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STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
Montpelier, Vermont 05633-5701

JOINT FISCAL COMMITTEE

AGENDA

Room 10

Tuesday, April 25, 2006

4:00 p.m.	**Vermont State Hospital Futures Plan** **Introduction** – Cynthia LaWare, Secretary, Agency of Human Services **Presentation** - Beth Tanzman, Director of Vermont State Hospital Futures Project, Department of Health, Division of Mental health Ira Sollace will be available to answer questions
4:20 p.m.	**Joint Legislative Mental Health Oversight Committee** Senator Jim Leddy and Representative Michael Fisher
4:30 p.m.	**Committee Discussion**

MINUTES

Joint Fiscal Committee
Meeting of April 25, 2006

Representative Martha Heath, Chair of the Joint Fiscal Committee, called the meeting to order at 4:05 p.m. in Room 10, State House.

Also present: Representatives Obuchowski, Perry, Severance and Westman
Senators Bartlett, Cummings and Snelling

Others attending the meeting included Senator James Leddy and Representative Michael Fisher on behalf of the Joint Legislative Mental Health Oversight Committee, Joint Fiscal Office staff, Administration officials and staff, and representatives of advocacy groups.

VERMONT STATE HOSPITAL FUTURES PLAN:

1. The sole purpose of the meeting was to consider and vote on a comprehensive implementation plan for replacement of services currently provided by the Vermont State Hospital (VSH). Section 141a. of Act No. 122 of 2004 required that the plan be presented to this Committee and the Joint Legislative Mental Health Oversight Committee (MHOC). The former group approved the plan on March 22, 2006 and on April 11 forwarded it to the Fiscal Committee.

In addition to the plan itself, the members received an April 25 memorandum from Representative Ann Pugh, Chair of the House Human Services Committee on the subject of the Division of Mental Health's request for an exemption from the need to obtain a Certificate of Need (CON) in order to build a new inpatient facility; a brief summary of the current program at VSH and of the continued planning process, together with a time line recapping decision points for the MHOC between the present time and September 2006; and a memorandum from Beth Tanzman, Futures Project Director, Vermont Department of Health, Division of Mental Health.

Secretary of Human Services Cynthia LaWare prefaced the presentation and discussion of the plan with general remarks about how critical the project is to the mental health community; the opportunity it provides for very significant system reforms in the delivery of mental health services; and the importance of affiliating a new inpatient facility with a teaching, tertiary care hospital (Fletcher Allen Health Care).

Ms. Tanzman then led the Committee through the highlights of the plan, including the major objectives and restructuring of inpatient care delivery into two levels. She stressed that the last objective of replacing current services at the State Hospital is not the same thing as replacing its staff.

Following her presentation, Committee members questioned Ms. Tanzman about various aspects of implementation of the plan and its oversight, covering such issues as costs associated with providing mental health support services at the community level, the past management of VSH, the Certificate of Need related to a new inpatient facility, the design and size of the structure; the status of current staff at VSH; the duration of the plan; and federal certification.

On the last subject, Ms. Tanzman observed that the staff probably is the most valuable resource in the State's delivery of mental health services.

The Chair expressed her dismay over the amount of money that has been spent, to no apparent avail, in the state's efforts to locate sites for sub-acute beds in local communities. In answer to her inquiry as to whether the situation has improved, Ms. Tanzman advised that the state has made good progress in locating a place in Williamstown that would serve as a residential care facility and that there have very positive, well-sequenced interactions with local officials in that town. She added that the state alternatively continues to seek a village setting for a facility.

Senator Leddy and Representative Fisher commented on the plan from their perspective as MHOC co-chairs. The latter stressed that that the MHOC regards the plan as a goal, that it is a work in progress with many aspects to be revisited.

The Senator made the point that while the discussion at this meeting has been narrowly focused on a particular subject, in actuality Vermont has a remarkable story in meeting the needs of its mentally ill citizens including developing strong community resources that provide quality infrastructure and services. He went on to say that in the matter of the State Hospital, there have been major mistakes, the collective responsibility for which rests on more than one Administration or Legislature or other decision-making body. Since the federal government decertified the State Hospital, remarkably little progress has been made in improving the quality of services to the mentally ill, and he believed that the plan represents not just an opportunity, but an obligation. Furthermore, he made the point that a partnership whereby those receiving services have a voice in those services and strengthening of connections with local communities need to be restored.

The discussion came to a close with a motion by Senator Snelling to approve the plan as presented. The motion was seconded by Senator Bartlett and approved on a voice vote, with no member registering a negative vote.

Prior to the vote, Representative Perry said he did not view what was presented as a plan, but rather as a concept, a statement of objectives. He said he was not ready to approve five years' funding given the financial information provided, and he hoped that approval of the plan did not carry such implications.

Chief Fiscal Officer Stephen Klein agreed with the need expressed by Representative Perry for ongoing review of the costs associated with implementation of the futures plan and suggested that approval might include that caveat. The Chair pointed out that the costs will be presented and reviewed each year as part of the legislative budget process. Representative Perry said he thought that annual appropriations requests to the Legislature should not be limited to the costs associated with implementation of the plan for a given budget year, but that they should be presented in a multi-year fashion.

In the meantime, there seemed to be a consensus that updates on the implementation of the Vermont Futures Plan, including cost estimates, should be presented to the Joint Fiscal Committee on a regular basis.

The meeting was adjourned at 5:05 p.m.

Respectfully submitted:

Virginia F. Catone

Virginia F. Catone
Joint Fiscal Office

Joint Fiscal Office

1 Baldwin Street • Montpelier, VT 05633-5701 • 802) 828-2295 • Fax: 802) 828-2483

MEMORANDUM

To: Members of the Joint Fiscal Committee

From: Virginia Catone

Date: April 26, 2006

Subject: Vermont State Hospital Futures Plan - substitute pages

Enclosed is an April 25 memorandum to the Joint Fiscal Committee from Beth Tanzman, Vermont State Hospital Futures Project Director. Attached to the memorandum are new pages 6 and 7 to substitute for those two pages contained in the Plan distributed to you on April 18. The substitutions are referenced and explained on page 2 of the memo but inadvertently were not distributed while the meeting was in progress.

Enclosure

cc: Stephen Klein, JFO
Maria Belliveau, JFO
Stephanie Barrett, JFO

Joint Fiscal Office

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MEMORANDUM

To: Senators Cummings, Sears and Welch

From: Virginia Catone

Date: April 26, 2006

Subject: Vermont State Hospital Futures Plan – April 25 handouts

Because you were unable to attend yesterday's JFC meeting, enclosed is an April 25 memorandum to the Joint Fiscal Committee from Beth Tanzman, Vermont State Hospital Futures Project Director. Attached to the memorandum are new pages 6 and 7 to substitute for those two pages contained in the Plan distributed to you on April 18. The substitutions are referenced and explained on page 2 of the memo.

In addition, I enclose: (1) April 25 memorandum from Rep. Pugh to the JFC Chair and Vice Chair which also was handed out at the meeting; and (2) April 18 letter to Ms. Tanzman from Bruce Darwin, Division Counsel in BISHCA . The latter was distributed at the request of Rep. Donahue.

Enclosures

cc: Stephen Klein, JFO

MEMORANDUM

TO: Joint Fiscal Committee

RE: VSH Futures Plan Update

DATE: April 25, 2006

FROM: Beth Tanzman, Futures Project Director, Vermont Department of Health, Division of Mental Health

I am pleased to present the Vermont State Hospital Futures Plan today. Vermonters hold a broad common vision regarding mental health care. We expect:

- services to be of high quality,
- services to be provided in a holistic, comprehensive continuum of care,
- consumers to be treated at all times with dignity and respect,
- individual rights will be protected,
- public resources to be allocated efficiently and produce the best possible outcomes, and
- direct services - overseen and provided by the Agency of Human Services and its community partners are - person and family centered.

We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary to achieve the desired outcomes.

Vermont's mental health system has many strengths of which we can be proud. The system also has significant challenges. From these challenges arises a unique opportunity for major system reform.

The Futures plan, fully implemented, would transform in-patient and rehabilitation services for the most severely ill. It would improve coordination of services and increase capacity for all adults with mental health problems. The result would be a continuum of care in which all of the elements are coordinated; prevention, early intervention and alternatives to hospitalization are pursued aggressively; peer supports are expanded and fully respected as essential to recovery; the individual is actively engaged in the

development of his or her treatment plan; and outcomes are measured and continuous improvement is a key goal.
On March 22 the Joint Mental Health Legislative Committee approved this plan with two suggested revisions.

- strengthen the reference to the Futures Advisory Committee and its ongoing role in the planning process; and
- request that the Mental Legislative Oversight Committee review a draft collaboration agreement between the State and inpatient partners at the same time as a draft VSH employee plan.

These revisions are attached; otherwise the plan is exactly as presented to the Joint Mental Health Legislative Committee.

Since March 22, we have clarified that AHS and BGS will need to apply for both a Conceptual Certificate of Need (CON) and a full CON for the inpatient portion of the Futures Plan. We believe that this will lengthen the time to a new inpatient program by at least two years. In addition to the estimated $100,000 of direct costs to complete the CON process, there are significant lost opportunity costs in terms of federal participation in the operations of VSH and inflation on construction costs. These additional costs are estimated to be approximately $29,400,000.

Good progress has been made in citing one of the key community service components of the plan, the residential recovery service at the sub-acute level of care. A consortium of three Designated Community Mental Health Agencies, in collaboration with a private developer, are working towards opening a program for 10-11 residents sometime this fall in Williamstown. We have been able to sequence the notification of the proposed project in a more appropriate fashion than in Greensboro; briefing local town and legislative officials first and then holding public forums, and meetings with abutting neighbors.

Finally, the first phase of work to assess the cost and campus citing options with FAHC will be completed in the near future, as will the independent actuarial study to help determine the number of psychiatric inpatient beds Vermont will need in the future.

We will continue to develop the tactical details association with the Futures Plan as we move into the implementation phases, and I look forward to updating this committee on our progress.

The Current Program at Vermont State Hospital

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH, along with the psychiatric services being provided by Fletcher Allen Health Care, will assist in a seamless transition towards an excellent, state-of-the-art psychiatric inpatient service in the future. VSH has established a strategic plan to implement the specific recommendations made in a review by Fletcher Allen Health Care. This plan has been updated to include the requirements of the Department of Justice, licensing conditions by the Vermont Board of Health, and meeting certification requirements under CMS or JCAHHO.

The Continued Planning Process

The Futures Advisory Committee will continue to be the lead multi-stakeholder group providing feedback and advice on the planning and implementation of the Futures project. This committee is advisory to the Secretary of the Agency of Human Services and is staffed by the (DMH). The Futures Advisory Committee membership represents the advocate, consumer, family, provider, and labor interests of the mental health community. This committee fulfills the legislative intent regarding the importance of broad stakeholder involvement in the Futures project.

Decision Points
For the Legislative Mental Health Oversight Committee

1. Approval of the overall scope and direction of the plan, as represented. Support for FY 07 appropriations request.	March 2006
2. Review of the actuarial study findings, approval for inpatient bed capacity to be developed.	June 2006
3. Approval to proceed with identified options or direction for alternatives. Considerations for the committee include *What is the estimated size, cost and location of the proposed facility? Is it appropriate to the need and affordable to the state? What other options could be explored as alternatives, and why have they been rejected at this stage?*	June 2006
4. Authorization to proceed with the Requests for Proposals to select the architectural / engineering team to continue with the design process.	April 2006
5. Release of the second installment of the FY'06 / FY'07 capital appropriations, as per presentation of needs by the Department of Buildings and General Services in order to execute the architectural / engineering contract	July 2006
6. Review plan to address VSH staff employment / benefit issues	September 2006
7. Review of collaboration agreement with Fletcher Allen (or other inpatient program), approval to proceed or identification of alternative approach Considerations for the committee include *What is the plan for property ownership and facility ownership? Who will operate the facility? How will the state exercise control over operations, and what are the projected annual operating costs*	September 2006

House of Representatives

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MEMORANDUM

To: Martha Heath, Chair Joint Fiscal
Susan Bartlett, Vice-Chair Joint Fiscal

From: Rep. Ann Pugh, Chair House Human Services

Date: April 25, 2006

Subject: Division of Mental Health's request for exception from CON requirement

The Division of Mental Health (DMH) has been working on a replacement plan for the State Hospital. Upon request of DMH, BISHCA ruled that DMH would be required to get a Certificate of Need (CON) in order to build a new hospital. DMH came to the Human Services committee asking for an exemption from the need for obtaining a CON. They cited the legislative oversight in place in the Futures Planning Advisory Group, the Mental Health Oversight Committee and the Joint Fiscal committee as more oversight than the CON process and a duplication of effort. They argued that this duplication would result in at least an 18-month delay in beginning construction. Secretary Cynthia LaWare made the formal request for the exemption. Beth Tanzman, the director of the project for DMH, their legal counsel Wendy Beinner and Tasha Wallis of BGS testified on their reasons for requesting the exemption. Finding people to contracting their request was easy, we hear from them over four hearing times. One of the most compelling was the President of the Rutland Region Medical Center. He described the CON process as a well defined, complete, careful planning process, saying it would be a benefit to the planning of the new State Hospital.

DMH submitted proposed changes to the CON law asking for a modified review by BISHCA taking no more than 6 months. Most committee members felt the CON process will be benefit to the whole planning and construction process and make for a better hospital. The committee voted 8-2-1 against DMH's request.

To: Steve Klein, JFO
FYI pp Anne Donahue

Beth Tanzman
Division of Mental Health
108 Cherry St, Suite 201
PO Box 70
Burlington, VT 05402-0070
(802) 652-2000

April 18, 2006

Dear Beth:

Following up on yesterday's Futures Advisory Committee meeting, I am writing to clarify some points related to the Certificate of Need (CON) laws and process. Specifically, I am writing because some of the information presented in the first agenda item at yesterday's meeting is not consistent with what I communicated to you in my letter of March 14, 2006. I hope this letter will clarify matters and prevent confusion.

As has always been the case, the Department of Banking, Insurance, Securities and Health Care Administration wants to help the Division of Mental Health proceed through the CON process as efficiently and expeditiously as possible. Please note I am working from my notes of what people said at yesterday's Futures meeting. If you feel my recollection of what was said is inaccurate in any way please let me know so we can have an accurate record. Thank you.

1. Filing of a Letter of Intent

In response to a question from Futures committee member Dr. David Fassler, who asked why DMH's revised timeline indicates a CON Letter of Intent (LOI) will not be filed with BISHCA until September of 2006, you indicated that is because DMH must have firm cost figures to include in the LOI. You indicated these would need to include prices for the primary site (probably at FAHC) and secondary sites (probably at Rutland Regional Medical Center and the Brattleboro Retreat).

Please refer to my letter to you of March 14, 2006 in which I stated that "...with respect to cost and scope of the project, DMH should provide, in phase one, sufficient information to allow for an understanding of what the estimated range of costs is likely to be for various types of options (single site, multiple sites, funding sources, etc.) ..."[1] I

[1] March 14, 2006 letter to Beth Tanzman, page 2

also stated that "A more detailed examination of costs at a specific site, however, would not be appropriate to review until phase two."
The March 14th letter went on to note that the criteria and standards to be primarily addressed in phase one review would not be about cost but would concern:

> "the need for the project
> how the project would facilitate the goals of the Health Resource Allocation Plan
> how the project would facilitate the chronic care initiative
> how the project would impact access to services
> how the project would meet the requirements of CON standard 16 regarding mental health services"[2]

I specifically noted that we would, in addition, need to obtain:

> "*preliminary* information about funding, costs, staffing and utilization (estimates of ranges would be acceptable) in phase one" (emphasis in the original)
>
> and that
>
> "As phase one is intended to precede most of the architectural and planning work that applicants will need to do, however, we expect that applicants will not present detailed cost, revenue and construction information in phase one. Rather, applicants are expected only to present sufficient information which the public, experts, interested parties, the Public Oversight Commission, and the Commissioner may use in order to provide constructive feedback and input to be used by applicants in their planning processes."

To be clear, particularly in the case of CON applications that must follow the Conceptual CON process (phase one) in addition to the traditional CON process (phase two), applicants are not expected to have firm or detailed cost information in phase one. Broad cost figures would certainly be adequate. It is also the case that even in the case of applicants that do not need to seek Conceptual CON approval, the cost figures presented by applicants in their LOIs and throughout the course of the due diligence review process may be amended as needed. In non-Conceptual CON cases the cost figure needs to be settled before an application can be ruled complete and set for a hearing before the Public Oversight Commission. Understandably, that requirement would not apply to applicants in the Conceptual CON process.

2. Meetings/communications with BISHCA

You indicated, in response to a question about the CON process, that DMH has "not been able to have those discussions with BISHCA". I think your answer might have been in response to questions about both the CON process and the timelines DMH has developed regarding the CON process. If this was not your intention please clarify.

[2] March 14, 2006 letter, page 2

In any event, I didn't understand your response because I am not aware of barriers to our staff assisting DMH in the application process. The Health Care Administration staff have been eager to assist DMH, as we assist any and all CON applicants or potential applicants, in proceeding through the CON process as efficiently and expeditiously as possible. Indeed we are pleased that applicants have commented positively about the assistance our staff provides both before and during the CON application process. To that end our office initiated meetings with your office quite some time ago. I also note that my March 14th letter indicated that we:

> "welcome any questions or feedback you have ...particularly if you believe a modification would be appropriate to the determinations of applicability of the criteria and standards..."
>
> and
>
> "Applicants are encouraged to consult with the Division of Health Care Administration for technical assistance in completing the application."

Perhaps the letter should have also specifically noted that we are eager to assist applicants *prior* to applications being filed. That certainly is the case and was the intent of the letter. We typically meet with applicants before they file applications to answer any questions they have, discuss the applicability of particular criteria and standards, get a feel for the likely complexity and time required for review, and answer questions applicants may have regarding the CON process. We have found this makes the reviews proceed more smoothly and more quickly. If this had not been clearly communicated to DMH in prior discussions, I hope this is helpful now.

Perhaps it would also be helpful to clarify the broader issue, that of "talking to the Regulator." There was a comment in yesterday's meeting to the effect that DMH "can't talk to the regulator" which comment is not accurate. The rules about applicants' communications with BISHCA are contained in Bulletin 112, located at our website, http://www.bishca.state.vt.us/HcaDiv/CON_/CON_Main_Index.htm. The basics are as follows:

- applicants can always talk with Division staff[3] about CON applications and are strongly encouraged to do so
- after a Letter of Intent is filed applicants may engage in communications with the Commissioner or members of the Public Oversight Commission so long as such communications are made a part of the public record
- after a Letter of Intent is filed applicants may not engage in ex parte communications with the Commissioner or with members of the Public Oversight Commission

3. Prioritization of CON applications and Timeline for CON reviews

[3] Note that this includes all employees of the Health Care Administration, including the Deputy Commissioner, Division Counsel Bruce Spector, CON Specialist Jennifer Garson, and Health Care Administrator Donna Jerry

Discussion at yesterday's meeting may have left folks with the erroneous impression that our office must review CON applications in the order in which they are filed and that we cannot prioritize or otherwise review applications out of chronological order. I want DMH and the Futures Committee to know that the CON review process does not proceed in such a manner.

The pace at which a CON application review proceeds is largely dictated by factors unique to that application. BISHCA is required by statute to ask questions within 30 days of every response by an applicant. Applicants may take as long as they need to respond except that if applicants fail to respond for 12 months or more an application becomes invalid. Reviews of all pending CON applications happen concurrently, not sequentially. The speed with which applications are reviewed is dependent primarily on the speed with which applicants respond to our questions.

Related to this point is the important fact that CON review can, and usually does, proceed *concurrently* with other reviews and planning work by applicants such as Act 250, local zoning, and financing (bond or otherwise) work being pursued by applicants.

4. Miscellaneous items

Application Fees:

I note in the April 4, 2006 document by DMH labeled "Factors Related to Adherence to CON PROCESS" a reference to having to pay an application fee of $20,000 twice, once for the Conceptual CON (phase one) and again for the phase two CON. Please be advised that the Department does not plan to charge such CON applicants fees for each of the two CON phases. Rather, applicants needing to apply for Conceptual CONs will have that application fee credited to both phase one and phase two.

Timing of Letters of Intent:

Although Letters of Intent must be filed at least 30 days prior to the filing of a CON application, applicants have six months from the filing of a letter of intent to file the related application. Also, if applicants find they are unable to file their application within that six-month period they may simply file a revised Letter of Intent and begin a new six-month period for the filing of the application.

Sincerely,

Bruce Darwin Spector, Esq.
Division Counsel

Encl.

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STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
Montpelier, Vermont 05633-5701

MEMORANDUM

To: Joint Fiscal Committee Members

From: Rebecca Buck, Staff Associate RB

Date: April 18, 2006

Subject: Joint Fiscal Committee Meeting

A Joint Fiscal Committee meeting has been scheduled for Tuesday, April 25 at 4:00 pm in Room 10 of the State House. The Joint Fiscal Committee will be meeting to review the Vermont State Hospital Futures Plan as submitted to and approved by the Legislative Mental Health Oversight Committee as set forth in Section 141a(i) of No. 122 of the Acts of 2004. A copy of the Legislative Mental Health Oversight Committee approved Plan and cover letter signed by the Co-Chairs is included in this mailing.

cc: Representative Michael Fisher, Co-Chair
Senator James Leddy, Co-Chair
James Reardon, Commissioner
Cynthia LaWare, Secretary
Beth Tanzman, Director
Paul Blake, Deputy Commissioner

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STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
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MEMORANDUM

TO: House members of Joint Fiscal Committee

FROM: Virginia Catone

DATE: April 12, 2006

SUBJECT: **Joint Fiscal Committee meeting – Approval of Vermont State Hospital Futures Plan**

We need to establish a date and time for the Joint Fiscal Committee to meet in the relatively near future. The purpose of the meeting is to consider the Vermont State Hospital Futures Plan for replacement of functions of the State Hospital. The Joint Legislative Mental Health Committee approved the plan on March 22, 2006. Presentation of the plan to both committees is required by Sec. 141a. of Act No. 122 of 2004.

The dates and times proposed for the JFC meeting are: either 9:00 a.m. or 4:30 p.m. Tuesday, April 25, or 9:00 a.m. or 4:30 p.m. on Wednesday, April 26.

Please let me know as soon as possible, preferably by Friday, April 14, which date(s) and time(s) are most convenient for you.

Thank you.

cc: Stephen Klein

MEMORANDUM

TO: Joint Fiscal Committee

RE: VSH Futures Plan Update

DATE: April 25, 2006

FROM: Beth Tanzman, Futures Project Director, Vermont Department of Health, Division of Mental Health

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- services to be of high quality,
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- strengthen the reference to the Futures Advisory Committee and its ongoing role in the planning process; and
- request that the Mental Legislative Oversight Committee review a draft collaboration agreement between the State and inpatient partners at the same time as a draft VSH employee plan.

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FROM: Virginia Catone

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The dates and times proposed for the JFC meeting are: either 9:00 a.m. or 4:30 p.m. Tuesday, April 25, or 9:00 a.m. or 4:30 p.m. on Wednesday, April 26.

Please let me know as soon as possible, preferably by Friday, April 14, which date(s) and time(s) are most convenient for you.

Thank you.

cc: Stephen Klein

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Thank you.

cc: Stephen Klein

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Memorandum

To: Senate Joint Fiscal Committee Members

From: Rebecca Buck

Date: April 12, 2006

Subject: JFC Meeting re: Approval of VT State Hospital Futures Plan

We are seeking a mutually convenient date and time for the Joint Fiscal Committee to meet and consider approval of the Vermont State Hospital Futures Plan as set forth in Sec. 141a of No. 122 of the Acts of 2004 (FY'05 Appropriations Bill). This plan was approved by the Joint Legislative Mental Health Committee on March 22, 2006.

The dates and times under consideration are: Tuesday, April 25 at 9:00 am or 4:30 pm; Wednesday, April 26 at 9:00 am or 4:30 pm.

Please let me know as soon as conveniently possible what your date and time of preference would be. Thanks.

cc: Stephen Klein

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STATE OF VERMONT
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MEMORANDUM

To: Joint Fiscal Committee Members

From: Rebecca Buck, Staff Associate RB

Date: April 18, 2006

Subject: Joint Fiscal Committee Meeting

A Joint Fiscal Committee meeting has been scheduled for Tuesday, April 25 at 4:00 pm in Room 10 of the State House. The Joint Fiscal Committee will be meeting to review the Vermont State Hospital Futures Plan as submitted to and approved by the Legislative Mental Health Oversight Committee as set forth in Section 141a(i) of No. 122 of the Acts of 2004. A copy of the Legislative Mental Health Oversight Committee approved Plan and cover letter signed by the Co-Chairs is included in this mailing.

cc: Representative Michael Fisher, Co-Chair
Senator James Leddy, Co-Chair
James Reardon, Commissioner
Cynthia LaWare, Secretary
Beth Tanzman, Director
Paul Blake, Deputy Commissioner

The Current Program at Vermont State Hospital

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH, along with the psychiatric services being provided by Fletcher Allen Health Care, will assist in a seamless transition towards an excellent, state-of-the-art psychiatric inpatient service in the future. VSH has established a strategic plan to implement the specific recommendations made in a review by Fletcher Allen Health Care. This plan has been updated to include the requirements of the Department of Justice, licensing conditions by the Vermont Board of Health, and meeting certification requirements under CMS or JCAHHO.

The Continued Planning Process

The Futures Advisory Committee will continue to be the lead multi-stakeholder group providing feedback and advice on the planning and implementation of the Futures project. This committee is advisory to the Secretary of the Agency of Human Services and is staffed by the (DMH). The Futures Advisory Committee membership represents the advocate, consumer, family, provider, and labor interests of the mental health community. This committee fulfills the legislative intent regarding the importance of broad stakeholder involvement in the Futures project.

Decision Points
For the Legislative Mental Health Oversight Committee

1. Approval of the overall scope and direction of the plan, as represented. Support for FY 07 appropriations request.	March 2006
2. Review of the actuarial study findings, approval for inpatient bed capacity to be developed.	June 2006
3. Approval to proceed with identified options or direction for alternatives. Considerations for the committee include *What is the estimated size, cost and location of the proposed facility? Is it appropriate to the need and affordable to the state? What other options could be explored as alternatives, and why have they been rejected at this stage?*	June 2006
4. Authorization to proceed with the Requests for Proposals to select the architectural / engineering team to continue with the design process.	April 2006
5. Release of the second installment of the FY'06 / FY'07 capital appropriations, as per presentation of needs by the Department of Buildings and General Services in order to execute the architectural / engineering contract	July 2006
6. Review plan to address VSH staff employment / benefit issues	September 2006
7. Review of collaboration agreement with Fletcher Allen (or other inpatient program), approval to proceed or identification of alternative approach Considerations for the committee include *What is the plan for property ownership and facility ownership? Who will operate the facility? How will the state exercise control over operations, and what are the projected annual operating costs*	September 2006

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STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
Montpelier, Vermont 05633-5701

JOINT FISCAL COMMITTEE

AGENDA

Room 10

Tuesday, April 25, 2006

4:00 p.m. **Vermont State Hospital Futures Plan**
Introduction – Cynthia LaWare, Secretary, Agency of Human Services
Presentation - Beth Tanzman, Director of Vermont State Hospital Futures Project, Department of Health, Division of Mental health
Ira Sollace will be available to answer questions

4:20 p.m. **Joint Legislative Mental Health Oversight Committee**
Senator Jim Leddy and Representative Michael Fisher

4:30 p.m. **Committee Discussion**

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AGENDA

Room 10

Tuesday, April 25, 2006

4:00 p.m.	**Vermont State Hospital Futures Plan** **Introduction** – Cynthia LaWare, Secretary, Agency of Human Services **Presentation** - Beth Tanzman, Director of Vermont State Hospital Futures Project, Department of Health, Division of Mental health Ira Sollace will be available to answer questions
4:20 p.m.	**Joint Legislative Mental Health Oversight Committee** Senator Jim Leddy and Representative Michael Fisher
4:30 p.m.	**Committee Discussion**

MEMORANDUM

TO: Joint Fiscal Committee

RE: VSH Futures Plan Update

DATE: April 25, 2006

FROM: Beth Tanzman, Futures Project Director, Vermont Department of Health, Division of Mental Health

I am pleased to present the Vermont State Hospital Futures Plan today. Vermonters hold a broad common vision regarding mental health care. We expect:

- services to be of high quality,
- services to be provided in a holistic, comprehensive continuum of care,
- consumers to be treated at all times with dignity and respect,
- individual rights will be protected,
- public resources to be allocated efficiently and produce the best possible outcomes, and
- direct services - overseen and provided by the Agency of Human Services and its community partners are - person and family centered.

We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary to achieve the desired outcomes.

Vermont's mental health system has many strengths of which we can be proud. The system also has significant challenges. From these challenges arises a unique opportunity for major system reform.

The Futures plan, fully implemented, would transform in-patient and rehabilitation services for the most severely ill. It would improve coordination of services and increase capacity for all adults with mental health problems. The result would be a continuum of care in which all of the elements are coordinated; prevention, early intervention and alternatives to hospitalization are pursued aggressively; peer supports are expanded and fully respected as essential to recovery; the individual is actively engaged in the

development of his or her treatment plan; and outcomes are measured and continuous improvement is a key goal.
On March 22 the Joint Mental Health Legislative Committee approved this plan with two suggested revisions.

- strengthen the reference to the Futures Advisory Committee and its ongoing role in the planning process; and
- request that the Mental Legislative Oversight Committee review a draft collaboration agreement between the State and inpatient partners at the same time as a draft VSH employee plan.

These revisions are attached; otherwise the plan is exactly as presented to the Joint Mental Health Legislative Committee.

Since March 22, we have clarified that AHS and BGS will need to apply for both a Conceptual Certificate of Need (CON) and a full CON for the inpatient portion of the Futures Plan. We believe that this will lengthen the time to a new inpatient program by at least two years. In addition to the estimated $100,000 of direct costs to complete the CON process, there are significant lost opportunity costs in terms of federal participation in the operations of VSH and inflation on construction costs. These additional costs are estimated to be approximately $29,400,000.

Good progress has been made in citing one of the key community service components of the plan, the residential recovery service at the sub-acute level of care. A consortium of three Designated Community Mental Health Agencies, in collaboration with a private developer, are working towards opening a program for 10-11 residents sometime this fall in Williamstown. We have been able to sequence the notification of the proposed project in a more appropriate fashion than in Greensboro; briefing local town and legislative officials first and then holding public forums, and meetings with abutting neighbors.

Finally, the first phase of work to assess the cost and campus citing options with FAHC will be completed in the near future, as will the independent actuarial study to help determine the number of psychiatric inpatient beds Vermont will need in the future.

We will continue to develop the tactical details association with the Futures Plan as we move into the implementation phases, and I look forward to updating this committee on our progress.

House of Representatives

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MEMORANDUM

To: Martha Heath, Chair Joint Fiscal
Susan Bartlett, Vice-Chair Joint Fiscal

From: Rep. Ann Pugh, Chair House Human Services

Date: April 25, 2006

Subject: Division of Mental Health's request for exception from CON requirement

The Division of Mental Health (DMH) has been working on a replacement plan for the State Hospital. Upon request of DMH, BISHCA ruled that DMH would be required to get a Certificate of Need (CON) in order to build a new hospital. DMH came to the Human Services committee asking for an exemption from the need for obtaining a CON. They cited the legislative oversight in place in the Futures Planning Advisory Group, the Mental Health Oversight Committee and the Joint Fiscal committee as more oversight than the CON process and a duplication of effort. They argued that this duplication would result in at least an 18-month delay in beginning construction. Secretary Cynthia LaWare made the formal request for the exemption. Beth Tanzman, the director of the project for DMH, their legal counsel Wendy Beinner and Tasha Wallis of BGS testified on their reasons for requesting the exemption. Finding people to contracting their request was easy, we hear from them over four hearing times. One of the most compelling was the President of the Rutland Region Medical Center. He described the CON process as a well defined, complete, careful planning process, saying it would be a benefit to the planning of the new State Hospital.

DMH submitted proposed changes to the CON law asking for a modified review by BISHCA taking no more than 6 months. Most committee members felt the CON process will be benefit to the whole planning and construction process and make for a better hospital. The committee voted 8-2-1 against DMH's request.

(1) issues relative to the delivery of services, including best practice models, group versus individualized services, preventive and primary care, service coordination options, and cost-effective approaches to delivering services;

(2) ways to ensure funding parity among mental health, substance abuse, and physical health;

(3) baseline infrastructure requirements;

(4) whether the system is underfunded and, if so, the impact of such underfunding;

(5) issues relative to realistic service expectations, including reasonable reimbursement rates and funding mechanisms that correlate with utilization trends;

(6) issues relative to human resources, including recruitment and retention strategies, training and education, licensing requirements, and competitive compensation; and

(7) issues relative to efficient business practices, including group purchasing of health insurance, workers' compensation, information technology, and business supplies; and efficient practices for revenue collection.

(d) The agency of human services shall contract with a third party consultant to review and make recommendations regarding the financial sustainability of the department of developmental and mental health services designated agency provider system. The secretary or designee, in collaboration with the committee, shall design the scope of work, design request for proposals, and select a consultant. The consultant selected by the agency shall submit its report to the secretary and the committee no later than November 1, 2004.

(e) On or before November 15, 2004, the secretary, in collaboration with the committee, shall provide a report, including the underlying data, regarding the financial sustainability, resources, efficiency, and services offered by designated provider agencies to the mental health oversight committee. The agency of human services shall ensure that the research is inclusive of the above elements and shall address the range of services or rate of any growth in the need of services.

(f) On or before December 15, 2004, the secretary shall file a report with the governor and the general assembly detailing the findings and recommendations with respect to the issues covered in subsections (c), (d), and (e) of this section, including comments from the mental health oversight committee. In addition, the report shall include recommendations for the short and longterm financial sustainability of the department of developmental and mental health services designated agency provider system, including options to create more reliable annual budget decisions.

(g) The committee is authorized to meet up to six times per year and shall cease to exist on July 1, 2006.

Sec. 141a. VERMONT STATE HOSPITAL FUTURE PLANNING ADVISORY GROUP

(a) It is the intent of the general assembly that all mental health programs, services, and supports, including inpatient psychiatric services, be provided to individuals with

psychiatric disabilities or diagnoses or emotional disorders in a holistic, comprehensive continuum of care, that consumers be treated at all times with dignity and respect, that public resources be allocated efficiently and produce the best positive outcomes, and that direct services overseen and provided by the agency of human services and its community partners be client- and family-centered and driven, accessible, and culturally competent.

(b) The secretary of human services shall be responsible for the development and, upon approval by the mental health oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The secretary shall upon passage establish a statewide state hospital future planning advisory group to advise the secretary on development and implementation of a strategic plan related to developing alternatives to the services currently provided by the Vermont state hospital.

(c) The members of the state hospital future planning advisory group may consist of the members of the current Vermont state hospital advisory committee. If the members of the Vermont state hospital advisory committee are unwilling or unable to serve as the members of the state hospital future planning advisory group for some or all of the functions identified in this section, a specific group shall be created with members appointed by the secretary. In either instance, the state hospital future planning advisory group shall have members representing the following: designated community mental health agencies; designated hospitals; the adult program standing committee; consumers and their family members; psychiatric and nursing staff of the Vermont state hospital; a recent patient of the Vermont state hospital; patient rights protection organizations; Vermont legal aid; the department of corrections; developmental services; child and adolescent mental health services; the Vermont psychiatric association; the Vermont psychological association; and the Vermont state employees' association.

(d) Members of the state hospital future planning advisory group not receiving compensation for service on the advisory group from another source are entitled to compensation under section 1010 of Title 32.

(e) The secretary or designee shall consult with the advisory group on all aspects of strategic planning, including methods of seeking further public input, investigation of program options and policies, and recommendations concerning organization, operations, funding, and implementation.

(f) The principles guiding the state hospital future planning advisory group in creating the immediate and longterm plans for the Vermont state hospital shall include the following:

(1) an understanding of the role of active treatment within the goal of recovery;

(2) an understanding of the role of trauma in the lives of individuals;

(3) accessible general medical care;

(4) minimal use of involuntary interventions such as seclusion, restraint, and involuntary medication;

(5) staff training in the use of safe and appropriate alternatives to involuntary interventions;

(6) consumers' participation in the development and implementation of their treatment plans;

(7) consumers' right to privacy and the right to have information regarding their care remain confidential, unless disclosure is authorized by the consumer or required under the law;

(8) ongoing consumer and community input with regard to program oversight and development; and

(9) accountability for all components of the mental health care system.

(g) The state hospital future planning advisory group shall consider and make recommendations to the secretary on the following:

(1) in general, the future of Vermont's inpatient psychiatric programs, including those currently provided by the Vermont state hospital and, more specifically, whether new general or forensic inpatient programs should be created, either in partnership with designated hospitals or with hospitals or other facilities that do not currently provide inpatient psychiatric services;

(2) designs for programs that are responsive to changes over time in levels and types of need, service delivery practices, and sources of funding;

(3) whether designated hospitals should be encouraged to expand existing psychiatric services;

(4) whether additional community-based, hospital alternative, or diversion programs should be developed;

(5) whether the state should expand community-based peer run programs;

(6) whether to create a flexible individual case management program to fund support services necessary to keep individuals out of the hospital;

(7) how to design mental health services to maximize safety and ensure appropriate protection for the legal rights of consumers;

(8) the development of ongoing quality monitoring and consumer satisfaction programs;

(9) methods for maximizing federal funding sources and mental health coverage under private and public insurance plans;

(10) the necessity of developing housing alternatives, including group homes, supportive housing, and independent living options;

(11) the integration of primary care with the mental health system of care, including the need for education on the appropriate uses of psychotropic medications and follow-up care;

(12) governance issues, including governance of the Vermont state hospital and an assessment of the role of the board of mental health and whether new members should be appointed; and

(13) ways to improve judicial proceedings concerning involuntary treatment and involuntary medication.

(h) On or before October 15, 2004, the secretary shall prepare and present for approval to the mental health oversight committee an outline of the findings and recommendations for replacement of the functions of the Vermont state hospital.

(i) On or before January 15, 2005, the secretary shall prepare and present to the mental health oversight committee and the joint fiscal committee a report containing a comprehensive implementation plan for replacing the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The report shall include proposals for legislation and capital and operational funding needed to implement the plan.

(j) For purposes of this section, the state hospital future planning advisory group shall cease to exist on July 1, 2006.

Sec. 141b. THE DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES PLAN

(a) The commissioner of corrections shall provide the mental health oversight committee with the corrections mental health services plan no later than January 15, 2005.

(b) The secretary shall ensure that the findings and recommendations of the corrections mental health services plan be coordinated with and complementary to the findings and recommendations required by Secs. 141 and 141a of this act.

Sec. 141c. THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to oversee the development and implementation of the secretary of human services' strategic plan to develop alternatives for services currently provided by the Vermont state hospital and to ensure that consumers have access to a comprehensive and adequate continuum of care and Vermont has a financially sustainable department of developmental and mental health services designated agency provider system. The committee shall be composed of one member from each of the house committees on health and welfare, institutions, and appropriations and a member-at-large to be appointed by the speaker of the house, not all from the same party, and one member from each of the senate committees on health and welfare, institutions, and appropriations and one member-at-large to be appointed by the committee on committees, not all from the same party. Initial appointments shall be made upon passage.

(b) The committee shall review whether the secretary's study on the department of developmental and mental health services designated agency provider system required in Sec. 141 of this act, the strategic plan for developing alternatives to the Vermont state hospital required in Sec. 141a of this act, and the department of corrections mental health services plan achieve the goals and principles stated herein effectively, efficiently, and satisfactorily, including that the findings and recommendations of the reports are coordinated and complementary. The committee shall specifically:

(1) solicit input from individuals and their families served by the mental health system;

(2) monitor the study and planning processes and time lines;

MEMORANDUM

TO: Joint Fiscal Committee

RE: VSH Futures Plan Update

DATE: April 25, 2006

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House of Representatives

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MEMORANDUM

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From: Rep. Ann Pugh, Chair House Human Services

Date: April 25, 2006

Subject: Division of Mental Health's request for exception from CON requirement

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To: Steve Klein, JFO
FYI Rep Anne Donahue

Beth Tanzman
Division of Mental Health
108 Cherry St, Suite 201
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Burlington, VT 05402-0070
(802) 652-2000

April 18, 2006

Dear Beth:

Following up on yesterday's Futures Advisory Committee meeting, I am writing to clarify some points related to the Certificate of Need (CON) laws and process. Specifically, I am writing because some of the information presented in the first agenda item at yesterday's meeting is not consistent with what I communicated to you in my letter of March 14, 2006. I hope this letter will clarify matters and prevent confusion.

As has always been the case, the Department of Banking, Insurance, Securities and Health Care Administration wants to help the Division of Mental Health proceed through the CON process as efficiently and expeditiously as possible. Please note I am working from my notes of what people said at yesterday's Futures meeting. If you feel my recollection of what was said is inaccurate in any way please let me know so we can have an accurate record. Thank you.

1. Filing of a Letter of Intent

In response to a question from Futures committee member Dr. David Fassler, who asked why DMH's revised timeline indicates a CON Letter of Intent (LOI) will not be filed with BISHCA until September of 2006, you indicated that is because DMH must have firm cost figures to include in the LOI. You indicated these would need to include prices for the primary site (probably at FAHC) and secondary sites (probably at Rutland Regional Medical Center and the Brattleboro Retreat).

Please refer to my letter to you of March 14, 2006 in which I stated that "...with respect to cost and scope of the project, DMH should provide, in phase one, sufficient information to allow for an understanding of what the estimated range of costs is likely to be for various types of options (single site, multiple sites, funding sources, etc.) ..."[1] I

[1] March 14, 2006 letter to Beth Tanzman, page 2

also stated that "A more detailed examination of costs at a specific site, however, would not be appropriate to review until phase two."
The March 14th letter went on to note that the criteria and standards to be primarily addressed in phase one review would not be about cost but would concern:

> "the need for the project
> how the project would facilitate the goals of the Health Resource Allocation Plan
> how the project would facilitate the chronic care initiative
> how the project would impact access to services
> how the project would meet the requirements of CON standard 16 regarding mental health services"[2]

I specifically noted that we would, in addition, need to obtain:

> "*preliminary* information about funding, costs, staffing and utilization (estimates of ranges would be acceptable) in phase one" (emphasis in the original)
>
> and that
>
> "As phase one is intended to precede most of the architectural and planning work that applicants will need to do, however, we expect that applicants will not present detailed cost, revenue and construction information in phase one. Rather, applicants are expected only to present sufficient information which the public, experts, interested parties, the Public Oversight Commission, and the Commissioner may use in order to provide constructive feedback and input to be used by applicants in their planning processes."

To be clear, particularly in the case of CON applications that must follow the Conceptual CON process (phase one) in addition to the traditional CON process (phase two), applicants are not expected to have firm or detailed cost information in phase one. Broad cost figures would certainly be adequate. It is also the case that even in the case of applicants that do not need to seek Conceptual CON approval, the cost figures presented by applicants in their LOIs and throughout the course of the due diligence review process may be amended as needed. In non-Conceptual CON cases the cost figure needs to be settled before an application can be ruled complete and set for a hearing before the Public Oversight Commission. Understandably, that requirement would not apply to applicants in the Conceptual CON process.

2. Meetings/communications with BISHCA

You indicated, in response to a question about the CON process, that DMH has "not been able to have those discussions with BISHCA". I think your answer might have been in response to questions about both the CON process and the timelines DMH has developed regarding the CON process. If this was not your intention please clarify.

[2] March 14, 2006 letter, page 2

In any event, I didn't understand your response because I am not aware of barriers to our staff assisting DMH in the application process. The Health Care Administration staff have been eager to assist DMH, as we assist any and all CON applicants or potential applicants, in proceeding through the CON process as efficiently and expeditiously as possible. Indeed we are pleased that applicants have commented positively about the assistance our staff provides both before and during the CON application process. To that end our office initiated meetings with your office quite some time ago. I also note that my March 14th letter indicated that we:

> "welcome any questions or feedback you have ...particularly if you believe a modification would be appropriate to the determinations of applicability of the criteria and standards..."
>
> and
>
> "Applicants are encouraged to consult with the Division of Health Care Administration for technical assistance in completing the application."

Perhaps the letter should have also specifically noted that we are eager to assist applicants *prior* to applications being filed. That certainly is the case and was the intent of the letter. We typically meet with applicants before they file applications to answer any questions they have, discuss the applicability of particular criteria and standards, get a feel for the likely complexity and time required for review, and answer questions applicants may have regarding the CON process. We have found this makes the reviews proceed more smoothly and more quickly. If this had not been clearly communicated to DMH in prior discussions, I hope this is helpful now.

Perhaps it would also be helpful to clarify the broader issue, that of "talking to the Regulator." There was a comment in yesterday's meeting to the effect that DMH "can't talk to the regulator" which comment is not accurate. The rules about applicants' communications with BISHCA are contained in Bulletin 112, located at our website, http://www.bishca.state.vt.us/HcaDiv/CON_/CON_Main_Index.htm. The basics are as follows:

- applicants can always talk with Division staff[3] about CON applications and are strongly encouraged to do so
- after a Letter of Intent is filed applicants may engage in communications with the Commissioner or members of the Public Oversight Commission so long as such communications are made a part of the public record
- after a Letter of Intent is filed applicants may not engage in ex parte communications with the Commissioner or with members of the Public Oversight Commission

3. Prioritization of CON applications and Timeline for CON reviews

[3] Note that this includes all employees of the Health Care Administration, including the Deputy Commissioner, Division Counsel Bruce Spector, CON Specialist Jennifer Garson, and Health Care Administrator Donna Jerry

Discussion at yesterday's meeting may have left folks with the erroneous impression that our office must review CON applications in the order in which they are filed and that we cannot prioritize or otherwise review applications out of chronological order. I want DMH and the Futures Committee to know that the CON review process does not proceed in such a manner.

The pace at which a CON application review proceeds is largely dictated by factors unique to that application. BISHCA is required by statute to ask questions within 30 days of every response by an applicant. Applicants may take as long as they need to respond except that if applicants fail to respond for 12 months or more an application becomes invalid. Reviews of all pending CON applications happen concurrently, not sequentially. The speed with which applications are reviewed is dependent primarily on the speed with which applicants respond to our questions.

Related to this point is the important fact that CON review can, and usually does, proceed *concurrently* with other reviews and planning work by applicants such as Act 250, local zoning, and financing (bond or otherwise) work being pursued by applicants.

4. Miscellaneous items

Application Fees:

I note in the April 4, 2006 document by DMH labeled "Factors Related to Adherence to CON PROCESS" a reference to having to pay an application fee of $20,000 twice, once for the Conceptual CON (phase one) and again for the phase two CON. Please be advised that the Department does not plan to charge such CON applicants fees for each of the two CON phases. Rather, applicants needing to apply for Conceptual CONs will have that application fee credited to both phase one and phase two.

Timing of Letters of Intent:

Although Letters of Intent must be filed at least 30 days prior to the filing of a CON application, applicants have six months from the filing of a letter of intent to file the related application. Also, if applicants find they are unable to file their application within that six-month period they may simply file a revised Letter of Intent and begin a new six-month period for the filing of the application.

Sincerely,

Bruce Darwin Spector, Esq.
Division Counsel

Encl.

STATE OF VERMONT
HOUSE OF REPRESENTATIVES
115 STATE STREET
MONTPELIER, VT
05633-5201

April 11, 2006

Steve Klein
Legislative Fiscal Officer
Joint Fiscal Committee
1 Baldwin Street, Drawer 33
Montpelier, VT 05633-5701

Steve,

Attached is the Vermont State Hospital Futures Plan. This plan fulfills the requirements set out in Section 141a(i) of No. 122 of the Acts of the 2003 Adj. Session (2004), the Fiscal Year 2005 Appropriations Act. Under this act, the Futures plan needs to be approved by the Joint Legislative Mental Health Committee and by the Joint Fiscal Committee.

The Joint Legislative Mental Health Committee approved the plan on March 22, 2006. We are forwarding it onto the Joint Fiscal with our support.

Senator James Leddy, Co-Chair
Joint Legislative MH Oversight
Committee

Representative Michael Fisher, Co-Chair
Joint Legislative MH Oversight
Committee

THE VERMONT MENTAL HEALTH FUTURES PLAN

Proposal to Transform and Sustain A Comprehensive Continuum of Care For Adults with Mental Illness

Presented to the
Legislative Mental Health Oversight Committee
March 22, 2006

The Agency of Human Services
Department of Health
Division of Mental Health

Approved by the Committee
With two amendments
Revised March 28, 2006

VERMONT

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Agency of Human Services

March 22, 20006

Representative Anne Donahue
Representative Gail Faller
Representative Michael Fisher, Co-chair
Senator James Leddy, Co-chair
Representative Pat O'Donnell
Senator Philip Scott
Senator Diane Snelling
Sen. Jeanette White

Mental Health Oversight Committee
State House
Montpelier, Vermont

Dear Committee Members,

The Vermont Mental Health Futures Plan calls for the continued transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health care. The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

This plan is based upon recommendations from the Vermont State Hospital Futures Advisory Group and discussions with your committee. It is also informed by:

- The Designated Agency Sustainability Study,
- The Vermont State Hospital Futures Plan: Report to Charles Smith, Secretary AHS (the Division of Mental Health's report)
- Recommendations for the Future of Services Provided at Vermont State Hospital (Secretary Smith's Futures report to the Legislature)
- The Health Resources Allocation Plan (H-RAP)
- The State Health Plan.

The enclosed plan builds on the previous work, updates the implementation status of VSH Futures Plan components for which there have already been appropriations, and outlines the work to do in the coming months and years.

This document is intended to continue fulfilling the requirements set out in the Fiscal Year 2005 Appropriations Act (Sec. 141a.) for Vermont State Hospital Future Planning.1

Specifically, AHS Secretary Cindy LaWare is seeking your committee's approval for the overall scope and direction of this Futures Plan as presented, and your approval to proceed with the next phases of project implementation.

Respectfully submitted,

Cynthia D. LaWare, Secretary
Agency of Human Services

Beth H. Tanzman, Director
Mental HealthFutures Project

[1] The secretary of human services shall be responsible for the development and, upon approval by the mental health oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services.
On or before January 15, 2005, the secretary shall prepare and present to the mental health oversight committee and the joint fiscal committee a report containing a comprehensive implementation plan for replacing the services currently provided by the Vermont state hospital developed within the context of long-range planning for a comprehensive continuum of care for mental health services. The report shall include proposals for legislation and capital and operational funding needed to implement the plan.

THE VERMONT MENTAL HEALTH FUTURES PLAN

Proposal to Transform and Sustain
A Comprehensive Continuum of Care
For Adults with Mental Illness

Revised March 28, 2006

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Overview of the Transformed System
THE **FUTURES** PLAN

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health. When fully implemented, the plan will transform inpatient and recovery services for the most severely ill and will improve coordination of services and increase capacity for all adults with mental illnesses. The result will be a continuum of care in which

- The individual is actively engaged in their own recovery.
- Prevention, early intervention and alternatives to more acute levels of care are pursued aggressively.
- Peer supports are expanded and recognized as essential to recovery.
- All the elements are coordinated.

This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

The replacement of Vermont State Hospital (VSH) services is proposed to take place within the context of the system's transformation towards care that is more integrated with the rest of medical care, and that emphasizes reduced reliance on inpatient care.

The core of the plan is the proposal for new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults.

New Inpatient Capacity for Intensive Care and Specialized Care

Two new levels of inpatient care, "intensive care" and "specialized care," are proposed, reflecting more intensive staffing patterns than currently exist at VSH or in Designated Hospital psychiatric inpatient programs. These new levels of care each will be configured with high staff-to-patient ratios, flexibly scalable environments, and specialized clinical programming. The intensive care service is planned for stabilization of individuals with the most dangerous behaviors. The specialized care service will offer staff-intensive programming, and the longer lengths of stay required by individuals with particularly severe or unresponsive symptoms. The plan proposes to create 32 new inpatient beds comprised of 12 intensive care and 20 specialized care beds.

The new inpatient programs will be created in three locations.

- A new facility is proposed to be built located at or adjacent to a hospital, preferably a tertiary level, academic medical center (Fletcher Allen Health Care). This program will provide both new levels of inpatient care, intensive care and specialized care.
- Retreat Healthcare and Rutland Regional Medical Center have agreed to enhance their capacity to develop specialized care inpatient programs. This will assist geographic access specialized inpatient care and will provide the entire system with needed surge capacity.

New, Residential Recovery and Secure Residential Treatment Programs

The plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care. These programs are residential recovery programs for sub-acute rehabilitation, with a capacity of 18, and secure residential treatment, with a capacity of six.

The ***residential recovery programs*** are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals often have a slow response to treatment and multiple disabling conditions. With individually focused rehabilitation programming in non-institutional settings, this population is believed to be capable of making significant gains towards recovery. The current VSH environment, while very caring and supportive, is fundamentally institutional. As such, it constitutes a very difficult environment for engagement in the building of adequate recovery skills to successfully maintain recovery in a less-structured setting.

Secure residential treatment programs will be designed to meet the needs of individuals whose symptoms are sufficiently stable to no longer need inpatient care, but who are legally restricted from discharge from a secure setting.

Crisis Beds for Stabilization and Diversion

The plan proposes to augment the existing network of **crisis beds** for stabilization of an individual's crisis within a community setting and diversion from hospitalization. The goal is to develop programs to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for 10 new crisis beds, based on a statewide assessment of gaps in the crisis intervention system.

Care Management

The Futures plan includes a ***Care Management Program*** to ensure that the system can manage and coordinate access to high-intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. The system will help to ensure that the most integrated and least restrictive care consistent with safety is being delivered. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), the ability to convey common information for clinical services, utilization management oversight, quality improvement and conflict resolution. The care management system will create a service network that coordinates the following components:

- General hospital psychiatric inpatient beds.
- Specialized care psychiatric inpatient beds.
- Intensive care psychiatric beds.
- 18 existing mental health crisis beds.
- 10 new crisis diversion / triage beds.
- Access to the new adult outpatient capacity, for community reintegration.
- Inpatient, residential and outpatient substance abuse treatment services.

Peer Services, Transportation, Supportive Housing, and Legal Services

The Futures Plan proposes new ***Peer Programming***. These services offer effective, recovery-oriented supports. The plan will create new peer support programs targeted to individuals who use VSH. Peers also will be an integral part of the provision of traditional and new services. The expansion of stand-alone peer services will also to be explored.

The plan provides resources to create secure, alternative ***Transportation*** options to the current system of using sheriffs. Additional resources for ***Transportation*** costs may be necessary as the Futures plan is implemented, due to the geographical distribution of programs.

The plan proposes new ***Supportive Housing*** resources. The lack of decent, affordable housing has been consistently identified by the Futures Advisory Group as one of the most significant unmet needs of Vermont's citizens with mental illness. There is broad consensus in the stakeholder community of providers, advocates, family members and consumers that safe and adequate housing is crucial to reducing hospitalization and supporting recovery. Therefore, housing supports will be expanded under the plan.

With inpatient hospital beds distributed in more than one location, this plan identifies the need for additional resources for ***Legal services***, due to the need for attorneys to consult with clients and witnesses in multiple locations.

Additional Enhancements
Proposed by Secretary Charlie Smith
And Supported by the Futures Advisory Committee

The context for planning the replacement of the services at Vermont State Hospital is the entire mental health service system. The Futures Advisory Group, the Legislative Mental Health Oversight Committee, and then-AHS Secretary C. Smith have viewed the successful implementation of the Futures Plan as contingent upon sustaining and enhancing the overall services system.

Sustaining Community Infrastructure

Planning for the Futures Project, for both inpatient and community services, needs to occur in the context of considering the overall financial health of the designated hospital and agency service providers. The plan assumes continuation of adequate resources to sustain all existing services, including caseload growth.

Enhancing Community Infrastructure

Fundamental to the plan is the recognition that a smaller, replacement inpatient unit, even with the addition of other residential programs, cannot succeed in meeting the needs of the population that VSH currently serves without enhancing the existing community mental health services infrastructure. This requires the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately dispersed geographically. In addition, this continuum of supports and services will be recovery-oriented and trauma informed.

Then-Secretary C. Smith's report to the legislature recommended developing and/or enhancing the following services.

Adult Outpatient Services

Secretary C. Smith's report to the Legislature proposed new capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Several different program approaches were described. These included replication of the Health Care & Rehabilitation Services of Southeastern Vermont (HCRS) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals; collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse; or integration of mental health care into primary care settings such as federally qualified health centers.

Expansion of the Co-Occurring Disorders Project

This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. The two existing programs, with teams in Burlington and Brattleboro, use an evidence-based integrated mental health and substance abuse treatment approach to provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and positive recovery results. Additional teams are needed in Rutland and Barre.

Public Health Prevention and Education Strategies

With the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population-based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources are needed to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

Offender Out-Patient Services & Mental Health Plan for Corrections

The current capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration is widely viewed as inadequate. The development of specific mental health and substance abuse programs targeted to this population may help reduce recidivism and increase the employment and general community participation of this group. Priority will be given to interventions with a high potential of supporting the offender's long-term success.

The Futures plan builds on ongoing efforts to implement phase-in of the Corrections plan submitted by the Secretary on February 4, 2005 under the Futures legislation.

The Current Program at Vermont State Hospital

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH, along with the psychiatric services being provided by Fletcher Allen Health Care, will assist in a seamless transition towards an excellent, state-of-the-art psychiatric inpatient service in the future. VSH has established a strategic plan to implement the specific recommendations made in a review by Fletcher Allen Health Care. This plan has been updated to include the requirements of the Department of Justice, licensing conditions by the Vermont Board of Health, and meeting certification requirements under CMS or JCAHHO.

The Continued Planning Process

The Division of Mental Health (DMH) will continue working with the Futures Advisory Committee as the lead multi-stakeholder group providing feedback and advice on the planning and implementation of the Futures project. This committee is advisory to the Secretary of the Agency of Human Services and is staffed by the (DMH). The Futures Advisory Committee has over thirty members representing the advocate, consumer, family, provider, and labor interests of the mental health community.

Decision Points
For the Legislative Mental Health Oversight Committee

1. Approval of the overall scope and direction of the plan, as represented. Support for FY 07 appropriations request.	March 2006
2. Review of the actuarial study findings, approval for inpatient bed capacity to be developed.	June 2006
3. Approval to proceed with identified options or direction for alternatives. Considerations for the committee include *What is the estimated size, cost and location of the proposed facility? Is it appropriate to the need and affordable to the state? What other options could be explored as alternatives, and why have they been rejected at this stage?*	June 2006
4. Authorization to proceed with the Requests for Proposals to select the architectural / engineering team to continue with the design process.	April 2006
5. Release of the second installment of the FY'06 / FY'07 capital appropriations, as per presentation of needs by the Department of Buildings and General Services in order to execute the architectural / engineering contract	July 2006
6. Review of collaboration agreement with Fletcher Allen (or other inpatient program), approval to proceed or identification of alternative approach Considerations for the committee include *What is the plan for property ownership and facility ownership? Who will operate the facility? How will the state exercise control over operations, and what are the projected annual operating costs*	September 2006
7. Review plan to address VSH staff employment / benefit issues	September 2006

Five Year Financial Plan

Description	Implement. Date	SFY' 07	SFY' 08	SFY' 09	SFY' 10	First Quarter SFY' 11	Total
Futures Plan: Ongoing Operations (Beds)							
Community Residential Recovery: Sub Acute Level of Care	Jul 06 (16)	3,714,842	3,993,455	4,292,964	4,614,937	1,240,264	17,856,462
General Fund		1,529,772	1,644,505	1,767,843	1,900,431	510,741	7,353,291
Federal Funds (100% Match)		2,185,070	2,348,950	2,525,122	2,714,506	729,523	10,503,171
Community Residential: Secure	Jul 06 (3), Jul 07 (3)	1,176,556	2,529,595	2,719,315	2,923,264	785,627	10,134,357
General Fund		484,506	1,041,687	1,119,814	1,203,800	323,521	4,173,328
Federal Funds (100% Match)		692,050	1,487,908	1,599,501	1,719,464	462,106	5,961,029
Crisis Beds	Jan 07 (4), Jul 07 (2), Jan 08 (4)	212,836	916,662	1,232,948	1,325,419	356,206	4,044,072
General Fund		87,646	377,482	507,728	545,808	146,686	1,665,349
Federal Funds (100% Match)		125,190	539,181	725,220	779,612	209,521	2,378,723
Total		5,104,234	7,439,713	8,245,227	8,863,619	2,382,098	32,034,892
General Fund		2,101,924	3,063,674	3,395,385	3,650,039	980,948	13,191,968
Federal Funds		3,002,310	4,376,039	4,849,843	5,213,581	1,401,150	18,842,923
Futures Plan: Ongoing Operations (Programs)							
Care Management IT Design & Software (45% Match)	Jul-06	187,775	0	0	0	0	187,775
Clinical Staffing for Care Mgt. (100% Match)	Oct-06	140,445	196,623	275,272	385,381	103,571	1,101,292
General Fund		195,908	80,969	113,357	158,700	42,651	591,585
Federal Funds		132,312	115,654	161,915	226,681	60,921	697,482
Peer Support Programming (Not Match)	Feb-07	79,961	230,266	247,536	266,101	71,515	895,379
General Fund		79,961	230,266	247,536	266,101	71,515	895,379

Five Year Financial Plan

Description	Implement. Date	SFY' 07	SFY' 08	SFY' 09	SFY' 10	First Quarter SFY' 11	Total
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Total		5,104,234	7,439,713	8,245,227	8,863,619	2,382,098	32,034,892
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Futures Plan: Ongoing Operations (Programs)							
Care Management IT Design & Software (45% Match)	Jul-06	187,775	0	0	0	0	187,775
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General Fund		195,908	80,969	113,357	158,700	42,651	591,585
Federal Funds		132,312	115,654	161,915	226,681	60,921	697,482
Peer Support Programming (Not Match)	Feb-07	79,961	230,266	247,536	266,101	71,515	895,379
General Fund		79,961	230,266	247,536	266,101	71,515	895,379

Description	Implement. Date	SFY' 07	SFY' 08	SFY' 09	SFY' 10	First Quarter SFY' 11	Total
Staff-Secure Transportation for Involuntary Adult Admissions	Jul-06	94,960	102,082	109,738	117,969	31,704	456,453
General Fund		67,032	72,060	77,464	83,274	22,380	322,210
Federal Funds (50% Match)		27,928	30,022	32,274	34,695	9,324	134,243
Recovery Housing	Jul-07		460,532	495,072	532,202	143,029	1,630,836
General Fund			325,090	349,471	375,682	100,964	1,151,207
Federal Funds (50% Match)			135,442	145,601	156,521	42,065	479,629
Total Ongoing Operations for Futures Plan Community		503,141	989,503	1,127,618	1,301,653	349,819	4,271,734
General Fund		342,901	708,385	787,828	883,757	237,510	2,960,381
Federal Funds		160,240	281,118	339,790	417,896	112,310	1,311,354
Futures Plan: Inpatient							
Current Operational Cost		18,708,479	20,111,615	10,809,993			49,630,087
Operations with enhancements for licensure	Jan-08			10,809,993	11,620,742		22,430,736
New Facilities	Jan-10				11,620,742	6,246,149	17,866,891
General Fund		18,298,479	19,701,615	16,533,236	12,304,972	3,306,961	70,145,262
Special and IDTs		410,000	410,000	410,000	410,000	102,500	1,742,500
Federal Funds (80% Match)		0	0	4,676,750	10,526,513	2,836,688	18,039,951
Capital Cost of Replacing State Hospital	Est. in 2005 Dollars			7,650,000	7,650,000		15,300,000
Total Yearly Vermont State Hospital and Alternative Costs	Not Including Capital Cost	24,315,854	28,540,831	30,992,832	33,406,757	8,978,066	126,234,339
General Fund		20,743,304	23,473,673	20,716,449	16,838,767	4,525,419	86,297,611
Special and IDTs		410,000	410,000	410,000	410,000	102,500	1,742,500
Federal Funds		3,162,550	4,657,158	9,866,383	16,157,990	4,350,147	38,194,228

Vermont Mental Health Futures Plan

Appendices

Current Implementation Status & Outstanding Issues

This section reviews the key components of the Futures plan and progress towards implementation. It also identifies current outstanding issues and how these are proposed to be addressed. The Futures Advisory Committee meets every two months with additional special topic-focused meetings called as needed. The committee has over thirty members. The Futures Advisory Committee has also commissioned work groups to complete more detailed planning for specific program areas. Currently there are five active work groups: residential recovery, care management, facilities design, housing and human resources. All work group meetings are publicly noticed and members of the Advisory Committee are welcome to attend.

New, Specialized Inpatient Capacity: Role of Designated Hospitals and Site Options

Summary

The Futures plan proposes creating 32 new inpatient beds with two different levels of intensive treatment capability, intensive care and specialized care. This includes an estimated capacity at any given time for four to eight forensic beds to support patients in the custody of the Department of Corrections in need of inpatient care. The Futures Advisory Committee has recommended that the preponderance of beds be created at a single, primary location, preferably with Fletcher Allen on its Burlington campus. In addition, they recommend that one or two smaller capacities be created for geographic access. These smaller capacities (at Rutland Regional Medical Center and Retreat Health Care) will offer the specialized level of care and will be expected to operate under the same programmatic guidelines and standards as the primary program.

Bed Number (Capacity)

The recommendation for 32 inpatient beds in the Futures Plan is derived from our analysis of current capacity, past utilization, and projected impact of the new residential programs to reduce the VSH census. We have also contracted for an independent actuarial study to assess the Vermont's psychiatric inpatient bed needs 10 years into the future. The actuarial study is due to be completed in mid April and is considering the following:

- The recommended bed capacity to replace VSH at two levels of inpatient care (intensive care and specialized care), 10 years into the future.
- The recommended bed capacity for general psychiatric inpatient care (the third level of care) state-wide, 10 years into the future.
- The analysis (projected bed need) will consider the impact of Vermont's community based system of care for mental health services, including the development of new programs as envisioned in the Futures Plan.
- The analysis will also consider the needs for psychiatric inpatient beds for the Department of Corrections population.

Facility Design

Pending the completion of an actuarial study, current planning is based upon an estimated need for a capacity for 28-32 individuals at a Fletcher Allen unit. The Department of Buildings and General Services has a contract with an architectural firm, Architecture Plus (A+) to:

- Develop a preliminary "program of space needs" for the primary facility and smaller capacities;

- To identify site options and evaluate the appropriateness of these for the primary facility with FAHC, and for the smaller capacities;
- To develop a statement of probable costs for capital construction of the proposed designs at different site options.

Most of this first phase of architectural work would need to be completed regardless of site options.

A+ will conclude work by the end of June. Both Rutland Regional Medical Center and the Brattleboro Retreat are being evaluated for an added geographic capacity of specialized inpatient care. Discussions with all three hospitals are based upon capital construction costs and feasibility as well as ability to reach partnership agreements with the state.

The next stage of work will be to continue with site-specific architectural/engineering plans, construction documents, and to proceed with the permitting process. This will require BGS to initiate a Request for Proposals (RFP) to select a design team to perform these services. BGS will use the same process as before to solicit interests and award this design contract. The selection process takes approximately three to four months to complete, so this needs to begin almost immediately so that we are positioned to proceed when final decisions are made on the size and site locations for these inpatient programs.

The RFP will clearly indicate the work will not start until all agreements are in place and approvals are received from the appropriate Legislative committees. This will require the authorization to proceed with the RFP process and the subsequent release of the remaining funds in the FY 06 Buildings and General Service's appropriation and funds proposed in the FY '07 appropriation for the Futures facility development. We estimate the next stage of the design and permitting process will take at least 18 months as follows:

- Schematic Design 2 months
- Design and Development 5 months
- Construction Documents 8 months
- Bidding 3 months

Collaboration Agreements and Host Hospitals

The policy recommendation to site the primary facility with FAHC derives from three primary considerations:

- The desirability to integrate with tertiary-level hospital care.
- Ongoing financial sustainability (FAHC is large enough to absorb a new program without becoming an Institute for Mental Disease and is therefore eligible for Medicaid payments).
- The interest and capability of FAHC to provide a new psychiatric inpatient program (intensive care and specialized care).

The State (AHS and BGS) and Fletcher Allen are working towards a draft collaboration agreement. The first phase of work is to assess the viability of different site options on the Burlington campus for a new inpatient program. Pending the results of this analysis, a more detailed collaboration agreement will be developed or alternative site options will be explored.

The policy recommendation to create one or two smaller inpatient capacities in addition to the primary program is aimed to provide better state-wide geographic access to specialized inpatient care and to

create surge capacity within the system overall. The Futures Committee recommended that those hospitals currently operating psychiatric inpatient services be considered first for developing smaller capacities. Both Rutland Regional Medical Center and Retreat Health Care expressed interest and a commitment to work with the state to implement additional specialized inpatient capacity consistent with the operational standards of the primary facility.

Workforce

The current workforce at the Vermont State Hospital is uniquely skilled and qualified to provide inpatient care to Vermonters with the most severe mental illnesses. While there is wide agreement that the current physical facility at VSH is not adequate, the Futures Planning process has introduced a climate of uncertainty for VSH employees: where will the new hospital be located? if the state doesn't operate the new program, who will employ us? The AHS secretary's office is committed to working with the VSH employees to fully understand and resolve to the best of our ability the employee issues which will present themselves throughout this project. To this end AHS, the Department of Human Resources and representatives from the VSEA and VSH are forming a working group to address these concerns.

Community Outreach

Staff of AHS, FAHC, and the Howard Center are developing several outreach and information strategies with the larger Chittenden County community. The goal is to develop the concept of locating the new inpatient program with FAHC into a concrete proposal that is responsive to the needs and concerns of the community. To date work has begun with the Burlington City Council, the Mayor's office, and the Ward 1 Neighborhood Planning Assembly. In addition, the Chittenden County Legislative delegation has had an initial project briefing and regular dialogue sessions will be scheduled.

New Residential Recovery and Secure Residential Treatment Programs

The Futures plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care; residential recovery programs for sub-acute rehabilitation with a capacity of 18, and secure residential treatment with a capacity of 6. In short, the Futures plan proposes to create 24 new community residential beds. The plan called for implementing these programs in the second half of FY 06 in order to help reduce the census pressures at the current VSH and to help clarify the remaining need for inpatient capacity.

Two unsuccessful attempts to site programs in Vergennes and Greensboro have delayed implementation of these programs. Much has been learned about how to work with communities and the residents of Greensboro offered the following thoughtful summary:

- Define the population to be served, their needs, how the program will meet those needs, and the level of supervision
- Identify the characteristic in a community that would best match such a program
- Build community support with good and early communication
- Develop more accountability through an approval process for proposed programs.

We are working to implement these sound recommendations. A consortium of Designated Mental Health Agencies (DA Consortium) is working to create new program proposals in a balance of rural and town locations. The Futures Advisory Committee is providing overall guidance for program and location characteristics. Proposed programs will be considered through a process that will involve the public and advisory committee members.

Crisis Stabilization and Diversion

The plan proposes to augment the existing network of ***emergency services, crisis stabilization and diversion programs*** to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for ten new beds after completion of a statewide assessment of gaps in the crisis intervention system.

Materials summarizing the current capacities in the service system have been developed and distributed to the Futures Advisory Committee to help identify current gaps in the system. The FY '07 appropriations request includes funding for 4 crisis stabilization beds to begin operation in January 2007. An additional 6 beds would be created over the following 18 months. The Futures Committee has not yet provided guidance on the specific program parameters and will focus on this in upcoming meetings.

Care Management System

The care management function would provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), ability to convey common information for clinical services, utilization management oversight, quality improvement, and conflict resolution.

A workgroup of the Futures committee has developed a set of principles to guide client movement through the system, a list of protocols to operationalize these principles, and an initial draft describing the role that each level of care plays in the overall system.

Group members are now charged with developing recommendations on admissions and discharge criteria for the new levels of care envisioned in the Futures Plan and with writing protocols to guide client placement across these care settings. In addition, the Vermont Psychiatric Survivors Inc has committed to review all the protocols from a peer resource and client rights perspective. The FY 07 appropriation requests funds to begin staffing the care management system and to create the common clinical information system needed to coordinate care across providers.

Supportive Housing

Safe and adequate housing is crucial to reducing hospitalization and supporting recovery. The Futures plan proposes to create new housing and/or rental subsidies to expand access of VSH patients to affordable, safe housing.

The Futures Advisory Committee has commissioned a work group to focus on identifying what type of housing approach (new building, rent subsidy etc) would have the greatest impact on easing the housing issues for people who use VSH. The group met for the first time in early March and will develop a work plan in the near future. An appropriation requests is planned for FY 08.

Peer Programming

Peer Programs offer effective, recovery-oriented supports. The Futures plan proposes new peer support programs targeted to individuals who use VSH. In addition to new peer programming, peers will be an integral part of the provision of traditional and new services.

The Futures Advisory Committee deferred work on this program area until late Spring or early summer of 2006. The FY 07 appropriations request contains partial year funding for new peer services.

Transportation

As the Futures plan envisions increased geographical distribution of programs, additional resources are needed for transportation. In addition, VDH is committed to seeking the least restrictive possible means of transportation for individuals in the care and custody of the commissioner, while also ensuring patient and staff safety. The FY07 appropriation requests new resources to create secure, alternative transportation options to the current system of using sheriffs.

To this end, the Division of Mental Health staff are working to expand the alternative transportation system developed recently for children to include adults.

Additional Community Resources

Secretary Charles Smith's recommendations to the Legislature included other new community capacities and underscore the importance of adequately funding the existing community mental health system. The Douglas administration has made an unprecedented commitment to a three year funding cycle for the Designated Community Agencies with consideration to annual inflationary pressures. In addition, resources for Corrections and housing are being addressed in initiatives outside of the Futures Plan.

Scope, Values and Assumptions

Scope of the Mental Health Futures Plan

The Vermont Mental Health Futures Plan calls for the continued transformation of our service system towards a consumer-directed, trauma-informed, and recovery oriented system of mental health. The core of the plan is the proposal for new investments in the essential community capacities that proactively meet people's needs and reduce the need for more intensive services, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

Values and Assumptions

General:

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across the continuum of services they need to achieve and maintain recovery.
- The State must remain committed to the principle of maintaining the locus of care in the community.
- Vermont's hospitals and designated agencies (DAs) should play an expanded role in addressing needs of Vermonters appropriate to their capacities and resources.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care when it is necessary.
- Vermont law directs that it be our policy "to work towards a mental health system that does not require coercion or the use of involuntary medication." (18 V.S.A. § 7629(c). At every point in our planning process, we must seek ways to reinforce a system that maximizes reasonable choices of voluntary services and avoids or minimizes involuntary treatment.

Assumptions specific to the development of new inpatient resources include:

- Recognition of the negative effects of institutional settings on a person's recovery and the importance of focusing inpatient services on those individuals who need inpatient-level care
- Recognition of the inadequacy of Vermont State Hospital's antiquated physical plant.
- Fiduciary responsibility and financial sustainability. The plan must protect long term access to federal matching funds. Therefore, a replacement inpatient facility must avoid classification as an IMD (Institute for Mental Disease) under federal regulations.
- Recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation. The provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- Recognition of the value of the expertise and experience of the current VSH staff as a resource.

Futures Advisory Group Recommendations

In November of 2005, the Futures Advisory Group made recommendations about the scope of the needed service infrastructure and its sustainability, endorsing in concept the overall components of the Futures Plan as presented to the legislature February of 2005. It recommended that inpatient services be located in one primary site with one or two satellites for geographic accessibility, with 15 site selection criteria to guide the Secretary. As defined, the primary site recommended was Fletcher Allen Health Care. The recommendation emphasized that its support was conditioned upon continued adequate support of existing community resources as well as full budget support for the augmented service components in the proposed Futures plan. With the caveat that other primary site alternatives needed to be reviewed as options and that the selection criterion recommendations were not intended to be binding, the Futures Advisory group reiterated its support for its November vote on February 23, 2006.

The full recommendations follow.

VSH FUTURES ADVISORY COMMITTEE
RECOMMENDATIONS TO SECRTARY MIKE SMITH
NOVEMBER 16, 2005

The VSH Futures Advisory Committee offers the following recommendations about the sustainability of the MH Services System, the selection criteria for the inpatient service sites and partners, and the scope of the needed services infrastructure to successfully implement the Futures Plan.

"*Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers.*"

"The VSH Futures Advisory Committee notes that its "support in concept" for the overall Futures plan, and its formal votes regarding advancing specific components, all remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that, in significant part based on prior direct experience, a replacement inpatient unit alone with or without the addition of sub acute beds can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services, including designated inpatient programs, and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the time line that targets a new inpatient facility opening in June, 2010; and that any expedited time line would also expedite the associated program components in the budget."

Primary
Site and Partner Selection Criteria

1. The primary VSH replacement service should not be an IMD
2. It should be attached to or near (in sight of) a tertiary / teaching hospital
3. Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.
4. There must be adequate space to develop or renovate a facility that will accommodate census needs.
5. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.
6. Costs - both ongoing operations and capital construction - should be considered.
7. Outdoor activity space should be readily accessible to the units.
8. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.
9. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.
10. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.
11. Willingness to participate in a public reporting of common quality standards is required.
12. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.
13. Ability to collaborate with neighbors.
14. Ability to work closely with state and designated agency partners
15. The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.

Smaller Inpatient Capacity(s)
Site and Partner Selection Criteria

1. Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.

2. A location consideration is to assure adequate distribution of services throughout the state.

3. Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.

The rest of the criteria are the same as for the primary site

4. Adequate space to develop or renovate a facility that will accommodate census needs.

5. The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.

6. Costs - both ongoing operations and capital construction - should be considered.

7. Outdoor activity space should be readily accessible to the units.

8. The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.

9. The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.

10. Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.

11. Willingness to participate in a public reporting of common quality standards is required.

12. Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.

13. Ability to collaborate with neighbors.

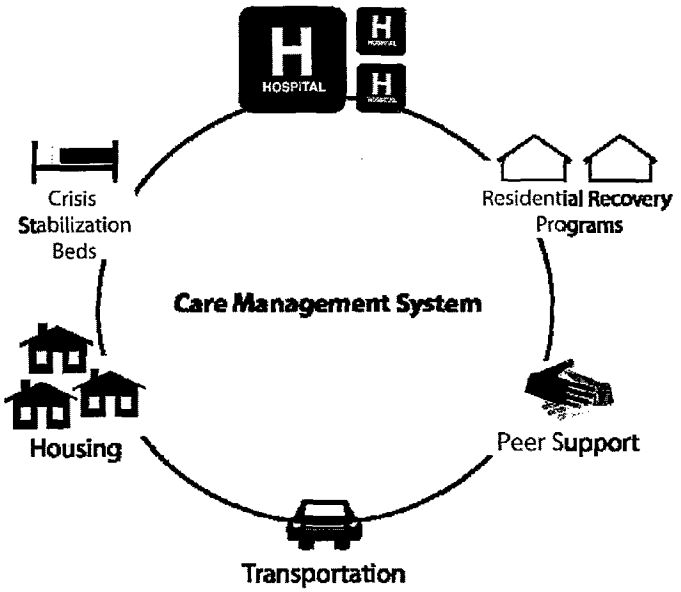
14. Ability to work closely with state and designated agency partners

15. The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.

Vermont Mental Health Futures: Summary Handout

Transforming & Sustaining a Comprehensive Continuum of Mental Care for Adults

The scope of the Futures plan is broad. It reconfigures the existing 54-bed capacity at Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. The plan also calls for significant investments in the core community capacities that proactively meet people's needs, reducing our reliance in inpatient services. The plan calls for the continued transformation of our service system towards a trauma-informed, recovery-oriented, voluntary system of supports.



General Assembly, FY 06 Appropriation

The General Assembly directed that

- The current VSH facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services.
- The operations and human resources of the current VSH must be supported and enhanced so that the environment is safe and the clinical programming effectively supports recovery.
- The capacity and network of community support services should be expanded to help meet needs in a clinically appropriate manner and in keeping with system values.

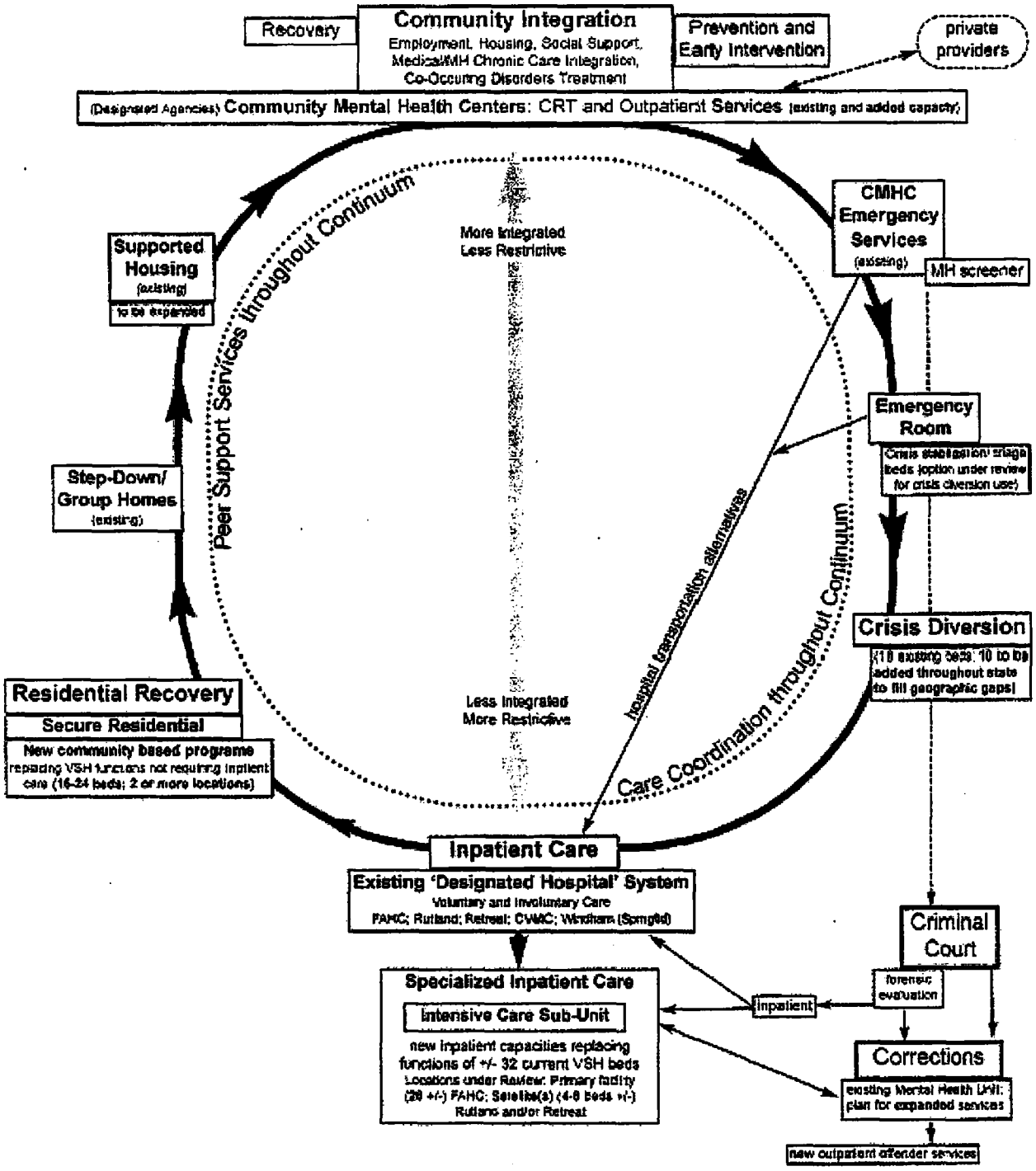
Service Components

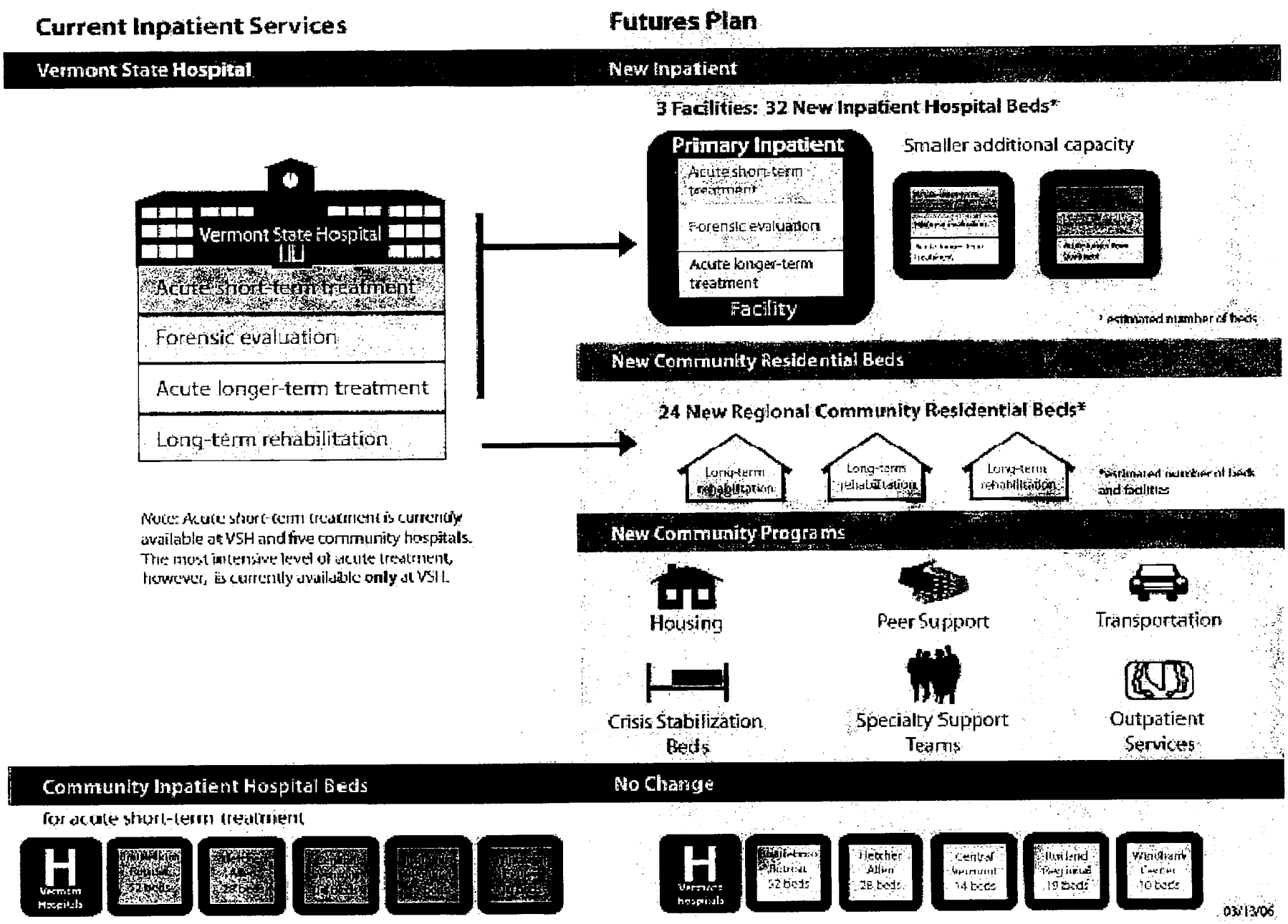
- New **Inpatient Care,** including intensive care and specialized care inpatient programs (estimated capacity of 32 beds) with more intensive staffing patterns than currently exist at VSH or in community hospital psychiatric units.
- **Crisis Stabilization Beds** (10 beds) in geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization.
- A **Care Management Program** to ensure that the system can manage and coordinate access to high-intensity services, so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently.
- New **Residential Recovery Programs** designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care or a secure setting. (capacity of 16-22).
- New **Transportation Services** (alternative to sheriff transport; additional resources), **Peer Support**, and **Housing.**

Current Work in Process (3/06)

- Architectural review to define space needs, to identify and evaluate site options for inpatient facility, to begin development of schematic plans, and to develop statements of probable costs for the various site options.
- Negotiations with inpatient (FAHC, Retreat Health Care, RRMC) partners
- Actuarial study to provide independent projection of psychiatric inpatient beds needs 10 years into the future
- Design and site identification for community residential recovery programs
- Design for a care management system

Overview of the Transformed System: The Futures Plan




Current Inpatient Services
Futures Plan
Vermont State Hospital
New Inpatient
3 Facilities: 32 New Inpatient Hospital Beds*
Primary Inpatient
Acute short-term treatment
Forensic evaluation
Acute longer-term treatment
Facility
Smaller additional capacity
Vermont State Hospital
Acute short-term treatment
Forensic evaluation
Acute longer-term treatment
Long-term rehabilitation
Note: Acute short-term treatment is currently available at VSH and five community hospitals. The most intensive level of acute treatment, however, is currently available only at VSH.
New Community Residential Beds
24 New Regional Community Residential Beds*
Long-term rehabilitation
Long-term rehabilitation
Long-term rehabilitation
*estimated number of beds and facilities
New Community Programs
Housing
Peer Support
Transportation
Crisis Stabilization Beds
Specialty Support Teams
Outpatient Services
Community Inpatient Hospital Beds
No Change
for acute short-term treatment
Fletcher Allen 28 beds
Central Vermont 14 beds
Rutland Regional 19 beds
Windham Center 10 beds
03/13/06

VERMONT FUTURES
STRATEGIC IMPLEMENTATION PLAN
TRANSFORMING AND SUSTAINING A COMPREHENSIVE CONTINUUM OF MENTAL HEALTH CARE FOR ADULTS

February 2005 – June 2010

Working Plan: March 2006
(List of Abbreviations at end)

PLAN OVERVIEW

Basis and Scope This implementation plan is based on the Designated Agency Sustainability Study, the Vermont State Hospital Futures Plan: Report to Secretary Smith and Secretary Smith's Recommendations for the Future of Services Provided at Vermont State Hospital to the Legislature, the Health Resources Allocation Plan (H-RAP) and the State Health Plan. The scope of this implementation plan is quite broad; it reconfigures the existing 54-bed capacity at VSH into a new array of inpatient, rehabilitation, and residential services for adults. The plan also calls for significant investments in the core community capacities that proactively meet people's needs thereby reducing our reliance in inpatient services. In addition, the Futures implementation plan calls for the continued transformation of our service system towards a trauma-informed, recovery oriented, and voluntary system of supports. Finally, this plan identifies the major decision points, implementation milestones, estimated resources needed, and process for stakeholder input in the design and implementation of programs.

Values and Assumptions Informing This Plan

- All people with psychiatric disabilities should have access to high quality, clinically appropriate care across a broad continuum of services.
- Widespread recognition of the negative effects of institutional settings on a person's recovery, and of the inadequacy of VSH's antiquated physical plant.
- The scheduled loss of federal funds due to federal policy changes affecting all of the country's institutes for mental disease (IMDs), of which VSH is one.
- Widespread recognition of the benefits of integrating psychiatric inpatient care with general inpatient medical services, and of the need to end VSH's historic isolation. Therefore, the provision of psychiatric inpatient services in a stand-alone IMD is not consistent with Vermont's policy of integrating mental health and general health care services.
- The State has ultimate responsibility for the provision and/or oversight of involuntary inpatient care.
- The expertise and experience of the current VSH staff is a valuable resource.
- Vermont's hospitals and designated agencies (DAs) should play an expanded role in the future care of discrete populations.
- The State must remain committed to the principle of maintaining the locus of care in the community.

Summary Conclusions The following statements summarize a general consensus among stakeholders as of June 2005 and this language was approved by the General Assembly.

1. The current VSH facility should be replaced; replacement facility or facilities will be smaller than 54 beds; and should be operated with meaningful programmatic integration with medical and ongoing community mental health services.
2. The operations and human resources of the current VSH must be supported, and enhanced so that the environment is safe and the clinical programming effectively supports recovery.
3. The network of community support services and capacities should be expanded to help meet needs in a clinically appropriate manner and in keeping with system values.

PLAN COMPONENTS

- Transforming the Acute Care System
  - Recovery Residential Programs (Sub Acute Rehabilitation Capacity)
  - Secure Residential Treatment Capacity
  - New Inpatient Capacity
  - Crisis Stabilization Beds
  - Care Management System
- Sustaining and Building the Operations at VSH
- Enhancing Community Infrastructure
  - Peer Services
  - Supported Housing
  - Transportation (Voluntary and Involuntary)
  - Ancillary Legal Services

OVER ARCHING COMPONENTS

Develop Vision / Description of a Comprehensive Continuum of MH Services

Action Steps & Decision Points	Timeline	Key Players
Review proposed phasing of program implementation	2005 July	
Create overall system design including component parts	September	VDH, VSHFAC VDH, VSHFAC, VCDMH, SPSC, private providers/payers'
Revise phasing based on input	September	VSHFAC, MHOC
Identify key system gaps by component and geography	November	
Revise plan & work group approach as needed	December, ongoing	VDH

TRANSFORMING THE ACUTE CARE SYSTEM

SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN

The Futures plan calls for the development of the new levels of inpatient care and new crisis stabilization or acute care triage resources. Specifically, two new levels of **inpatient care** called intensive care and specialized care (estimated capacity of 32 beds) are proposed both of which reflect more intensive staffing patterns than currently exist at VSH or in Designated Hospital programs. In addition, the plan proposes ***Crisis stabilization beds*** (10 beds) in geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The Futures plan also envisions a ***Care Management Program*** to ensure that the system can manage and coordinate access to high intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. Finally, the plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care **recovery residential programs at the *sub-acute level of care*** capacity of 16-20) and ***secure residential treatment*** (capacity of 6).

Residential Recovery Programs (Sub Acute Rehabilitation Capacity)

Action Steps & Decision Points	Timeline	Key Players
	2005	
FY 06 Appropriation request $763,400 G.F.	February	VDH CFO, AHS Secretary
Engage designated providers in program development	March June	VCDMH, Adult MH Director
Clarify BISCHA Jurisdiction for CON	June	VDH Chief Attorney
FY 07 Appropriation Development $1,526,800[2]	October	VDH CFO, AHS Secretary

[2] This represents annualization of initial appropriation. Actual program implementation costs may be higher. As no programs are currently operational, VDH CFO recommends addressing this in budget adjustment process.

Resolve legal status of program (voluntary, involuntary) and of program residents	December	Residential Work Group, VDH, Chief Attorney
	2006	
Identify potential site locations		DA Leadership, Residential Work Group
Refine programmatic characteristics	Ongoing	
	Ongoing	SPSC & LPSCs; VSHFAC; MHOC
Solicit feedback on site locations and program characteristics	Ongoing	
		Chief Attorney, Residential Work group
Request scheduling guidelines for ONH Modification/Revocation		DA Leadership DA Leadership, MH Deputy
Request necessary zoning permits, engage local communities in program plans and solicit feedback	April Ongoing	DA Leadership VSH & DA Clinical Teams
Recruit and train staff		DA Leadership, VDH, VSHFAC
Begin transition of VSH patients	Prior to Start-up	
Evaluate program		

Secure Residential Treatment Capacity

Action Steps and Decision Points	Timeline	Key Players
	2005	
FY 06 Appropriation request $241,782 G.F.	February	VDH CFO, AHS Secretary
Engage designated providers in program development	March	VCDMH, Adult MH Director
Clarify BISCHA Jurisdiction for CON	June	VDH Chief Attorney
Identify potential site locations	Ongoing	DA Leadership, Residential Work Group
Refine programmatic characteristics	Ongoing	SPSC & LPSCs; VSHFAC; MHOC
Solicit feedback on site locations and program characteristics	Ongoing	
	Ongoing	VDH CFO, AHS Secretary
FY 07 Appropriation Development $483,564 G.F.	October	
	2006	Residential Work Group, VDH, Chief Attorney
Refine security and staffing plans	March-May	DA Leadership
	June	DA Leadership
Rent single family home/apartments	May-June	DA Leadership
Develop protocols with local law enforcement	June	
Recruit and train Staff		DA Leadership
	Ongoing	
Begin transition of VSH patients		

New Inpatient Capacity

Action Steps and Decision Points Phase 1: Planning & Site Selection	Timeline 7/05-6/06	Key Players
	2005	
FY 06 Appropriation request $625,000 G.F.	February	VDH CFO, AHS Secretary VSHFAC
Formalize creation of Inpt work group	August	VDH
Identify pro's and con's of single vs multiple sites		
RFP for Architectural Services	October	Inpt Work Group, VSHFAC, MHOC
Preliminary Space Program, Site Feasibility and Cost	November	B&GS
RFP for Actuarial Services		
Develop recommendation for single or	November	VDH, Inpt Work Group

multiple sites	December	VSHFAC
Develop recommendation for inpatient partner(s)	By Dec	VDH CFO, AHS Secretary MH Deputy, Inpt Work Group
Contract for Architectural Services	December	B&GS, A+
FY 07 Appropriation request $1,350,000 for continued planning & design	2006 January	
Identify options of inpatient partner(s)	January	B&GS MH Deputy
Contract for actuarial services	January	VDH staff, Selection Committee
Develop Program of Space for Primary and Smaller Inpatient Capacities	Jan-March	B&GS, A+, Facilities Work Group VSHFAC, VDH
Develop Collaboration Agreements w/Inpatient Partners	Jan-June Ongoing	VDH,AHS,Inpt Partners
Develop Community Outreach	February Ongoing	VDH, City of Burlington, FAHC Futures Group
Develop Feasibility Assessment & Cost of Site Options	Feb-May	B&GS, A+ Inpt Partners & MH Deputy
Conduct actuarial study (completed)		VDH, Milliman
Refine bed capacity needed	April	VDH, VSHFAC,AHS
Submit Letter of Intent to BISHCA	April	VDH, Inpt Partner(s)
Identify site for primary unit, permitting requirements, design work	May May-Oct Ongoing	B&GS, VDH, Inpt Partner, VSHFAC
Identify renovation/construction needs for smaller inpatient capacities		A+, B&GS, VDH, Inpt Partners
Conceptual CON application	Feb-May	VDH, Inpt Partner, VDH Chief Attorney BISHCA, VDH, Inpt Partner(s)
CON Q&A, Interested Parties, Due Diligence	June	
***Phase II architectural and engineering studies, Permitting**	Aug-Oct	B&GS, Inpt Partners
FY 08 Appropriation request (based on estimates completed May 06)	Aug-Dec	B&GS, VDH, AHS
Public process for construction (zoning, select board)	October	B&GS, VDH, AHS, Inpt Partner
*Conflicts with time line for Conceptual CON	Aug-Dec, Ongoing	
Action Steps and Decision Points Phase 2: Design and CON	Timeline 7/06-12/07	Key Players
*Draft Construction Drawings	2006 November	Contractor
Solicit feedback on draft drawings	December, Ongoing	SPSC, VSHFAC, Burlington Futures, Legislature
*Local permitting process	Ongoing	Inpt Partner, B&GS,

Conceptual CON awarded	December 2007	BISHCA
Local permits and begin Act 250 process	January, Ongoing	Inpt Partner, VDH Chief Attorney Inpt Partner,
Select contractor determine building process	January	Buildings & General Services
Submit full application to BISHCA for CON (site and architectural plans schematic label; basic electrical and mechanical engineering details - sufficient for BISHCA)	January	Inpt Partner, VDH Chief Attorney
Submission to & review of additional information by BISHCA	February-April May	Inpt Partner, VDH Chief Attorney, BISHCA staff
BISHCA Rules "Application Complete" and issues public notice for competing applications, interested party status or Amicus Curiae		BISCHA Commissioner BISHCA Staff
Public oversight commission hearing date scheduled	June	
Commissioner BISHCA makes final determination of CON	August	BISCHA Commissioner
Action Steps and Decision Points Phase 3: Construction & Program Design	Timeline 8/07-1/10	Key Players
Groundbreaking Construction Initial program design		Building Contractor Building Contractor Inpt Partner, VDH, VSH Staff
Solicit feedback on program design Revise program design		SPSC, Partner Advisory Groups, legislature Inpt Partner, VDH, VSH Staff
Action Steps and Decision Points Phase 4: Program Implementation	Timeline 8/09-1/10	Key Players
Staff Recruitment and Training Clinical and Program Characteristics Refined		Inpt Partner, VSH staff Inpt Partner, VSH staff
Crisis Stabilization Beds		
Action Steps and Decision Points	Timeline	Key Players
FY 07 Appropriation Request Development	2005 October	VDH CFO, AHS Secretary
Clarify Role of these Beds w/ Emergency Directors & local stakeholders including Public Inebriate use ?	November, Ongoing	VSHFAC, VCDMH, VDH, CM Work Group
Complete geographic analysis for proposed locations	November 2006	VSHFAC, SPSC, MHOC
Solicit Feedback on program roles & on proposed locations	February-March January	VDH VSHFAC AHS
FY07 Appropriation Request $87,646 (4 beds, 6 months operations)	April	DA Leadership VSHFAC, SPSC, MHOC
Solicit program development options in target areas	August September October	DA Leadership VSHFAC DA Leadership

Refine programmatic characteristics **Solicit feedback on program characteristics** Revise program plans **Develop FY 08 Appropriation Request** (6 new beds, annualization of 4 beds) Recruit and train staff Program start up (4 beds) Solicit program development options in target areas (6 new beds Refine programmatic characteristics **Solicit feedback on program characteristics** Revise program plans Recruit and Train Staff **Develop FY 09 Appropriation Request** Program Start-Up	October November <u>2007</u> January March May June July September, ongoing October December	VDH, AHS DA Leadership DA Leadership VDH, DA Leadership VDH, DA Leadership, VSHFAC DA Leadership DA Leadership VDH, AHS Secretary DA Leadership

Care Management System

Action Steps and Decision Points	Timeline	Key Players
	<u>2005</u>	
Formalize Identification of CM Work Group	July	VSHFAC
FY 07 Appropriation Request Development Estimate $300,000	October	VDH CFO, AHS Secretary
Develop program design, screening, triage, disposition protocols in collaboration with stakeholders	December	CM Work Group
	<u>2006</u>	
	January	VSHFAC, SPSC, LPSCs, MHOC
Solicit feedback on program design	January	
FY 07 Appropriation Request $161,112 (partial yr operations)	March	CM Work Group
Refine program design	April	CM Work Group
Define IT System support needs	June	CM Work Group
Design management approach and staffing plan	July	Contractor (likely)
Design IT system	August	Participating partners
Pilot protocols	September	CM Work Group
Revise protocols based on pilot	October	Participating partners
Implement		

Sustaining & Building the Operations at VSH

The current program at Vermont State Hospital

Operations at the current VSH will continue until the new program capacities described in the Futures plan can be implemented. As community capacities come on line, the bed capacity at the VSH can begin to shrink. However, due to the need to enhance the current VSH staffing levels, significant staff reductions are not anticipated. The investments made now in the staff and resources at the current VSH will assist in building towards an excellent, state-of-the-art psychiatric inpatient service in the future.

Action Steps and Decision Points	Timeline	Key Players
	2005	
Develop enhanced staffing plan	February	VSH leadership
FY 06 Appropriation Request $16,001,347 G.F.	March	VDH CFO, AHS Secretary
Design staff recruitment & retention package	April	VSH Leadership, AHS Deputy
Implement staffing pattern	Ongoing	VSH leadership
Develop Fletcher Allen contract for psychiatry svcs	May June	VDH leadership VDH Commissioner, Administration, VSH Governing Body
Approve Fletcber Allen Contract		
Continue facility improvements	Ongoing	VSH leadership, Buildings and General Svcs
Continue improvements to Clinical and Quality Systems	Ongoing	FAHC, VSH Leadership, VSH Governing Body MHOC VDH CFO, AHS Secretary
Develop FY 07 Appropriations Request	October	

SERVICE COMPONENTS RECOMMENDED IN THE FUTURES PLAN

The Futures Plan calls for the transformation of community based and peer services into a voluntary and upstream system of supports and services that ultimately reduces Vermont's reliance on psychiatric inpatient care and involuntary care. These services need to respond to the practical needs of citizens and be appropriately geographically dispersed. In addition, this continuum of supports and services will be recovery-oriented and trauma informed. Specifically the Futures Plan calls for the development of the following new services.

Supportive Housing safe and adequate housing is crucial to reducing hospitalization and supporting recovery. ***Peer Programming*** offers effective, recovery-oriented supports. The plan proposes to create new peer support programs targeted to individuals who use VSH. In addition to new peer programming, peers can and should be an integral part of the provision of traditional services. This area, both stand alone peer services, and the integration of peers into formal services needs more exploration. This plan includes funding for ***Transportation*** costs, made necessary by the geographical distribution of programs. If the inpatient hospital beds are distributed in more than one location, this plan includes additional resources for ***Legal services***, due to the higher costs of having attorneys consult with clients and witnesses in multiple locations.

Additional Recommendations by Secretary Charles Smith to the Legislature

Secretary Charles Smith's February 4th recommendations to the Legislature included additional program capacities not named in the Futures Plan. These include the implementation of the Mental Health Plan for Corrections and other community-based mental health services designed to strengthen the outpatient and co-occurring treatment infrastructure. Specifically these are:

Adult Outpatient Services added capacity for the community mental health agencies and / or private providers to provide adult out-patient service. Examples might include:

- A program focused specifically on the mental health needs of service men and women returning from a war zone, and / or their families during the deployment;
- Replication of the HCRS (Health Care & Rehabilitation Services of Southeastern Vermont) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals;
- Collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse.
- Integration of mental health care into primary care settings such as federally qualified health centers.

Offender Out-Patient calls for capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration with priority given to interventions with a high potential of supporting the offender's long-term success. ***Expansion of the Co-Occurring Disorders Project*** This is a successful collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. Using integrated mental health and substance abuse treatment, teams in Burlington and Brattleboro provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly

reduced risk of re-offense, reduction in hospital care, and good recovery results. Two new teams are proposed, in Rutland and Barre.

Public health prevention and education strategies with the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources will be used to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

Peer Services

Action Steps and Decision Points	Timeline	Key Players
	2005	
Develop FY 07 Appropriations Request $200,000 G.F.	October	VDH CFO, AHS Secretary
	2006	
FY 07 Appropriation Request $79,961 (partial yr operations)		
Develop program approach	May -Sept	VPS, SPSC, VSH FAC
Solicit input on program approach	October	VSHFAC, LPSCs, MHOC
Develop FY 08 Appropriation Request (C. Smith Recommend $200,000)	October	VPS VDH, AHS
Solicit proposals from peer organizations	November	SPSC (consider)
Review proposals	December	SPSC or Ad Hoc Review Committee
	2007	
Develop contract	January	VDH
Program start up	February	Contractor

Supported Housing

Action Steps and Decision Points	Timeline	Key Players
	2006	VDH CFO, AHS Secretary
Solicit input on program approach	January	
Identify location based on geographic need		VCDMH, VPS, SPSC
Form Workgroup	February	VSHFAC, LPSCs, MHOC
Develop Program approach	March-June	Workgroup
Depending on program approach:		
Determine viability of HUD or other funding options	June-Ongoing	Workgroup, VSHFAC VDH
Identify sites, renovation / acquisition costs		VDH
Identify Providers (depends on program approach)	June-Ongoing	VDH
Next steps based on decisions above		
Or:	October	
Design rental subsidy / assistance program		
	2007	VDH, AHS
Develop FY 08 appropriation request (C. Smith recommend $400,000)	Jan-March January	
	April	VDH, Work Group, VSHFAC
	July	AHS,VDH
Design Program		Work Group, VDH
FY O8 Appropriation		DA, Contractor
Solicit Program Bids		

Program Start-up		
Transportation (Voluntary and Involuntary)		
Action Steps and Decision Points	Timeline	Key Players
Develop FY 07 Appropriations Request $67,032	2005 October	VDH CFO, AHS Secretary
	2006 March	
Develop safety guidelines		Sheriffs, MH Emergency Directors, NAMI, VPS
	April-May	VDH
Identify alternative transport options	June-August	
Negotiate contracts	September	VDH, Emergency Directors
	October	VDH, Emergency Directors
Train on approach, pilot	November	VDH
Evaluate efficacy, revise as needed		VDH, Emergency Directors, Contractor
Start Up		
Ancillary Legal Services		
Action Steps and Decision Points	Timeline	Key Players
	2006	
Identify potential changes	October	VDH Chief Attorney, Legal Aid, VT P&A
Work group recommended?	November	VDH Chief Attorney, Legal Aid, VSHFAC
Statutory changes required?	November	VDH Chief Attorney, Legal Aid, VSHFAC
(next steps dependent on above)		
Quantify impact of potential changes to legal system		

Sustaining Community Infrastructure

The Designated Agency Sustainability Study, conducted in the Fall of 2004, made several recommendations regarding the effectiveness and sustainability of the Designated Agency network for the provision of community mental health, developmental, and alcohol and drug treatment services. Based on this report, AHS Secretary Charles Smith recommended that a multi-year budget planning cycle be developed. Below are the specific action steps he recommended.

Action Steps and Decision Points	Timeline	Key Players
	2006	
Develop Allocation Agreement Between Cost of Living Adjustment and Service Growth Requirements	February March	VDH, DAIL, VCDMH VDH, DAIL, VCDMH
Identify Medicaid Maximization Opportunities / Risks	Ongoing	DA Providers
Target Resources to Adult Outpatient, Emergency, and Substance Abuse Programs	March	VDH, DAIL, VCDMH VDH, DAIL
Start DA Designation Cycle	July	VDH, VCDMH
Establish FY 07 Allocations and Performance Contracts	2007 January 07	OVHA, SPSC, (others)
	TBD	VDH, DAIL, VCDMH, SPSC, LPSCs
Begin System Improvement Process to: - Develop comparable financial and performance data across DA providers - identify redundancy in data collection procedures - Focus data collection on most impactful measures of system performance and client		

outcomes - Establish, with stakeholders, clear performance expectations - Design consistent "therapeutic thresholds" and individual case plans - Vermonters with comparable needs will receive comparable services regardless of DA provider - Develop case mix factors for DA budget allocation - Apply case mix concepts to annual performance contracts		

List of Abbreviations:

H-RAP	Health Resource Allocation Plan
VDH	Vermont Department of Health
VSH	Vermont State Hospital
IMD	Institute for Mental Disease (stand alone psychiatric hospital or program)
DA	Designated Agency to provide comprehensive mental health services in a defined geographic region
ICU	Intensive care (inpatient)
SIP	Specialized care (inpatient)
BISHCA	Banking, Insurance, Securities and Health Care Administration
CON	Certificate of Need
CM Work Group	Care Management Work Group
VCDMH	VT Council of Developmental and Mental Health Services Providers
VSHFAC	VSH Futures Advisory Committee
MHOC	Joint Legislative Mental Health Oversight Committee
SPSC	Adult Mental Health State Standing Committee
LPSC	Adult Mental Health Local Standing Committee
Inpt	Inpatient
DOC	Department of Corrections
ADAP	Division of Alcohol and Drug Abuse Programs
DAIL	Department of Disabilities, Aging and Independent Living
OVHA	Office of Vermont Health Access
VPS	Vermont Psychiatric Survivors
NAMI-VT	National Alliance for the Mentally Ill – Vermont chapter

Policy, Legislation, and Appropriations Flow

POLICY Context

Mental health programs, services, and supports, including inpatient psychiatric services, will be provided in a holistic, comprehensive and coordinated continuum of care.

Consumers will be treated at all times with dignity and respect.

Public resources will be allocated efficiently and produce the best positive outcomes.

The services overseen and provided by the agency of human services and its community partners will be client- and family-centered and -driven, accessible, and culturally competent.

The locus of care is the community; investments in ongoing community supports and early interventions services will reduce the need for inpatient care.

We are committed to reducing coercion in the system of care.

Mental health and substance abuse treatment will have parity with health care and we seek the integration of mental health care and health care.

Time Line	Actions	Appropriation
January 26, 2004	**Study commissioned by DDMHS Commissioner Susan Besio concludes:** 1. Support VSH to play a unique role in the VT public MH system 2. Create a new setting for VSH 3. Develop a financial strategy for the community services needed to reduce the demand for VSH Services	**None**
May, 2004	**FY 05 Appropriation "BIG BILL"** Sec. 141a. **Commissions the Futures Planning Process** 1. "The AHS Secretary shall be responsible for the development and, upon approval by the MH oversight committee and joint fiscal committee, implementation of a comprehensive strategic plan for the delivery of services currently provided by VSH. 2. Establishes the Futures Advisory Group and that the Secretary will consult on all aspects of strategic planning and recommendations concerning organization, operations, funding, and implementation; and sets out 9 planning principles and 13 specific areas of recommendation. 3. Requires a comprehensive implementation plan for replacing services currently provided by the VSH to be presented to the MH oversight committee and the joint fiscal committee	**None**
February 4th 2005	**MH Division's VSH Futures Plan** published, submitted to Legislature **Recommendations to the Legislature for the Future of Services Provided at the VSH: Secretary Charlie Smith** Responds to Sec 141(a) and (b) of Appropriations Act of 2005; recommends $21,800,000 of expenditures to replace VSH direct services (28 beds plus 4); Residential Recovery programs (16-bed sub acute rehabilitation; 6-bed secure residential); new programs for: housing, care management, peer support, out patient, crisis stabilization, offender outpatient, co-occurring disorders, corrections MH services, legal and transportation services	**AHS Secretary C. Smith recommends $21,800,000**
May 11, 2005	**MH Division presents VSH Futures Strategic Implementation Plan to MH Legislative Oversight Committee** This plan provides implementation timeframes and appropriations requests for all the recommendations in Secretary Charlie Smith's report as per Sec	

Time Line	Actions	Appropriation
	141(a) and (b) of Appropriations Act of 2005. On recommendation of committee members, this plan was redrafted to include policy context and planning assumptions. **Futures Advisory Committee** endorses development of sub-acute rehabilitation and secure residential services as first phase of the project	
May 31, 2005	**MH Division presents VSH Futures Planning Outline to House Human Services Committee** This outline summarizes the core components of Secretary Smith's recommends to create a continuum of care in the most integrated and least restrictive environment. It offers specific recommendations for legislative approval and sets forth a proposal for phased implementation. House Human Services Committee approves the plan and inserts language into the appropriations bill (see below)	
June 2005	**FY 06 Appropriation "BIG Bill"** Sec113e. (a) The general assembly adopts the principles in the May 31, 2005 draft report from the department of health for restructuring the delivery of mental health services currently received in the Vermont state hospital, including the following: (1) The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services. **FY 06 Appropriation "BIG Bill"** Sec113e. Continued (2) As the replacement occurs, the operations and human resources in the state hospital should be supported and enhanced to ensure safety, and the clinical programming should effectively support recovery. (3) The capacity and network of community support services should be expanded to meet patient needs in a clinically appropriate manner consistent with system values. (b) When the general assembly is not in session, the department of health shall seek and receive approval from the mental health oversight committee on specific programmatic recommendations, plans, or implementation steps to achieve the principles in the May 31, 2005 draft report prior to implementation. The mental health oversight committee shall approve or deny the recommendations and steps within two weeks of submission and shall oversee the implementation of the restructuring of the delivery of mental health services currently received in the Vermont state hospital. (c) The commissioner of health shall report to the mental health oversight committee upon request in order to meet the requirements of this section.	**$625,000 B&GS** for preliminary design work for a new hospital facility **$1,857,421 MH** for half year of operating sub acute rehabilitation program **$588,278 MH** for half year of operating secure residential program
July 12, 2005	**Mental Health Legislative Oversight Committee** VSH Futures Strategic Implementation Plan draft 2 presented	

Time Line	Actions	Appropriation
August 23, 2005	**Mental Health Legislative Oversight Committee approves B&GS "New Inpatient Capacity Spending Plan"** 1. $50,000 to assist in site(s) selection and obtain site information to analyze opportunities and constraints with the various sites under consideration 2. $50,000 to develop design and space needs for the patients, the associated treatment programs and staffing requirements, including site infrastructure requirements. 3. $150,000 to produce schematic designs that address the space needs and site requirements for review and approval	**Permission to spend $250,000 of B&GS appropriation**
November 2005	**Futures Advisory Committee recommends:** 1. Creation of a primary inpatient program, preferably with FAHC. 2. Develop 1 or 2 smaller capacities, with the same programmatic standards as the primary program, preferably with existing inpatient psychiatric services. 3. Support for proceeding with inpatient program development is contingent upon funding and implementation of the community capacities in Secretary Charlie Smith's recommendations to the legislature	
January 2006	**Governor's Recommended Budget (for FY 07)** 1. Staffing to oversee Futures project implementation (2 FTE plus contract services) Implementation goals: a new, state-of – the- art psychiatric inpatient facility with a hospital partner designed to provide active treatment for the most acute and clinically complex patients; new community residential and rehabilitation programs designed to serve patients who do not require inpatient care thereby focusing the role of the new hospital on inpatient treatment; expand the capacity and network of community programs including a a state-wide care management system	Futures Project Staffing: **$105,000**
January 2006 Annualize program operations	**Governor's Recommended Budget FY 07 (continued)** 2. Recovery Residential programs (sub-acute and secure) Programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care (*sub-acute rehabilitation service* capacity of 16-20 and *secure residential treatment* capacity of 6)	**$2,010,364**
Implemented in phases, beginning calendar 2007	3. Community Based Hospital Diversion Support (4 beds) In geographically dispersed locations to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. This supports 4 of the 10 recommended by C. Smith	**$87,646**
Begininng February, 2007	4. Peer Support Services The plan proposes to create new peer support programs targeted to individuals who use VSH.	**$79,961**
Beginning July 2006	5. Staff-Secure Transportation for Involuntary Adult Admissions As an alternative to sheriff transport – this is a legislative requirement	**$67,032**
	6. Care Management System: To ensure that the system can manage and coordinate access to high -	**$161,112**

Time Line	Actions	Appropriation
	intensity services so that Vermonters have access to the appropriate level of care.	
January 2006	**Governor's Recommended Budget FY 07 (continued)** 7. Planning, Design, Permitting new inpatient facility The first phase of work approved by the MH Legislative Oversight Committee on August 23, 2005 will be completed this May. The second phase of work requires detailed site-specific architectural designs, floor plan schematics, construction engineering, and permitting. These costs are necessary to support the development of a new facility at any site.	**$1.350,000 B&GS**