adjustment Disorder, Unspecified
309.24	F43.22	Adjustment Disorder, with anxiety
309	F43.21	Adjustment Disorder, with depressed mood
309.3	F43.24	Adjustment Disorder, with disturbance of conduct
309.28	F43.23	Adjustment Disorder, with mixed anxiety and depressed mood
309.4	F43.25	Adjustment Disorder, with mixed disturbance of emotions and conduct
309.89	F43.8	Other Specified Trauma and Stressor-Related Disorder
309.9	F43.9	Unspecified Trauma and Stressor-Related Disorder

		Dissociative Disorders
300.14	F44.81	Dissociative Identity Disorder
300.12	F44.0	Dissociative Amnesia
300.13	F44.1	Dissociative Amnesia, with dissociative fugue
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
		Somatic Symptom and Related Disorders
300.82	F45.1	Somatic Symptom Disorder
300.7	F45.21	Illness Anxiety Disorder
300.11	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder), with abnormal movement
300.11	F44.6	Conversion Disorder (Functional Neurological Symptom Disorder), with anesthesia or sensory loss
300.11	F44.5	Conversion Disorder (Functional Neurological Symptom Disorder), with attacks or seizures
300.11	F44.7	Conversion Disorder (Functional Neurological Symptom Disorder), with mixed symptoms
300.11	F44.6	Conversion Disorder (Functional Neurological Symptom Disorder), with special sensory symptoms
300.11	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder), with speech symptoms
300.11	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder), with swallowing symptoms
300.11	F44.4	Conversion Disorder (Functional Neurological Symptom Disorder), with weakness/paralysis
316	F54	Psychological Factors Affecting Other Medical Conditions
300.19	F68.10	Factitious Disorder
300.89	F45.8	Other Specified Somatic Symptom and Related Disorder
300.82	F45.9	Unspecified Somatic Symptom and Related Disorder
		Feeding and Eating Disorders
307.52	F50.8	Pica, in adults
307.52	F98.3	Pica, in children
307.53	F98.21	Rumination Disorder
307.59	F50.8	Avoidant/Restrictive Food Intake Disorder
307.1	F50.02	Anorexia Nervosa, Binge-eating/purging type
307.1	F50.01	Anorexia Nervosa, Restricting Type
307.51	F50.2	Bulimia Nervosa
307.51	F50.8	Binge-Eating Disorder
307.59	F50.8	Other Specified Feeding or Eating Disorder

307.5	F50.9	Unspecified Feeding or Eating Disorder
		Elimination Disorders
307.6	F98.0	Enuresis
307.7	F98.1	Encopresis
787.6	R15.9	Other Specified Elimination Disorder, with fecal symptoms
788.39	N39.498	Other Specified Elimination Disorder, with urinary symptoms
787.6	R15.9	Unspecified Elimination Disorder, with fecal symptoms
788.3	R32	Unspecified Elimination Disorder, with urinary symptoms
		Parasomnias
307.46	F51.4	Non-Rapid Eye Movement Sleep Arousal Disorders, sleep terror type
307.46	F51.3	Non-Rapid Eye Movement Sleep Arousal Disorders, sleepwalking type
307.47	F51.5	Nightmare Disorder
		Sexual Dysfunctions
302.74	F52.32	Delayed Ejaculation
302.72	F52.21	Erectile Disorder
302.73	F52.31	Female Orgasmic Disorder
302.72	F52.22	Female Sexual Interest/Arousal Disorder
302.76	F52.6	Genito-Pelvic Pain/Penetration Disorder
302.71	F52.0	Male Hypoactive Sexual Desire Disorder
302.75	F52.4	Premature (Early) Ejaculation
302.79	F52.8	Other Specified Sexual Dysfunction
302.7	F52.9	Unspecified Sexual Dysfunction
		Gender Dysphoria
302.85	F64.1	Gender Dysphoria in adolescents and adults
302.6	F64.2	Gender Dysphoria in children
302.6	F64.8	Other Specified Gender Dysphoria
302.6	F64.9	Unspecified Gender Dysphoria
		Disruptive, Impulse-Control, and Conduct Disorders
313.81	F91.3	Oppositional Defiant Disorder
312.34	F63.81	Intermittent Explosive Disorder
312.82	F91.2	Conduct Disorder, Adolescent-onset type
312.81	F91.1	Conduct Disorder, Childhood-onset type
312.89	F91.9	Conduct Disorder, Unspecified onset
312.33	F63.1	Pyromania
312.32	F63.2	Kleptomania
312.89	F91.8	Other Specified Disruptive, Impulse-Control, and Conduct Disorder
312.9	F91.9	Unspecified Disruptive, Impulse-Control, and Conduct Disorder

		Personality Disorders
		Cluster A- Personality Disorders
301	F60.0	Paranoid Personality Disorder
301.2	F60.1	Schizoid Personality Disorder
301.22	F21	Schizotypal Personality Disorder
		Cluster B- Personality Disorders
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
301.5	F60.4	Histrionic Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
		Cluster C- Personality Disorders
301.81	F60.6	Avoidant Personality Disorder
301.6	F60.7	Dependent Personality Disorder
301.4	F60.5	Obsessive-Compulsive Personality Disorder
		Other Personality Disorders
310.1	F07.0	Personality Change Due to Another Medical Condition
301.89	F60.89	Other Specified Personality Disorder
301.9	F60.9	Unspecified Personality Disorder
		Paraphilic Disorders
302.82	F65.3	Voyeuristic Disorder
302.4	F65.2	Exhibitionistic Disorder
302.89	F65.81	Frotteuristic Disorder
302.83	F65.51	Sexual Masochism Disorder
302.84	F65.52	Sexual Sadism Disorder
302.2	F65.4	Pedophilic Disorder
302.81	F65.0	Fetishistic Disorder
302.3	F65.1	Transvestic Disorder
302.89	F65.89	Other Specified Paraphilic Disorder
302.9	F65.9	Unspecified Paraphilic Disorder
		Other Mental Disorders
294.8	F06.8	Other Specified Mental Disorder Due to Another Medical Condition***
294.9	F09	Unspecified Mental Disorder to Another Medical Condition
300.9	F99	Other Specified Mental Disorder
300.9	F99	Unspecified Mental Disorder

ATTACHMENT F

December 11, 2018

Megan Douglas, JD
Assistant Professor, Department for Community Health and Preventive Medicine
Policy Director, National Center for Primary Care
Associate Director for Policy, Kennedy-Satcher Center for Mental Health Equity
720 Westview Drive
Atlanta, GA 30310

Dear Ms. Douglas,

Thanks for your response to my inquiry about the Kennedy-Satcher Center's evaluation of Vermont's mental health parity law as well as for attaching the state-specific data upon which Vermont's Report Card grade was based. The attachment provides a helpful overview of how Vermont's final grade was determined by the Center.

I understand that, in preparing a nationwide report, it is difficult to perform a wholistic evaluation of each state's laws that pertain to access to mental health care services. Nevertheless, I believe there are several Vermont statutes and regulations that, if considered in the Center's analysis, would have resulted in a grade that more accurately reflects Vermont's longstanding commitment to mental health parity.

For example, Vermont's grade appears to have been based, in part, upon the Center's conclusion that state law is silent on the question of whether the Commissioner of Financial Regulation is authorized to enforce the requirements of the federal mental health parity law. *See* Question 8 of the scoring rubric. In fact, 8 V.S.A. § 4062c specifically requires the Commissioner to enforce the applicable provisions of federal health care law, including the Patient Protection and Affordable Care Act, using his general enforcement powers. The fact that this obligation is set forth in a different section of Title 8, rather than in the mental health parity statute (8 V.S.A. § 4089b) itself, does not diminish its binding nature.

Question 7 of the scoring rubric looks at the question of whether state law requires that the standards for utilization review and prior authorization of mental health care services be comparable to and no more restrictive than the standards for review and authorization of other medical services. Although Vermont received no credit on this question, Section 3.1(E)(5) of Department Regulation H-2009-03 ("Consumer Protection and Quality Requirements for Managed Care Organizations") directly addresses the issue by mandating that utilization

management for mental health or substance abuse benefits "be based on the complexity of the individual case and shall not require greater burden to the member or the treating health care provider than would be required for utilization management of similar benefits." The fact that this requirement is embodied in a regulation which has the force of law, rather than in a statute, does not make compliance any less obligatory for health insurers and utilization review agents.

Finally, Question 10 in the scoring rubric asks whether state law requires "health insurance/benefit plans to submit reports demonstrating how they comply with the Federal Parity Law and/or any state parity statutes of regulations." Vermont received no credit on this question as well, despite the fact that Department Regulation 2000-03-H ("Health Insurance Coverage of Mental Health and Substance Abuse Services") requires the five largest health insurance companies doing business in the state to file annually with the Commissioner a report card on the health insurance plan's performance in relation to eleven different "quality measures for the care, treatment and treatment options of mental health and substance abuse conditions covered under the plan."

There are other areas where the Department believes the Center's Report Card fails to consider Vermont laws that are relevant to the delivery of quality mental health care and I would be happy to discuss them with you or your staff. As I stated in my e-mail to you last week, Vermont takes its commitment to ensuring access to affordable mental health treatment very seriously. While the Department understands the limitations inherent in producing state-by-state report cards, we do believe that it is fairer to focus on the entirety of a state's regulatory framework for mental health care rather than looking at a single statute such as 8 V.S.A. 4089b in isolation. Toward that end, I wonder if it would make sense the next time the Center undertakes such a project to forward the preliminary results to the states for comment rather than moving directly to publication. I suspect that if Vermont had had an opportunity to comment in this case, its grade on the Report Card would have been considerably better and would have more accurately reflected the state's efforts in this important area.

Please do not hesitate to call me if you would like to discuss these concerns further.

Best regards,

/s/ Phil Keller

Phil Keller
Director of Insurance Regulation
Vermont Department of Financial Regulation
(802) 828-1464

cc: Michael Pieciak, Commissioner

ATTACHMENT G

Response to Phil Keller Letter 12/14/18

From: Douglas, Megan <mdouglas@msm.edu>
Sent: Friday, December 14, 2018 4:43 PM
To: Keller, Phil <Phil.Keller@vermont.gov>
Cc: Pieciak, Michael <Michael.Pieciak@vermont.gov>; Rouleau, Christina R. <Christina.Rouleau@vermont.gov>; Boyles, Gavin <Gavin.Boyles@vermont.gov>; Brown, Emily <Emily.Brown@vermont.gov>
Subject: RE: Kennedy Forum 2018 State Report Cards on Mental Health Parity

Hi Phil,

Thank you for your letter and the additional information. I agree with all of your points. As I mentioned, our review was limited to statutes and did not include regulations. We understand that regulations also have the force of law, but we did not have the capacity to take on the regulatory environment for the initial project. However, we will absolutely include the regulations you mentioned in our regulatory review that is ongoing.

Unfortunately, the compliance statute you mentioned was not included in our coding since it was not part of the parity statute. As you rightly point out, this does not diminish its binding nature. Given the large volume of state statutes reviewed (more than 300 across all 50 states), we had to develop limiting criteria and this is one example of how our methodology can be improved in future iterations. We will keep this in mind and again, appreciate your bringing this to our attention.

We truly attempted to undertake this project in the most transparent way possible, which is why we published our methodology and statutory coding instrument in as much detail as we could and why I am more than happy to provide the state-level data. We wanted to be very clear on what we included and did not include in our analysis. We completely understand that this was not a comprehensive assessment of how states are performing, but rather a small first step that will enable us to evaluate the impact of state laws and policies on outcomes.

I appreciate your continued engagement and would love to consult you as we continue to develop this project. Happy holidays to you and your team!

Kindest regards,

Megan

Megan Douglas, JD

Assistant Professor, Department of Community Health and Preventive Medicine
Policy Director, National Center for Primary Care
Associate Director for Policy, Kennedy-Satcher Center for Mental Health Equity
Course Director, Health Policy & Advocacy Rotation
T: (404) 756-5275 | E: mdouglas@msm.edu

720 Westview Drive Atlanta, Georgia 30310 | www.msm.edu
Leading the creation and advancement of health equity

MOREHOUSE SCHOOL OF MEDICINE

REFERENCES

[i] National Alliance on Mental Illness. (2017*). Types of mental health professionals.* Retrieved from https://www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionals

[ii] State of Vermont Secretary of State (10/9/2018). Office of Professional Regulation. Retrieved from https://www.sec.state.vt.us/professional-regulation.aspx

[iii] State of Vermont Agency of Human Services Department of Mental Health (1/1/2019). Retrieved from https://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Mental_Health_Provider_Manual_v5.11.pdf

[iv] For a complete listing of requirements, see Designated Agency Emergency Services Standards Manual: http://mentalhealth.vermont.gov/sites/dmh/files/documents/Manuals/Emergency%20Services%20Standards%202017-12.pdf

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

[vi] Mental Health America. (2018). *Mental health in America- Access to care data.* Retrieved from http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data

[vii] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral health barometer: Vermont, volume 4: Indicators as measured through the 2015 national survey on drug use and health, the national survey of substance abuse treatment services, and the uniform reporting system*. Retrieved from https://store.samhsa.gov/system/files/sma17-barous-16-vt.pdf

[viii] Ibid.

[ix] Ibid.

[x] Ibid.

[xi] Data Resource Center for Child & Adolescent Health. (2016-2017). *2016 and 2016-2017 Combined national survey of children's health interactive data query*. Retrieved from http://www.childhealthdata.org/browse/survey

[xii] Ibid.

[xiii] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral Health Barometer*

[xiv] Ibid.

[xv] Ibid.

[xvi] Ibid.

[xvii] Data Resource Center for Child & Adolescent Health. (2016-2017). *Combined National Survey*

[xviii] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral Health Barometer*

[xix] Ibid.

[xx] Data Resource Center for Child & Adolescent Health. (2016-2017). *Combined National Survey*

[xxi] Ibid.

[xxii] National Survey of Children's Health (2016). *Percent of children with a medical home*. As cited by the Henry J Kaiser Family Foundation. Retrieved from https://tinyurl.com/y78c87f2

[xxiii] Substance Abuse and Mental Health Services Administration. (2017). *Behavioral health barometer*

[xxiv] Ibid.

[xxv] Centers for Disease Control and Prevention (CDC) & National Center for Health Statistics (NCHS) (2014). *National health interview survey (NHIS)*. As cited by the Henry J Kaiser Family Foundation. Retrieved from https://tinyurl.com/ybvhjxrz

[i] VT Agency of Human Services Department of Health (2018). *Vermont Household Health Insurance Survey 2018 Report.* Retrieved from http://www.healthvermont.gov/sites/default/files/documents/pdf/VHHIS_Report_2018.pdf

[xxvi] Walker ER, Cummings JR, Hockenberry JM, Druss BG. Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatr Serv*. 2015;66(6):578-84. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4461054/

[xxvii] VT Agency of Human Services Department of Vermont Health Access. (2018). *Global Commitment to Health Annual Report, CY 2017.* Retrieved from http://dvha.vermont.gov/global-commitment-to-health/vt-2017-gc-annual-report-final-attachments.pdf

[xxviii] VT Agency of Human Services Department of Health. (2018). Health statistics and vital records: Health care systems reporting: Health care workforce data. Retrieved from http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/health-care-workforce & http://www.healthvermont.gov/sites/default/files/documents/pdf/HS_MHC-2017.pdf

[xxx] Department of Vermont Health Access. (2016). *Access to care plan*. Retrieved from: http://dvha.vermont.gov/global-commitment-to-health/1final-access-to-care-plan-oct-2016.pdf

[xxxi] Agency of Human Services. (2017). *Travel time and distance from claims data: Access review plan: Statewide comparison 2015 vs. July 2016-June 2017*

[xxxii] State of Vermont Agency of Human Services. (2018). *Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1. Retrieved from* http://dvha.vermont.gov/global-commitment-to-health/global-commitment-to-health-1115-waiver-2018-documents

[xxxiii] World Health Organization. (2003). *Quality Improvement for Mental Health*. Retrieved from www.who.int/mental_health/resources/en/Quality.pdf?ua=1

[xxxiv] Agency of Human Services Department of Mental Health. (2019). *Results Based Accountability Scorecard.* Retrieved from: http://mentalhealth.vermont.gov/reports/results-based-accountability

[xxxv] Agency of Human Services Department of Disabilities, Aging, and Independent Living. (2018). *Hospital survey statements.* Retrieved from https://dlp.vermont.gov/document-categories/hospital-survey-statements

[xxxvi] Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Retrieved from: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf

[xxxvii] Ness, D., Lansky, D., Gilfillan, R., & Cohen, J. (2016). How person-centered is your health care organization? *Health Affairs*. Retrieved from: https://www.healthaffairs.org/do/10.1377/hblog20160830.056139/full/

[xxxviii] World Health Organization. (2015). *WHO global strategy on integrated people-centered health services 2016-2026: Executive summary: Placing people and communities at the center of health service*, pg 9. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/180984/WHO_HIS_SDS_2015.20_eng.pdf;jsessionid=6685A80E0B71DB31FDFB549A1A1E566F?sequence=1

[xxxix] State of Vermont Agency of Human Services. (2018). *ACT 264 and coordination of services*. Retrieved from https://ifs.vermont.gov/docs/sit

[xl] State Interagency Team and the Interagency Agreement Support Committee. (2006*). Act 264 and the DOE/AHS interagency agreement users guide.* Retrieved from https://ifs.vermont.gov/sites/ifs/files/Act%20264%20users%20guide%20final.pdf

[1] Copeland, R. (2000). *Vermont's vision of a public system for developmental and mental health services without coercion.* Vermont Department of Developmental and Mental Health Services.

[iii] Monahan, J., Lidz, C., Hoge, S. K., Mulvey, E.P., Eisenburg, M. M., Roth, L. H., Gardner, W.P., & Bennett, N. (1999). Coercion in the provision of mental health services: The macarthur studies. In J. P. Morrissey & J. Monahan (Eds.), *Research in community mental health: Coercion in mental health services: International perspectives* (Vol. 10, pp. 25-27). Bingley BD16 1WA, UK: Emerald Group Publishing Limited.

[xli] World Health Organization. (2015). *WHO global strategy on integrated people-centered health services 2016-2026: Executive summary: Placing people and communities at the center of health service*, pg 4. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/180984/WHO_HIS_SDS_2015.20_eng.pdf;jsessionid=6685A80E0B71DB31FDFB549A1A1E566F?sequence=1

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