ADVANCING FROM VISION TO RESULTS

Findings and Recommendations to Implement Act 79 and Improve Vermont's Mental Health System

Prepared for:

Vermont General Assembly
Special Committee on Mental Health

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ADVANCING FROM VISION TO RESULTS

Findings and Recommendations to Implement Act 79 and Improve Vermont's Mental Health System

ACKNOWLEDGEMENTS

We acknowledge the individuals and organizations who contributed to our efforts to conduct a review of planning and early implementation of Vermont's Act 79 of 2012, "An Act Relating to Reforming Vermont's Mental Health System." Foremost are the members of the Vermont State Legislature and Governor Shumlin. In our decades of work in behavioral health, we have yet to meet with and hear the views of as many Legislators as we did in Vermont. It is clear that Vermont has many champions in the Legislature and Governor's Office who care deeply about Vermonters with mental health conditions and are committed to supporting systems and service improvements on their behalf.

We were fortunate to meet with dozens of concerned and committed administrators and staff from State and local government departments and agencies, public and private health and human service providers, consumers, family members, advocates, law enforcement, and many others during our site visit to Montpelier. Those with whom we met gave freely and openly of their time and their thoughts, for which we remain grateful.

Commissioned by the Vermont Legislative Joint Fiscal Office, the project was administered by Stephen Klein, Fiscal Officer, and Catherine Benham, Associate Fiscal Officer. We appreciate their steadfast guidance and assistance. Patrick Flood, Commissioner, and other senior and administrative staff from the Department of Mental Health could not have been more responsive to our requests for background materials, data, in-person interviews, and our follow-up questions. We thank them for their cooperation and their many contributions.

Finally, we thank the many people who were involved in this effort for a challenging and rewarding opportunity to share our expertise, perspectives, and recommendations on how Vermont can seize the opportunities and challenges presented by Act 79 to improve and sustain a recovery-oriented mental health system throughout the State.

We are pleased to deliver this final report, "Advancing from Vision to Results: Findings and Recommendations to Implement Act 79 and Improve Vermont's Mental Health System." It is our hope and belief that, if successfully implemented, these strategies will greatly assist Vermont achieve a community-based mental health system with positive outcomes for consumers of mental health care.

Gail P. Hutchings, MPA
on behalf of the
Behavioral Health Policy Collaborative Team
Alexandria, VA
July 2012

Table of Contents

List of Abbreviations

ACT: Assertive Community Treatment
ADA: American with Disabilities Act
BHPC: Behavioral Health Policy Collaborative
CMS: Centers for Medicare and Medicaid Services
CRT: Community Rehabilitation and Treatment
CSAC: The Counseling Services of Addison County, Inc.
DMH: Department of Mental Health
DRVT: Disability Rights Vermont
ED: Emergency Departments
FFP: Federal Financial Participation (in Medicaid)
PDSA: Plan, Do, Check/Study, Act
HRSA: Health Resources and Services Administration
HUD: U.S. Department of Housing and Urban Development
ICM: Intensive Case Management
IMD: Institutions for Mental Disease
IOM: Institute of Medicine
IPS: Individual Placement and Support
NAMI: National Alliance on Mental Illness
NASMHPD: National Association of State Mental Health Program Directors
RFP: Request for Proposals
RN: Registered Nurse
SAMHSA: Substance Abuse and Mental Health Services Administration
TAC: Technical Assistance Collaborative
TCM: Targeted Care (Case) Managers
TCM: Targeted Care Management
VAHHS: Vermont Association of Hospital and Health Systems
VAMH: Vermont Association for Mental Health
VPS: Vermont Psychiatric Survivors
VSH: Vermont State Hospital

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EXECUTIVE SUMMARY

In 2012, Vermont passed Act 79, "An Act Relating to Reforming Vermont's Mental Health System," creating a meaningful opportunity for large system change designed to raise the bar on services provided to adult Vermonters with mental illnesses. Shortly after the Governor signed the bill, the Behavioral Health Policy Collaborative (BHPC), comprising several experts in mental health and substance abuse policy, programs, and services, was commissioned to analyze the new law, ascertain stakeholder expectations, and provide recommendations for planning and implementation of the Act.

Act 79 is a comprehensive piece of legislation designed to significantly improve the delivery of mental health services within Vermont. The Act includes a wide range of provisions ranging from the temporary and long-term replacement of inpatient capacity previously provided at the Vermont State Hospital to the expansion of peer support programs. The Act's goal is to create a system of care directed and shaped by the principles of recovery, integrated community living, adequate supports, and least restrictive care. Moving toward this goal will require a great deal of work by a system already stressed by the sudden closure of the hospital and a history of budgetary and personnel cutbacks.

With any large system change, there are great opportunities, as well as risks. Both must be weighed and, in particular, the risks must be addressed in order for Vermont to fully realize the potential of Act 79. Below we identify several of the most salient opportunities and risks brought about by Act 79 and other factors affecting Vermont's mental health system.

OPPORTUNITIES AND RISKS

Act 79 offers Vermont the chance to:

- Reorganize the mental health system with a focus on developing and providing the services and supports, including housing, needed by individuals with mental illnesses in the least restrictive setting possible (i.e., integrated community living).
- Infuse evidence-based practices throughout the system of care.
- Realign services and systems to take a whole-person approach to health care, addressing mental health, substance abuse, and primary care with the same urgency.
- Expand recognized models of peer-provided services and supports.
- Build in performance-based outcomes in all service and support contracts.
- Develop processes that use data to manage daily operations, measure performance, inform decisions, and evaluate outcomes.

Along with the abundance of opportunity presented by Act 79 come significant risks that all stakeholders need to be aware of and address. Risks in the current environment include the following considerations:

- Unless the State identifies a broadly agreed upon set of values and principles built upon those in Act 79, this process could become stymied by trying to be all things to all people. This will greatly slow the change process and ultimately water down

priorities, leading to misunderstanding and failure to meet fundamental expectations.

- Vermont's financing strategy for its system of care depends on significant "ifs" that range from the need for the continuation of its Medicaid Global Waiver at least in the mid-term to assurances by federal authorities that the new psychiatric hospital will not be considered an IMD (Institutions for Mental Disease) and thus will not be precluded from federal payments. Should either of the assumptions not hold, the State will be forced to either absorbing significant expenses that are not currently budgeted or cutting vital services.
- Vermont's systems change and redesign must remain cognizant of federal ADA (Americans with Disabilities Act) laws and the Supreme Court's *Olmstead* decision regarding community inclusion. Ignoring these will thwart development of a state-of-the-art system of care and could result in wasted time and resources.
- The historic difficulty in moving from "discussing" to "doing" must be overcome; Act 79 presents the impetus to do so. System change is hard, complicated, messy, and imperfect, and total risk avoidance is not possible. The State must move swiftly and decidedly for time is important to those awaiting new or improved services. Failure to demonstrate significant strides in services and outcomes risks losing the crucial support of the Legislature, Administration, and the public at large.

BHPC has taken these opportunities and risks into close consideration as we developed our work product. This report contains BHPC's findings and our 24 recommendations, as presented to the Special Committee on Mental Health of the Vermont General Assembly.

PRIORITY RECOMMENDATIONS

The body of the report mirrors the order of the relevant topics/sections as contained in Act 79. However, because we realize that the State remains focused on finding placements for consumers in need of inpatient beds due to the closure of the Vermont State Hospital and our emphasis on the need to identify priority activities, we recommend giving priority consideration and attention to the following five recommendations from our set of 24 recommendations.

RECOMMENDATION 2: *The Department of Mental Health should develop a detailed ACT 79 implementation plan.*

RECOMMENDATION 9: *The Department of Mental Health should enhance its capacity to hire sufficient and competent staff with the expertise to aggressively monitor the utilization of all services currently financed under the State's mental health system, including Community Rehabilitation and Treatment clients and clients receiving adult outpatient services.*

RECOMMENDATION 23: *Create a quality assurance unit within the Department of Mental Health to develop standards and to assess the clinical efficacy, capacity, and effectiveness of current and new services provided under contract to the State.*

RECOMMENDATION 19: *Immediately direct Act 79 funds toward ensuring timely statewide access to quality crisis services. This should entail the establishment of access and quality standards for these services that can be used to identify and direct new resources to closing gaps in services.*

RECOMMENDATION 12: *The Department of Mental Health should create a set of system objectives that ensures that both inpatient and community services align. This should include the establishment of clearly defined clinical expectations relative to admission, discharge and continuity of care.*

COMPLETE SET OF BHPC RECOMMENDATIONS

Below is the complete set of BHPC recommendations, including those listed above as suggested priorities (highlighted in bold). Grounded in the nine principles outlined in Act 79 (Sec. 1a § 7251), BHPC recommends:

Producing an Updated DMH Mission, Vision, Values, and Principles Statement

RECOMMENDATION 1: *The Department of Mental Health (DMH) should develop an updated mission, vision, values and principles statement that not only aligns and adheres with those in Act 79, but goes beyond to articulate DMH's core values, principles of recovery and key tenets of service provision.*

Developing a Comprehensive Implementation Plan

RECOMMENDATION 2: (PRIORITY) ***The Department of Mental Health should develop a detailed ACT 79 implementation plan.***

Establishing System Performance Measures

RECOMMENDATION 3: *Establish a set of broad "system" performance measures that include reports on service and support "process" delivery, as well as outcomes of these changes. All of this data should be*

used to compile and deliver monthly or quarterly dashboard reports that can be used to track progress and identify needed changes.

RECOMMENDATION 4: *DMH should provide real-time web access to the Act 79 implementation plan and the measures that will be used to gauge implementation progress.*

Developing a Communications Strategy

RECOMMENDATION 5: *The Administration and Legislature should develop a communications strategy for sharing with the public the progress made to implement Act 79.*

Clinical Resource Management and Oversight (Act 79, § 7253)

Establishing Clinical Authority and Leadership

RECOMMENDATION 6: *There should be an established single point of clinical responsibility and authority within the State's mental health system.*

RECOMMENDATION 7: *The State should undertake a "high utilizer" study to identify those individuals who cycle through community and state inpatient psychiatric facilities, homeless shelters, emergency departments, prisons and other costly settings.*

RECOMMENDATION 8: *The Department of Mental Health should consider using contractual performance measures to incentivize providers to meet system level outcomes by allocating a small percentage (2-5%) of all service dollars tied to ACT 79 funding.*

Employing Care/Utilization Management

RECOMMENDATION 9: (PRIORITY) ***The Department of Mental Health should enhance its capacity to hire sufficient and competent staff with the expertise to aggressively monitor the utilization of all services currently financed under the State's mental health system, including Community Rehabilitation and Treatment clients and clients receiving adult outpatient services.***

RECOMMENDATION 10: *Based upon the "high utilizer" review (see Recommendation 7), the Department of Mental Health should enhance its care management capacity to include sufficient staff and expertise to identify and coordinate behavioral health and medical care for the top (10-20%) of high-risk/high-cost consumers with serious mental illness and high risk/high cost consumers receiving adult outpatient services.*

Integration of the Treatment for Mental Health, Substance Abuse, and Physical Health (Act 79, Sec. 1a § 7254)

Expanding on the Blueprint for Health

RECOMMENDATION 11: *The Department of Mental Health should work with the Department of Vermont Health Access, Department of Health and the Division of Alcohol and Drug Abuse Programs to expand the scale and scope of Blueprint activities as they relate to the integration of mental health and substance abuse services with primary medical care.*

System of Care (Act 79, Sec. 1a § 7255)

Ensuring Alignment of Inpatient and Outpatient Care

RECOMMENDATION 12: (PRIORITY) ***The Department of Mental Health should create a set of system objectives that ensures that both inpatient and community services align. This should include the establishment of clearly defined clinical expectations relative to admission, discharge and continuity of care.***

RECOMMENDATION 13: *The Department of Mental Health should establish comparative performance targets and measures (e.g., admission, discharge, readmission) that document how well providers manage patient flow between inpatient and community-based care. DMH should develop methods for incentivizing its providers to attain specific system level outcomes aimed at aligning inpatient and community care.*

Planning for Inpatient Hospital Beds

RECOMMENDATION 14: *The Agency of Human Services should continue to seek written clarification from the Centers for Medicare and Medicaid Services on the opportunity for Medicaid reimbursement for the future psychiatric hospital.*

RECOMMENDATION 15: *The Department of Mental Health should immediately develop a workgroup led by its medical director to develop appropriate policies, procedures and plans for the operation of the new Vermont state psychiatric hospital that meet federal standards of care and are directed by the ADA and the* Olmstead *Decision, for example, in terms of discharge planning. The workgroup should prioritize the development of new services that will prevent people from entering the inpatient care system, and provide intensive services and supports to those being discharged from care to help them become integrated in their communities.*

RECOMMENDATION 16: *The State should formally establish "use liens" for any space where state capital funds are being used to renovate non state-owned or -controlled space as alternatives to the state psychiatric hospital.*

Expanding Community Services

RECOMMENDATION 17: *Evaluate the clinical eligibility criteria and raise the cap on Community Rehabilitation and Treatment (CRT) to accommodate increased need for CRT services.*

RECOMMENDATION 18: *Consider the benefits and drawbacks of "Medicaiding" most or all of mental health services for the Community Rehabilitation and Treatment program and adult outpatient population.*

Providing Mobile Crisis and Emergency Psychiatric Services

RECOMMENDATION 19: (PRIORITY) ***Immediately direct Act 79 funds toward ensuring timely statewide access to quality crisis services. This should entail the establishment of access and quality standards for these services that can be used to identify and direct new resources to closing gaps in services.***

RECOMMENDATION 20: *The Department of Mental Health should expand jail diversion and crisis intervention teams available to work with local and state police.*

Expanding Peer Services

RECOMMENDATION 21: *The Department of Mental Health should ensure adequate training and supervision of lay peer counselors as peer-run services expand. DMH should also explore the potential to certify peer counselors for quality assurance purposes and to understand potential reimbursement for these services under Medicaid.*

RECOMMENDATION 22: *The Department of Mental Health should establish a relationship with a nonprofit support center or other similar organization to help consumers develop new peer-operated services.*

Conducting Quality Management

RECOMMENDATION 23: (PRIORITY) ***Create a quality assurance unit within the Department of Mental Health to develop standards and to assess the clinical efficacy, capacity and effectiveness of current and new services provided under contract to the State.***

Building Capacity

RECOMMENDATION 24: *The Department of Mental Health should establish a dedicated program development team that can provide training, technical assistance and support to new and existing providers in the development of new programs and services across the State.*

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INTRODUCTION/PROJECT PURPOSE AND SCOPE

Charge to Project Team

In early April 2012, Vermont's Governor Shumlin signed into law Act 79 of 2012 (Act 79), "An Act Relating to Reforming Vermont's Mental Health System."[1] Section 33(e) of the Act calls for "an independent consultant…to evaluate the structure, services and financial implications of Vermont's proposed mental health system."[2] (See Appendix A for the full text of Act 79). The law requires the consultant to submit a report to the General Assembly by December 1, 2012 that addresses:

1. Whether Vermont's proposed mental health system appropriately serves the needs of individuals with mental health conditions throughout the state and, if any unmet needs are identified, how they may be addressed.

2. The data and evaluation mechanisms necessary to manage and improve the quality of care and outcomes for Vermonters with a mental health condition.

Later in April 2012, the Special Committee on Mental Health consisting of the members of the Joint Fiscal Committee and the chairs and vice-chairs of the House Committee on Human Services and the Senate Committee on Health and Welfare, with a financial contribution from the Department of Mental Health (DMH), contracted with the Behavioral Health Policy Collaborative, LLC (BHPC) to conduct an independent review of planning and initial implementation of Act 79's requirements. As the project's objective, the agreement stated, "BHPC will provide a professional, independent assessment of the State's 2012 Mental Health Plan [Act 79] and will provide a written report identifying areas of strengths and potential improvements. BHPC will assist the State with identifying key financing strategies and mental health outcome and accountability measures to ensure that adults with serious mental illnesses receive quality care."

Project Scope

The scope of the project was limited to adults in Vermont with serious mental illness, including individuals who currently need and/or use mental health and other related services, as well as those who may develop such needs in the future. While many people with mental health conditions have co-occurring substance use and/or physical health disorders, this project was not intended to separately address these other conditions or the systems

[1] Vermont Act 79, An act relating to reforming Vermont's mental health system. 2012.
[2] The full text of Act 79, Section 33(e) states: A special committee consisting of the members of the joint fiscal committee and the chairs and vice chairs of the senate committee on health and welfare and the house committee on human services, in consultation with the commissioner of mental health shall contract with an independent consultant who has expertise in the field of mental health and psychiatric hospital services to evaluate the structure, services, and financial implications of Vermont's proposed mental health system. The joint fiscal office shall administer the contract for the special committee. The department of mental health shall transfer to the joint fiscal committee one-half the cost of this contract and the joint fiscal committee is authorized to transfer one-half the cost of this contract from the legislative budget to the joint fiscal committee.

associated with them. In addition, as we understand that most persons with serious mental illnesses or in need of adult outpatient services are, or will be, covered under Vermont's 1115 Global Commitment Medicaid waiver, we do not distinguish between Medicaid and non-Medicaid services and populations.

Team Composition

Our review of planning and initial implementation of Act 79 and this resulting report were conducted by a BHPC team of national mental health policy, services, and financing experts, including Gail Hutchings, MPA, BHPC President and CEO, who served as project director; senior consultants Martin Cohen, MSW, Leslie Schwalbe, MPA, and Kevin Huckshorn, RN, MSN; and writer/editor Heather Cobb.

Project Approach and Key Activities

BHPC submitted a project approach and work plan to the Legislative Joint Fiscal Committee in April 2012. Given the tight timeframe to conduct the work, five primary activities were planned under the project: (1) developing and submitting a list of needed background materials and data; (2) reviewing the materials provided; (3) planning and holding a 2-½ day site visit in Vermont to conduct key informant interviews and to identify additional information needed for the project; (4) preparing and submitting draft and final versions of the outline and report; and (5) presenting BHPC's major findings and recommendations via teleconference to members of the Special Committee on Mental Health and other interested legislators. These activities took place between April and July 2012.

Guided by the contents of Act 79, the BHPC team requested and reviewed volumes of materials provided by a variety of sources. These materials span legislative documents; prior consultants' reports on the State's mental health services; block grant applications and implementation reports; DMH reports and materials on budgets, utilization management, quality improvement, contract and network management documents and information systems; advocacy reports; and other resources (see Appendix B).

Three members of the BHPC team, Gail Hutchings, MPA, Martin Cohen, MSW, and Leslie Schwalbe, MPA, conducted a site visit to Vermont from May 21 to May 23, 2012, spending in excess of 20 hours in onsite interviews of key stakeholders. During the site visit, we interviewed dozens of Vermont legislators, government and other public and private sector administrators, mental health care providers, advocates, consumers, and family members (see Appendix C for a complete list of stakeholders). The interviews were designed to elicit specific examples of services and supports to mental health consumers in Vermont that work well and examples of others that are not working well and need improvement or replacement; and to gather input and recommendations for systems improvements consistent with the requirements of Act 79. We were gratified by the level of direct and open discourse that occurred during the site visits and the genuine desire of those we interviewed to achieve real improvements in service availability, access, and outcomes for Vermont's mental health consumers. During the course of our visit, several stakeholders asked for our assistance in identifying resources and materials relative to a range of mental health clinical,

programmatic, administrative, and policy matters. Appendix D contains a list of resources and organizations in direct response to these requests.

Finally, following the site visit, we developed and submitted a draft outline for the project report to the Legislative Joint Fiscal Office; the outline was reviewed by its staff. A presentation of BHPC's key findings and recommendations to the Legislature is scheduled for late July 2012.

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BACKGROUND AND UNDERSTANDING

Act 79, "An Act Relating to Reforming Vermont's Mental Health System," passed by the State Legislature on March 27, 2012 and signed by Governor Shumlin on April 4, 2012, represents the culmination of more than 10 years of advocating and planning for an improved mental health system for Vermonters. Plagued by an inadequate physical structure and lack of attention to appropriate therapeutic interventions, the Vermont State Hospital was regularly under federal investigation either by the Department of Justice for alleged civil rights violations or the Centers for Medicare and Medicaid Services (CMS) for non-compliance with Medicare hospital certification requirements. Report after report documented the need to rebalance the role of the Vermont State Hospital with the need for a more community-based system of care that emphasized avoiding unnecessary hospitalization and instead serving people with serious mental illness in integrated settings whenever possible. Federal oversight, lost revenue, a devastating tropical storm and an effective advocacy strategy compelled policymakers to address the proper and efficient use of state resources for treating serious mental illness and other co-occurring chronic health and social conditions.

> "Vermont still has a fragmented mental health system."
>
> ~ *Sheriff*

Act 79 establishes a legislative purpose and intent to reform Vermont's mental health system. The Act intends to both strengthen the mental health system by offering a wide variety of traditional and alternative services and ensure that mental health care is on par with other health care initiatives. Accordingly, the Act states:

> "(a) It is the intent of the general assembly to strengthen Vermont's existing mental health care system by offering a continuum of community and peer services, as well as a range of acute inpatient beds throughout the state. This system of care shall be designed to provide flexible and recovery-oriented treatment opportunities and to ensure that the mental health needs of Vermonters are served.
>
> "(b) It is also the intent of the general assembly that the agency of human services fully integrate all mental health services with all substance abuse, public health, and health care reform initiatives, consistent with the goals of parity."[3]

> "Act 79 is a wonderful step forward."
>
> ~ *Advocate*

A set of nine principles for mental health care reform included in the Act provides a framework within which the Department of Mental Health (DMH) and other state agencies will practice when planning and implementing a reformed mental health system.

[3] Vermont Act 79, Section 1.

These principles set the expectations for the public, policy makers, and persons receiving treatment from the publically funded mental health system.

The moment the Vermont State Hospital closed was the moment in which the mental health system changed – both positively and negatively. DMH, along with community hospitals, designated agencies, and other social service providers, now have a collective responsibility to ensure the safety, treatment and positive outcomes of persons who are in the custody of the Commissioner of Mental Health – yet in some instances, with fewer immediate resources to do so. On the positive side, stakeholders, providers and advocates shared the following as promising opportunities presented by Act 79:

- An end to the years of controversy and resulting inertia about if, how and when to close the Vermont State Hospital;
- An acknowledgement that there is a need for some inpatient psychiatric beds as part of a continuum of care (although continued disagreement about the number and placement of those beds exists);
- An experienced DMH staff dedicated to ensuring implementation of Act 79;
- Funds for additional community-based services, including alternative non-traditional services designed to increase self-direction and treatment choices that aid recovery;
- Room for "out-of-the-box" thinking that may lead to systems and services innovations; and
- The universal desire to have uniform quality standards and performance measures throughout the system.

The State's mental health system has been under considerable and significant stress, especially since the closure of the Vermont State Hospital. Several noticeable and concerning patterns are emerging that signal "systems cracking" and duress, including:

- An increase in the average length of stay in an acute hospital from 8 days before the Vermont State Hospital closure to two new cohorts of patients experiencing 7-8 day average stays and 40+ day average stays, respectively;
- Numbers of told and untold stories depicting persons with acute psychiatric conditions with "nowhere to go";
- A lack of clarity among all key stakeholders (pre- and post-enactment of Act 79) regarding the conditions that permit a person access to adult outpatient services (e.g., eligibility, benefits, designated provider responsibilities);
- The workforce reduction of approximately 70 Vermont State Hospital employees that was a "cataclysmic" event for those who lost their jobs, their families, and co-workers;
- A continued state of "the unknown" for individuals committed to the Commissioner's custody while waiting 2-3 years for a new psychiatric hospital to be built;

> "Everything is in flux; it is a turbulent time. All parts of the mental health system are undergoing changes and every day there is a new, unanticipated challenge."
>
> *~ DMH staff*

- The acknowledgement that better care coordination among and between providers and DMH is necessary to develop and sustain a seamless system of care;
- Public safety officers in many parts of the State who feel overwhelmed by and undertrained to engage in negative situations with persons with an active mental illness; and
- Lack of comprehensive, system-wide care management practices from DMH and the Agency of Human Resources that operate as a Medicaid managed care organization.

Given Vermont's current needs resulting from the closure of the only state hospital and recognition of the need to look at the entire mental health care system – not just the number of beds – BHPC offers our findings and recommendation in the next section. Based on a number of core documents founded in national research and best practices, these suggestions include key values and principles, best practice standards based on current literature, and current federal laws. These core documents include, but are not limited to: the Americans with Disability Act (1990); the Supreme Court's *Olmstead* Decision (1999); the Institute of Medicine (IOM) Report, "Crossing the Quality Chasm (2001); the New Freedom Commission Report (2003); the IOM Report, "Improving the Quality of Health Care for Mental and Substance-use Conditions" (2006); SAMHSA's Consensus Statement on Recovery (2012); and other current evidence-based core services and supports, including care management services in a fidelity model.

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KEY FINDINGS AND RECOMMENDATIONS

THE IMPLEMENTATION OF ACT 79

Producing an Updated Department of Mental Health Mission, Vision, Values, and Principles Statement

Act 79 is a comprehensive piece of legislation designed to significantly improve the delivery of mental health services within Vermont. The Act includes a wide range of provisions ranging from the temporary and long-term replacement of inpatient capacity previously provided at the Vermont State Hospital to the expansion of peer-support programs. The Act's goal is to create a system of care directed and shaped by the principles of recovery, integrated community living, adequate supports, and least restrictive care. Moving toward this goal will require a great deal of work by a system already stressed by the sudden closure of the hospital and a history of budgetary and personnel cutbacks.

RECOMMENDATION 1: ***The Department of Mental Health (DMH) should develop an updated mission, vision, values and principles statement that not only aligns and adheres with those in Act 79, but goes beyond to articulate DMH's core values, principles of recovery and key tenets of service provision.***

The system approach for both short- and long-term planning in Vermont must be based on and developed in conjunction with the nine principles for mental health care reform, as enumerated in Act 79, Sec. 1a § 7251. DMH should expand and deepen these to publish, with stakeholder input, an updated mission, vision, values and principles statement to guide its direction and focus for all systems reform and implementation. We cannot emphasize enough the importance of this upfront work.

Developing a Comprehensive Implementation Plan

Much work is required to implement Act 79, and expectations are already running high that this work will be accomplished quickly and without problems, two expectations that need to be tempered in light of current circumstances and the reality of large system change. Learning from other states that have implemented large system redesigns, we know that it is never fast and always messy. From the beginning, all Vermont stakeholders must be prepared to accept and accommodate these constructs.

Mental health care in Vermont, as in most other states, has different constituencies that advocate for a particular program, treatment approach or service philosophy. While Act 79 includes projects that appeal to a broad range of constituencies, implementation of the Act will require a true "systems approach" that responds to immediate, pressing concerns such as the need for a more robust, prevention-based crisis system that will greatly reduce the State's need for inpatient capacity. Vermont leaders will need to determine which services

must be developed first, as this kind of programmatic expansion takes time. Such an approach will require that constituents temper their individual and collective expectations for systems reform as urgent needs are addressed in the order that makes greatest sense for the State. Some changes and projects will need to be prioritized while other projects, although important to system reform, may need to wait.

RECOMMENDATION 2: (PRIORITY) ***The Department of Mental Health should develop a detailed ACT 79 implementation plan.***

Managing expectations will require much work of DMH. Founded in the expanded-upon set of values and principles recommended above, DMH must create a comprehensive, detailed work plan that delineates the steps and sequence for the Act's implementation, together with responsible entities and each task's projected timetable. Goals and activities addressed in the implementation plan should link to federal law and/or evidence-based practices. A dynamic document, this work plan can be updated as necessary and shared with key constituents so that all stakeholders understand where DMH stands on the Act's implementation.

Establishing System Performance Measures

Establishing a narrow set of "system goals" that can be tracked, measured, and reported monthly or quarterly will be important to monitor progress in meeting the intent of Act 79.

RECOMMENDATION 3: ***Establish a set of broad "system" performance measures that include reports on service and support "process" delivery, as well as outcomes of these changes. All of this data should be used to compile and deliver monthly or quarterly dashboard reports that can be used to track progress and identify needed changes.***

With any large-scale system reform, there is always the question about how to measure progress. Act 79 includes a variety of performance expectations and measures. The Vermont mental health system has a great deal of data, but the data must be used and communicated in ways that enhance performance measurement. Not an issue unique to Vermont, indeed one common in most state mental health systems, DMH has seasoned, qualified staff who can lead in this area. In addition, too many data points can often lead to a focus on the wrong measures of system performance. In some respects, it is similar to trying to see the forest through the trees. For this reason, the mental health system must establish a dashboard of a limited number of salient measures that enable the reader to see system level trends as Act 79 is implemented.

We recommend DMH consider a small number of process measures (i.e., rates of client engagement, retention in care, and utilization of services) and outcome measures (i.e., improvement in functioning, reduction in symptomatology, increase in number of days housed), related to persons with serious mental conditions, from the list that we offer under Recommendation #12 to incorporate into such a dashboard. Dashboards are a tool, usually web-based, that permit users to track performance and outcome measures across health care

settings. Typically, in behavioral health service delivery systems, dashboards track key indicators in four outcomes domains: clinical care, service coordination, recovery and accountability.

RECOMMENDATION 4: ***DMH should provide real-time web access to the Act 79 implementation plan and the measures that will be used to gauge implementation progress.***

We further recommend that DMH make its Act 79 draft implementation plan and core expected outcomes with performance measures available publicly by using a "Results Scorecard" or other similar web-based tool. This will ensure that all constituents are informed about the progress of implementation, the outcomes that have been achieved to date, and those items that remain in the pipeline for completion. Sharing the work plan will help normalize constituent expectations and ensure everyone follows the same plan as the State moves to full implementation of the Act. That said, all parties should understand and agree in advance that complex systems change can result in unforeseen circumstances that often require an adjusted response/approach. DMH must be afforded the ability to modify plans and measures easily and flexibly as situations demand.

Developing a Communications Strategy

The emergency closure of the Vermont State Hospital was a widely publicized event in Vermont, as was the debate and subsequent passage of Act 79. The implementation of the Act deserves the same level of attention, as it will represent a significant investment of funds to strengthen Vermont's mental health system and provide flexible and recovery-oriented treatment to Vermonters.

RECOMMENDATION 5: ***The Administration and Legislature should develop a communications strategy for sharing with the public the progress made to implement Act 79.***

A communications strategy should define how general progress and important milestones in Act 79 implementation are shared with the public. This should include traditional and new media such as press releases, periodic meetings with editorial boards and speaking engagements before advocacy, special interest and community groups. The State should also consider a special Act 79 implementation website that could serve as the platform for progress and public reporting on performance. Please know that communicating effectively with all stakeholders will require DMH to request assistance from these same stakeholders. It might be wise to develop a communications "tree," similar to a disaster response communication plan, in which important information can be sent out to key stakeholders who then send to other key constituents and so forth. It will be a burden on one State office to expect it to communicate alone this information timely and well.

> "We need a big picture painted, and we need to know where we are going."
> ~ *Peer Advocate*

CLINICAL RESOURCE MANAGEMENT AND OVERSIGHT (ACT 79, SEC. 1a §7253)

Establishing Clinical Authority and Leadership

RECOMMENDATION 6: ***There should be an established single point of clinical responsibility and authority within the State's mental health system.***

In a diffuse community mental health system such as that found in Vermont, confusion as to who has ultimate clinical authority for managing the system is common. Each designated agency has someone ultimately responsible for clinical decisions, as does the State for its inpatient services. However, someone must also have such authority for the system as a whole and must use that position to ensure that the system's parts work as a whole for the benefit of consumers. We believe that responsibility rests within DMH, specifically with the Commissioner and the Medical Director, and must be exercised to ensure that all services are utilized to their maximum clinical potential. As the single point of clinical authority under the Commissioner, the DMH Medical Director would also be responsible for convening the clinical leadership from all parts of the system to ensure that everyone is focused on best clinical practices, processes and outcomes.

RECOMMENDATION 7: ***The State should undertake a "high utilizer" study to identify those individuals who cycle through community and state inpatient psychiatric facilities, homeless shelters, emergency departments, prisons and other costly settings.***

A high utilizer study would help identify those individuals for whom the system of care is not working at its full potential, as well as any gaps in the system and where system improvements or alternative services may be needed. Clinical system reviews should focus on these cases to determine how care could be better provided and coordinated to improve client outcomes.

RECOMMENDATION 8: ***The Department of Mental Health should consider using contractual performance measures to incentivize providers to meet system level outcomes by allocating a small percentage (2-5%) of all service dollars tied to ACT 79 funding.***

In contemporary public mental health systems, it is imperative that state-contracted providers share accountability in outcomes in a clear, objective manner that is data-driven and -based. Many state mental health authorities have moved to performance contracting as a means to achieve system outcomes. Using this approach, Vermont could establish performance benchmarks and incentivize providers to meet them. For example, the number of persons in integrated community living arrangements could be framed as a performance objective such as "10% increase in persons living in integrated community living

arrangements within 6 months of implementation of community support expansion pursuant to Act 79," or "a 5% reduction in the number of persons with new criminal justice involvement within 6 months of implementation of community support expansion pursuant to Act 79."

Employing Care/Utilization Management

DMH has already moved forward with the development of a care management team to better identify, track and manage the provision of services and supports to people with mental illnesses that receive services in the Vermont system of care and to expedite the appropriate flow of people through the system. The primary focus of this team, at this time, is on the individuals who would have been served by the Vermont State Hospital and are now being served in other inpatient settings developed after the hospital's closure. This team is a needed and welcomed addition in this system reform process. However, it must be expanded to ensure all individuals needing mental health services receive what they need and want and that the outcomes support the expenditures.

RECOMMENDATION 9: (PRIORITY) ***The Department of Mental Health should enhance its capacity to hire sufficient and competent staff with the expertise to aggressively monitor the utilization of all services currently financed under the State's mental health system, including Community Rehabilitation and Treatment clients and clients receiving adult outpatient services.***

Throughout our visit to Vermont, we heard reference to the State's Medicaid system serving as a "managed care entity" that monitors the utilization of services under the State's Global Commitment waiver. We support this model, but additional capacity is critically needed within DMH to fully actualize this concept. This capacity should include additional staff, utilization management tools (e.g., standards, protocols, tracking software, risk grouping and predictor tools, provider interface) and clinical support.

> "The new care management program is intended to act as an air traffic controller for the system and to help provide a coordinated response for client care."
>
> *~ DMH staff*

A number of targeted care (case) managers (TCM) tasked with immediately responding to any new person admitted to any inpatient service are needed to engage clients and seek to prevent future involvement in deep end services. This model of support provides staff who understand crisis intervention in the most basic sense and who understand that many people who end up in hospital beds were experiencing a personal or domestic crisis not related to a serious mental condition. The goal is to follow clients until they exit the system or ensure that they get connected with outpatient mental health or substance abuse services. The number of clients served by a

TCM staff member at any given time ranges from 15 to 35 and depends on the clients' acuity levels and the program's goals.

This added capacity will help prevent the current and planned system from backing up. It will also help identify those stress points in the system where there is under or over utilization of services and where additional resources may need to be targeted to avoid system disruption. The use of the soon-to-be-implemented electronic Bed Board is one step in this process, but it will need to be closely managed and monitored to ensure that it remains an active and vital tool in identifying the use of inpatient bed utilization and where other actions need to be focused. This work should come under the direction of a patient placement coordinator who is part of DMH's care management team; we recommend a registered nurse (RN) with extensive experience in providing this kind of oversight. An RN is paramount as the overall manager of this service as no other discipline has the background and experience an RN has in physical health conditions that often direct placement decisions. In addition, several physicians will be needed on call for consultation.

> "Act 79 is opening the door to peer-run services."
>
> *~ Peer Advocate*

DMH has developed a draft vision of the Vermont Clinical Resource Management System, draft functions of the Acute Care Management Team and data sets needed to review utilization of services and supports. DMH also foresees the creation of a steering committee to oversee system development. These first steps are critical to developing consensus, managing resources and implementing statewide service management and utilization review processes and procedures that will improve the quality of care provided to persons receiving mental health services in Vermont. We commend DMH for developing these initial ideas and sharing their plans with our team.

RECOMMENDATION 10: ***Based upon the "high utilizer" review (see Recommendation 7), the Department of Mental Health should enhance its care management capacity to include sufficient staff and expertise to identify and coordinate behavioral health and medical care for the top (10-20%) of high-risk/high-cost consumers with serious mental illness and high risk/high cost consumers receiving adult outpatient services.***

Nationally, Medicaid, Medicare and other public health care payers rely on care management, care coordination strategies and, most important, prevention approaches to increase the public value of health care expenditures while reducing unnecessary health care costs. Persons with serious mental illness have or are at risk of having multiple co-morbid physical and mental health conditions; they are often at risk of unnecessary admissions to the highest level of services – emergency and inpatient care.

Many recent studies have focused on the impact of major mental illness on other chronic health conditions. One of the most relevant, "The Faces of Medicaid III,"[4] included an analyses of 2002 national Medicaid claims data and patterns among Medicaid recipients. The research showed that more than one-half of disabled Medicaid enrollees with psychiatric conditions also had claims for diabetes, cardiovascular disease or pulmonary disease at substantially higher rates than those without psychiatric conditions.[5] These are conditions that can be managed earlier with a prevention approach. However, doing this must come with the assurance that vulnerable and ill people who meet these criteria get comprehensive and state-of-the-art services from accountable providers with this specific expertise.

> "Mental health is integral to health reform."
>
> *~ Staff, Department of Vermont Health Access*

If DMH is unable to perform this care management function for the highest utilizers/highest cost clients, then we recommend that the State issue an RFP to procure the services of an organization with experience managing the care of these clients. DMH should develop a case rate and an incentive fund, based on an actuarial analysis of what the care of these individuals has cost for the past 2 years. Vermont should consider how such an organization can be incentivized to fully manage and care for these clients while being financially at-risk for inpatient and outpatient services. Maryland and Delaware currently use this approach.

[4] Kronick RG, Bella M, Gilmer TP. The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic
Conditions. Center for Health Care Strategies, Inc., 2009.
[5] Druss, BG, Walker, ER. The Synthesis Project, Issue #21. Robert Wood Johnson Foundation, February 2011.

Integration of the Treatment for Mental Health, Substance Abuse And Physical Health (Act 79, sec. 1a § 7254)

Expanding on the Blueprint for Health

Act 79 includes language calling for the full integration of all mental health services with all substance abuse services, public health and health reform initiatives consistent with the goals of mental health parity. We applaud the legislature for including this bold statement of integration as a guiding principle and see many opportunities to realize this goal in the implementation of the Act.

Vermont's Blueprint for Health[6] offers an integrated model of health care delivery: the medical home model and enhanced care coordination. This model promotes the connection to specialized mental health services available through local providers, including designated care agencies and private providers. It provides a mechanism to enhance integration and could lead to additional opportunities for colocation of mental health and primary medical care or the colocation/coordination of medical services with existing designated agencies.

RECOMMENDATION 11: ***The Department of Mental Health should work with the Department of Vermont Health Access, Department of Health and the Division of Alcohol and Drug Abuse Programs to expand the scale and scope of Blueprint activities as they relate to the integration of mental health and substance abuse services with primary medical care.***

Although the Blueprint's model of medical homes provides some access to mental health and substance abuse services, this work could be expanded to create greater opportunities for specialty mental health and substance abuse care and to further develop the capacity within specialty substance abuse and mental health settings to provide coordinated health care for those served in such programs. This recommendation can also apply to the State's recently enacted "hub and spoke" program for the treatment of opiate addiction.

Several integrated and coordinated care models exist in managed care and fee-for-service systems. Managed care organizations often manage utilization, provide medical services and coordinate physical and behavioral health care through expertly trained nurses and other clinical staff and focus integrated care efforts at the "plan level." Many traditional fee-for-service systems are adopting medical home and health home practices at the "provider level." The Vermont Legislature, Department of Health Access, Department of Health, Department of Mental Health and Division of Alcohol and Drug Abuse Programs should consider the pros and cons of multiple methods of integrating care, from the most basic of care coordination among mental health providers (inpatient and outpatient) in the short-term and full integration among mental health, substance abuse and medical providers in the long-term.

[6] Vermont Department of Health, Agency of Human Services. (January 2007). Vermont 2007 Blueprint for Health: Strategic Plan. Report to the Legislature on Act 191. Burlington.

SYSTEM OF CARE (ACT 79, SEC. 1a § 7255)

Ensuring Alignment of Inpatient and Outpatient Care

Vermont has a strong community mental health system and has been a leader in such areas as supported housing, employment and peer support services. At this time, the State also has an inpatient care system made up of community hospital providers. However, whether it is because of the sudden closure of the Vermont State Hospital and the associated pressure this has placed on the current system of care, these two systems seem to run parallel rather than as a true unified or aligned system of care.

This misalignment between community and inpatient segments of the system has meant that the Department of Mental Health (DMH) has had to assume greater responsibility for ensuring the seamless transition of patients as they move between systems. We believe this responsibility actually rests with the designated agencies where these patients reside, as their care will ultimately be provided in the community. The State's role should be to ensure that all providers (inpatient and outpatient) work in tandem, and to remove any and all barriers that stand in the way of a unified system of care.

We suggest that the State establish performance measures to ensure that every community agency providing ACT, ICM or TCM services participates in the clients' care within 24-48 hours of their admission to an inpatient bed. In order to track their participation in care, these community providers should document their participation in clients' service provision in the clinical hospital record. At the same time, inpatient hospital providers should be expected to contact a newly admitted client's community provider within 24 hours of admission to notify them of the client's appearance, invite participation and request his/her community records. Then, together, the inpatient and community providers can work to discharge the client. Both of these provider entities should be accountable for the individual's length of stay in any inpatient facility or emergency department.

> "We want and expect to have quality standards applied throughout the system with consistency."

RECOMMENDATION 12: (PRIORITY) ***The Department of Mental Health should create a set of system objectives that ensures that both inpatient and community services align. This should include the establishment of clearly defined clinical expectations relative to admission, discharge and continuity of care.***

Act 79 reduces the size of state-operated inpatient hospital beds from 54 to a maximum of 25. It also increases the availability of community-based psychiatric beds and alternatives to inpatient hospitalization in several important ways. The Act includes the following additions: the creation of intensive residential recovery beds; a recovery residence that is peer-supported with emphasis on psychosocial approaches with minimal use of psychotropic

medications; housing subsidies for persons engaged in treatment; and additional alternatives to the designated agency's crisis and outpatient service systems for both Community Rehabilitation and Treatment (CRT) and adult outpatient services. DMH, in cooperation with the community, should create a set of system objectives for existing and anticipated services in the short- and long-term, with the primary objective of supporting people in their communities and close to home. Such objectives would correlate to dashboard markers that should include:

Statewide Crisis System

Crisis Prevention

- The number of calls by individuals to the 24/7 statewide hotline for mental health emergencies
- The time these calls took to handle and their resolution
- Complaints about this service
- Staff involved in responding to each call

Statewide Mobile Crisis

- Recording of every call that comes in by date, time and nature
- Time taken to respond by phone and resolution
- Time taken to get to scene of event, if warranted
- Resolution of crisis and outcomes
- Staff involved
- Complaints about this service

Inpatient Services

- Emergency psychiatric admissions (by designated agency region and provider following that client)
- State hospital or state hospital alternative admissions (by designated agency region)
- Average length of stay for state hospital or state hospital alternative admissions (by designated agency region or the client's community provider)
- State hospital or state hospital alternative discharge rates (by designated agency region)
- 7-, 14-, 30-, 60- and 90-day readmission rates for state hospital or state hospital alternative beds (by designated agency region)
- Monthly seclusion and restraint hours and rates (aggregate reporting) by facility
- Monthly use of involuntary medication administration (that generally requires restraint to perform) by facility

Peer Services

- Number of individuals receiving peer support services from a trained peer
- Number of peer-run drop-in centers or other peer-run programs where the directors are self-identified as peers and the unduplicated and duplicated numbers of people they serve
- Number of peers employed by each provider agency
- Complaints
- Number of successful discharges by peer support program or individual

Community

- Number of persons in the target population, where they reside and their provider of record
- Number of persons served in Crisis Respite Services in community and disposition
- Number of persons accessing emergency departments for psychiatric services and how long each person stayed in each emergency department
- Number of persons detained, arrested or incarcerated who are clients of the public mental health system by Designated Agency Region
- Number of persons in integrated community living arrangements of their choice
- Number of persons in community congregate living arrangements
- Reasons for placement of persons in congregate living arrangements (e.g. medical, psychiatric, cognitive)
- Number of persons receiving supported employment services
- Number of persons receiving sheltered workshop services
- Number of persons in paid employment for 10-, 30- and 90-days
- Number of persons with new criminal justice involvement, including mental health courts
- Number of persons receiving psychiatric rehabilitation services to help them learn how to manage their illnesses and relearn skills that may have been lost due to long-term institutionalization
- Wait list status for the two to four most needed community services
    - Number of persons receiving care management services, including ACT, ICM and TCM services
    - Number of persons not receiving care management services, but receiving other outpatient mental health services
    - Number of persons by client and provider and doctor in ACT, ICM or TCM community services that present at an emergency department, call the crisis line or get admitted to an inpatient bed
    - Number of hospital admissions avoided through care coordination efforts, if obtainable
    - Number of providers on capitated, shared risk contracts that are solely responsible to manage individuals' care, including paying for inpatient care, when required

The current data on each of these measures should be reported to the DMH Commissioner and legislative oversight committee monthly or more frequently and should be monitored and trended monthly to facilitate reporting on the State's beginning baseline of people served and what services they receive and where. This will help identify service gaps and needed services for which additional funding may be necessary. DMH should share its plan for measurement with key legislative oversight committees early in the process to foster consistency in how each approaches oversight and monitoring.

> "The current pace and flow of our system is too slow and results in patients getting stuck in acute inpatient beds."
>
> ~ *Hospital representative*

RECOMMENDATION 13: ***The Department of Mental Health should establish comparative performance targets and measures (e.g., admission, discharge, readmission) that document how well providers manage patient flow between inpatient and community-based care. DMH should develop methods for incentivizing its providers to attain specific system level outcomes aimed at aligning inpatient and community care.***

Staying in one service setting for too long or going without timely, appropriate services because of a lack of capacity and care coordination are two major system failures that result in poor outcomes for persons with mental health conditions. Increased funding for both crisis services and enhanced outpatient services should alleviate some of the pressures caused by lack of capacity. DMH, in conjunction with providers, should establish a dashboard of comparative performance targets that publically documents the reduction in inpatient days and readmission rates for the population with serious mental illnesses.

> "There is no question that the system is challenged."
>
> ~ *Designated Agency Representative*

The current system of care has few incentives or disincentives built in to achieve system-level performance expectations. While clinical leadership and authority may help get all providers focused on the same outcomes, the best way to see real change is through financial incentives and disincentives. For example, states that have put community mental health agencies at shared financial risk for inpatient hospital utilization have seen significant changes in the utilization of such services and in the development of alternative approaches. As Act 79 is implemented, consideration should be given to exploring what kinds of incentives and disincentives could be employed to move providers to the system goals embraced in the legislation. The State may consider, for example, rewarding providers for care in integrated or less restrictive settings or impose financial penalties when care is provided outside the patient's geographic region.

Planning for Inpatient Hospital Beds

Given the circumstance of Tropical Storm Irene, DMH staff must be commended for their work to quickly create alternative bed capacity. The State has also been creative in developing alternatives to state hospital inpatient care, including plans to invest capital in existing facilities to make necessary accommodations to accept patients who had been or would have been hospitalized at the Vermont State Hospital.

Planning for a new, smaller state hospital has already begun. Two sites are currently under consideration. As part of this review, we did not visit either site under consideration and have no formal recommendation as to a preferred site. However, we do believe that the opportunity to house the hospital as part of a larger, more integrated medical complex could

bring potential benefits through joint ventures, particularly in ancillary support services, specialized medical care and staff training and development. It was further discussed during the course of our site visit that locating the state hospital within an integrated medical complex could promote care coordination among physical and behavioral health providers while reducing stigma associated with admission to a state psychiatric hospital. Finally, the colocation of a state hospital with a general hospital may open up new funding opportunities.

RECOMMENDATION 14: ***The Agency of Human Services should continue to seek written clarification from the Centers for Medicare and Medicaid Services on the opportunity for Medicaid reimbursement for the future psychiatric hospital.***

We understand from our visit that the size of the new facility, whether it includes 16 or 25 beds, is largely dependent on the opportunity for Medicaid reimbursement. Facilities of 16 beds or fewer are generally not considered "institutions for mental disease" (IMD) and are therefore eligible for Medicaid reimbursement. Facilities of 17 beds or more are considered IMDs and ineligible for reimbursement for those between 22-65 years of age. The state is proceeding under the assumption that the new state hospital of 25 beds will be eligible for Medicaid reimbursement for this population under its current Global Commitment waiver from the Centers for Medicaid and Medicare (CMS). We agree with this strategy and the State has secured a written commitment from CMS so that proper planning can move forward. We also understand that this waiver runs out December 31, 2013 and the State may have to manage the required additional funding.

Whatever size, Medicaid reimbursement will depend on the new hospital achieving certification as an eligible provider. While physical plant and health and safety considerations are an important part of achieving certification, the State must also show that the new hospital meets all requirements for the adequacy and training of staff, for the provision of active treatment and in recording demonstrated progress in meeting patients' care requirements. These areas will require considerable attention immediately to be ready when the new facility opens.

RECOMMENDATION 15: ***The Department of Mental Health should immediately create a workgroup led by its medical director to develop appropriate polices, procedure and plans for the operation of the new Vermont state psychiatric hospital that meet federal standards of care and are directed by the ADA and the* Olmstead *Decision, for example, in terms of discharge planning. The workgroup should prioritize the development of new services that will prevent people from entering the inpatient care system, and provide intensive services and supports to those being discharged from care to help them become integrated in their communities.***

It is not too early to develop a vision and mission statement for the new hospital. These important considerations should serve as a basis for clinical decision-making and should also drive final physical plant design. This workgroup should be tasked with the following:

- Ensuring people admitted are made to feel comfortable, welcomed by staff, provided access to staff at all times without barriers, including "glassed-in nursing stations," and provided active treatment programs off unit.
- Developing policies on how the hospital will provide active "engagement activities" to newly admitted clients or those who are too ill to yet engage.
- Employing peer specialists at the new hospital. For a 25-bed hospital, we suggest at least three peer specialists and one peer coordinator who together would provide support to patients. These support services and attention to preventative planning will significantly reduce conflicts, the need for the use of seclusion, restraint the forced involuntary medications and injuries in the new hospital.
- Eliciting input from current and previous Vermont State Hospital patients, family members, legislators, advocates and other interested stakeholders.
- Drawing up plans for both the physical and therapeutic environments that promote healthy living, engagement in treatment services, reduced lengths of stay and appropriate utilization of hospital beds.
- Reporting monthly to a legislative committee on the status of the capital constructions and medical, clinical and social service plans for the new state hospital.

> "We need to strike a better balance in Vermont. The current pressure on the system is to move patients through it versus making the best clinical decisions."
>
> *~ DMH staff*

In 2008, in anticipation of the eventual replacement of the Vermont State Hospital, DMH staff completed the report, "The Vermont State Hospital Futures Project, Surveys of State's Experiences." DMH staff compiled the experiences of 21 states in an effort to document national trends with respect to acute and long-term need for inpatient psychiatric beds as part of the certificate of need process for the Vermont Department of Banking, Insurance, Securities and Health Care Administration. DMH staff should review their previous findings and consider how any lessons learned might affect Vermont's planning process.

RECOMMENDATION 16: ***The State should formally establish "use liens" for any space where state capital funds are being used to renovate non state-owned or -controlled space as alternatives to the state psychiatric hospital.***

Under Act 79, the State will move forward with capital investments in private facilities to provide alternative bed capacity for those who would have used the Vermont State Hospital. We believe this to be a prudent use of state capital funds, but as these facilities are not

owned or operated by the State, we encourage the establishment of use liens as a way to ensure the facilities are available to the State for the foreseeable future.

A use lien places a deed restriction on the future use of property for the expressed purposes that state funds invested in the property have been directed toward. For example, in many jurisdictions where state or local government funds are used to purchase or renovate housing for special needs populations, the jurisdiction places a use lien on the property requiring that it remain as special needs housing for a defined period of time (10-50 years). This ensures that the use of the property does not change after the investment of state or local government funding.

In the case of Vermont, the State could place a use lien on the property where state capital funds are invested to ensure that these facilities continue to be used as inpatient psychiatric capacity for those under the care of DMH. The State in negotiation with the property owner could determine under what conditions the lien could be lifted. See Appendix D. for sample contract language that includes use liens.

Expanding Community Services

Act 79 provides funds to greatly expand Vermont's community mental health system. These community services, including enhanced peer support services, are essential as alternatives to hospitalization and as supports for those discharged from inpatient care. The plan's range of services is comprehensive, and the designated agencies and specialty providers are poised to take on these development efforts. Throughout our visit, we heard the need for enhanced outpatient capacity, crisis stabilization and mobile crisis capacity and peer support. Many of these enhancements will be funded through savings generated by increasing matching federal funds (FFP) for inpatient services provided in non-IMD (Institutions for Mental Disease) settings and redirecting savings into community services.

As current system pressures focus on inpatient capacity, investment of new state dollars or reinvestment of dollars from the Vermont State Hospital should be directed to those community services that will have the highest impact on hospital utilization. This should include crisis services, as well as intensive outpatient services such as Community Rehabilitation and Treatment (CRT). Plans developed by the designated agencies for expanded community services must document clear and measureable targets as to how these new services will reduce hospital utilization, including community hospital utilization.

RECOMMENDATION 17: ***Evaluate the clinical eligibility criteria and raise the cap on Community Rehabilitation and Treatment (CRT) to accommodate increased need for CRT services.***

CRT is the most comprehensive service available within Vermont's community mental health system. However, not everyone that needs CRT services receives them. Access to this broad array of services will be important as patients are stabilized and discharged from inpatient care back into the community. To ensure adequate access to these services, the DMH should evaluate the clinical eligibility requirements that permit access to CRT services and thereby lift the cap on CRT services. As result of such an evaluation we expect that people currently receiving less comprehensive adult outpatient services would become eligible for and offered CRT services. State hospital funds should be reallocated to provide the necessary match to

allow for expansion of this service. To ensure ongoing capacity within the CRT program, discharge criteria for moving into less intensive outpatient care should also be explored and included as part of DMH's utilization review and management process.

RECOMMENDATION 18: ***Consider the benefits and drawbacks of "Medicaiding" most or all of mental health services for the Community Rehabilitation and Treatment program and adult outpatient population.***

Across the country, state and local mental health agencies have increased their reliance on Medicaid to fund a majority of their community mental health services. As of 2009, Medicaid (both the state and federal shares) accounted for almost 50% of mental health state mental health agency revenues (almost $18.3 billion).[7] While Medicaid is an important revenue source for mental health services for adults with serious and persistent mental illnesses, many of the services that have been "Medicaided" (conversion of 100% state-funded mental health services to at least 50% federal match) are optional services and are vulnerable to government budget cuts during economic downturn and changes in political climate. The Vermont Legislature may want to consider its own mandatory services for persons with serious mental illness and a basic package of adult outpatient services independent of the economic and political climate.

Providing Mobile Crisis and Emergency Psychiatric Services

A key to managing utilization of state psychiatric inpatient beds will be ensuring easy access across the state to quality psychiatric emergency services. These services include the availability of mobile crisis teams, crisis stabilization beds (23-hour), peer support, crisis and warm lines and psychiatric consultation within hospital emergency departments.

> "Our 21st century law enforcement is a crossroad of every social issue on the planet."
>
> ~ *Sheriff*

In our visit to the State, we met with several mental health and law enforcement personnel. We heard examples of how designated services agencies have to develop a range of psychiatric emergency programs, including mobile crisis, and existing positive relationships between police and mental health clinicians. However, we also heard that that there is a wide disparity across the State in capacity and accessibility of such services. This is not surprising given the State's rural nature.

Current best practices in crisis prevention and stabilization that Vermont should examine include:

- A robust crisis prevention service that diverts people from entering inpatient care;
- A 24/7 hotline staffed by the state mobile crisis statewide service system;

[7] NRI-Inc. Table 24: SMHA-Controlled Mental Health Revenues, By Revenue Source and by State, FY 2009 at www.nri-inc.org/projects/Profiles/RevExp2009/T24.pdf

- A fully mobile statewide crisis response team; and
- 24/7 staffed crisis respite beds for persons who do not require inpatient care, as they only need support and supervision navigating a current crisis that is not imminently dangerous to themselves or others. (This is usually fulfilled with providers organizations that already have housing in place and can bring in on-call staff.)

A report prepared by the Technical Assistance Collaborative, Inc., "A Community-Based Comprehensive Psychiatric Crisis Response Service" (April 2005),[8] is one of the best resources to help Legislators and State staff understand the service components, contracting issues, and the role of crisis services in the continuum of care. This instructional monograph is one of the most comprehensive and understandable guides for policymakers and practitioners interested in developing alternatives to psychiatric inpatient hospitalization through multiple service points while collaborating and coordinating care with outpatient providers, hospitals, law enforcement and social service providers.

RECOMMENDATION 19: (PRIORITY) ***Immediately direct Act 79 funds toward ensuring timely statewide access to quality crisis services. This should entail the establishment of access and quality standards for these services that can be used to identify and direct new resources to closing gaps in services.***

The State's psychiatric emergency service is the front door to the mental health system, and ultimately to the utilization of its inpatient capacity. It is impossible to control inpatient bed use without a quality psychiatric emergency system. In many areas, community hospital emergency departments and local or state law enforcement have become the organizations that people in crisis turn to when quality psychiatric emergency services are unavailable. These organizations cannot serve as the State's de facto mental health system.

> "From a boots on the ground perspective, dealing with people with active mental illness is overwhelming for most frontline police officers."
>
> *~ Sheriff*

Act 79 provides the opportunity to improve the availability of mobile crisis and psychiatric emergency services across the State. To do so will require the establishment of access standards that can be used to measure service performance and identify gaps in services. Work should also continue with law enforcement to ensure well-defined expectations guide how the mental health and law enforcement systems support each other, especially in remote areas where access to services may be difficult. We also recommend that the State explore technologies to facilitate greater psychiatric consultation to community hospital emergency departments and other settings requiring such assistance to stabilize patients.

[8] The full report can be found at www.tacinc.org/downloads/Pubs/Crisis_Monograph_Final.pdf.

RECOMMENDATION 20: ***The Department of Mental Health should expand jail diversion and crisis intervention teams available to work with local and state police.***

Efforts should be made to enhance the availability of mental health clinicians to support local and state police departments for crisis intervention. These clinicians can help law enforcement identify appropriate mental health services and can divert hospitalization and/or arrest. Successful programs already exist in Vermont (i.e., Burlington, Montpelier) that allow police to return to their duties while also ensuring individuals access adequate psychiatric and stabilization services. The expansion of crisis stabilization beds such as through the Safe Haven Program throughout the State will also provide bed capacity that could shift patients away from these more restrictive settings.

Expanding Peer Services

Act 79 provides $1 million for existing and new peer-run services. Vermont has a well-developed peer advocacy system and a good track record in using peer support services within its community mental health system. Further expanding this network is encouraged, including replication of the Safe Haven model and the development of peer-run warm lines across the State.

RECOMMENDATION 21: ***The Department of Mental Health should ensure adequate training and supervision of lay peer counselors as peer-run services expand. DMH should also explore the potential to certify peer counselors for quality assurance purposes and to understand potential reimbursement for these services under Medicaid.***

CMS now recognizes peer support providers as a distinct provider for the delivery of mental health support services and considers peer support an evidence-based model of care. The role of certified peer specialists continues to develop as states create certification programs and incorporate formally-trained, certified peer specialists into traditional (outpatient clinics) and non-traditional (peer-run organizations) service settings. Not intended to replace other mental health professionals, certified peer specialist and peer support programs are an important addition to an array of supportive and recovery-based mental health services.

> "$1 million to support new peer services is huge."
>
> *~ Peer Advocate*

As peer-run services continue to expand nationwide, 26 states now offer enhanced training and certification for peers. Vermont should develop a similar program for its expanded peer-run services network.

RECOMMENDATION 22: ***The Department of Mental Health should establish a relationship with a nonprofit support center or other similar organization to help consumers develop new peer operated services.***

The development of new and expanded peer support services will require additional development capacity. Current consumer advocacy and peer-operated organizations already feel pressure to move quickly to enhance their ability to meet Act 79's expectations for new peer-run services. Yet, these organizations have limited programmatic, workforce and financial infrastructure to take on such projects within the tight timetables the legislation envisioned. Rather than see these groups struggle to develop the infrastructure necessary to compete for these new services successfully, we suggest that DMH contract with a nonprofit support center or other financial intermediary to work with the State's consumer leadership for a limited time to develop the tools needed for effective program development. This would include such activities such as grant writing, governance, financing and evaluation. Careful attention will be needed to ensure the organizations and services remain peer-run.

Conducting Quality Management

As Vermont's mental health service system expands through the implementation of Act 79, it must be ensured that all services meet the highest possible standards of quality. We were disappointed to learn that budget cutbacks eliminated DMH's quality assurance system several years ago. This function is especially important in light of the Vermont State Hospital closing and resulting purchase of inpatient beds in external facilities. The State must proactively seek assurance and evidence that consumers are safe and receiving clinically appropriate and high quality care. An overarching role of any state mental health authority is expected to include the following tasks:

- Developing the mission, vision and values of the system of care that are relied upon to direct decision making on policies and processes.
- Developing a flowchart on client movement within the current system of care and its rationale, as well as the goals of the future system of care.
- Identifying people with mental illnesses who receive state-funded services in a database that identifies them, where they reside and from whom they receive services. An expanded database would be open to all privacy-approved providers and able to track in real time what services an individual was receiving and from whom.
- Identifying, tracking and approving the level of care requested by any entity approved to have such information for a client in the state system, including inpatient hospitalization and length of treatment. This oversight would include all state funded individuals' movements in the Vermont system of care.

Contemporary mental health systems have the ability to develop and implement quality management systems that rely on a PDSA Cycle ("plan, do, check/study, act") model of continuous quality improvement to ensure procedures are in place to evaluate the delivery of

mental health services and to recommend and require measurement and improvement of client care. Rather than a function by itself, a state quality management office works collaboratively with all functional areas of the organization in the ongoing assessment and evaluation of the quality of services provided. At a minimum, the quality management program for the Vermont mental health system should include the following requirements:

- A structural framework for communication and data sharing between DMH committees, contracted providers and persons receiving services.
- Clearly articulated quality management goals that support the mission of the mental health system to improve the quality of care provided to clients, improve the clients' satisfaction with services received and improve outcomes for all persons receiving mental health services.
- A defined scope of quality management activities to be conducted by the DMH and its contracted providers. Evaluation data and performance assessment should be standardized across the entire mental health system.
- The analysis of the system's performance, feedback from clients and evidence-based practices should drive the performance improvement activities and new initiatives undertaken by the mental health system.
- A quality management system developed according to a quality management plan that includes:
    - monitoring and evaluation activities
    - data integrity activities
    - administrative and clinical reviews (both internal and external)
    - provider profiling and monitoring
    - customer surveys
    - care coordination
    - recovery-focused outcomes
    - actions to improve care
    - tracking and trending of client and provider issues
    - performance measures and reporting for special populations
    - performance improvement projects
    - regular quality management reporting
- An assurance of effective and continuous patient care through medical record documentation of each person's health status, changes in health status and health care needs and services provided.

RECOMMENDATION 23: (PRIORITY) ***Create a quality assurance unit within the Department of Mental Health to develop standards and to assess the clinical efficacy, capacity and effectiveness of current and new services provided under contract to the State.***

Significant service expansion is anticipated as Act 79 is implemented. As these new services are developed, a corresponding process must be in place to define the standards of care and quality indicators that each service will be responsible to meet. Without such criteria, there is no way for the State to know if these services are provided in accordance with best clinical and evidence-based practices.

DMH should provide regular benchmarks of performance for each service it purchases and develop performance targets as part of its contracting process. This will enable the State to adequately track differences in provider performance and seek changes when necessary.

The goal of such monitoring and evaluation is not intended as punitive, but rather a way to seek constant improvement and to ensure the services supported or contracted by DMH reflect the best knowledge in the field. This quality monitoring process should develop and implement cross-system training and technical assistance programs that can raise and enhance the standard of care over time.

Building Capacity

Although Vermont has a robust community mental health system, Act 79 will require the development of new services and supports, including peer-run services. Adding to the challenge is the expectation that such services will be developed quickly, especially new inpatient, residential and crisis stabilization beds.

In order to meet this challenge, the State must ensure that adequate provider, staff and physical plant capacity exists that can lead to timely and quality program development.

RECOMMENDATION 24: ***The Department of Mental Health should establish a dedicated program development team that can provide training, technical assistance and support to new and existing providers in the development of new programs and services across the State.***

This program development team should ensure that sufficient capacity exists to meet the program expectations of Act 79. This will include work to develop new service specifications consistent with evidence-based and best practices. The team should also identify potential organizations capable of meeting these program development requirements. Lastly, the team must work with regional educational and workforce development organizations to ensure that an adequate mental health workforce will be cultivated and available to provide these services as they become operational.

CONCLUSION

Act 79 contains great opportunities to better treat mental health conditions and improve the lives of Vermonters living with these conditions. However, as is the case with all large system change, these great opportunities require great planning, attention to implementation and quality assurance measures to realize Act 79's full potential.

With this independent review, the Behavioral Health Policy Collaborative (BHPC) intends to provide policymakers, the Department of Mental Health, persons receiving services and other Vermont stakeholders with a chance to voice expectations for the implementation of Act 79. Simultaneously, it permits BHPC to share our assessment of current progress of Act 79 planning and implementation with the Vermont Legislature, as well as enables us to impart recommendations to guide the short- and long-term future of Vermont's mental health system as it relates to the Act 79 implementation.

The State's mental health system is at a pivotal junction on its journey to create a community-based and recovery-oriented statewide mental health system. One fork will lead to sustained public support for mental health service capacity expansion buttressed by data and outcomes that demonstrate value and quality. The other fork leads to missed opportunities for consensus building among legislators, providers and recipients of care on realistic expectations for Act 79's implementation, true collaboration and integration.

The increase in funding is a beacon for Vermont's future mental health system. Yet, the State is only at the beginning of a system wide change effort that will span several years. While universal satisfaction is an unattainable goal, strategic planning and implementation of the Act will undoubtedly meet and even exceed the expectations of many. Much is left to be done, but the fruition of Act 79 is a shining light of continued hope.

APPENDIX A: ACT 79 OF 2012

No. 79. An act relating to reforming Vermont's mental health system.

(H.630)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. PURPOSE

(a) It is the intent of the general assembly to strengthen Vermont's existing mental health care system by offering a continuum of community and peer services, as well as a range of acute inpatient beds throughout the state. This system of care shall be designed to provide flexible and recovery-oriented treatment opportunities and to ensure that the mental health needs of Vermonters are served.

(b) It is also the intent of the general assembly that the agency of human services fully integrate all mental health services with all substance abuse, public health, and health care reform initiatives, consistent with the goals of parity.

Sec. 1a. 18 V.S.A. chapter 174 is added to read:

CHAPTER 174. MENTAL HEALTH SYSTEM OF CARE

§ 7251. PRINCIPLES FOR MENTAL HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for reforming the mental health care system in Vermont:

(1) The state of Vermont shall meet the needs of individuals with mental health conditions, including the needs of individuals in the custody of the commissioner of corrections, and the state's mental health system shall reflect excellence, best practices, and the highest standards of care.

(2) Long-term planning shall look beyond the foreseeable future and present needs of the mental health community. Programs shall be designed to be responsive to changes over time in levels and types of needs, service delivery practices, and sources of funding.

(3) Vermont's mental health system shall provide a coordinated continuum of care by the departments of mental health and of corrections, designated hospitals, designated agencies, and community and peer partners to ensure that individuals with mental health conditions receive care in the most integrated and least restrictive settings available. Individuals' treatment choices shall be honored to the extent possible.

(4) The mental health system shall be integrated into the overall health care system.

(5) Vermont's mental health system shall be geographically and financially accessible. Resources shall be distributed based on demographics and geography to increase the likelihood of treatment as close to the patient's home as possible. All ranges of services shall be available to individuals who need them, regardless of individuals' ability to pay.

(6) The state's mental health system shall ensure that the legal rights of individuals with mental health conditions are protected.

(7) Oversight and accountability shall be built into all aspects of the mental health system.

(8) Vermont's mental health system shall be adequately funded and financially sustainable to the same degree as other health services.

(9) Individuals with a mental health condition who are in the custody of the commissioner of mental health and who receive treatment in an acute inpatient hospital, intensive residential recovery facility, or a secure residential facility shall be afforded at least the same rights and protections as those individuals cared for at the former Vermont State Hospital.

§ 7252. DEFINITIONS

As used in this chapter:

(1) "Adult outpatient services" means flexible services responsive to individuals' preferences, needs, and values that are necessary to stabilize, restore, or improve the level of social functioning and well-being of individuals with mental health conditions, including individual and group treatment, medication management, psychosocial rehabilitation, and case management services.

(2) "Designated agency" means a designated community mental health and developmental disability agency as described in subsection 8907(a) of this title.

(3) "Designated area" means the counties, cities, or towns identified by the department of mental health that are served by a designated agency.

(4) "Enhanced programming" means targeted, structured, and specific intensive mental health treatment and psychosocial rehabilitation services for individuals in individualized or group settings.

(5) "Intensive residential recovery facility" means a licensed program under contract with the department of mental health that provides a safe, therapeutic, recovery-oriented residential environment to care for individuals with one or more mental health conditions who need intensive clinical interventions to facilitate recovery in anticipation of returning to the community. This facility shall be for individuals not in need of acute inpatient care and for whom the facility is the least restrictive and most integrated setting.

(6) "Mobile support team" means professional and peer support providers who are able to respond to an individual where he or she is located during a crisis situation.

(7) "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.

(8) "No refusal system" means a system of hospitals and intensive residential recovery facilities under contract with the department of mental health that provide high intensity services, in which the facilities shall admit any individual for care if the individual meets the eligibility criteria established by the commissioner in contract.

(9) "Participating hospital" means a hospital under contract with the department of mental health to participate in the no refusal system.

(10) "Peer" means an individual who has a personal experience of living with a mental health condition or psychiatric disability.

(11) "Peer services" means support services provided by trained peers or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery.

(12) "Psychosocial rehabilitation" means a range of social, educational, occupational, behavioral, and cognitive interventions for increasing the role performance and enhancing the recovery of individuals with serious mental illness, including services that foster long-term recovery and self-sufficiency.

(13) "Recovery-oriented" means a system or services that emphasize the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(14) "Serious bodily injury" means the same as in section 1912 of this title.

(15) "Warm line" means a nonemergency telephone response line operated by trained peers for the purpose of active listening and assistance with problem-solving for persons in need of such support.

§ 7253. CLINICAL RESOURCE MANAGEMENT AND OVERSIGHT

The commissioner of mental health, in consultation with health care providers as defined in section 9432 of this title, including designated hospitals, designated agencies, individuals with mental health conditions, and other stakeholders, shall design and implement a clinical resource management system that ensures the highest quality of care and facilitates long-term, sustained recovery for individuals in the custody of the commissioner.

(1) For the purpose of coordinating the movement of individuals across the continuum of care to the most appropriate services, the clinical resource management system shall:

(A) ensure that all individuals in the care and custody of the commissioner receive the highest quality and least restrictive care necessary;

(B) develop a process for receiving direct patient input on treatment opportunities and the location of services;

(C) use state-employed clinical resource management coordinators to work collaboratively with community partners, including designated agencies, hospitals, individuals with mental health conditions, and peer groups, to ensure access to services for

individuals in need. Clinical resource management coordinators or their designees shall be available 24 hours a day, seven days a week to assist emergency service clinicians in the field to access necessary services;

(D) use an electronic, web-based bed board to track in real time the availability of bed resources across the continuum of care;

(E) use specific level-of-care descriptions, including admission, continuing stay, and discharge criteria, and a mechanism for ongoing assessment of service needs at all levels of care;

(F) specify protocols for medical clearance, bed location, transportation, information sharing, census management, and discharge or transition planning;

(G) coordinate transportation resources so that individuals may access the least restrictive mode of transport consistent with safety needs;

(H) ensure that to the extent patients' protected health information pertaining to any identifiable person that is otherwise confidential by state or federal law is used within the clinical resource management system, the health information exchange privacy standards and protocols as described in subsection 9351(e) of this title shall be followed;

(I) review the options for the use of ambulance transport, with security as needed, as the least restrictive mode of transport consistent with safety needs required pursuant to section 7511 of this title; and

(J) ensure that individuals under the custody of the commissioner being served in designated hospitals, intensive residential recovery facilities, and the secure residential recovery facility shall have access to a mental health patient representative. The patient representative shall advocate for patients and shall also foster communication between patients and health care providers. The department of mental health shall contract with an independent, peer-run organization to staff the full-time equivalent of a patient representative.

(2) For the purpose of maintaining the integrity and effectiveness of the clinical resource management system, the department of mental health shall:

(A) require a designated team of clinical staff to review the treatment received and clinical progress made by individuals within the commissioner's custody;

(B) coordinate care across the mental and physical health care systems as well as ensure coordination within the agency of human services, particularly the department of corrections, the department of health's alcohol and drug abuse programs, and the department of disabilities, aging, and independent living;

(C) coordinate service delivery with Vermont's Blueprint for Health and health care reform initiatives, including the health information exchange as defined in section 9352 of this title and the health benefit exchange as defined in 33 V.S.A. § 1803;

(D) 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;

(E) actively engage stakeholders and providers in oversight processes; and

(F) provide mechanisms for dispute resolution.

§ 7254. INTEGRATION OF THE TREATMENT FOR MENTAL HEALTH,

SUBSTANCE ABUSE, AND PHYSICAL HEALTH

(a) The director of health care reform and the commissioners of mental health, of health, and of Vermont health access and the Green Mountain Care board or designees shall ensure that the redesign of the mental health delivery system established in this act is an integral component of the health care reform efforts established in 3 V.S.A. § 2222a. Specifically, the director, commissioners, and board shall confer on planning efforts necessary to ensure that the following initiatives are coordinated and advanced:

(1) any health information technology projects;

(2) the integration of health insurance benefits in the Vermont health benefit exchange to the extent feasible under federal law;

(3) the integration of coverage under Green Mountain Care;

(4) the Blueprint for Health;

(5) the reformation of payment systems for health services to the extent allowable under federal law or under federal waivers; and

(6) other initiatives as necessary.

(b) The department of banking, insurance, securities, and health care administration shall ensure that private payers are educated about their obligation to reimburse providers for less restrictive and less expensive alternatives to hospitalization.

§ 7255. SYSTEM OF CARE

The commissioner of mental health shall coordinate a geographically diverse system and continuum of mental health care throughout the state that shall include at least the following:

(1) comprehensive and coordinated community services, including prevention, to serve children, families, and adults at all stages of mental illness;

(2) peer services, which may include:

(A) a warm line;

(B) peer-provided transportation services;

(C) peer-supported crisis services; and

(D) peer-supported hospital diversion services;

(3) alternative treatment options for individuals seeking to avoid or reduce reliance on medications;

(4) recovery-oriented housing programs;

(5) intensive residential recovery facilities;

(6) appropriate and adequate psychiatric inpatient capacity for voluntary patients;

(7) appropriate and adequate psychiatric inpatient capacity for involuntary inpatient treatment services, including patients receiving treatment through court order from a civil or criminal court; and

(8) a secure residential recovery facility.

§ 7256. REPORTING REQUIREMENTS

Notwithstanding 2 V.S.A. § 20(d), the department of mental health shall report annually on or before January 15 to the senate committee on health and welfare and the house committee on human services regarding the extent to which individuals with mental health conditions receive care in the most integrated and least restrictive setting available. The report shall address:

(1) Utilization of services across the continuum of mental health services;

(2) Adequacy of the capacity at each level of care across the continuum of mental health services;

(3) Individual experience of care and satisfaction;

(4) Individual recovery in terms of clinical, social, and legal outcomes; and

(5) Performance of the state's mental health system of care as compared to nationally recognized standards of excellence.

§ 7257. REPORTABLE ADVERSE EVENTS

An acute inpatient hospital, an intensive residential recovery facility, a designated agency, or a secure residential facility shall report to the department of mental health instances of death or serious bodily injury to individuals with a mental health condition in the custody of the commissioner.

§ 7258. REVIEW OF ADVERSE COMMUNITY EVENTS

The department of mental health shall establish a system that ensures the comprehensive review of a death or serious bodily injury occurring outside an acute inpatient hospital when the individual causing or victimized by the death or serious bodily injury is in

the custody of the commissioner or had been in the custody of the commissioner within six months of the event. The department shall review each event for the purpose of determining whether the death or serious bodily injury was the result of inappropriate or inadequate services within the mental health system and, if so, how the failure shall be remedied.

Sec. 2. DELETED

Sec. 3. DELETED

Sec. 4. DELETED

Sec. 5. DELETED

Sec. 6. PEER SERVICES

The commissioner of mental health is authorized to contract for new peer services and to expand existing programs managed by peers that provide support to individuals living with or recovering from mental illness. Peer services shall be aimed at helping individuals with mental illness achieve recovery through improved physical and mental health, increased social and community connections and supports, and the avoidance of mental health crises and psychiatric hospitalizations. The commissioner of mental health shall:

(1) Establish a warm line or warm lines accessible statewide which shall be staffed at all times to ensure that individuals with a mental health condition have access to peer support;

(2) Establish new peer services focused on reducing the need for inpatient services;

(3) Improve the quality, infrastructure, and workforce development of peer services; and

(4) Develop peer-run transportation services.

Sec. 7. COMMUNITY SERVICES

To improve existing community services and to create new opportunities for community treatment, the commissioner of mental health is authorized to:

(1) Improve emergency responses, mobile support teams, noncategorical case management, adult outpatient services, and alternative residential opportunities at designated agencies.

(A) Each designated agency shall provide the scope and category of services most responsive to the needs of designated areas, as determined by the commissioner of mental health.

(B) Designated agencies shall work collaboratively with law enforcement officials, corrections, local hospitals, the department of disabilities, aging, and independent living, and peers to integrate services and expand treatment opportunities for individuals living with or recovering from mental illness.

(2) Contract for at least four additional short-term crisis beds in designated agencies for the purpose of preventing or diverting individuals from hospitalization when clinically appropriate and for the purpose of increasing regional access to crisis beds.

(3) Contract for a voluntary five-bed residence for individuals seeking to avoid or reduce reliance on medication or having an initial episode of psychosis. The residence shall be peer supported and noncoercive, and treatment shall be focused on a nontraditional, interpersonal, and psychosocial approach, with minimal use of psychotropic medications to facilitate recovery in individuals seeking an alternative to traditional hospitalization.

(4) Provide housing subsidies to individuals living with or recovering from mental illness for the purpose of fostering stable and appropriate living conditions. If necessary to achieve successful housing outcomes, housing subsidies may be provided without an agreement to accept certain services as a condition of assistance. The department of mental health shall ensure that housing subsidies are monitored and managed in coordination with other relevant community services and supports.

Sec. 8. INTENSIVE RESIDENTIAL RECOVERY FACILITIES

(a) To support the development of intensive residential recovery facilities, the commissioner of mental health is authorized to contract for:

(1) Fifteen beds located in northwestern Vermont;

(2) Eight beds located in southeastern Vermont; and

(3) Eight beds located in either central or southwestern Vermont or both.

(b) Notwithstanding 18 V.S.A. § 9435(b), all facilities contracted for under subsection (a) of this section shall be subject to the certificate of approval process, which shall take into consideration the recommendations of a panel of stakeholders appointed by the commissioner to review each proposal and conduct a public hearing.

Sec. 9. INPATIENT HOSPITAL BEDS

(a) To replace the services provided at the Vermont State Hospital, the department of mental health shall oversee the delivery of emergency examination and involuntary inpatient treatment services at four acute inpatient hospitals throughout the state:

(1) The department of mental health shall enter into contracts that meet the requirements of subdivision (2) of this subsection with a hospital in southeastern Vermont and a hospital in southwestern Vermont for the establishment of a 14-bed unit and a six-bed unit, respectively, contingent upon receipt by the hospitals of certificates of need pursuant to 18 V.S.A. chapter 221, subchapter 5. Certificate of need applications for the 14-bed unit and the six-bed unit, whether prepared jointly by a hospital and the department or solely by a hospital, shall be reviewed by the commissioner of mental health prior to a certificate of need approval to ensure the architectural and program proposals meet industry standards for quality of care and emotional and physical safety standards and otherwise protect patients' rights.

(2) Initial contract terms for the 14-bed unit and the six-bed unit shall require participation in the no refusal system for four years and until the facility has recouped its initial investment. Contracts referenced in subdivision (1) of this subsection shall apply to participating hospitals, notwithstanding their status as designated hospitals, and shall contain the following requirements:

(A) Funding shall be based on the ability to treat patients with high acuity levels;

(B) Units shall be managed as part of a statewide no refusal system;

(C) Reimbursement by the state shall cover reasonable actual costs for enhanced programming and staffing in accordance with Sec. 33b of this act;

(D) Units shall be managed to ensure access to peer supports;

(E) Participating hospitals shall maintain a stakeholder advisory group with nonexclusionary membership to ensure high quality and appropriate levels of care;

(F) The department shall be solely responsible for responding to requests for records concerning the implementation of this contract between the department and the hospital. The hospital and its employees shall cooperate and provide reasonable assistance to the department in producing records that are within the custody of the hospital that are responsive to records requests and that are not confidential by law; and

(G) The state shall retain the option to renew the contract upon expiration of the initial four-year term.

(b)(1)(A) The department of buildings and general services, with broad involvement from the department of mental health and stakeholders, shall design a 25-bed hospital owned and operated by the state in central Vermont and proximate to an existing hospital. Applying the most expeditious methodology possible, the department of buildings and general services shall supervise the construction of the hospital with an expressed goal of completing the project in 24 months. The operations of the hospital shall be under the jurisdiction of the commissioner of mental health.

(B)(i) The general assembly finds that the Centers for Medicare and Medicaid Services (CMS) advised the state of Vermont on March 14, 2012 that:

(I) any newly constructed hospital owned and operated by the state that exceeds 16 beds will be eligible to receive federal matching funds for services rendered at the hospital under the state's current Global Commitment waiver, which is set to expire on December 31, 2013.

(II) although CMS was unable to provide a definitive answer as to whether a new hospital owned and operated by the state with 25 beds would be eligible for federal matching funds after December 31, 2013, the state will be able to cease use of nine beds at that time and amend the hospital's license from 25 beds to 16 beds if the Global Commitment waiver is not renewed or extended and a new waiver is not granted under similar terms and conditions.

(ii) In the event the hospital owned and operated by the state loses or is no longer eligible for federal matching funds after December 31, 2013, the commissioner of mental health shall cease use of nine beds within the time frame set by CMS and reduce the hospital's license from 25 to 16 beds. At that time, the commissioner of mental health shall begin planning for an orderly transition to a 16-bed hospital that shall proceed in a manner that protects the health, safety, and integrity of individuals treated at the state owned and operated hospital. The commissioner's transition plan shall ensure the nine-bed deficit in acute inpatient beds be addressed by expanding acute inpatient capacity elsewhere in the state if necessary and that the nine decommissioned beds in the state owned and operated hospital be repurposed in a manner that does not jeopardize federal matching funds for the remaining 16 beds. If the loss or denial of federal matching funds occurs while the general assembly is in session, the commissioner shall notify and seek approval of the transition plan from the senate committees on health and welfare and on institutions and the house committees on human services and on corrections and institutions before proceeding with the transition plan. If the loss or denial of federal matching funds occurs while the general assembly is not in session, the commissioner shall notify and seek approval of the transition plan from a special committee composed of members of the joint fiscal committee and the chairs and vice chairs of the senate committees on health and welfare and on institutions and the house committees on human services and on corrections and institutions before proceeding with the transition plan. The special committee shall be entitled to per diem and expenses as provided in 32 V.S.A. § 1010.

(2) To foster coordination between the judiciary and mental health systems, the hospital owned and operated by the state shall contain:

(A) adequate capacity to accept individuals receiving a court order of hospitalization pursuant to 18 V.S.A. chapter 181; and

(B) a private room used and outfitted for the purpose of judicial proceedings.

(3) The commissioner of buildings and general services may purchase, lease for a period of up to 99 years plus any contracted for renewal options, or enter into a lease-purchase agreement for property in central Vermont for the purpose described in this subsection.

(4) The commissioner of buildings and general services shall inform the chairs and vice chairs of the senate committee on institutions and house committee on corrections and institutions prior to entering into an agreement pursuant to subdivision (3) of this subsection, upon substantial completion of a design pursuant to this section, prior to the commencement of construction, and when any other substantial step is taken in furtherance of this section.

(c)(1) The commissioner is authorized to contract for seven to 12 involuntary acute inpatient beds at Fletcher Allen Health Care until the hospital owned and operated by the state described in subsection (b) of this section is operational, to cover the increased cost of care; and

(2)(A) If a viable setting is identified by the commissioner and licensed by the department of health, the commissioner is authorized to provide acute inpatient services at a temporary hospital and shall discontinue services at that hospital when the hospital owned and operated by the state described in subsection (b) of this section is operational. The department shall pursue Medicare and Medicaid certification for any such temporary hospital.

(B) If the temporary hospital identified under subdivision (2)(A) of this subsection (c) is located in Morrisville, acute inpatient services shall be discontinued at the facility when the hospital owned and operated by the state described in subsection (b) of this section is operational, but no later than September 1, 2015. At that time, the temporary hospital shall revert to prior permitted uses. The temporary hospital shall be initially licensed for eight acute inpatient beds. Before an expansion of the number of beds at the temporary Morrisville hospital may occur, the department shall confer with the host community to seek permission for such expansion.

(d) To the extent amounts of potential funding from various sources are not clear upon passage of this act, the legislative intent for funding the capital costs of this section to the extent practicable is first through insurance funds that may be available for these purposes; second through the Federal Emergency Management Agency (FEMA) funds that may be available for these purposes and any required state match; third, in the case of the 14-bed unit and the six-bed unit, through a rate payment with clearly defined terms of services; and last with state capital or general funds. It is also the intent of the general assembly that, notwithstanding 32 V.S.A. §§ 134 and 135, any capital funds expended for projects described in this act that are reimbursed at a later date by insurance or FEMA shall be reallocated to fund capital projects in a future act relating to capital construction and state bonding.

Sec. 10. SECURE RESIDENTIAL RECOVERY PROGRAM

(a) The commissioner of mental health is authorized to establish and oversee a secure seven-bed residential facility owned and operated by the state for individuals no longer requiring acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time. The program shall be the least restrictive and most integrated setting for each of the individual residents.

(b) The opening of the facility described in subsection (a) of this section is contingent upon the passage of necessary statutory amendments authorizing judicial orders for commitment to such a facility, which shall parallel or be included in 18 V.S.A. § 7620 (related to applications for continuation of involuntary treatment), and shall include the same level of statutory protections for the legal rights of the residents as provided for individuals at inpatient facilities.

* * * Vermont Employees Retirement System * * *

Sec. 11. 3 V.S.A. § 455 is amended to read:

§ 455. DEFINITIONS

(a) Unless a different meaning is plainly required by the context, the following words and phrases as used in this subchapter shall have the following meanings:

* * *

(28) "Successor in interest" means the mental health hospital owned and operated by the state that provides acute inpatient care and replaces the Vermont State Hospital.

Sec. 12. 3 V.S.A. § 459(d)(2)A) is amended to read:

(2)(A) Upon early retirement, a group F member, except facility employees of the department of corrections and department of corrections employees who provide direct security and treatment services to offenders under supervision in the community and Woodside facility employees, shall receive an early retirement allowance which shall be equal to the normal retirement allowance reduced by one-half of one percent for each month the member is under age 62 at the time of early retirement. Group F members who have 20 years of service as facility employees of the department of corrections, as department of corrections employees who provide direct security and treatment services to offenders under supervision in the community or as Woodside facility employees or as Vermont ~~state hospital~~ State Hospital employees, or as employees of its successor in interest, who provide direct patient care shall receive an early retirement allowance which shall be equal to the normal retirement allowance at age 55 without reduction; provided the 20 years of service occurred in one or more of the following capacities as an employee of the department of corrections, Woodside facility~~[~~, or the Vermont ~~state hospital]~~ State Hospital, or its successor in interest: facility employee, community service center employee, or court and reparative service unit employee.

* * * Executive: Human Services * * *

Sec. 13. 3 V.S.A. § 3089 is amended to read:

§ 3089. DEPARTMENT OF MENTAL HEALTH

The department of mental health is created within the agency of human services as the successor to and the continuation of the division of mental health services of the department of health. The department of mental health shall be responsible for the operation of the Vermont ~~state hospital~~ State Hospital, or its successor in interest as defined in subdivision 455(28) of this title.

* * * Crimes and Criminal Procedure: Escape * * *

Sec. 14. 13 V.S.A. § 1501 is amended to read:

§ 1501. ESCAPE AND ATTEMPTS TO ESCAPE

* * *

(b) A person who, while in lawful custody:

* * *

(4) escapes or attempts to escape from the Vermont ~~state hospital~~ State Hospital, or its successor in interest or a participating hospital, when confined by court order pursuant to chapter 157 of ~~Title 13 or chapter 199 of Title 18~~ this title, or when transferred there pursuant to ~~section~~ 28 V.S.A. § 703 ~~of Title 28~~ and while still serving a sentence, shall be imprisoned for not more than five years or fined not more than $1,000.00, or both.

* * *

(d) As used in this section:

(1) "No refusal system" means a system of hospitals and intensive residential recovery facilities under contract with the department of mental health that provides high intensity services, in which the facilities shall admit any individual for care if the individual meets the eligibility criteria established by the commissioner in contract.

(2) "Participating hospital" means a hospital under contract with the department of mental health to participate in the no refusal system.

(3) "Successor in interest" shall mean the mental health hospital owned and operated by the state that provides acute inpatient care and replaces the Vermont State Hospital.

* * * Crimes and Criminal Procedure: Insanity as a Defense * * *

Sec. 15. 13 V.S.A. § 4815 is amended to read:

§ 4815. PLACE OF EXAMINATION; TEMPORARY COMMITMENT

* * *

(b) The order for examination may provide for an examination at any jail or correctional center, or at the state hospital, or at its successor in interest, or at such other place as the court shall determine, after hearing a recommendation by the commissioner of mental health.

* * *

(g)(1) Inpatient examination at the ~~state hospital~~ Vermont State Hospital, or its successor in interest, or a designated hospital. The court shall not order an inpatient examination unless the designated mental health professional determines that the defendant is a person in need of treatment as defined in 18 V.S.A. § 7101(17).

* * *

(3) An order for inpatient examination shall provide for placement of the defendant in the custody and care of the commissioner of mental health.

(A) If a Vermont ~~state hospital~~ State Hospital psychiatrist, or a psychiatrist of its successor in interest, or a designated hospital psychiatrist determines that the defendant is not in need of inpatient hospitalization prior to admission, the commissioner shall release the defendant pursuant to the terms governing the defendant's release from the commissioner's custody as ordered by the court. The commissioner of mental health

shall ensure that all individuals who are determined not to be in need of inpatient hospitalization receive appropriate referrals for outpatient mental health services.

(B) If a Vermont ~~state hospital~~ State Hospital psychiatrist, or a psychiatrist of its successor in interest, or designated hospital psychiatrist determines that the defendant is in need of inpatient hospitalization:

(i) The commissioner shall obtain an appropriate inpatient placement for the defendant at the Vermont ~~state hospital~~ State Hospital, or its successor in interest, or a designated hospital and, based on the defendant's clinical needs, may transfer the defendant between hospitals at any time while the order is in effect. A transfer to a designated hospital outside the no refusal system is subject to acceptance of the patient for admission by that hospital.

(ii) The defendant shall be returned to court for further appearance on the following business day if the defendant is no longer in need of inpatient hospitalization, unless the terms established by the court pursuant to subdivision (2) of this section permit the defendant to be released from custody.

* * *

(i) As used in this section:

(1) "No refusal system" means a system of hospitals and intensive residential recovery facilities under contract with the department of mental health that provides high intensity services, in which the facilities shall admit any individual for care if the individual meets the eligibility criteria established by the commissioner in contract.

(2) "Successor in interest" shall mean the mental health hospital owned and operated by the state that provides acute inpatient care and replaces the Vermont State Hospital.

Sec. 15a. 13 V.S.A. § 4822(c) is amended to read:

(c) Notwithstanding the provisions of subsection (b) of this section, at least 10 days prior to the proposed discharge of any person committed under this section the commissioner of ~~developmental and~~ mental health ~~services~~ shall give notice thereof to the committing court and state's attorney of the county where the prosecution originated. In all cases requiring a hearing prior to discharge of a person found incompetent to stand trial under section 4817 of this title, the hearing shall be conducted by the committing court issuing the order under that section. In all other cases, when the committing court orders a hearing under subsection (a) of this section or when, in the discretion of the commissioner of ~~developmental and~~ mental health ~~services~~, a hearing should be held prior to the discharge, the hearing shall be held in the ~~criminal~~ family division of the superior court~~, Waterbury circuit~~ to determine if the committed person is no longer a person in need of treatment or a patient in need of further treatment as set forth in subsection (a) of this section. Notice of the hearing shall be given to the commissioner, the state's attorney of the county where the prosecution originated, the committed person and the person's attorney. Prior to the hearing, the state's attorney may enter an appearance in the proceedings and may request examination of the patient by an independent psychiatrist, who may testify at the hearing.

Sec. 16. DELETED

* * * General Provisions (Pertaining to Mental Health) * * *

Sec. 17. 18 V.S.A. § 7101 is amended to read:

§ 7101. DEFINITIONS

As used in this part of this title, the following words, unless the context otherwise requires, shall have the following meanings:

* * *

(26) "No refusal system" means a system of hospitals and intensive residential recovery facilities under contract with the department of mental health that provides high intensity services, in which the facilities shall admit any individual for care if the individual meets the eligibility criteria established by the commissioner in contract.

(27) "Participating hospital" means a hospital under contract with the department of mental health to participate in the no refusal system.

(28) "Successor in interest" means the mental health hospital owned and operated by the state that provides acute inpatient care and replaces the Vermont State Hospital.

Sec. 18. 18 V.S.A. § 7108 is amended to read:

§ 7108. CANTEENS

The ~~superintendents~~ chief executive officer of the Vermont State Hospital ~~and the Training School~~, or its successor in interest, may conduct a canteen or commissary, which shall be accessible to patients, ~~students,~~ employees, and visitors of the ~~state hospital and training school~~ Vermont State Hospital, or its successor in interest, at designated hours and shall be operated by employees of the hospital ~~and the school~~. A revolving fund for this purpose is authorized. The salary of an employee of the hospital ~~or training school~~ shall be charged against the canteen fund. Proceeds from sales may be used for operation of the canteen and the benefit of the patients~~, students~~ and employees of the hospital ~~or training school~~ under the direction of the ~~superintendents~~ chief executive officer and subject to the approval of the commissioner. All balances of such funds remaining at the end of any fiscal year shall remain in such fund for use during the

succeeding fiscal year. An annual report of the status of the funds shall be submitted to the commissioner.

Sec. 19. 18 V.S.A. § 7110 is amended to read:

§ 7110. CERTIFICATION OF MENTAL ILLNESS

A certification of mental illness by a licensed physician required by section 7504 of this title shall be made by a board eligible psychiatrist, a board certified psychiatrist or a resident in psychiatry, under penalty of perjury. In areas of the state where board eligible psychiatrists, board certified psychiatrists or residents in psychiatry are not available to complete admission certifications to the Vermont ~~state hospital~~ State Hospital, or its successor in interest, the commissioner may designate other licensed physicians as appropriate to complete certification for purposes of section 7504 of this title.

* * * The Department of Mental Health * * *

Sec. 20. 18 V.S.A. § 7205 is amended to read:

§ 7205. SUPERVISION OF INSTITUTIONS

(a) The department of mental health shall operate the Vermont State Hospital, or its successor in interest, and shall be responsible for patients receiving involuntary treatment ~~at a hospital designated by the department of mental health~~.

(b) The commissioner of the department of mental health, in consultation with the secretary, shall appoint a chief executive officer of the Vermont State Hospital, or its successor in interest, to oversee the operations of the hospital. The chief executive officer position shall be an exempt position.

Sec. 21. DELETED

Sec. 22. DELETED

* * * The Commissioner of Mental Health * * *

Sec. 23. 18 V.S.A. § 7401 is amended to read:

§ 7401. POWERS AND DUTIES

Except insofar as this part of this title specifically confers certain powers, duties, and functions upon others, the commissioner shall be charged with its administration. The commissioner may:

* * *

(5) supervise the care and treatment of ~~patients at the Retreat in the same manner and with the same authority that he supervises patients at the Vermont State Hospital~~ individuals within his or her custody;

* * *

(16) contract with accredited educational or health care institutions for psychiatric services at the Vermont State Hospital, or its successor in interest;

* * *

* * * Admission Procedures * * *

Sec. 24. 18 V.S.A. § 7511 is amended to read:

§ 7511. TRANSPORTATION

(a) The commissioner shall ensure that all reasonable and appropriate measures consistent with public safety are made to transport or escort a person subject to this chapter to and from any inpatient setting, including escorts within a designated hospital or the Vermont ~~state hospital~~ State Hospital, or its successor in interest, or otherwise being transported under the jurisdiction of the commissioner in any manner which:

(1) prevents physical and psychological trauma;

(2) respects the privacy of the individual; and

(3) represents the least restrictive means necessary for the safety of the patient.

(b) The commissioner shall have the authority to designate the professionals or law enforcement officers who may authorize the method of transport of patients under the commissioner's care and custody.

(c) When a professional or law enforcement officer designated pursuant to subsection (b) of this section decides an individual is in need of secure transport with mechanical restraints, the reasons for such determination shall be documented in writing.

* * *

* * * Care and Treatment * * *

Sec. 25. 18 V.S.A. § 7703 is amended to read:

§ 7703. TREATMENT

(a) Outpatient or partial hospitalization shall be preferred to inpatient treatment. Emergency involuntary treatment shall be undertaken only when clearly necessary. Involuntary treatment shall be utilized only if voluntary treatment is not possible.

(b) The department shall establish minimum standards for adequate treatment as provided in this section, including requirements that, when possible, psychiatric unit staff be used as the primary source to implement emergency involuntary procedures such as seclusion and restraint.

* * * Transfer of Patients * * *

Sec. 26. 18 V.S.A. § 7901 is amended to read:

§ 7901. INTRASTATE TRANSFERS

The commissioner may authorize the transfer of patients between the Vermont ~~state hospital~~ State Hospital, or its successor in interest, and designated hospitals if the commissioner determines that it would be consistent with the medical needs of the patient to do so. Whenever a patient is transferred, written notice shall be given to the patient's

~~attorney,~~ legal guardian or agent, if any, ~~spouse, parent, or parents, or, if none be known, to any other interested party in that order~~, and any other person with the consent of the patient. In all such transfers, due consideration shall be given to the relationship of the patient to his or her family, legal guardian, or friends, so as to maintain relationships and encourage visits beneficial to the patient. Due consideration shall also be given to the separation of functions and to the divergent purposes of the Vermont ~~state hospital~~ State Hospital, or its successor in interest, and designated hospitals. No patient may be transferred to a correctional institution without the order of a court of competent jurisdiction. No patient may be transferred to a designated hospital outside the no refusal system unless the head of the hospital or his or her designee first accepts the patient.

* * * Support and Expense * * *

Sec. 27. 18 V.S.A. § 8101(b) is amended to read:

(b) The commissioner shall promulgate, pursuant to 3 V.S.A. chapter 25 ~~of Title 3~~, regulations which set forth in detail the levels of income, resources, expenses, and family size at which persons are deemed able to pay given amounts for the care and treatment of a patient, and the circumstances, if any, under which the rates of payment so established may be waived or modified. A copy of the payment schedule so promulgated shall be made available in the admissions office ~~and in the office of each supervisor~~ at the ~~state hospital~~ Vermont State Hospital, or its successor in interest.

Sec. 28. 18 V.S.A. § 8105 is amended to read:

§ 8105. COMPUTATION OF CHARGE FOR CARE AND TREATMENT

The charge for the care and treatment of a patient at the Vermont ~~state hospital~~ State Hospital, or its successor in interest, shall be established at least annually by the commissioner. The charge shall reflect the current cost of the care and treatment,

including depreciation and overhead, for the Vermont ~~state hospital~~ State Hospital, or its successor in interest. Depreciation shall include but not be limited to costs for the use of the plant and permanent improvements, and overhead shall include but not be limited to costs incurred by other departments and agencies for the operation of the hospital. Accounting principles and practices generally accepted for hospitals shall be followed by the commissioner in establishing the charges.

Sec. 29. 18 V.S.A. § 8010 is amended to read:

§ 8010. VOLUNTARY PATIENTS; DISCHARGE; DETENTION

~~(a) If a voluntary patient gives notice in writing to the head of the hospital of a desire to leave the hospital, he or she shall promptly be released unless he or she agreed in writing at the time of his admission that his or her release could be delayed.~~

~~(b) In that event and if the head of the hospital determines that the patient is a patient in need of further treatment, the head of the hospital may detain the patient for a period not to exceed four days from receipt of the notice to leave. Before expiration of the four-day period the head of the hospital shall either release the patient or apply to the family division of the superior court in the unit in which the hospital is located for the involuntary admission of the patient. The patient shall remain in the hospital pending the court's determination of the case.~~

~~(c) If the patient is under 18 years of age, the notice to leave may be given by the patient or his r her attorney or the person who applied for admission, provided the minor consents thereto.~~ [Repealed.]

* * * Municipal and County Government * * *

Sec. 29a. 24 V.S.A. § 296 is amended to read:

§ 296. TRANSPORTATION OF PRISONERS ~~AND MENTAL PATIENTS~~

All commitments to a state correctional facility ~~or state mental institution~~ or to any other place named by the commissioner of corrections~~, commissioner of mental health~~ or committing court~~,~~ shall be made by any sheriff, deputy sheriff, state police officer, police officer, or constable in the state, or the commissioner of corrections or his or her authorized agent.

* * * Professions and Occupations: Nursing * * *

Sec. 30. 26 V.S.A. § 1583 is amended to read:

§ 1583. EXCEPTIONS

This chapter does not prohibit:

* * *

(6) ~~The work and duties of psychiatric technicians and other care attendants employed in the Vermont state hospital at Waterbury. The agency of human services shall consult with the board regarding standards for the education of the technicians and care attendants.~~

~~(7)~~ The work and duties of attendants in attendant care services programs.

~~(8)~~(7) The practice of any other occupation or profession licensed under the laws of this state.

~~(9)~~(8) The providing of care for the sick in accordance with the tenets of any church or religious denomination by its adherents if the individual does not hold himself or herself out to be a registered nurse, licensed practical nurse, or licensed nursing assistant and does not engage in the practice of nursing as defined in this chapter.

* * * Public Institutions and Corrections: Juveniles * * *

Sec. 31. 28 V.S.A. § 1105 is amended to read:

§ 1105. TRANSFER OF JUVENILES TO STATE HOSPITAL

~~The transfer of any child committed to the custody of the commissioner from a facility of or supported by the department to the state hospital shall be conducted pursuant to the same procedures established for the transfer of adult inmates by sections 703-706 of this title.~~ [Repealed.]

* * * Regulation of Long-Term Care Facilities * * *

Sec. 32. 33 V.S.A. § 7102 is amended to read:

§ 7102. DEFINITIONS

For the purposes of this chapter:

* * *

(11) "Therapeutic community residence" means a place, however named, excluding ~~a hospital~~ hospitals as defined by statute ~~or the Vermont state hospital~~ which provides, for profit or otherwise, short-term individualized treatment to three or more residents with major life adjustment problems, such as alcoholism, drug abuse, mental illness, or delinquency.

* * *

Sec. 33. REPORTS

(a) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committees on human services and on judiciary on issues and protections relating to decentralizing high intensity inpatient mental health care. The commissioner of mental health shall:

(1) Recommend whether any statutory changes are needed to preserve the rights afforded to patients in the Vermont State Hospital. In so doing, the commissioner shall consider 18 V.S.A. §§ 7705 and 7707, the Vermont Hospital Patient Bill of Rights as provided in 18 V.S.A. § 1852, the settlement order in Doe, et al. v. Miller, et al., docket number S-142-

82-Wnc dated May 1984, and other state and federal regulatory and accreditation requirements related to patient rights.

(2) Work with designated hospitals and stakeholders to develop a process to ensure public involvement with policy development relevant to individuals in the care and custody of the commissioner.

(3) Develop consistent definitions and measurement specifications for measures relating to seclusion and restraint and other key indicators, in collaboration with the designated hospitals. The commissioner shall prioritize the use of measures developed by national organizations such as the Joint Commission and the Centers for Medicare and Medicaid Services.

(4) Report on the efficacy of the department of mental health's housing subsidies program on the status of stable housing.

(b) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committee on human services regarding the department's efforts to date to plan for implementation, quality improvement, and innovation of Vermont's mental health system and how the department recommends that it proceed in its efforts to improve the system. The recommendation shall be based on an assessment of outcome and financial measures focused on at least the following criteria for individuals with a mental health condition:

(1) the development of sufficient capacity for inpatient and community psychiatric services and peer supports across the continuum of care;

(2) the support of individuals in accessing the services nearest to their home;

(3) the reduction in emergency department usage and law enforcement intervention;

(4) the reduction in hospital admissions and length of inpatient stays, including any impact on readmissions;

(5) the implementation of quality assessment tools for evaluation of services at all levels, including those needed to measure the effectiveness of the care management system;

(6) the department's use of current financial data to conduct a fiscal analysis of the capital and annual operating costs associated with the plan as enacted; and

(7) individuals' satisfaction with provided services.

(c) Prior to submitting the reports required by subsections (a) and (b) of this section, the department of mental health shall solicit comments from the department's patient representative described in 18 V.S.A. § 7253, Vermont Legal Aid, and Disability Rights Vermont, and shall append any comments received to the respective report.

(d) On or before January 15, 2013, the department of mental health shall report to the senate committee on health and welfare and the house committee on human services with a plan for streamlining overlapping state and federal reporting requirements for providers in

the mental health system, including recommendations for any statutory changes needed to do so.

(e) A special committee consisting of the members of the joint fiscal committee and the chairs and vice chairs of the senate committee on health and welfare and the house committee on human services, in consultation with the commissioner of mental health shall contract with an independent consultant who has expertise in the field of mental health and psychiatric hospital services to evaluate the structure, services, and financial implications of Vermont's proposed mental health system. The joint fiscal office shall administer the contract for the special committee. The department of mental health shall transfer to the joint fiscal committee one-half the cost of this contract and the joint fiscal committee is authorized to transfer one-half the cost of this contract from the legislative budget to the joint fiscal committee. The independent consultant shall submit a report to the general assembly by December 1, 2012 and shall specifically address:

(1) Whether Vermont's proposed mental health system appropriately serves the needs of individuals with mental health conditions throughout the state and, if any unmet needs are identified, how they may be addressed;

(2) The data and evaluation mechanisms necessary to manage and improve the quality of care and outcomes for individuals in Vermont with a mental health condition.

Sec. 33a. RULEMAKING

On or before September 1, 2012, the commissioner of mental health shall initiate a rulemaking process that establishes standards that meet or exceed and are consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission for the use and reporting of the emergency involuntary procedures of seclusion or restraint on individuals within the custody of the commissioner and that require the personnel performing emergency involuntary procedures to receive training and certification on the use of these procedures. Standards established by rule shall be consistent with the recommendations made pursuant to Sec. 33(a)(1) and (3) of this act.

Sec. 33b. COST-BASED REIMBURSEMENT FOR ACUTE HOSPITAL SERVICES

(a) The department of mental health shall ensure that hospitals are paid reasonable actual costs for providing necessary care to persons who otherwise would have been cared for at the Vermont State Hospital as defined by the department. The department shall contract with a third party with experience in psychiatric hospital care and expenses to conduct a comprehensive fiscal review to determine if the department's cost reimbursement methodology reflects reasonable actual costs.

(b) The department of mental health shall report to the joint fiscal committee regarding the fiscal review described in subsection (a) of this section on or before September 1, 2012.

Sec. 34. TRANSFER OF APPROPRIATIONS

To continue the training program established in Sec. 13 of No. 80 of the Acts of the 2003 Adj. Sess. (2004) (amending Sec. 57 of No. 66 of the Acts of 2003), for assisting selected law enforcement officers during the performance of their duties in their interactions with persons exhibiting mental health conditions, $20,000.00 of the general funds appropriated to the department of mental health for fiscal year 2012 shall be transferred to the office of the attorney general.

(1) The office of the attorney general, in consultation with the Vermont coalition for disability rights and other organizations, shall implement this training program.

(2) By January 15 of each year and until funds are fully expended, the attorney general shall submit to the secretary of administration and the house and senate committees on appropriations a report summarizing how the funds have been used and how the trainings have progressed.

(3) Unexpended funds shall be carried forward and used for the purpose of this section in future years.

Sec. 34a. Sec. 33 of No. 43 of the Acts of 2009 (amending Sec. 124d(e) of No. 65 of the Acts of 2007) is amended to read:

(e) For purposes of this section, the council shall cease to exist when the development of the alternatives to the Vermont state hospital is completed, but no later than ~~July~~ September 1, ~~2012~~ 2015.

* * * Fiscal Year 2012 Appropriations * * *

Sec. 35. Sec. B.301 of No. 63 of the Acts of 2011 (FY12 Big Bill), as amended by Sec. 14 of H.558 of 2012 (FY12 Budget Adjustment) is amended to read:

Sec. B.301 Secretary's office - global commitment

Grants ~~1,080,785,264~~	1,107,604,567	
Total ~~1,080,785,264~~	1,107,604,567	
Source of funds		
General fund 135,947,833		~~139,267,121~~
Special funds 19,052,361		~~18,630,961~~
Tobacco fund 36,978,473		36,978,473
State health care resources fund	~~221,579,040~~	234,205,524

Catamount fund	~~23,948,700~~	25,226,979	
Federal funds 655,505,262		~~639,692,834~~	
Interdepartmental transfers	688,135	688,135	
Total ~~1,080,785,264~~	1,107,604,567		

Sec. 36. Sec. B.314 of No. 63 of the Acts of 2011 (FY12 Big Bill), as amended by Sec. 24 of H.558 of 2012 (FY12 Budget Adjustment) is amended to read:

Sec. B.314 Mental health - mental health

Personal services	~~5,486,339~~	5,482,633	
Operating expenses	~~1,117,984~~	1,040,984	
Grants ~~124,369,250~~	139,483,645		
Total ~~130,973,573~~	146,007,262		
Source of funds			
General fund 961,295		~~811,295~~	
Special funds		6,836	6,836
Federal funds 6,552,154		~~6,555,971~~	
Global Commitment fund	~~123,579,471~~	138,466,977	
Interdepartmental transfers	20,000	20,000	
Total ~~130,973,573~~	146,007,262		

Sec. 37. Sec. B.315 of No. 63 of the Acts of 2011 (FY12 Big Bill), as amended by Sec. 25 of H.558 of 2012 (FY12 Budget Adjustment) is amended to read:

Sec. B.315 Mental health – Vermont state hospital

Personal services	~~20,479,188~~	20,228,969	
Operating expenses	~~2,056,312~~	1,394,734	

Grants 82,335	82,335		
Total ~~22,617,835~~	21,706,038		
Source of funds			
General fund 5,963,977		~~17,016,067~~	
~~Special funds~~		~~835,486~~	0
Federal funds		~~213,564~~	93,117
Global Commitment fund	~~4,252,718~~	15,648,944	
~~Interdepartmental transfers~~	~~300,000~~	0	
Total ~~22,617,835~~	21,706,038		

Sec. 37a. REDUCTION IN FORCE OF VERMONT STATE HOSPITAL EMPLOYEES

(a) Permanent status classified employees who were officially subjected to a reduction in force from their positions with the Vermont State Hospital on or after February 6, 2012, whose reemployment rights have not otherwise terminated and who have not been reemployed with the state during the two-year reduction in force reemployment rights period, shall be granted a continuation of their reduction in force reemployment rights, in accordance with the provisions of the applicable collective bargaining agreement, but solely to vacant classified bargaining unit positions at any new state-owned and -operated psychiatric hospital which management intends to fill. All other contractual reduction in force reemployment terms and conditions shall apply.

(b) Permanent status classified employees employed by the Vermont State Hospital as of February 6, 2012 who are employed by the state shall, in accordance with the provisions of the applicable collective bargaining agreement, be eligible to receive one mandatory offer of reemployment to any new state-owned and -operated psychiatric hospital, solely to the job classification that they last occupied at the Vermont State Hospital, provided management intends to fill positions within that job classification. An employee who accepts such mandatory offer of reemployment shall be appointed in accordance with the provisions of the applicable collective bargaining agreement. If an employee who accepts a mandatory offer of reemployment fails the associated working test period, he or she shall be separated from employment and granted full reduction in force reemployment rights in accordance with the applicable collective bargaining agreement.

(c)(1) Participating hospitals and designated agencies developing acute inpatient, secure residential, and intensive residential recovery services, as described in Secs. 8–10 of this act,

shall provide the department of human resources with a description of the minimum qualifications for those open positions related to the care of individuals with mental health conditions. Participating hospitals and designated agencies shall be encouraged to hire former state employees who meet minimum requirements or have equivalent experience. The department shall use the most effective method to notify former employees of the Vermont State Hospital of these positions.

(2) The general assembly encourages the administration through its contracting process with participating hospitals and designated agencies to provide former employees of the Vermont State Hospital with the opportunity to apply for available positions.

(3) The provisions of this subsection shall not affect any existing collective bargaining agreement.

(d) Subsections (a) and (b) of this section are repealed one year after the opening of any new state-owned and -operated psychiatric hospital.

Sec. 37aa. VERMONT STATE HOSPITAL EMPLOYEE RETIREMENT INCENTIVE

(a) An individual who was employed by the department of mental health as of March 1, 2012, who was employed at the Vermont State Hospital on August 28, 2011, who participates in either the defined benefit or defined contribution plan, and who does not initiate the purchase of any additional service credit after March 1, 2012 shall be eligible for the retirement incentive outlined in subsection (b) of this section if the individual has:

(1) 30 years of creditable retirement service as of April 13, 2012;

(2) five years of creditable retirement service as of April 13, 2012 and is 62 years of age or older on April 13, 2012; or

(3) 20 years of creditable retirement service as of April 13, 2012 as a facility employee who provides or who has provided direct security and treatment services as provided in 3 V.S.A. § 459(2)(A) and is 55 years of age or older on April 12, 2012.

(b) If the employee applies for retirement on or before April 13, 2012 for a retirement effective on or before May 1, 2012, the employee shall be entitled to payment by the state of at least 80 percent of the cost of the premium for health insurance coverage offered by the

state of Vermont to retirees, provided that the employee continues to meet the eligibility requirements for at least seven years following retirement unless the employee elects the premium reduction option under 3 V.S.A. § 479(e) and:

(1) $750.00 per complete year of service if the employee has five years of creditable service or more and fewer than 15 years of creditable service; or

(2) $1,000.00 per complete year of service if the employee has 15 years of creditable service or more.

(c) The cash incentive set forth in subsection (b) of this section shall not exceed $15,000.00 per employee. The employee shall receive the cash portion of the incentive in two equal payments in fiscal years 2013 and 2014. The first payment shall be made within 90 days of the retirement date. The second payment shall be made within 90 days of the one-year anniversary of the retirement date. The retirement incentive shall not be paid from the Vermont state retirement fund, as outlined in 3 V.S.A. § 473.

(d) No employee who receives the incentive set forth in subsection (b) of this section may return to permanent or limited classified service with the state for at least two full fiscal years from the date of his or her retirement unless the secretary of administration expressly approves otherwise. The joint fiscal committee shall be notified of any employee who received the incentive set forth in subsection (b) of this section and returned to state employment within two years.

(e) An employee who receives the incentive set forth in subsection (b) of this section is not entitled to receive any mandatory reemployment rights to a successor state facility and will not be eligible for any rights under Sec. 37a of this act.

(f) The retirement incentive set forth in subsection (b) of this section shall be treated as a

severance payment under 21 V.S.A. § 1344(a)(5)(C) and shall be a disqualifying remuneration.

Sec. 37b. LEGISLATIVE INTENT

(a) It is the intent of the general assembly that the department of mental health contract with the Brattleboro Retreat for a 14-bed unit and with Rutland Regional Medical Center for a six-bed facility pursuant to Sec. 9(a) of this act.

(b) It is the understanding of the general assembly that the proposed temporary hospital in Sec. 9(c)(2) of this act, the Brattleboro Retreat, Rutland Regional Medical Center, and an interim secure residential facility are to temporarily meet the immediate needs of the state.

Sec. 38. EFFECTIVE DATES

This act shall take effect on passage, except for Sec. 34 of this act which shall take effect on July 1, 2012.

Approved: April 4, 2012

Appendix B: Vermont Mental Health Resources Reviewed for Project

The Vermont Legislative Joint Fiscal Office and the Department of Mental Health responded to BHPC's request for information, data and other materials by providing a variety of print and electronic resources before and during the May 2012 site visit. The following is a partial list of documents and websites made available or reviewed during the course of this project.

Available prior to the site visit:

1) Act 79 as passed by the Vermont Legislature and signed into law by Governor Shumlin

2) Vermont Legislature Joint Fiscal Office website including 2012 Session documents; Future's Project reports; and reports generated by and submitted to the Mental Health Oversight Committee at: http://www.leg.state.vt.us/jfo/vsh_replacement_plan.aspx

3) Governor Shumlin's Plan for Mental Health, Version 3, January 9, 2012

4) Agency of Human Services, Community Mental Health Services Block Grant Application and State Implementation Report

5) State Implementation Report, Community Mental Health Services Block Grant, Uniform Application 2011.

6) The following DMH Overview reports and documentation:

    a) Acute Care Management Program Manual for CRT and Crisis Programs, October, 2008

    b) VSH Patient Population and Alternatives, January 1, 2012

    c) DMH Organization Chart 2012

    d) DMH State Strategic Plan: 2011-2013 (Draft)

    e) Title 18, Vermont Statutes

    f) Title 12, Vermont Administrative Code

    g) Recommendations for Enhancing Mental Health Peer Services in Vermont

    h) IPS Supported Employment Sites – Quarterly Outcomes Report for the Johnson & Johnson - Dartmouth Community Mental Health Program, January – March 2012

    i) PS Supported Employment Family Advocacy Project, Quarterly Outcomes Report for the Johnson & Johnson – Dartmouth Community Mental Health Program

    j) Employment Quarterly Outcomes Report, 2002 – 2011

k) NAMI – Vermont 2010 Annual Report

l) United States of America v. The State of Vermont, et. al, Vermont State Hospital Settlement Agreement

m) Implementation of IDDT in Vermont Community Rehabilitation and Treatment Programs, SAMHSA Grant # 1 HD9 SM56150-01, October 2007

n) Vermont Integrated Services Initiative (VISI), SAMHSA Grant # 1 HD9 SM56150-01, Final Report, February 2011

o) Psychotropic Medication Prescriptions Before and After Incarceration, March-August 2007.

p) Excerpt from "The Big Overview" relating to the implementation of Act 79.

q) "Level 1 Patient" Definition and Utilization Review Protocol (DMH)

7) The following DMH Utilization Management Reports:

a) FY 2011 Statistical Report

b) FY 2010 Wide Book, Community Mental Health Agencies, Cost Per Unit, Cost Per Client, Cost Per Capita and Cost Per Medicaid Enrollee, June 30, 2010

c) Date for Vermont Workgroup on Psychotropic Medications for Children and Adolescents, January 5, 2009

d) Evaluation of Mental Health Drug Use in Children, SFYs 2009 – 2011

e) Inpatient Mental Health and Addiction Services Provided to Vermont Residents During 1990 – 2009, July 2011

f) Vermont Mental Health Performance Indicator Project, memos and reports from John Pandiani and Walter Ochs to the Vermont Mental Health Performance Indicator Project Advisory Group and Interested Parties (February 8, 2008, January 13, 2012, February 24, 2012, and April 20, 2012)

g) Community Rehabilitation and Treatment Utilization Report, March 2010- March 2012

h) Vermont State Hospital Monthly Utilization Report, August 2009 – August 28, 2011

i) Vermont Department of Corrections, Medical Services at Instate Facilities, November 21, 2011

j) Several contract amendments between DMH and designated agencies adding clauses requiring utilization reports for admissions and discharges from agency programs,

monthly bed day utilization, referral to admission day counts, and other utilization measures.

8) The following DMH Quality Improvement documents:

   a) Evidence Based Support Employment Report, December 2009

   b) CRT Supported Employment Program Strategic Plan 2010 – 2014

   c) IPS Supported Employment Fidelity Report, June 2010

9) The following DMH Contract and Network Management documents:

   a) Grant Awards for federal grants and amendments, where applicable, to Vermont Psychiatric Survivors, Inc., Good Samaritan Haven, Rutland County Housing Coalition, Brattleboro Area Drop-In Center, Addison County Community Action Group; Community Health Center of Burlington, Another Way, and Northeast Kingdom Community Action

   b) Contract for Services between DMH and Health Care and Rehabilitation Services of Southeastern Vermont, Inc., DMH and Rutland Mental Health Services, Inc., and DMH and Counseling Services of Addison County

   c) Clara Martin Center, Designation Report, May 17, 2011

10) The following Information System documents:

   a) CRT Eligibility Determination Form, effective March 3, 2010

   b) CRT Disenrollment Form

   c) Monthly Tier Cluster, 105 Day Window, and Cost Variance Report, Service Period 7/1/2011 to 12/31/2011, report date May 8, 2011

   d) Readiness and Data Needs for Participation in the Vermont Health Information Exchange, January 2012

   e) MSR Data Submissions, Version 47.0, April 28, 2011

   f) CY2011 Employment of Community Rehabilitation and Treatment Clients in Vermont

   g) Various reports and excepts from the Agency of Human Resources, Department of Vermont Health Access, Implementation Advance Planning Documents (IAPD)

   h) CRT Service Utilization by DA and Cost Center for the period 7/1/2011 to 12/31/2011 (date of report: 5/9/2012)

i) CSAC Case Clients for Billing Month December, 2011 (date of reports: 12/12/2011)

j) CSAC CRT Mid Month Report (date of report: 12/14/2011)

k) Counseling Services of Addison County, CRT Clients Active as of 12/01/2011, Not Served in 2+ Years (date of report: 12/19/2011)

l) Counseling Services of Addison County Medicaid Status for CRT Clients as of 12/01/2011 (date of report: 12/1/2011)

m) Counseling Services of Addison County CRT service listing by client, unit of service and cost 7/1/2011 – 12/31/2011 (without client identifier)

n) State of Vermont Point in Time Homeless Survey – Summary by County and by AHS District, January 25, 2012

Documents received onsite or post-site visit:

1) (No title) Population and funding clarifications as requested by consulting team (DHM)

2) Designated agency summary proposals outlining enhances programming as a result of H.630 (DMH)

3) Proposal for the Creation of a Vermont Evidence-Based Practices Cooperative (DMH)

4) Self-Sufficiency Outcome Matrix (DMH)

5) Draft – Clinical Resource Management System: Vision of Adult MH Delivery System, Steering Committee, Functions of Adult Care Management Team, Connections to other meetings/teams, Work to Do (DMH)

6) The BIG Overview relating to the implementation of Act 79 (long version DMH)

7) VSH and Community Impact FY 13 (DMH Financial)

8) Community Rehabilitation and Treatment (CRT) Program, Designated Agency Provider Manual, Third Edition, March 2004

9) Second Spring Community Recovery Residence information packet

APPENDIX C: LIST OF KEY INFORMANTS

Montpelier, Vermont, May 21– 23, 2012

DMH Staff	Patrick Flood	Sarah Merrill
	Mary Mouton	Laura Flint
	Dr. Jaskenwar Batra	Brian Smith
	Frank Reed	Jeff Rothenberg
	Nick Nichols	Dena Monahan
	Heidi Hall	

AHS — Suzanne Santarcangelo

Council
- Julie Tessler (VT Council)
- Bernard Norman (CRT & ES)
- Bob Bick (Director of Mental Health & Substance Abuse
- Paul Dupre (ED)
- Margaret Joyal (AOP)
- Anthony Stevens (ES)
- Judith Hayward (ED)
- Vic Martini (AOP Clinical Director)

Transformation Council Members
- Patrick Flood (DMH)
- Judy Rosenstreich (DMH)
- Linda Cory (VPS)
- Kathy Gallagher (VPS)
- Sherri Silver (DRVT)
- Jaskanwar Batra (DMH)
- Nancy Hodgkins (Comm. Activist)
- Laura Ziegler (Activist)
- Cathy Rickerby (Family Member)
- Ruth Grant (NAMIVT)
- Anne Donahue (Counterpoint)
- Matthew Rowle (Wellness Co-op)
- Ed Paquin (DRVT)
- Melanie Janney (Wellness Co-op)
- Jill Olson (VAHHS)
- Betty Keller (Family Member)
- Patricia Rickard, DMH
- Dena Monahan (DMH)
- Nick Emlen (VT Council)
- Jeff Rothenberg (DMH)
- Mary Moulton (DMH)
- Nick Nichols (DMH)
- Laura Flint (DMH)
- Andrew Nemethy (VT Digger)
- Robert Appel (VT Human Rights Commission)
- Wendy Beinner (NAMI)

Hospital Representatives
Robert Pierattini, FAHC
Mark Depman and Jim Tautfest, CVMC
Jeff McKee (RRMC)
Peter Albert (Retreat)
Ed Haak (NWMC)

Psychiatrists
Joe Lasek
Stuart Graves
Isabelle Desjardins
Gordon Frankle
Fritz Engstrom
Alice Silverman

Second Spring
Jim MacDonald, Staff and Residents

Law Enforcement
Tony Facos (Montpelier Police Chief)
Mike Schirling or Deputy, Burlington Police Chief
Paul White, Middlesex State Police
Keith Clark, Sheriff
Blake Cushing, Rutland State Police

Panel of Peers Laura Ziegler
Linda Corey
Steven Morgan
Gloria van den Berg

Advocates Jack McCullough (VT Legal Aid)
Ed Paquin (Disabilities Rights)
Floyd Nease (VAMH)

Vermont State Hospital
Dave Jennison

Mental Health Oversight Committee
Representative Anne B. Donahue, Co-Chair
Senator Sally Fox, Co-Chair
Senator Joe Benning
Representative Mary S. Hooper
Representative Thomas F. "Tom" Koch
Senator Diane Snelling
Representative Kitty Beattie Toll
Senator Jeanette K. White

Blueprint, Substance Abuse & Health Care Reform
Beth Tanzman (Blueprint)
David Reynolds (Health Care Reform)
Barbara Cimaglio (Substance Abuse)

Corrections Andy Pallito
Dee Burroughs-Biron

Special Committee on Mental Health
Joint Fiscal Office
Senator Ann Cummings, Chair
Representative Martha Heath, Vice-Chair
Senator Diane Snelling, Clerk
Representative Janet Ancel
Representative Carolyn Branagan
Senator John Campbell
Representative Mitzi Johnson
Senator Jane Kitchel
Senator Richard Sears, Jr.
Representative David Sharpe

Chair and Vice Chair of House Human Services
Representative Ann Pugh, Chair
Representative Sandy Haas, Vice-Chair

Chair and Vice-Chair of Senate Health and Welfare
Senator Claire Ayer, Chair
Senator Kevin Mullin, Vice Chair

APPENDIX D: RECOMMENDED RESOURCES

- **Community Integration/*Olmstead* Compliance**
  - Department of Justice/Olmstead Enforcement website: www.ada.gov/olmstead/olmstead_enforcement.htm

- **Criminal Justice and Mental Health**
  - GAINS Center: gainscenter.samhsa.gov/
  - Council of State Governments, Justice Center: http://consensusproject.org/

- **Housing**
  - Technical Assistance Collaborative, www.tacinc.org/
  - HUD Section 811 Grants, "HUD RELEASES SECTION 811 NOFA: $85 MILLION AVAILABLE FOR NEW INTEGRATED HOUSING FOR PERSONS WITH DISABILITIES" see: http://www.tacinc.org/Program_Policy/Sect811_legisltn.php

- **Integrated Behavioral Health and Primary Care**
  - National Council for Community Behavioral Health Care: Four Quadrant Model on Integrated Behavioral Health and Primary Care http://www.thenationalcouncil.org/cs/resources_services/resource_center_for_healthcare_collaboration/clinical/overview
  - SAMHSA-HRSA Center for Integrated Heath Solutions: www.integration.samhsa.gov/

- **Seclusion and Restraint Elimination**
  - National Association of State Mental Health Program Directors. "Six Core Strategies to Reduce Seclusion and Restraint Use" (c): http://www.nasmhpd.org/Publications_NASMHPD.cfm

- **State Mental Health Agency Data**
  - NASMHPD Research Institute (NRI): http://www.nri-inc.org/
    - "Mental Health Services Provided Across State Government Agencies" http://www.nri-inc.org/reports_pubs/pub_list.cfm?getby=State%20Systems

APPENDIX E: SAMPLE USE LIEN CONTRACT LANGUAGE

Source: State of Arizona, Department of Health Services – Notice of Request for Proposal *HP632209 - Maricopa County Managed Behavioral Health Care*, March 7, 2007.

Excerpt:

e. Housing

The Contractor shall develop and manage housing services for behavioral health recipients with a serious mental illness (Title XIX/XXI and Non Title XIX/XXI), Title XIX/XXI general mental health and substance abuse behavioral health recipients and Title XIX/XXI transition age youth, i.e. youth ages 18 through 24 years inclusive. Housing includes a range of options based upon individual need. For behavioral health recipients with serious mental illness, the Contractor shall comply with the requirements in the ADHS/DBHS Strategic Plan for Housing for Maricopa County, using the Housing First model and approach for housing services. The Contractor shall subcontract with a Community Development Corporation or other non-profit entity within two (2) months of the Contract Start Date to manage the housing program. The Contractor shall include a continuum of housing options, housing advocacy, networking and resource development as part of a unified and well-coordinated housing program. The Contractor shall submit a plan that outlines the steps and time frames for contracting with a Community Development Corporation or non-profit entity to manage housing as part of their Network Transition Plan described in the Network Development and Management Section of this Contract.

For the interim period, prior to subcontracting with a Community Development Corporation or non-profit entity, the Contractor shall:

i. on an interim basis, accept any assignment of grant-funded contracts previously developed for housing programs in the GSA until the Contractor subcontracts with a non-profit entity. During the interim period, the Contractor shall manage all program activities and be accountable to funding agencies as required under the assigned contract and pursue the renewal of existing housing grants and develop new housing funding resources;

ii. cooperate with any other entity under contract or partnership with ADHS that is administering a supplemental housing or homeless outreach program for ADHS for persons with a serious mental illness, including at a minimum, a subcontractor that is administering a PATH grant for ADHS;

iii. utilize all housing units previously purchased in the GSA, including units acquired through the use of HB2003, *Arnold vs ADHS* and ComCare trust funding for purposes of providing housing for persons with a serious mental illness; and

iv. contract with the property management companies under the sponsor-based housing program.

The Contractor shall require its housing subcontractor to meet the requirements listed above as well as the following requirements:

i. maintain a dedicated staff of housing professionals with technical knowledge to collaborate with behavioral health and housing providers;

ii. maintain a monthly accounting of all behavioral health recipients in its housing program and of its housing and service providers, which is updated monthly;

iii. develop and maintain a semi-annual monitoring plan for all Office of Behavioral Health Licensure (OBHL) licensed residential living programs, including the physical plant and program and taking into account the privacy needs of individual residents as well as the privacy of individuals who live independently. The Contractor shall conduct more frequent monitoring and require corrective action plans for housing or residential programs that have been found to be non-compliant with housing quality standards;

iv. coordinate with the PNOs serving individuals with serious mental illness to provide individuals residing in unlicensed supervisory care homes with opportunities for more independent living;

v. any real property or buildings and improvements to buildings ("the property") purchased by the Contractor or its subcontractor with funds provided by ADHS under the Contract, excluding net profits earned under the Contract, for housing for behavioral health recipients shall include:

1) a use restriction in the deed, and
2) covenants, conditions, or restrictions, or
3) another legal instrument subject to prior written approval by ADHS that requires the property to be used solely for the benefit of behavioral health recipients; and

vi. meet monthly with the Contractor's Key Personnel and interested groups, organizations, or individuals identifying themselves as advocates to discuss housing.

f. Annual Housing Plan, Housing Committee, and Disclosures

Within the first sixty (60) days of each new fiscal year, the Contractor shall submit an Annual Housing Plan for development, maintenance, use, and acquisition of housing properties in a format specified by ADHS. The Annual Housing Plan is subject to approval of the ADHS Housing Committee. The Contractor shall submit proposals for purchase or acquisition of new housing to the Housing Committee for approval prior to awarding providers contracts for new housing programs. The Contractor shall include provider requirements for needed recovery support services to be delivered onsite in addition to treatment, medication, and case management services in all proposals for new purchase or lease acquisition of housing.

Notwithstanding the funding source used, prior to the purchase of any new property, the Contractor shall submit a Notice of Real Property Transactions, including the following:

i. Disclosure to ADHS of the funding source used to purchase the property that clarifies whether the purchase is to be made with funds provided by ADHS under the Contract, with funds from net profits earned under the Contract, or other funds;

ii. Disclosure to ADHS of the financing arrangements made to purchase the property; and

iii. If the property is purchased with funds provided by ADHS under the Contract, submit to ADHS, for prior approval, a deed containing the use restrictions and covenants, conditions or restrictions, or another legal instrument that ensures the property is used solely for the benefit of behavioral health recipients and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions.