NORC at the University of Chicago

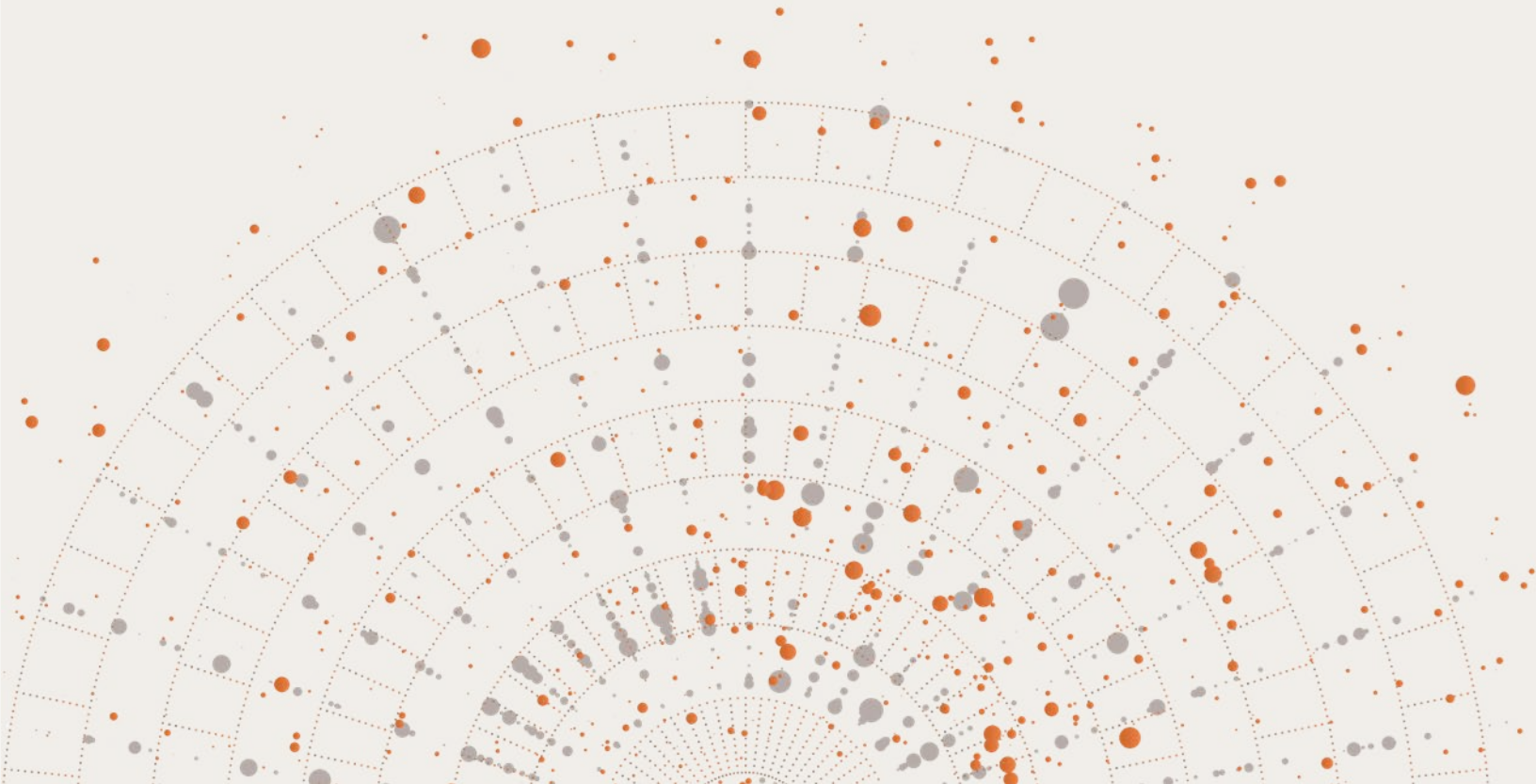
SERIOUS MENTAL ILLNESS/SERIOUS EMOTIONAL DISTRUBANCE MID-POINT ASSESSMENT

June 2024

Vermont Global Commitment to Health Medicaid 1115 Demonstration

Presented by:
NORC at the University of Chicago

Presented to:
Vermont Agency of Human Services



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Abbreviation	Definition
ACO	Accountable Care Organization
AHS	Agency of Human Services
AOD	Alcohol and Other Drug
CCBHC	Certified Community Behavioral Health Clinic
CMS	Centers for Medicare & Medicaid Services
CRT	Community Rehabilitation and Treatment Services
DMH	Department of Mental Health
FQHC	Federally Qualified Health Center
IMD	Institution of Mental Disease
NORC	NORC at the University of Chicago
MPA	Mid-Point Assessment
SAMHSA	Substance Abuse and Mental Health Services' Administration
SBINS	Screening, Brief Intervention, and Navigation to Services
SDOH	Social Determinant of Health
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SUD	Substance Use Disorder
VHIE	Vermont Health Information Exchange

Chapter 1: General Background Information

In December 2019, the Centers for Medicare & Medicaid Services (CMS) approved an amendment to the Vermont Global Commitment to Health Demonstration ("the Demonstration) to provide expenditure authority for services administered to Medicaid members with serious mental illness (SMI) or serious emotional disturbance (SED) in residential and inpatient settings.[i] In accordance with CMS requirements, the state submitted an SMI/SED Demonstration Implementation Plan ("SMI/SED Implementation Plan") to document the state's approach to implementing the amendment. The SMI/SED Implementation Plan includes a summary of the current and future statuses of CMS-dictated milestones that aim to track implementation progress. The state's SMI/SED Implementation Plan was approved on December 5, 2019, for the period from December 5, 2019, to December 31, 2021, and remains in effect for the period January 1, 2022, through December 31, 2027.[ii,iii]

The Vermont Agency of Human Services (AHS) contracted with NORC at the University of Chicago (NORC) to conduct an independent evaluation of the Demonstration, inclusive of a Mid-Point Assessment (MPA) on the SMI/SED Implementation Plan. This MPA assesses the state's progress toward the milestones from the time of the SMI/SED Implementation Plan approval to the time of this reporting. This report includes findings from claims-based metrics from 2020 to 2022, interviews with provider organizations conducted in 2024, and a provider survey fielded in 2024.

1.1 Demonstration Goals

Vermont's Global Commitment to Health Demonstration is an agreement between Vermont AHS and CMS that is designed to use principles of public health, effective administration of a Medicaid managed care delivery system, and programmatic flexibilities to improve the health and welfare of Vermonters.[iv] Since its initial approval in 2005, the Demonstration has made significant strides toward care delivery and payment transformation. This Demonstration extended coverage beyond the traditional Medicaid eligibility groups and enhanced health care access for Vermonters.[v]

Among the Demonstration's wide range of supports, it has a strong focus on providing and expanding care for Medicaid members with SMI/SED.[1] The Demonstration aims to improve member access to high-quality, evidence-based SMI/SED treatment services, including acute inpatient, residential, outpatient, and community-based services.[vi] On December 5, 2019, CMS approved an amendment to the Demonstration that provides expenditure authority for SMI/SED services in institutions for mental

[1] Vermont uses the Substance Abuse and Mental Health Services' Administration's (SAMHSA's) definition of "serious emotional disturbance" and "serious mental illness." SAMHSA has defined "adults with a serious mental illness" as persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities." SAMHSA has defined "children with a serious emotional disturbance" as "persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities." Source: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

diseases (IMDs) ("SMI/SED amendment"). The SMI/SED amendment broadly seeks to "maintain and enhance access to mental health services and continue delivery system improvements to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SMI or SED."[vii]

Specifically, since CMS's approval of the SMI/SED amendment, settings that qualify as an IMD are eligible to receive federal financial participation for short-term residential and inpatient mental health services provided to Medicaid members. Further, the Demonstration requires the state to maintain a level of state and local funding for outpatient, community-based mental health services for Medicaid members throughout the duration of the SMI/SED Implementation Plan approval period. The state must maintain budget neutrality for these services.

Innovative Investments for Achieving SMI/SED Demonstration Goals

The most recent renewal of the Demonstration authorized the use of Medicaid funding for 66 innovative investments in public health, health care, and health-related services that aim to strengthen the social safety net and address social determinants of health (SDOH). Several of these investments contribute to the state's progress on the SMI/SED implementation plan. For example, the "Emergency Mental Health for Children and Adults" investment provides funding to community-based crisis teams that respond to mental health crisis episodes over the phone, in the community, and in emergency departments. The investment aims to stabilize immediate crises and connect individuals to the most appropriate level of care.

To carry out the activities included in the SMI/SED Implementation Plan, AHS collaborates with the Vermont Department of Mental Health (DMH), which serves as the state mental health authority.[2] AHS and DMH collaborate to design, deliver, and monitor services for Medicaid members with SMI/SED.[iv]

Notably, the Demonstration has several concurrent programs that aim to support the goals of the state's SMI/SED Implementation Plan **(Exhibit 1)**. In addition, the Demonstration authorized several "Innovative Investments" that focus on individuals with SMI/SED.[3] Some programs and investments have been long-standing features of Vermont's health care system, while others were newly introduced under the Demonstration's most recent renewal.[4] Many of these programs and investments are components of the state's plan to achieve SMI/SED Implementation Plan milestones.

[2] DMH is housed within AHS and aims to improve the health care of Vermonters of all ages with their mental health through its two divisions: the Adult Mental Health Services Division and the Child, Adolescent, and Family Mental Health Services Division. DMH manages community-based and inpatient services to allow for early intervention mental health treatment and support that allow Vermonters to succeed in their daily life and their community. DMH also manages the health care of two of the high-needs populations involved in the demonstration: people with severe and persistent mental illness and children experiencing severe emotional disturbance. For more information, see: https://mentalhealth.vermont.gov/.

[3] AHS has obtained federal Medicaid matching funds for 66 programs focused on public health, health care, and health-related investments in Vermont. While Demonstration programs serve only Medicaid members, these investments serve a combination of Medicaid members and other Vermonters and may be delivered by non-traditional Medicaid providers. Investments may be long-standing features of the Demonstration, or new in the most recent renewal period. For more information, see: https://legislature.vermont.gov/assets/Legislative-Reports/Global-Commitment-Fund-Investment-Report-SFY22-10.12.22.pdf.

[4] In 2022, CMS approved a fourth renewal of the Demonstration, effective July 1, 2022, to December 31, 2027. For more information, see https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf.

Exhibit 1. Demonstration programs that focus on patients with SMI/SED

Demonstration Program	Description
Community Rehabilitation and Treatment (CRT)	This program offers recovery-oriented, community-based, and personalized treatment services for adults facing severe and persistent mental illness. CRT has been a part of the state's Medicaid waiver since 1999 and has been included in the Demonstration since its initial approval. Under the most recent renewal, peer support was added to the list of eligible services for CRT recipients.
Mental Health Under 22	This program supports children and adolescents diagnosed with SMI/SED by allowing them to stay in their homes and communities while receiving treatment. The program provides community-based treatment services to more than 300 children and adolescents who have a primary mental health or SED diagnosis. Mental Health Under 22 has been a part of the Demonstration since its initial approval and is a continuing feature in the most recent renewal of the Demonstration.
Maternal Health and Treatment Services	This program provides access to residential and inpatient mental health and substance use disorder (SUD) services for individuals who are pregnant or postpartum and mothers with children up to age 5, and who are obtaining care in the social service organization Lund. This is a new feature of the most recent renewal of the Demonstration.

SOURCE: Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment.

Through progress toward milestones, the state aims to achieve the following goals:

1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduce preventable readmissions to acute care hospitals and residential settings.
3. Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units. Intensive outpatient services, as well as services provided during acute and short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

The SMI/SED Implementation Plan is organized by milestones detailed in **Exhibit 2**.[1,iv] The SMI/SED Implementation Plan includes summaries of the state's progress toward each milestone and any actions required to complete each milestone. Milestones are determined by CMS for all SMI/SED Demonstration Implementation Plans.[iv]

Exhibit 2. SMI/SED Implementation Plan Milestones

SMI/SED Implementation Plan Milestone	Description
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)	• Set and uphold standards for psychiatric hospitals and residential settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes • Ensure individuals with SMI or SED and co-morbid health conditions and SUD are screened and receive treatment for commonly co-occurring conditions while in a treatment setting
Improving Care Coordination and Transitioning to Community-Based Care (Milestone 2)	• Confirm patients have the services needed to transition to and be successful in community-based mental health care settings • Create partnerships between hospitals, residential providers, and community-based care providers • Ensure Medicaid programs focus on improving care coordination and transitions to community-based care
Increasing Access to Continuum of Care, Including Crisis Stabilization Services (Milestone 3)	• Understand the need for access to a continuum of care as mental health disorders can be episodic and symptoms can vary • Increase the availability of crisis stabilization programs to reduce unnecessary visits to EDs or inpatient facilities • Establish ongoing treatment in outpatient settings to address less acute symptoms and help members with SMI or SED in their communities • Create strategies to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible
Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)	• Establish critical strategies for improving care for individuals with SMI/SED • Create opportunities for earlier identification and treatment for patients with SMI/SED

This MPA describes the state's progress toward SMI/SED milestones, as well as the facilitators, barriers, and risks associated with achieving each milestone by the end of the SMI/SED Implementation Plan approval period. The report is organized into the following chapters:

- Chapter 1: General Background Information
- Chapter 2: Methodology
- Chapter 3: Findings
- Chapter 4: Assessment Of Overall Risk Of Not Meeting Milestones & Recommendations

Chapter 2: Methodology

This chapter discusses data sources and analytic methods used to assess the state's progress toward SMI/SED Implementation Plan milestones. We applied rigorous analytic methods throughout this assessment and drew on both qualitative and quantitative approaches to triangulate findings and comprehensively assess the status and risk for each milestone.

2.1 Data Sources

This assessment includes analysis of both qualitative and quantitative data from primary and secondary data sources available at the time of this report. **Exhibit 3** summarizes each data source.

Exhibit 3. Summary of SMI/SED Mid-Point Assessment Data Sources

Data Source	Description	Data Type
Key Informant Interviews	Interviews conducted with provider organizations in Vermont	Primary
Provider Survey	Survey of organizations providing mental health services in Vermont	Primary
SMI Quarterly Metrics Reports (Part A)	Report with claims-based monitoring measures used to assess progress on SMI/SED milestones	Secondary
SMI Quarterly Metrics Reports (Part B)	Report with narrative descriptions of trends and activities used to assess progress on SMI/SED milestones	Secondary
Provider Availability Assessment Data	Data on the availability of mental health providers in Vermont	Secondary
State and Demonstration Program Documents	Additional content related to the Demonstration's SMI/SED milestones on AHS and CMS websites	Secondary

Key Informant Interviews. With the state's support, we conducted email and phone outreach to 14 provider organizations across Vermont. We followed up with each organization at least three times before deeming them unresponsive to interview requests. Ultimately, we conducted eight 60–90-minute individual and group interviews with a total of 14 designated hospital,[5] IMD,[6] and Designated Agency[7] leaders between February and April 2024. The SMI/SED Implementation Plan milestones, document review, and provider survey responses (see below) informed the interview guides for each type of interview participant. Interview questions addressed specific milestones and activities detailed in the SMI/SED Implementation plan and probed on challenges identified in survey responses.

Provider Survey. We conducted a Qualtrics survey with organizations in Vermont that provide mental health services from January – March 2024. The key domains of the survey aligned with Milestones 2 and 3. The survey aimed to better understand providers' perspectives on improving care coordination, transitioning to community-based care, and increasing access to services across the continuum of care. We fielded the survey to all Vermont Designated Agencies, Specialized Services Agencies, and hospitals, including both IMDs for a total of 30 provider organizations. We received 16 complete responses (53% response rate). Of the 16 completed surveys, nine were from hospitals (one IMD, three designated hospitals, and five other hospitals), five Designated Agencies, and two Specialized Service Agencies.

SMI Quarterly Metrics Reports (Part A). As a condition of the Demonstration, the state must submit quarterly reports to CMS to monitor quarterly and annual trends in SMI/SED claims-based metrics.[viii] The state constructs these metrics from the Medicaid Management Information System. These metrics are calculated from claims and administrative data and reports are available publicly on Vermont's Global Commitment to Health Demonstration webpage once approved by CMS.

CMS identified a subset of these monitoring metrics as "critical" monitoring metrics for the SMI/SED population, each of which is associated with a specific SMI/SED milestone. The critical monitoring metrics were calculated annually in 2020, 2021 and 2022 (the most recent data available at the time of this report). **Exhibit 4** shows the critical monitoring metrics and their associated milestones.

[5] DMH designates hospitals in Vermont ("Designated hospitals") to provide services to individuals who are involuntarily hospitalized. There are currently 6 designated hospitals in Vermont. All 6 hospitals provide inpatient services to adults, while only 1 provides inpatient services to children and youth requiring psychiatric hospitalization. For more information, see: https://mentalhealth.vermont.gov/services/psychiatric-hospitalization/designated-hospitals.

[6] The State defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, which includes substance use disorders (SUDs)." There are currently 2 IMDs in Vermont. For more information, see: https://vermontcarepartners.org/wp-content/uploads/2020/01/Legislative-update-for-January-27-2020.pdf.

[7] Vermont's Designated Agencies, or community mental health centers, are private nonprofit agencies that work with the Department of Mental Health to provide mental health care. The Designated Agencies are organized under Vermont Care Partners, a collaboration between the Vermont Council and the Vermont Care Network of 16 nonprofit community-based member agencies that provide mental health, substance use, and developmental disability services and supports to Vermonters. For more information, see: https://mentalhealth.vermont.gov/individuals-and-families/designated-and-special-services-agencies.

Exhibit 4. Critical Monitoring Metrics Assessed by Milestone

#	Metric Name	Milestone
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	1[a]
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	2[b]
7	Follow-up After Hospitalization for Mental Illness: Ages 6–17	2
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older	2
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse	2
10	Follow-up After Emergency Department Visit for Mental Illness	2
19	Average Length of Stay in Institutions of Mental Diseases	3
26	Access to Preventative/Ambulatory Health Services for Medicaid Beneficiaries with SMI	4
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	4
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	4

NOTES: [a]CMS identified two optional metrics for assessing Milestone 1; however, the state does not report on those metrics in their SMI quarterly metrics reports and thus these metrics are not included in this assessment. [b]CMS identified one additional critical monitoring measure for Milestone 2 (Metric 3, All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care); however, the state does not report on this metric in their SMI quarterly reports and thus that metric is not included in this assessment.

We also report on SMI/SED utilization metrics to assess service utilization rates, which are reported monthly in the SMI Quarterly Metrics Reports (Part A). We used quarterly reports from 2020Q2 – 2023Q1 to assess trends in utilization metrics in this report. **Exhibit 5** shows the monitoring metrics we use to assess service utilization rates.

Exhibit 5. Monitoring Metrics Used to Assess Service Utilization Rates

#	Metric Name
13	Mental Health Services Utilization – Inpatient
14	Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization
15	Mental Health Services Utilization – Outpatient
16	Mental Health Services Utilization – Emergency Department
17	Mental Health Services Utilization – Telehealth
18	Mental Health Services Utilization – Any Services

SMI Quarterly Metrics Reports (Part B). As part of the quarterly metrics report submission, the state is also required to provide narrative information contextualizing metrics trends from the beginning of the Demonstration through the end of the current reporting period. The purpose of this report is to add context to quantitative trends demonstrated in Part A reports, as well as to report on progress made on the SMI/SED implementation plan.[viii]

Provider Availability Assessment Data. The state must also conduct an annual assessment of the availability of mental health providers as a condition of the Demonstration. The assessment describes the adequacy of the state's ability to provide services for individuals with SMI/SED and any changes in the state's ability to provide these services since the start of the Demonstration.[ix] In this report, we used assessment data from 2021-2023 to assess access to mental health services.

State and Demonstration Documents. To understand the Demonstration's design and implementation to date, we conducted a thorough review of all relevant documentation, including the SMI/SED Implementation Plan, legislative reports, and other internal and public documentation produced by AHS and other state agencies. These documents described specific Demonstration programs, goals and milestones, and implementation status.

2.2 Analytic Methods

We assessed the Demonstration's progress using quantitative and qualitative methods to provide in-depth insight into specific programs or events and examine trends in utilization and quality.

2.2.1 Quantitative Analysis

We assessed monthly trends in utilization measures (Metrics 13 - 18) to observe how the number of members who used different types of mental health services changed, particularly around the onset of the COVID-19 pandemic. For annual metrics, we followed CMS guidance to compute the absolute and relative change in each metric between the baseline (2020) and mid-point (2022) using the following formulas:

$$\boldsymbol{Absolute\ change} = (value\ of\ metric\ in\ 2022) - (value\ of\ metric\ in\ 2020)$$

$$\boldsymbol{Percent\ change} = (value\ of\ metric\ in\ 2022 - value\ of\ metric\ in\ 2020)\ /\ value\ of\ metric\ in\ 2020$$

For metrics that had a change exceeding two percentage points in either direction, we further examined change between 2020 and 2021 versus change between 2021 and 2022 to understand whether the change occurred gradually or was primarily in a given year. Additionally, we examined changes in numerators and denominators to examine whether trends were driven by changes in the number of members eligible for the service or outcome, changes in the number of members who received the service or experienced the outcome, or a combination thereof. Finally, we referenced the metric

specifications to understand whether observed trends could be attributed to changes in measure construction.

2.2.2 Qualitative Analysis

Following data collection, NORC developed an initial codebook based on overall Demonstration goals, milestones, and themes that emerged during data collection activities. We conducted a thematic analysis of interview notes, using an inductive and deductive approach to identify themes. To code interview and survey data, NORC used Dedoose, a cloud-based analysis application.

We integrated findings from the document review to add context to observed quantitative outcomes and qualitative themes. The analysis of the documents also informed key informant outreach and interview guide development.

2.2.3 Assessment of Overall Risk Of Not Meeting Milestones

For each milestone, we assessed the risk of not meeting the milestone by the end of the Demonstration period. We report our detailed findings on progress towards each milestone in Chapter 3. To assess the risk for each milestone, we assessed monitoring metrics, implementation action items, and feedback from provider organizations independently. We report our overall assessments of risk for each milestone in Chapter 4. To determine risk assessments, we synthesized findings from all data sources to develop a comprehensive assessment and assign risk ratings as “low,” “medium,” or “high.”

Monitoring Metrics. Monitoring metrics were assessed relative to the state’s target as identified in the monitoring protocol; we assessed that the state had made progress on a metric if the directionality at the time of the mid-point assessment was concordant with the stated goal (increase, decrease, or maintain). We then calculated the percentage of monitoring metrics on which the state had made progress by milestone.

Implementation Action Items. We determined the status of each implementation action item as no action needed, completed, ongoing, or suspended. We defined each status as the following:

- No action needed: the SMI/SED implementation plan indicates that no action items are planned.
- Complete: the state has reported that all activities planned for the action item are complete at the time of this MPA.
- Ongoing: the state has reported progress on the action item and is currently engaging in activities that reflect the goals of the associated milestone, but there is no scheduled completion date.
- Suspended: the state has not completed the action item and does not plan to complete it.

We determined the percentage of action items that were complete or ongoing at the mid-point assessment for each milestone.

Feedback. We identified themes from feedback obtained through primary data collection and used these findings to contextualize or adjust risk ratings as appropriate.

Risk Assessment. We assigned risk ratings based on a holistic assessment of the findings from monitoring metrics, action items, and provider feedback. We also considered additional contextual factors that may have affected state progress towards a milestone. For example, because the beginning of the Demonstration overlapped with the height of the COVID-19 PHE, we considered the impact of the pandemic in our assessment, especially for milestones with a medium or high risk level.

Recommendations & State Responses. For milestones with a medium or high risk level, we provided recommendations for implementation improvements and/or modifications. Recommendations considered all relevant quantitative and qualitative evidence available at the time of this MPA. The state reviewed all recommendations and provided brief responses.

2.3 Limitations

Trends in monitoring metrics over time may be influenced by underlying changes in the metric specifications; where available, we provided context for metric specification changes. Additionally, the interpretation of the provider availability assessments is limited. While we were able to track trends in the total number of providers authorized to prescribe psychiatric medications or to treat mental illness, we were unable to examine changes in staffing capacity within community mental health centers, institutional providers of outpatient and residential services for mental health treatment, psychiatric hospitals, crisis stabilization centers, units, and teams, or FQHCs providing SMI/SED services. Thus, trends in the number of institutional providers and crisis stabilization units and teams may not reflect true changes in service capacity. Finally, trends in metrics between baseline and mid-point cannot be interpreted causally because this was not a causal analysis, and effects of the overlap with the COVID-19 PHE cannot be isolated.

Self-reported survey and interview responses could, in some cases, not be independently verified and may be subject to social desirability bias. To decrease potential bias, we informed participants that their responses would be confidential and reported only in aggregate; we also used a self-administered survey instrument.[x] Because the target population for the survey was relatively small, we relied on descriptive statistics for close-ended responses.

Chapter 3: Findings – Progress Towards Demonstration Milestones

This chapter presents the state's progress toward meeting each SMI/SED milestone by the time of this MPA. We begin by presenting SMI/SED service utilization trends, followed by analyses of critical monitoring metrics, SMI/SED Implementation Plan action items, and feedback from provider organizations (where available) for each milestone.

3.1 SMI/SED Service Utilization Trends

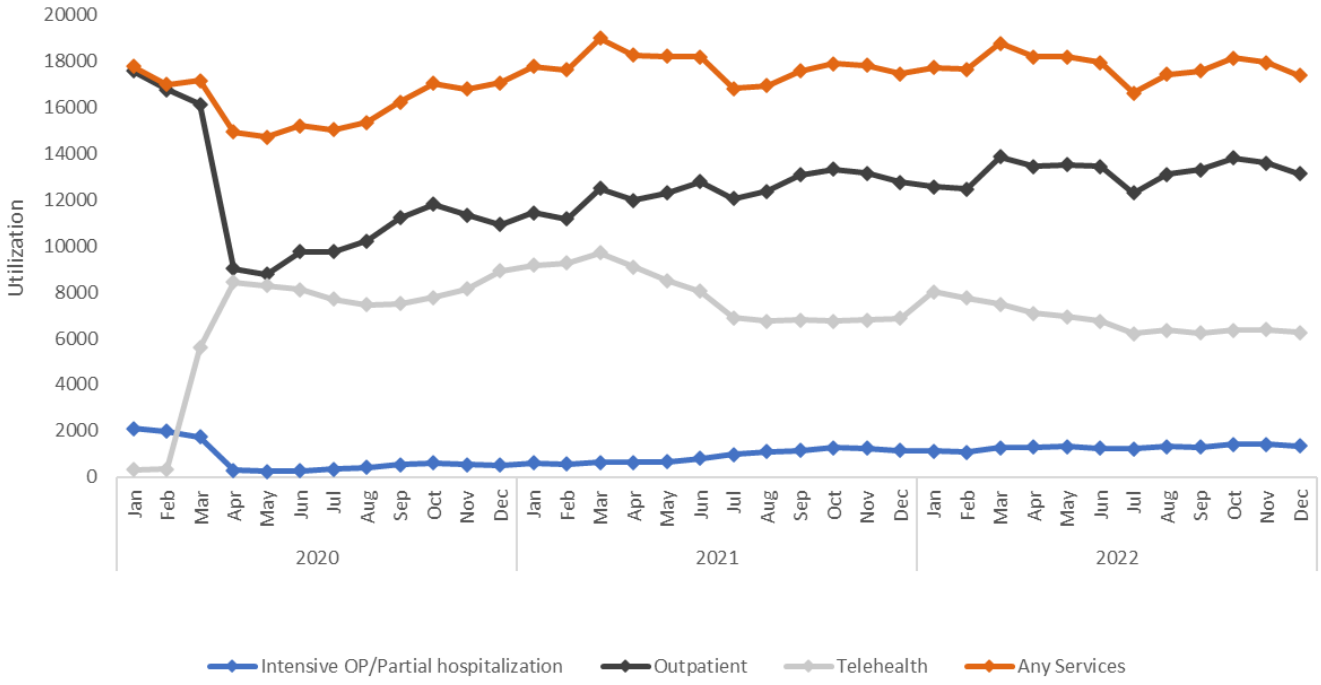
Between 2020 and 2022, overall mental health services utilization (**Exhibit 6)** increased by almost 10 percent, driven by increased use of intensive outpatient and partial hospitalization (increase of 60.6%), outpatient (increase of 10.7%), and telehealth services (increase of 4.1%). There was minimal change in use of inpatient mental health services (decline of 5.7%) and a substantial decline in the use of mental health services in the ED (decline of 12.8%)

Exhibit 6. SMI/SED Service Utilization, 2020-2022

Metric #	Metric Name	Monitoring Metric Rate				Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change	
13	Mental Health Services Utilization – Inpatient	1,711	1,631	-80	-5.7%	Decrease
14	Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization	9,547	15,335	+5,788	+60.6%	Increase
15	Mental Health Services Utilization – Outpatient	143,209	158,525	+15,316	+10.7%	Increase
16	Mental Health Services Utilization – Emergency Department	881	768	-113	-12.8%	Decrease
17	Mental Health Services Utilization – Telehealth	78,543	81,780	+3,237	+4.1%	Increase
18	Mental health services utilization – Any services	194,139	213,447	+19,308	+10.0%	Increase

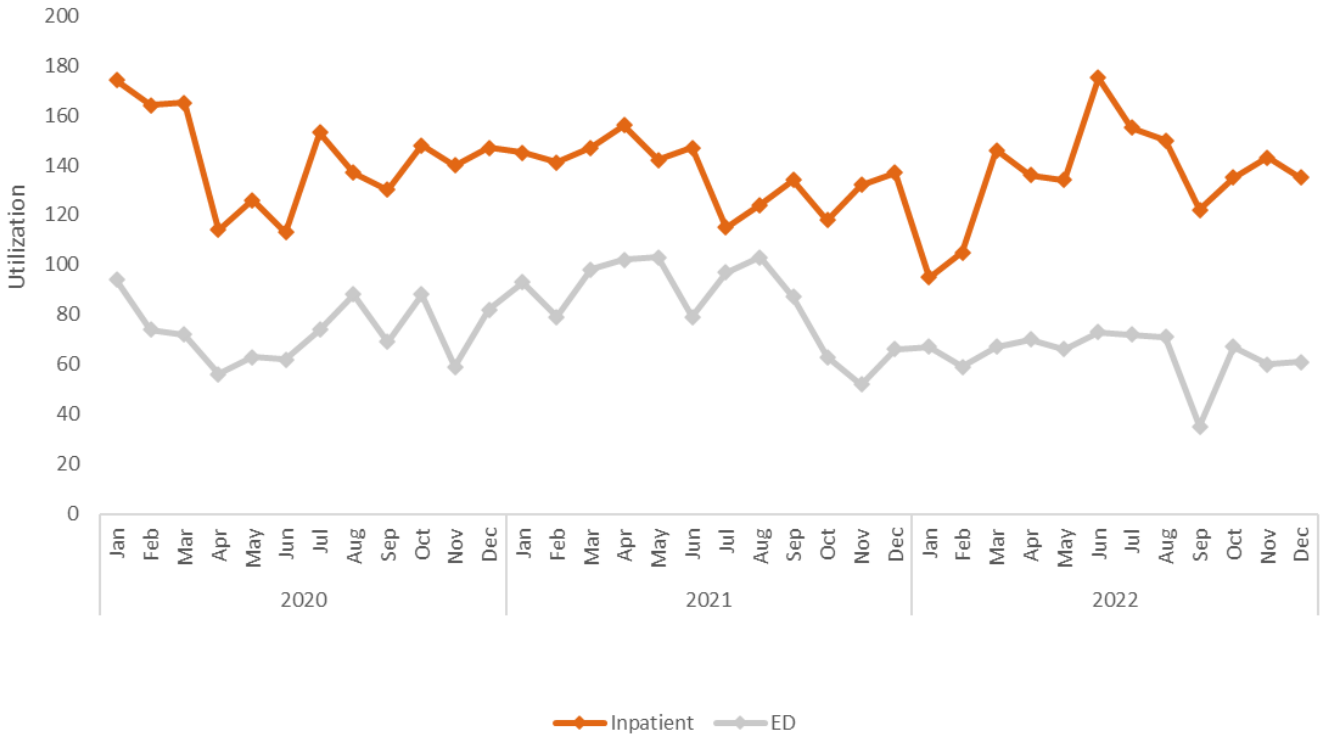
Monthly trends showed sharp declines in the number of outpatient and intensive outpatient/partial hospitalization services in April 2020, mirrored by a sharp increase in telehealth services in March/April 2020 associated with the COVID-19 PHE (**Exhibits 7A-7B**). As of 2022, while service utilization gradually increased over the subsequent months, in-person utilization did not return to levels seen before the COVID-19 PHE. Telehealth trends decreased beginning in April of 2021 but remained higher than before the COVID-19 PHE.

Exhibit 7A. Monthly Trends in SMI/SED Intensive Outpatient/Partial Hospitalization, Outpatient, Telehealth, and Any Service Utilization, January 2020 to December 2022



NOTES: Exhibit 7A displays the number of indicated services utilized for each given month for the months of January 2020 through December 2022. The monthly variations in utilization may not reflect the overall yearly changes in utilization as indicated in Exhibit 6.

Exhibit 7B. Monthly Trends in SMI/SED Inpatient and ED Utilization, January 2020 to December 2022Monthly Trends in SMI/SED Inpatient and ED Service Utilization, January 2020 to December 2022



NOTES: Exhibit 7B displays the number of indicated services utilized for each given month for the months of January 2020 through December 2022. The monthly variations in utilization may not reflect the overall yearly changes in utilization as indicated in Exhibit 6.

3.2 Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings

Milestone 1 focuses on ensuring Vermont Medicaid with SMI/SED members receive high-quality care in hospitals and residential settings through requirements on licensure and accreditation, monitoring and oversight, and program integrity. In addition, Milestone 1 aims to improve integration of care for individuals with SMI/SED who have a co-morbid physical health condition. The critical monitoring metrics and milestone implementation action items encompass accreditation, compliance, and monitoring efforts.

3.2.1 Monitoring Metrics

Milestone 1 is associated with one critical monitoring metric (Metric 2, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics). Progress on this milestone is assessed by calculating the change in the metric at baseline (2020) to the mid-point (2022) and comparing this change to state targets described in the SMI/SED Implementation Plan.[iv]

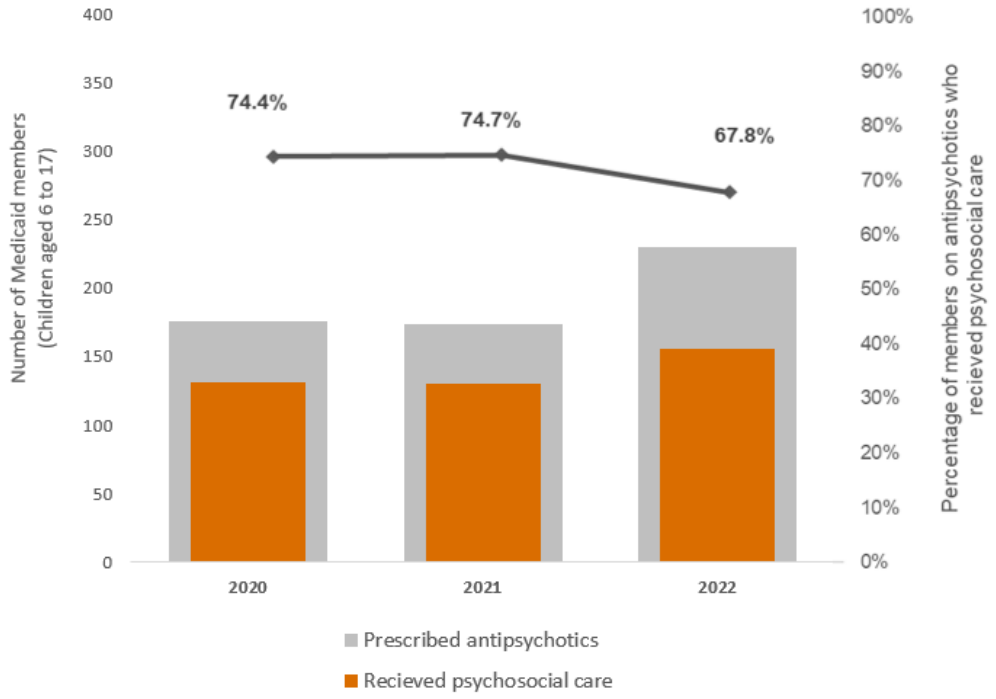
Exhibit 8 summarizes the state's progress on the critical metric. The percentage of children and adolescents on antipsychotics who receive first-line psychosocial care declined between 2020 and 2022, moving in the opposite direction of the state's target.

Exhibit 8. Summary of Critical Monitoring Metrics for Milestone 1, 2020-2022

Metric #	Metric Name	Monitoring Metric Rate				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	74.4%	67.8%	-6.6 pct. pts.	-8.9%	Increase	Decrease

As shown in **Exhibit 9**, the decline in Metric 2 was driven by a large increase in the total number of children and adolescent members on antipsychotics (denominator) in 2022. While the number of first-line psychosocial care services provided also increased (numerator), it was proportionately smaller than the increase in the total number of children and adolescents prescribed antipsychotics.

Exhibit 9. Use of First-Line Psychosocial Care for Children and Adolescent Medicaid Members on Antipsychotics (Metric 2), 2020-2022



NOTES: Exhibit 9 displays the number of Medicaid members (children and adolescents ages 6-17) who were prescribed antipsychotics during the indicated year, and the subset of those members (%) who received first-line psychosocial care as a result. The number of children and adolescent members prescribed antipsychotics increased in 2022, though the percentage of those who received psychosocial care was lower than in the previous two years.

3.2.2 Implementation Plan Action Items

All criteria in Vermont's SMI/SED implementation plan under Milestone 1 were deemed to require no further action under the Demonstration (**Exhibit 10**). Therefore, the state did not identify any action items nor detail any expected changes for this milestone.[iv]

Exhibit 10. Milestone 1 Implementation Plan Action Items and Current Status

Action Item #	Milestone Criteria	Action Item Description	Date to be Completed	Current Status
1a	Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	No action needed	NA	No action needed
1b	Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	No action needed	NA	No action needed
1c	Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	No action needed	NA	No action needed
1d	Compliance with program integrity requirements and state compliance assurance process	No action needed	NA	No action needed
1e	State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	No action needed	NA	No action needed
1f	Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	No action needed	NA	No action needed

Vermont has several programs and policies in place that aim to ensure high-quality care in hospital and residential treatment settings that predate the SMI/SED amendment. Vermont Department of Health's Hospital Licensing Rule establishes standards that guide the licensure and accreditation, oversight, and utilization review in psychiatric hospitals and units. The Rule requires that "No organization or individual may establish, conduct, or maintain operation of a Hospital in Vermont without being granted a license by the State Licensing Agency." Further, the Rule has several components to ensure that comprehensive care is administered to patients with co-morbid physical health conditions, such as standards around including co-morbid physical health conditions as part of the admitting diagnosis and ensuring medical and surgical diagnostic and treatment services are available either within the treatment center or that the treatment center has a partnership with an organization who can provide those services. In addition to the Hospital Licensing Rule, oversight of designated hospitals is governed by the DMH's Designated Hospitals Manual and Standards, which requires hospitals to be redesignated as a designated hospital every two years.[iv] Finally, the Hospital Licensing Rule was updated in January 2022 to include section 5.1.7 which states, "Any psychiatric hospital or psychiatric facility classified as an Institution for Mental Disease for Medicaid purposes shall use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay for their patients."

Utilization Review Processes in Vermont

Under the Hospital Licensing Rule, in 2012, the Department of Vermont Health Access and Vermont Department of Mental Health created a unified, consistent utilization management system from all Vermont Medicaid-funded inpatient psychiatric services. The Department of Mental Health also formed and expanded a Care Management Unit to facilitate care management and utilization throughout the continuum of care. Further, Medicaid holds weekly utilization review calls with the Brattleboro Retreat to support care coordination.

Source: Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment

Similar licensure, oversight, and compliance for children and adult residential treatment centers is administered by the Vermont Department for Children and Families and the Vermont Department of Disabilities, Aging and Independent Living.[iv] Compliance with state and federal laws is reinforced in the terms of the Medicaid Provider Contract, which applies to all Medicaid-enrolled providers.[iv] In addition, the state uses the Results Based Accountability framework to evaluate the performance of programs and initiatives.[iv]

3.3 Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

Milestone 2 focuses on understanding the services and infrastructure required to improve collaboration and coordination between provider organizations across the care continuum, including partnerships between hospitals, residential providers, and community-based care providers. The focus of this milestone builds upon other statewide planning and activities; in January 2020, DMH published a ten-year plan to create an integrated and holistic system of care known as Vision 2030.[xi] Many of the action areas identified in Vision 2030 (e.g., enhancing intervention and discharge planning services, making peer supports accessible in all aspects of care) are aligned with the SMI/SED implementation action items under this milestone, which center follow-up care, discharge planning, and connections to services that address SDOH.**Error! Bookmark not defined.**[xiii]

3.3.1 Monitoring Metrics

CMS identified seven critical monitoring metrics associated with Milestone 2. One critical monitoring metric (Metric 3, All-Cause Emergency Department Utilization Rate for Medicaid Members Who May Benefit from Integrated Physical and Behavioral Health Care) is no longer required by CMS and is therefore not reported by the state. Four of the critical metrics (Metrics 7, 8, 9, and 10) pertain to follow-ups and are calculated at both 30 days and 7 days.

Exhibit 11 summarizes the state's progress on the six reported critical metrics for Milestone 2. With the exception of Metric 9 (Follow-up Within 30 Days After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older), metrics for Milestone 2 moved in the opposite direction to the state's targets (**Exhibit 11**).

Exhibit 11. Summary of Critical Monitoring Metrics for Milestone 2, 2020-2022

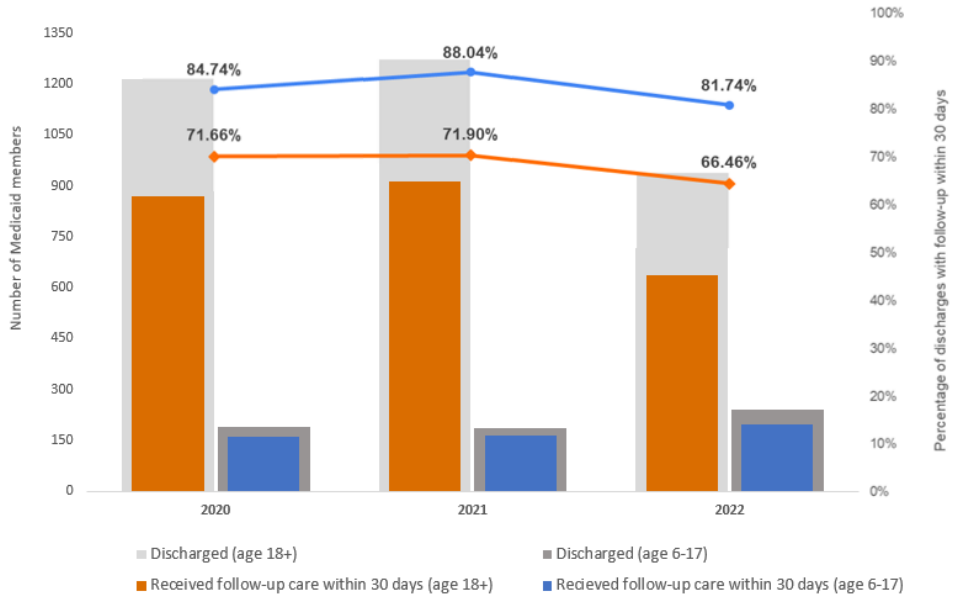
	Metric Name	Monitoring Metric Rate or Count				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	2.2%	3.4%	+1.2 pct. pts.	+52.3%	Decrease	Consistent
7a	Follow-up Within 30 Days After Hospitalization for Mental Illness: Ages 6 to 17	84.7 %	81.7 %	-3.0 pct. pts.	-3.5%	Increase	Decrease
7b	Follow-up Within 7 Days After Hospitalization for Mental Illness: Ages 6 to 17	70.5 %	63.1 %	-7.5 pct. pts.	-10.6%	Increase	Decrease

	Metric Name	Monitoring Metric Rate or Count				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
8a	Follow-up Within 30 Days After Hospitalization for Mental Illness: Age 18 and Older	71.7 %	66.5 %	-5.2 pct. pts.	-7.3%	Increase	Decrease
8b	Follow-up Within 7 Days After Hospitalization for Mental Illness: Age 18 and Older	55.2 %	48.1 %	-7.1 pct. pts.	-12.8%	Increase	Decrease
9a	Follow-up Within 30 Days After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older	33.3 %	62.1 %	+28.9 pct. pts.	+86.7%	Increase	Increase
9b	Follow-up Within 7 Days After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older	22.5 %	44.5 %	+22.0 pct. pts.	+97.9%	Increase	Increase
10a	Follow-Up Within 30 Days Ater Emergency Department Visit for Mental Illness: Age 18 and Older	75.1 %	74.7 %	-0.3 pct. pts.	-0.5%	Increase	Consistent
10b	Follow-Up Within 7 Days Ater Emergency Department Visit for Mental Illness: Age 18 and Older	66.0 %	65.8 %	-0.1 pct. pts.	-0.2%	Increase	Consistent

NOTES: "Consistent" directionality indicates a change of under two percentage points at mid-point. Metric 3 (All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care) is a Milestone 2 critical monitoring metric but is not reported by the state.

The total number and rate of follow-ups after inpatient discharge for adults declined (Metric 8), despite a substantial reduction in the total number of discharges over this time (**Exhibit 12**). Among children (ages 6-17), the rate of follow-up after inpatient discharge also declined (Metric 7); however, this was driven by a larger increase in the total number of discharges, along with a proportionately smaller increase in number of follow-up services provided (**Exhibit 12**).

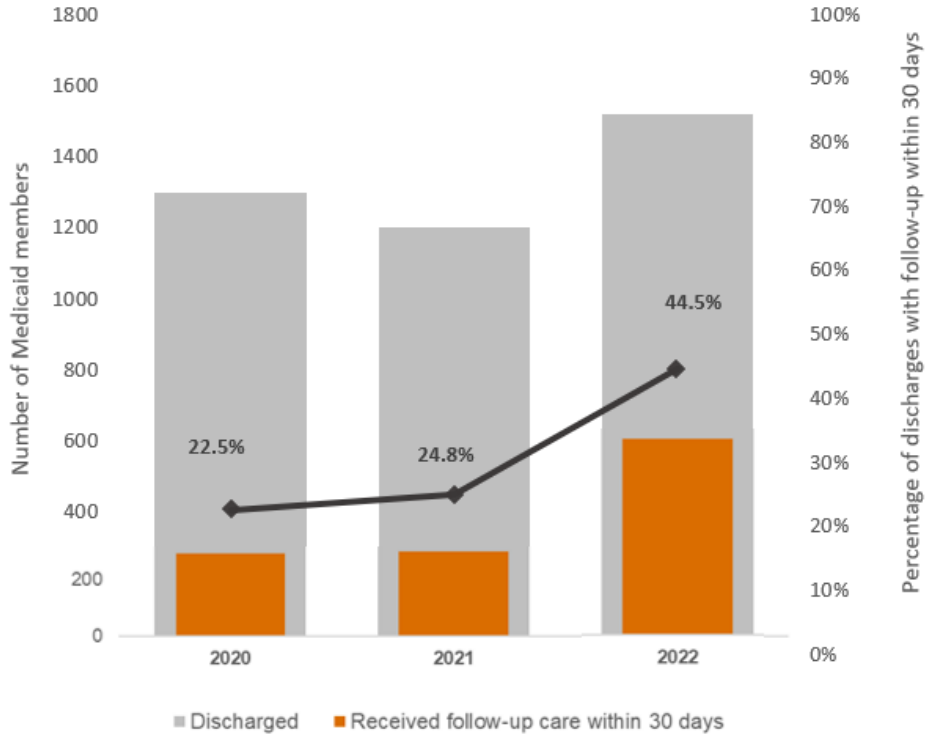
Exhibit 12. Follow-up Within 30 Days After Hospitalization for Mental Illness: Age 18 and Older (Metric 8a) and Ages 6-17 (Metric 7a), 2020-2022



NOTES: Exhibit 12 displays the number of Medicaid members—children and adolescents ages 6-17, and adults age 18 and over—who were discharged following a hospitalization for mental illness, and the subset of those members (%) who received follow-up care within 30 days of their discharge date. These two metrics (7a and 8a) are reported separately given the distinct denominators for the rate of follow-up, but both metrics show similar trends over the 2020-2022 period.

While follow-up after ED visits for mental illness (Metric 10) declined marginally, rates of follow-up after ED visits for Alcohol and Other Drug (AOD) abuse or dependence (Metric 9) increased substantially, with the rate in 2022 reaching almost double the rate in 2020 and 2021 despite a 17% increase in the total number of ED visits for AOD abuse or dependence (**Exhibit 13**). However, this trend is likely due in part to a change in the measure specifications in 2022. Specifically, the updated specifications (1) added unintentional/undetermined overdose for commonly used drugs with addiction potential, which has a higher rate of follow-up, and (2) substantially expanded the types of services that can be considered an eligible follow-up visit in the numerator, including pharmacotherapy, outpatient and telehealth visits for a drug "use" or overdose, services with CPT codes related to substance use without a diagnosis requirement, behavioral health assessment/screening visits, outpatient and telehealth visits with a mental health provider, and substance use services provided by peer recovery support specialists.[xii]

Exhibit 13. Follow-up Within 30 Days After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (Metric 9a), 2020-2022



NOTES: Exhibit 13 displays the number of Medicaid members (adults aged 18 and over) who were discharged following an emergency department visit for alcohol and other drug abuse and/or dependence, and the subset of those members (%) who received follow-up care within 30 days of their discharge date. The rate of follow-up care increased dramatically in 2022, though some of this increase can be attributed to the increase in emergency department discharges overall during 2022.

3.3.2 Implementation Plan Action Items

Exhibit 14. Milestone 2 Implementation Plan Action Items and Current Status

Action Item #	Milestone Criteria	Action Item Description	Date to be Completed	Current Status
2a	Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	No action needed	NA	No action needed
2b	Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available	No action needed	NA	No action needed
2c	State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	Establish state policy to ensure that facilities are providing high quality follow-up care that aligns with this milestone.	7/1/2022	Complete
2d	Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	DMH will work within required processes for the state's executive branch and must defer to the state's legislative process for any future decisions on investments that may be possible.	12/31/27	Open
2e	Other State requirements/policies to improve care coordination and connections to community-based care	No action needed	NA	No action needed

In January 2022, the state completed implementation action item 2c (Establish state policy to ensure that facilities are providing high quality follow-up care that aligns with this milestone). Specifically, the Vermont Department of Health's Hospital Licensing Rule was updated to include a requirement that states that IMDs should follow up with patients within 72 hours of discharge through mechanisms such as email, text, or phone call. IMDs must continue to follow up until they have connected with patients or until they have attempted and documented contact five times every 24 hours for up to 72 hours.[xiii]

The state made progress maintaining and enhancing strategies/activities related to implementation action items 2a, 2b, and 2e despite reporting no action needed in the SMI/SED Implementation Plan. Efforts to enhance 2a included practicing Vermont's vision of the Open Dialogue approach, referred to as the Collaborative Network Approach, that increases patient-

centered care planning and awareness of available community work supports for staff and individuals in psychiatric hospital care (e.g., offering a work incentive to a Specialized Service Agency), hosting employment-related, in-house groups based on individuals' lead, such as employing a Recovery-Orientated Cognitive Therapy approach, and developing ways for local community employment specialists or vocational rehabilitation counselors to meet with patients and staff prior to discharge whenever possible. Currently, in support of implementation action item 2b, Vermont's two IMDs conduct assessments of members' social and clinical needs from the time of referral.[iv] Hospitals also conduct active discharge planning with social work staff and the local Designated Agency to facilitate post-discharge care planning.[iv] The state plans to maintain these efforts by establishing a policy around housing coordination and services.

The state has also made progress on the implementation action item 2d. In Vermont's SMI/SED Implementation Plan, several strategies were underway to meet the aims of 2d, including Medicaid funding of telepsychiatry consultation to emergency department staff, providing peer support in emergency departments, the use of Screening, Brief Intervention, and Navigation to Services (SBINS), and the use of a Vermont Psychiatric Survivor peer support staff in the Rutland County Community Links Program.[iv] In March 2022, act H.654 was signed into effect, providing temporary Vermont licensure to out-of-state, qualified providers to offer telehealth services to Vermonters with SMI/SED through June 2023.[xiv] In 2024, the Vermont General Assembly passed H.847: An act relating to peer support provider and peer recovery support specialist certification. This act charges the Vermont Office of Professional Regulation to certify peer support providers and recovery support specialists and established definitions of peer support providers and recovery support specialists.[xv] This act was the culmination of many years of work by DMH to establish credentialing and certification process to help meet the mental health needs of the state. DMH is working to improve the capacity of intensive residential services for children by soliciting proposals from qualified health care organizations. Furthermore, as part of Act 50, which was signed into effect on June 1, 2021, DMH collected information from Designated and Specialized Service Agencies, and peer-run agencies, for developing and implementing programming for unlocked community residences for transitional support for individuals being discharged from inpatient psychiatric care or for intervention to prevent inpatient care. A report with findings was presented to the Vermont legislature in 2022 with recommendations to improve peer support workers' wages. The DMH was also tasked in 2019 with conducting a bed needs assessment for all levels of care in the mental health system. However, the report, which was provided to the Vermont legislature in 2020, acknowledged availability and needs were "*profoundly influenced by the COVID-19 pandemic and accompanying public health emergency*."[xiii] Finally, as discussed above, the state is making progress on Vision 2030 action areas, aligned with the goals of 2d, such as increasing screenings for health-related social needs.**Error! Bookmark not defined.**

The SMI/SED Implementation Plan builds on years of care coordination and management funding and support in Vermont, including several programs and initiatives, like the Vermont Blueprint for Health, a statewide program launched in 2003 with the aim of "integrating a system of health care for patients, improving the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management." However, as

the state recovers from the COVID-19 PHE, many provider organizations have struggled to coordinate care for Vermonters with SMI/SED. To address these challenges, DMH is focused on addressing workforce shortages and wait times in the emergency department.[xiii]

3.3.3 Feedback on Implementation Progress

Most hospitals, Designated Agencies, and Specialized Service Agencies reported conducting care coordination and care transition activities for their patients with SMI/SED. The majority (12 of 16) of provider organizations surveyed engaged and monitored patients through care coordination services and care transition support, such as emergency department follow-up calls. Thirteen of 16 provider organizations surveyed reported participating in shared care planning or care conferences to facilitate patient care goals.

"Since COVID, our interactions with Designated Agencies have greatly improved due to being able to meet via teams…If there is a Designated Agency that's only 35 miles away, but over the mountain gap, it's a two-hour drive. That's a lot to ask the case manager."

– Designated Hospital Staff

Provider organizations reported bringing on new staff, screening patients for clinical and social needs, and implementing community-oriented systems and processes to improve care coordination. Several hospitals and Designated Agencies hired new staff to support care coordination or restructured current staff to improve care transitions. Over half of the provider organizations surveyed (9 of 16) provided peer-to-peer support services. Hospital leadership reported that peer support services, implemented in inpatient units and emergency departments, have been helpful in connecting patients to follow-up care. Implementation of peer support services varied across hospitals and units, with some hospitals offering peer support weekly in inpatient units and others providing peer support ad hoc in emergency departments. As one hospital leader shared, "*The [peer support] program is legitimately outstanding*." Designated Agencies described using embedded providers within other clinical settings, such as primary care and hospital emergency departments, to facilitate transitions and connections to non-hospital services. Over half of provider organizations surveyed (10 of 16) reported that they screen patients for at least some social service needs, like housing and transportation. Additionally, most provider organizations surveyed (14 of 16) reported partnering with social service organizations, such as education, child welfare, and housing organizations, to coordinate care and address patients' social needs. Several organizations described participating in multidisciplinary care coordination meetings within their communities. Some hospitals reported conducting weekly care coordination meetings with Designated Agencies for patients admitted to the hospital and already connected to a Designated Agency and reported prioritizing making those connections for patients not already connected to a Designated Agency. Several providers suggested that the shift to virtual case management meetings that began during the COVID-19 PHE reduced the burden and travel times for case managers and enabled more frequent collaborations. Additionally, one Designated Agency and one Specialized Service Agency focused on improving their access to

patient information while in the hospital to facilitate care coordination. For example, one Designated Agency described a process for identifying and following up with patients admitted to the hospital using Patient Ping, a care coordination platform.

To improve access to hospital services and support complex case management, hospitals coordinated with the state and increased their use of telehealth. To facilitate care transitions and discharge planning, some hospitals reported participating in calls with DMH staff to support their inpatient units. Most provider organizations surveyed (14 of 16) utilized telepsychiatry to meet the needs of patients with SMI/SED. Several hospitals and Designated Agencies reported a major shift in the use of telepsychiatry because of the COVID-19 PHE, with some hospitals increasing psychiatrists in the emergency department through initiatives such as telepsychiatry and daily psychiatry rounds to aid in admission or disposition decisions. Finally, to improve transitions from the emergency department for patients in crisis across the state, the Brattleboro Retreat, one of Vermont's two IMDs and the only organization providing inpatient services to children and youth requiring psychiatric hospitalization, partnered with OneCare Vermont, the only statewide Accountable Care Organization (ACO) and only ACO participating in the Vermont All-Payer ACO model, to address capacity challenges of emergency medical services.[8][xvi] In February 2023, OneCare Vermont issued a waiver that enabled Vermonters in emergency departments across the state to receive transportation from Brattleboro's ambulance service to the Brattleboro Retreat for inpatient services.

Challenges to offering care coordination services and transition support included workforce shortages that limited the availability of services, technological barriers, and unmet social needs. The limited availability of clinicians to staff Designated Agencies and residential facilities, coupled with relatively low wages for the peer support workforce and increasing demand following the COVID-19 PHE, increased the barriers to care transitions. Designated Agencies described challenges in recruiting and retaining staff, particularly case management staff and psychiatrists. One hospital provider explained that while services like CRT may exist for the most acute patients, providers struggled to connect less acute patients to case management services in a timely manner. Hospitals also noted challenges in connecting people to higher levels of support, such as residential facilities. In some cases, outpatient and residential treatment facilities may be available, but not within the patient's community. In addition, provider organizations reported increased housing needs and transportation challenges, especially in rural communities, which constitute 11 of the state's 14 counties,[xvii] which increase barriers to access to care and limit providers' abilities to discharge plan. Finally, provider organizations also struggled to receive and share patient data without a centralized EHR. Several hospitals and Designated Agencies described being unable to receive patient documents from outside organizations. While some Designated Agencies reported using Vermont's Health Information Exchange (VHIE) to receive patient information on admissions and discharges, the information is limited and they do not upload patient information into the exchange. Designated Agencies requested the ability to

[8] The Vermont All-Payer ACO Model was launched by CMS in 2017 and tests whether scaling an ACO structure across all major payers in the state would support broad care delivery transformation and ultimately reduce statewide spending and improve population health outcomes. OneCare Vermont, the only ACO in the Vermont All-Payer ACO Model, supports model implementation in the delivery system. Source: https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model.

track referrals and care paths in the VHIE to facilitate shared care planning and reduce the administrative burden on providers to track and monitor patients who are admitted to the hospital.

3.4 Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

Milestone 3 focuses on ensuring access to all levels of care for patients with SMI/SED, including outpatient, crisis stabilization, residential, and inpatient services. The monitoring metrics and implementation action items under this milestone aim to divert Medicaid members from avoidable visits to emergency departments and inpatient admissions, as well as to reduce criminal justice involvement.[iv]

3.4.1 Monitoring Metrics

Milestone 3 is associated with one critical monitoring metric (Metric 19, Average Length of Stay in Institutions of Mental Diseases [IMDs]), summarized in **Exhibit 15.**

Exhibit 15. Summary of Critical Monitoring Metrics for Milestone 3, 2020-2022

Metric #	Metric Name	Monitoring Metric Rate or Count				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
19	Average Length of Stay in IMDs	15.4 days	13.6 days	-1.8 days	-11.9%	Maintain under 30 days	Decrease

The state met the target for the critical monitoring metric associated with this milestone, maintaining an average length of stay in IMDs under 30 days. The total number of members with SMI/SED treated in an IMD did not change between 2020 and 2022, but the average length of stay in IMDs (for all IMDs and populations) declined by almost two days. Notably, the variation in length of stay between the two IMD facilities is significant. The average length of stay at the Brattleboro Retreat was eight days, while the average length of stay for the Vermont Psychiatric Care Hospital was 110 days. Together, the average length of stay for all inpatients at an IMD is 15 days.[xix] Documents and interviews with hospital leaders highlighted factors contributing to longer hospital stays including a state law enforcing a waiting period before commencing involuntary medication and hospitals' efforts to avoid discharging patients to homelessness.[xviii]

3.4.2 Implementation Action Items

No action was needed by the state on three of the five action items under Milestone 3 (**Exhibit 16**). To maintain the current status on implementation action items 3a and 3c, the state plans to continue tracking and reporting mental health service availability and pursue regulatory solutions to standardize the use of screening tools.[iv] For 3b, while the state reported no action needed in the SMI/SED Implementation Plan, the state continued its efforts to improve the availability of SMI services in Vermont.

Exhibit 16. Milestone 3 Implementation Plan Action Items and Current Status

Action Item #	Milestone Criteria	Action Item Description	Date to be Completed	Current Status
3a	The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state	No action needed	NA	No action needed
3b	Financing plan	No action needed	NA	No action needed
3c	Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	No action needed	NA	No action needed
3d	State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	Establish state policy to require the use of evidence-based, publicly available patient assessment tool(s) in order to achieve this milestone.	7/1/22	Complete
3e	Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	DMH will work within required processes for the state's executive branch and must defer to the state's legislative process for any future decisions on investments that may be possible.	12/3/27	Ongoing

The state has completed implementation action item 3d. All participating IMD facilities currently use InterQual/McKesson to help determine the appropriate level of care and lengths of stay. In addition, the January 2022 update to the Vermont Department of Health's Hospital Licensing Rule

requires IMDs to use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay for their patients."[xiii]

The state made progress on 3e through two key initiatives. First, the River Valley Therapeutic Residence opened on May 8, 2023, and serves as transitional support for those who are ready to be discharged from an inpatient setting, but who require care that exceeds the capacity of community providers. The River Valley Therapeutic Residence is a 16-bed, secure facility that will permanently replace the 7-bed Middlesex Therapeutic Residence, expanding access to this level of care for Vermonters.[iv]

Second, Vermont planned for and piloted expanded community-based mobile crisis intervention services. Since the beginning of the Demonstration period, the state convened community members, providers, hospital leadership, and state leaders to identify gaps and opportunities for the current mobile crisis intervention system. The state found that most consumers (54 percent) did not know where or who to call about getting crisis services, (64 percent) received services in emergency departments even though most (65 percent) indicated they would like to receive services in the community, and that individuals who were unhoused, have intellectual or developmental disabilities, have a substance use disorder, and children and youth were most likely to respond that they are not well served by the current mobile crisis system. In addition, half of hospital and emergency department leadership indicated that 50 to 75 percent of individuals who present to the emergency department for a mental health or substance use-related crisis could have been evaluated in the community, presenting significant savings potential for Medicaid.**Error! Bookmark not defined.**

Based on these results, the state executed two solutions. One program, called the Enhanced Mobile Crisis Program, includes rapid community response, screening and assessment, stabilization and de-escalation services, coordination with and referrals to health, social, and other services and supports, and follow-up services as needed (see text box below). In addition, Rutland Mental Health Services piloted a mobile response and stabilization service from October 2021 to June 2023. During the pilot period, Rutland Mental Health Services received 167 calls, of which 125 (75 percent) resulted in a mobile response. Mobile response staff were on-site within 45 minutes 98 percent of the time. The state plans to expand this service to continue its progress on this milestone.[xiii]

The state's progress toward Milestone 3 in the SMI/SED Implementation Plan builds on Vermont's long history of reform activities. Through many concurrent initiatives, Vermont has developed an array of community-based mental health services for children and adults, including crisis stabilization services. Funding for these services has generally come from several sources including state and federal grants, city budgets, community donors, state legislature appropriations, OneCare Vermont, as well as the Demonstration.[xix, xx] The state has further supported these services by introducing case rate payments for Designated Agencies and Specialized Service Agencies in 2019, enabling greater flexibility for these organizations to initiate and expand community-based mental health services.[xxi] These services support implementation action items 3b and 3e. Examples of these services are shown below.

To further bolster access to crisis stabilization services, the state has made several infrastructure investments for children and youth. These include a six-bed expansion of a hospital diversion program in southern Vermont and a utilization review of continued stay requests in children's crisis programs. More detail about the current capacity of Vermont's mental health system of care can be found in the Provider Availability Assessment **(Chapter 3.6)**.

The state's 10-year strategy for an integrated and holistic system of care aligns with the goals under Milestone 3. Specifically, the state's strategy encompasses increasing the capacity of inpatient and community residential treatment centers, implementing payment reform activities to fund community-based services, and bolstering peer support across all levels of care. Put together, Vermont's concurrent and long-standing health reform efforts and the state's strategic plan aim to support progress on Milestone 3. As a result of the state's sustained focus on access to mental health care, Vermont ranks first in the nation for mental health access.[xxii] However, as the State recovers from the COVID-19 PHE, many provider organizations have struggled to coordinate care for Vermonters with SMI/SED.

Community-based Crisis Stabilization Services in Vermont

- Psychiatric Urgent Care for Kids (PUCK): PUCK provides a community-based crisis intervention site for elementary and middle school-aged children experiencing mental or psychological distress. PUCK is a joint effort between the United Counseling Services (UCS) and the Southwestern Vermont Medical Center (SVMC). PUCK was initially funded through the Innovation Fund grant from OneCare Vermont and currently receives funding from the Demonstration. PUCK has reduced emergency department utilization by 40%. The program began in late 2019.
- Enhanced Mobile Crisis Program (EMCP): EMCP provides 24/7 access to in-person responses to mental health crisis episodes. The EMCP is funded by the Demonstration and led by Health Care and Rehabilitation Services of Southeastern Vermont, who subcontracts with Vermont's nine other Designated Agencies to provide this service in their respective regions. The EMCP was launched January 1, 2024.
- Embedded Mental Health Crisis Specialist Program: This program facilitates collaboration between local law enforcement agencies and Designated Agencies to enable trauma-informed law enforcement responses and connect individuals to the most appropriate level of care. Since its implementation, the program has been well received by Designated Agencies and front-line staff. It receives funding from the Vermont Department of Mental Health. The program began as a pilot in 2016 and has since expanded to nine out of ten Vermont State Police barracks.
- Alyssum: Alyssum is a two-bed, peer-run, short-term residential crisis respite service funded by the Vermont Department of Mental Health. Alyssum opened in 2011. The program has received positive feedback from guests and staff.
- Call centers: The state funds a peer-run warm line that operates 18 hours per day/seven days a week. Vermont received a grant from the National Suicide Prevention Lifeline to support training and accreditation for staff. In addition, all ten Designated Agencies have 24-hour crisis call centers.

Sources: PUCK: A Game Changer for Youth Mental Health; PUCK Presentation; PUCK Expands Age Range of Children Served, Reports Increase in Use by Teenagers During COVID-19; Vermont Global Commitment to Health CMS Approved Investment Attachment H; Vermont launches statewide enhanced Mobile Crisis Program; Community-Based Mobile Crisis Coverage for the Uninsured and Underinsured – Medicaid Investment; Vermont Mental Health and Law Enforcement Collaborations: They Lay of the Land; Building Community Relationships through Intervention; Most Vermont Barracks Now Have a Mental Health Crisis Worker; Inside the program changing Vermont's approach to policing – Pt. 1Inside the program changing Vermont's approach to policing – Pt. 1; Alyssum; Founding Director to Step Down; Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment

3.4.3 Feedback on Implementation Progress

Most provider organizations reported offering a variety of crisis stabilization services for patients with SMI/SED, and additional funding for these services could expand access. Of the 16 provider organizations surveyed, six reported having call centers, such as a mental health or suicide prevention hotline, 11 reported offering emergency/crisis units, and five reported providing crisis bed alternative programs.

Provider organization leadership indicated that additional funding for Designated Agencies, Specialized Service Agencies, and hospitals to implement crisis stabilization services could expand service availability. One Specialized Service Agency leader specifically mentioned that more state funding to support trauma-informed care could improve access.

Workforce shortages are a barrier to accessing mental health care services across the continuum of care. Provider organizations underscored this barrier and its persistence beyond the COVID-19 PHE. They noted shortages across several provider types, including social workers, care managers, psychiatrists, PCPs, nurses, therapists, mobile crisis teams, developmental services teams, and community-based providers who can prescribe medications. Hospital, Designated Agency, and Specialized Service Agency leaders explained that these shortages have led to longer wait times, higher caseloads, delays in transferring patients to more appropriate levels of care and releasing patients with sub-optimal discharge plans.

Provider organizations pointed to several drivers causing workforce shortages. These include high rates of retirement among providers across the state, a lack of affordable housing for staff, and high costs of living in Vermont. Furthermore, many also noted that provider burnout led to understaffing. Specifically, high caseloads and increased acuity among patients paired with sustained low wages for roles like peer supporters added burden to providers. Administrative burdens such as lengthy documentation and prior authorization intensified provider burnout.

The lack of availability of inpatient and crisis stabilization beds is an acute barrier to accessing care. One hospital leader noted that, as part of the Medicaid bed board, the state's central data office collects data on individuals boarding in an emergency department or in corrections and refers them to an inpatient care setting based on bed availability. Notably, however, hospitals and Designated Agencies face a lack of available beds, contributing to greater lengths of stay in emergency departments. Workforce shortages, as mentioned above and in Chapter 3.3.3, are a major driver of this phenomenon. Several hospital leaders reported that they are not able to operate at pre-pandemic capacity because they are not able to achieve staffing levels to make all of their beds available.

Many hospitals, Designated Agencies, and Specialized Service Agency leaders suggested that increased support for community-based programs, intensive outpatient programs, and workforce across the continuum of care could help the state address access gaps in inpatient and crisis stabilization services.

"We have yet to find any type of nursing home that's willing to take any of our psychiatric patients because of, typically, their assaultive history. So, we are having to refer those folks out of

Hospitals, Designated Agencies, and Specialized Service Agencies have implemented several strategies to connect individuals to appropriate levels of care and enable ongoing treatment in outpatient settings. As detailed in **Chapter 3.4.2**, Vermont has several community-based systems of support including local crisis bed alternative programs, emergency services provided by mobile crisis teams, and short-term residential supports that aim to connect patients with SMI/SED to the appropriate level of care. Further, over half of provider organizations surveyed (9 of 16) reported offering intensive outpatient services.

state, which I think is a huge disservice to them. It takes them away from their family, from their communities. We have a patient here who's been here for years because we're trying to get them in a nursing home."

– Hospital Leader

Coordination and strong relationships between hospital and non-hospital providers were also noted as key strategies to connect individuals to appropriate levels of care. Hospital and Designated Agency leaders reported working with providers across a care team (which may include social workers, dieticians, nurses, psychiatrists, etc.) to determine the level of care that a patient needs. Some Designated Agencies noted strong partnerships with primary care offices, and even having social workers and other Designated Agency staff members embedded within local primary care offices. In addition, both hospitals and Designated Agencies reported leveraging telehealth to reach patients in rural areas who may face transportation barriers, as well as to collaborate with providers across the state.

Moreover, Designated Agency leaders also explained that there are several initiatives that address patients' health-related social needs. For example, two Designated Agencies mentioned addressing transportation barriers through transit programs and emphasizing community-based services. In addition, several Designated Agencies mentioned conducting screenings for health-related social needs as well as for SDOH. Fourteen of 16 provider organizations surveyed reported screening patients for housing assistance, transportation, safety, and food assistance "often" or "sometimes."

"We don't have enough primary care to meet the demand. So, we worry that we send people home that are gonna have trouble getting safe care in an expeditious manner elsewhere. So sometimes we do admit people if we don't know if [they're] gonna be able to see their doctor in a week."

– Hospital Leader

While effective, these strategies face resource constraints. Specifically, provider organizations reported implementation barriers associated with a shortage of non-hospital providers, resulting in few providers or organizations to refer patients to. In turn, this may keep patients in acute care settings longer than required and/or may lead to referral options that require long-distance travel for patients, including those who are out-of-state. Provider organizations noted that challenges in

finding appropriate levels of care are exacerbated for people with disabilities, people with overlapping social and medical needs, and older adults.

3.5 Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

Milestone 4 focuses on improving care through earlier identification of SMI/SED and earlier engagement of individuals with these conditions in appropriate levels of care. Monitoring metrics and implementation action items under this milestone include strategies to integrate physical and mental health care, improve access to preventive/ambulatory services, and enhance community-based services to improve treatment engagement.

3.5.1 Monitoring Metrics

Milestone 4 is associated with three critical monitoring metrics. **Exhibit 17** summarizes the state's progress on the three critical monitoring metrics for Milestone 4. The state goal was an increase in all metrics. While one critical monitoring metric remained consistent, the remaining metrics decreased. Metric 29 (Metabolic Monitoring for Children and Adolescents on Antipsychotics) is calculated for blood glucose testing and cholesterol testing separately, as well as in aggregate. We found that the overall decrease in this metric was driven by cholesterol testing; glucose testing in this population increased during this time period.

Exhibit 17. Summary of Critical Monitoring Metrics for Milestone 4, 2020-2022

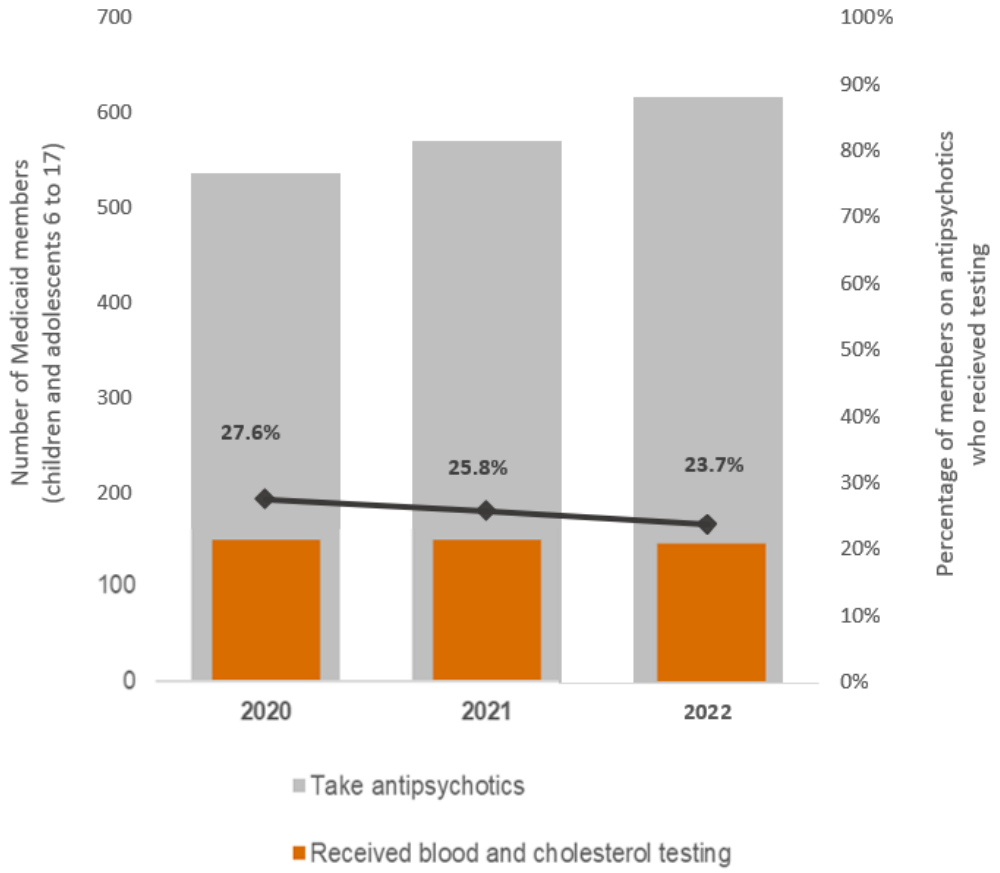
Metric #	Metric Name	Monitoring Metric Rate or Count				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
26	Access to Preventative/ Ambulatory Health Services for Medicaid Beneficiaries with SMI	96.3%	95.9%	-0.4 pct. pts.	-0.4%	Increase	Consistent
29a	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	44.0%	47.2%	+3.2 pct. pts.	+7.3%	Increase	Increase
29b	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	28.4%	24.5%	-3.8 pct. pts.	-13.6%	Increase	Decrease
29c	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	27.6%	23.7%	-3.9 pct. pts.	-14.2%	Increase	Decrease

Metric #	Metric Name	Monitoring Metric Rate or Count				State's Target	Directionality at Mid-Point
		Baseline (2020)	Mid-Point (2022)	Absolute Change	Percent Change		
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	73.5%	69.0%	-4.6 pct. pts.	-6.2%	Increase	Decrease

NOTES: "Consistent" directionality indicates a change of under 2 percentage points at mid-point.

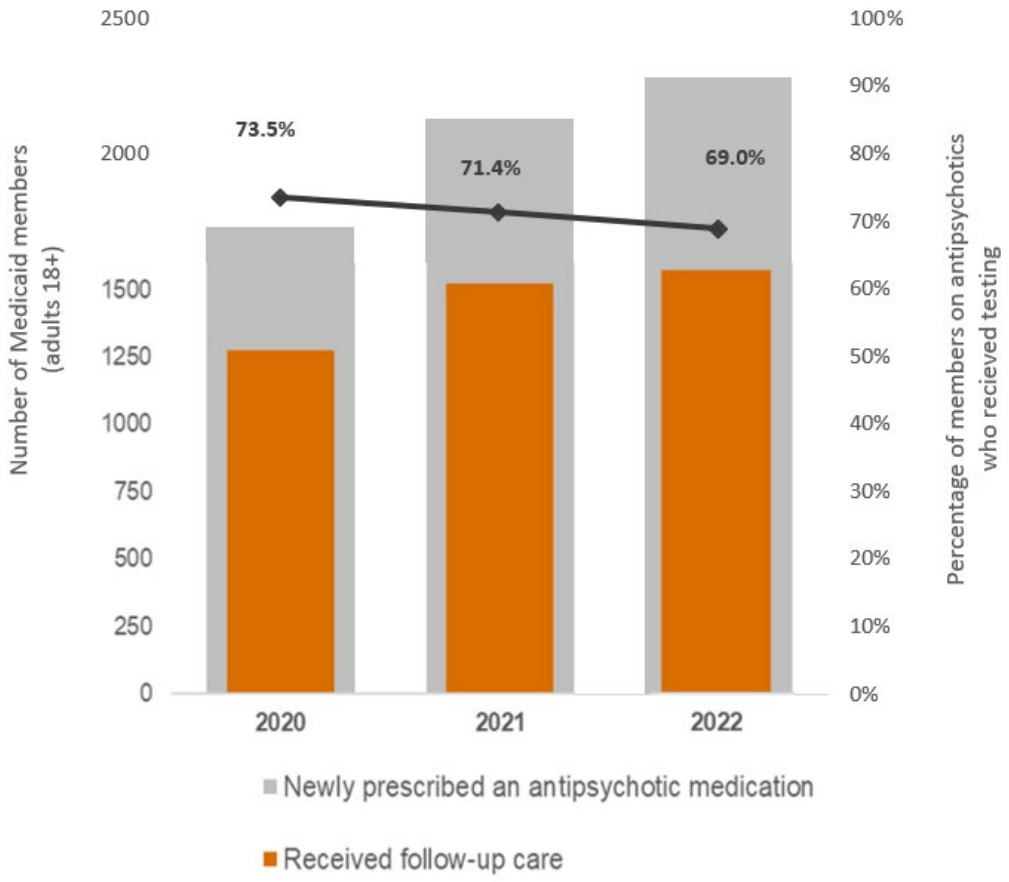
As shown in **Exhibit 18,** the total number of children and adolescents on antipsychotics increased, while the number receiving metabolic monitoring remained largely unchanged, resulting in an overall decline in the rate of metabolic monitoring (Metric 29c). Notably, the rate of metabolic screening in Vermont is lower than national Medicaid HMO averages, which increased from 32.1% to 36.3% over the same period.[xii]

Exhibit 18. Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (Metric 29c), 2020-2022



Though Metric 30 (Follow-up Care for Adult Beneficiaries who are Newly Prescribed an Antipsychotic Medication) also declined, the absolute number of members receiving follow-up care increased but did not keep pace with the total number of adult Medicaid members newly prescribed antipsychotic medication (**Exhibit 19**).

Exhibit 19. Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Metric 30), 2020-2022



NOTES: Exhibit 19 displays the number of Medicaid members (adults 18 and over) who take antipsychotics, and the subset of those members (%) who had blood glucose and cholesterol testing performed during a given year. The number of children and adolescent members on antipsychotics gradually increased between 2020 and 2022. However, those receiving blood and cholesterol testing did not increase or decrease significantly between these years. Therefore, the rate of testing (metric 29c) decreased from 2020 to 2022.

3.5.2 Implementation Action Items

The state reported no action needed for the four action items under Milestone 4 (**Exhibit 20**). Despite this, Vermont has implemented numerous initiatives intended to maintain and build upon existing strategies for identifying and engaging Medicaid members with SMI/SED, increasing integration of behavioral health in non-specialty settings, and expanding access and capacity.

Exhibit 20. Milestone 4 Implementation Plan Action Items and Current Status

Action Item #	Milestone Criteria	Action Item Description	Date to be Completed	Current Status
4a	Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	No action needed	NA	No action needed
4b	Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	No action needed	NA	No action needed
4c	Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	No action needed	NA	No action needed
4d	Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	No action needed	NA	No action needed

Many of these initiatives focus on youth, adolescents, and young adults, and many are supported by several different funding streams such as Vermont Medicaid and federal grants. Examples of these initiatives are included in **Exhibit 21**. In addition, the state maintains specialized settings for young people experiencing mental illness, including respite services and intensive residential programs. To continue to sustain progress on the milestone, the state plans to sustain and expand funding for existing initiatives.[iv]

Exhibit 21. Examples of Initiatives to Identify and Engage Individuals in Treatment Sooner

Initiative	Description
School mental health	Designated Agency staff provide mental health services in schools to address the mental health needs of identified students and provide mental health consultation.
Developmental Understanding and Legal Collaboration for Everyone	Ensures that newborns and their families receive quality medical care as well as all social services and community supports needed in the first six months of the newborn's life. A social worker is embedded in a pediatrician's office.
Psychiatric consult for primary care	DMH contracts with child psychiatrists to provide psychiatric consultation to pediatric and family medicine primary care providers to support the management of psychiatric needs in children. This consultation supports mental health assessments, intervention planning, and implementation.
JOBS programs	Community and school-based programs focusing on keeping youth who are at risk of dropping out of school.
Peer-run community centers	Engages young adults with serious and persistent mental illness who may be reluctant to engage in traditional mental health services.

SOURCE: Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment.

3.5.3 Feedback on Implementation Progress

Provider organizations reported using screening tools to identify patients in need of treatment for mental health conditions as well as other clinical needs. Over half of provider organizations surveyed (10 of 16) reported using screening tools such as InterQaul/McKesson, Child & Adolescent Service Intensity Instrument, Child and Adolescent Needs and Strengths, and Level of Care Utilization System. Of the 10 organizations that reported using screening tools, seven indicated that they use the Screening, Brief Intervention, and Navigation to Services tool, which the state identified in its implementation plan as a strategy that emergency departments can use to identify risks to the patient.[iv]

Designated Agencies and Specialized Services Agencies are key players in advancing Milestone 4. As described in **Chapter 3 and Exhibit 21**, Designated Agencies and Specialized Service Agencies are on the front lines of community-based mental health initiatives including psychiatric urgent care, crisis stabilization services, and care coordination across the continuum of care. These initiatives overlap with goals under Milestone 4 such as earlier identification and treatment and greater treatment engagement. Designated Agencies and Specialized Service Agencies also offer a variety of supports specifically for young people experiencing SMI/SED. For example, respite services provided by Designated Agencies provide a planned break for parents/guardians or foster care providers for children with SMI/SED. Designated Agencies offering respite services emphasized the importance of the service, noting that one of the goals of the program is to help create sustainable supports for children and families in their communities. Designated Agencies screen patients for services, identifying children who have repeat hospitalizations or are at risk of hospitalization. Designated Agencies work with AHS to apply respite services to prevent higher acuity.

As discussed in **Chapters 3.3.3 and 3.4.2**, workforce shortages affected access to these services and increased wait times. Designated Agencies reported struggling to meet the demand for services. To address these challenges, Designated Agencies are hosting more group sessions for youth and their families. To meet the needs of all families in their communities, Designated Agencies are determining the appropriate length of time for services to care for those on the waiting list.

3.6 Capacity to Provide SMI/SED Services: Provider Availability Assessment

Under Milestone 3 (Access to Continuum of Care Including Crisis Stabilization), the state aims to increase the availability of and access to providers who deliver SMI/SED services to members. The state conducted three annual Provider Availability Assessments for SMI/SED providers between 2021 and 2023. For the purposes of this report, we consider the 2021 Provider Availability Assessment as the baseline, and the 2023 Provider Availability Assessment as the mid-point. Between the 2021 and 2023 assessments, despite an 11.9% increase in the total

number of Medicaid members, the number of members with SMI/SED decreased by 1,818 members, or a 7.5% decrease (**Exhibit 22**).

Exhibit 22. Medicaid Members with SMI/SED, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members	171,567	184,562	191,903	20,336	11.9%
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
% of Medicaid Members with SMI/SED	14.1%	12.2%	11.7%	-2.4%	-17.3%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.

In each annual assessment, the state considered the number of providers who were providing SMI/SED services to Medicaid members across multiple settings, including 1) providers with prescribing authority for psychiatric medications, 2) providers who are not licensed to prescribe psychiatric medications but are licensed to treat mental illness, 3) community mental health centers, 4) intensive outpatient services, 5) residential facilities, 6) inpatient services, 7) IMDs, 8) crisis stabilization services, and 9) federally qualified health centers (FQHCs).

Since 2021, the state's capacity to provide SMI/SED services, as measured by the ratio of Medicaid members with SMI/SED to providers authorized to prescribe psychiatric medications and/or treat mental illness, improved between baseline and midpoint (**Exhibit 23**). While the total number of providers declined over this period, the staffing ratios improved because the number of SMI/SED members dropped over that same period. In each assessment, most but not all providers authorized to provide psychiatric and mental health services were accepting new Medicaid patients. For providers authorized to prescribe psychiatric medications, 13-14% were not accepting new Medicaid patients. For other providers authorized to treat mental illness, between 12-15% were not accepting new Medicaid patients.

Exhibit 23. Availability for Psychiatric and Mental Health Service Providers, 2021-2021

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
Providers Authorized to Prescribe Psychiatric Medications **Psychiatrists licensed to practice in the state and other mental health providers authorized to prescribe psychiatric medications (defined by state licensure laws). Provider specialty is self-reported by Medicaid-enrolled providers in Vermont.**					
# Providers	2,701	3,287	2,597	-104	-3.9%
Staffing Ratio	9.0	6.8	8.6	-0.3	-3.8%
Providers Accepting New Patients	2,340	2,849	2,242	-98	-4.2%
Staffing Ratio for New Patients	10.3	7.9	10.0	-0.4	-3.5%
Other Providers Authorized to Treat Mental Illness **Providers certified or licensed to independently treat mental illness in Vermont, including licensed psychologists, clinical social workers, and professional counselors, who are not authorized to prescribe psychiatric medications.**					
# Providers	2,045	2,008	1,972	-73	-3.6%
Staffing Ratio	11.8	11.2	11.4	-0.5	-4.1%
Providers Accepting New Patients	1,805	1,765	1,685	-120	-6.6%
Staffing Ratio for New Patients	13.4	12.7	13.3	-0.1	-0.9%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All providers in the table are Medicaid-enrolled.

Vermont has 42 community mental health centers, organized under the Designated Agency in each geographic area of the state (**Exhibit 24**). While the number of community mental health centers has remained stable from 2021-2023, the decline in Medicaid members with SMI/SED caused the staffing ratio to improve over this period. All 42 community mental health centers were accepting new Medicaid patients at the time of the availability assessment.

Exhibit 24. Availability of Community Mental Health Centers, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
Community Mental Health Centers	42	42	42	0	--
Staffing Ratio	576.4	535.6	533.1	-43.3	-7.5%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All community mental health centers in the table are Medicaid-enrolled.

Intensive outpatient services can include partial hospitalization programs, day treatment services, intensive case management and/or peer supports, and other services that are less intensive than inpatient or residential care but more intensive than outpatient care. There are 12 providers in Vermont offering intensive outpatient services, which has not changed between baseline and mid-point (**Exhibit 25**). All 12 providers indicated that they were accepting new Medicaid patients at the time of the assessment.

Exhibit 25. Providers Offering Intensive Outpatient Services, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
Providers Offering Intensive Outpatient Services	12	12	12	0	--
Staffing Ratio	2,017.3	1,874.7	1,865.8	-151.5	-7.5%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All providers in the table are Medicaid-enrolled.

Residential facilities for mental health treatment are non-hospital facilities that are licensed to provide individualized programs of mental health services in a residential setting for adults, excluding SUD treatment facilities. Vermont has seven residential mental health treatment

facilities with a total of 54 beds for adult patients, which has remained unchanged over the time period of this assessment (**Exhibit 26**). A decline in the number of adult Medicaid members with SMI from 2021-2023 led to the facility and bed ratios improving for both metrics.

Exhibit 26. Availability of Residential Mental Health Treatment Facilities, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI (Adults Only)	5,382	5,064	4,890	-492	-9.1%
Residential Facilities for Psychiatric Treatment	7	7	7	0	--
Facility Ratio	768.9	723.4	698.6	-70.3	-9.1%
Available Beds (Adults Only)	54	54	54	0	--
Bed Ratio	99.7	93.8	90.6	-9.1	-9.1%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All facilities in the table are Medicaid-enrolled.

According to the 2021 Provider Availability Assessment, seven hospitals in Vermont were designated by the state's Department of Mental Health to provide psychiatric inpatient care, with 229 hospital beds available (**Exhibit 27**). The number of psychiatric hospitals remained stable over the course of this assessment, while the number of psychiatric beds available increased by nine. In 2024, 229 hospital beds were available.[xxiii] All seven hospitals provide services to adults, while the Brattleboro Retreat also provides the only inpatient services for children and adolescents who require psychiatric hospitalization.

Exhibit 27. Availability of Psychiatric Hospitals, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
Psychiatric Hospitals	7	7	7	0	--
Hospital Ratio	3,458.3	3,213.7	3,198.6	-259.7	-7.5%
Psychiatric Beds	193	193	202	9	4.7%
Bed Ratio	125.4	116.6	110.8	-14.6	-11.6%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All hospitals in the table are Medicaid-enrolled. Both public and private psychiatric hospitals are included. The count for psychiatric hospitals provided here differs from the Provider Availability Assessments provided by the state, which lists 6 psychiatric hospitals in 2023; the numbers presented here correctly reflects the correct number of facilities.

There are two psychiatric hospitals in Vermont that qualify as IMDs, a number that has remained unchanged between the baseline and mid-point (**Exhibit 28**).

Exhibit 28. Availability of Psychiatric Hospitals Certified as IMDs, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
Psychiatric Hospitals Certified as IMDs	2	2	2	0	--
IMD Ratio	12,104.0	11,248.0	11,195.0	-909.0	-7.5%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.
NOTES: All IMDs in the table are Medicaid-enrolled.

Activities under Milestone 3 are designed to improve the availability of care across the continuum, including crisis stabilization services, for Medicaid members with SMI/SED. Each county had three crisis call centers, one mobile crisis unit, and one crisis observation/assessment center; all

counties except two (Essex and Orleans) had one or more crisis stabilization units, and two counties (Rutland and Chittenden) had coordinated community crisis response teams (**Exhibit 29**). Due to differences in populations in these counties, crisis stabilization capacity varied substantially across counties. The availability of these services did not change between the baseline and mid-point.

Exhibit 29. Availability of Crisis Stabilization Services by County, 2021-2023

	Number of Crisis Call Centers		Number of Mobile Crisis Units		Number of Crisis Observation/ Assessment Centers		Number of Crisis Stabilization Units		Number of Coordinated Community Crisis Response Teams	
	Baseline (2021)	Mid-Point (2023)	Baseline (2021)	Mid-Point (2023)	Baseline (2021)	Mid-Point (2023)	Baseline (2021)	Mid-Point (2023)	Baseline (2021)	Mid-Point (2023)
Addison	3	3	1	1	1	1	1	1	0	0
Bennington	3	3	1	1	1	1	1	1	0	0
Caledonia	3	3	1	1	1	1	1	1	0	0
Chittenden	3	3	1	1	1	1	1	1	1	1
Essex	3	3	1	1	1	1	0	0	0	0
Franklin	3	3	1	1	1	1	1	1	0	0
Grand Isle	3	3	1	1	1	1	1	1	0	0
Lamoille	3	3	1	1	1	1	1	1	0	0
Orange	3	3	1	1	1	1	1	1	0	0
Orleans	3	3	1	1	1	1	0	0	0	0
Rutland	3	3	1	1	1	1	1	1	1	1
Washington	3	3	1	1	1	1	2	2	0	0
Windham	3	3	1	1	1	1	1	1	0	0
Windsor	3	3	1	1	2	2	1	1	0	0
TOTAL	42	42	14	14	15	15	13	13	2	2

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.

There are fifty FQHC locations in Vermont that provide SMI/SED services, a number that has remained unchanged since between the baseline and mid-point (**Exhibit 30**).

Exhibit 30. Availability of Federally Qualified Health Centers Providing SMI/SED Services, 2021-2023

	Annual Estimates			Mid-Point Difference (2023 vs. 2021)	
	2021 (Baseline)	2022	2023 (Mid-Point)	Absolute	Percent
Medicaid Members with SMI/SED	24,208	22,496	22,390	-1,818	-7.5%
FQHCs Providing SMI/SED Services	50	50	50	0	--
FQHC Ratio	484.2	449.9	447.8	-36.4	-7.5%

SOURCE: 2021-2023 Provider Availability Assessments provided by the state.

Chapter 4: Assessment Of Overall Risk Of Not Meeting Milestones & Recommendations

This chapter summarizes the findings from **Chapter 3** and describes the assigned risk rating for each milestone. Milestones deemed at medium or high risk include NORC's recommendations and responses from the state. **Exhibit 31** summarizes each SMI/SED milestone and progress towards critical metrics and implementation action items and includes key themes that emerged from provider organization feedback.

Exhibit 31. Summary of Mid-Point Assessment of Overall Risk of Not Achieving Demonstration Milestones

Milestone	Metric Progress Achieved	Implementation Action Item Status	Key Themes from Feedback	Risk of Not Meeting Milestone
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)	0% (0/1)	100% No action needed (6/6)	No feedback from provider organizations related to Milestone 1 is available	Low
Improving Care Coordination and Transitions to Community-based Care (Milestone 2)	20% (1/5)	• 60% No action needed (3/5) • 20% Complete (1/5) • 20% Ongoing (1/5)	Workforce challenges; lack of availability in community-based settings; unmet social needs; lack of centralized EHR; hired new staff for care coordination; participated in coordination meetings with DMH local provider organizations, facilitated by the shift to virtual case management meetings that began during COVID-19	Medium
Access to Continuum of Care Including Crisis Stabilization (Milestone 3)	100% (1/1)	• 60% No action needed (3/5) • 20% Complete (1/5) • 20% Ongoing (2/5)	Workforce crisis; inadequate program funding/state support; unmet social needs; lack of availability in community-based settings	Low
Earlier Identification and Engagement in Treatment (Milestone 4)	0% (0/3)	100% No action needed (4/4)	Workforce challenges	Medium

4.1 Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

We assign an overall risk rating of low for SMI/SED Milestone 1. There is one critical monitoring metric (Metric 2, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics) associated with this milestone. While this metric moved in the direction opposite the state's goal, decreasing by 6.6 percent, we note that this decrease is due in part to an increase in the number of children being prescribed antipsychotics in 2022 (i.e. the measure denominator). While receipt of psychosocial care among this population also increased during this period, it was not proportionate to the increase in prescribing. We also note that this milestone is limited to the pediatric population rather than the waiver population overall. Therefore, we assess the completed action items as more central to the milestone's goal.

All six implementation criteria under Milestone 1 required no action under the Demonstration. Implementation action items for this milestone focused on ensuring psychiatric hospital quality using strategies including licensure of inpatient facilities and IMDs, utilization review policies, and DMH's Results Based Accountability framework for evaluating the performance of SMI/SED initiatives. Vermont has several programs and policies in place that aim to ensure high-quality care in hospital and residential treatment settings that predate the SMI/SED Demonstration, including the Vermont Department of Health's Hospital Licensing Rule, which establishes standards that guide the licensure and accreditation, oversight, and utilization review in psychiatric hospitals and units.

4.2 Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

We assign an overall risk rating of medium for SMI/SED Milestone 2. Of the five critical metrics under this milestone that are reported by the state, Vermont reports progress at the mid-point for one metric (Metric 9). Two additional metrics (Metrics 4 and 10) remained consistent (defined as a change of less than 2 percentage points), and the remaining three metrics moved in the direction opposite the stated goal. Despite decreases in overall rates of follow-up observed in the monitoring metrics, most hospitals, Designated Agencies, and Specialized Service Agencies reported conducting care coordination and care transition activities for their patients with SMI/SED. We note that the period assessed in this report includes the height of the COVID-19 PHE. The overall change between 2020 and 2022 obscures annual trends driven by the PHE; multiple core metrics for this milestone (Metrics 4, 7a, 10a, and 10b) worsened (i.e. moved in the direction opposite the stated goal) between 2020 and 2021 but reversed direction and began to return to pre-pandemic levels in 2022 reports. Provider organizations also reported hiring new staff, screening patients for clinical and social needs, and implementing community-oriented systems and processes to improve care coordination activities. However, workforce challenges and a lack of a centralized EHR were cited as barriers to achieving progress for this Milestone.

The SMI/SED Implementation Plan identified five criteria under this milestone. For three criteria, no action items were identified. The state completed action item 2c (state requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible) in January of 2022 when the Vermont Department of Health's Hospital Licensing Rule was updated to require IMDs to follow up with patients within 72 hours of discharge through mechanisms such as email, text, or phone call. The state has also made progress on the remaining action item related to implementation action item 2d (strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission). For example, in FY22, the state granted an award to Pathways VT to fund a process for developing and implementing a statewide peer support specialist certification program in Vermont. Also in FY22, The Department of Mental Health solicited proposals for Inpatient Psychiatric Units for Children and Adolescents and selected one vendor from the competitive bid process. The goal of this additional facility is to further stabilize and improve the current availability of services and access to inpatient psychiatric care.

Recommendations

- **Maintain and enhance current discharge planning and care coordination initiatives.** Many hospital, Designated Agency, and Specialized Service Agency leaders suggested that increased support for community-based programs, intensive outpatient programs, and workforce across the continuum of care could help the state address access gaps and transitions of care. The state is already undertaking several such activities; we recommend that the state continue to implement initiatives aimed at improving the discharge planning and care coordination processes and consider implementing policies that would expedite follow-up after ED visits and inpatient hospitalizations.
- **Continue investing in a robust, integrated health data exchange infrastructure that can be accessed by hospital and nonhospital providers.** To facilitate continuity of care, Designated Agencies requested the ability to track referrals and care paths in the VHIE to enable shared care planning and reduce the administrative burden on providers to track and monitor patients admitted to the hospital. We recommend that the state continue investing in health IT infrastructure.
- **Consider additional efforts to address workforce challenges.** Although the ratio of Medicaid members with SMI/SED to providers authorized to prescribe psychiatric medications and/or treat mental illness improved between baseline and midpoint, the overall number of behavioral health providers in the state declined. Provider feedback also indicated that workforce shortages and challenges in Vermont may be contributing to the lack of observed progress on critical metrics related to this milestone. We recommend that the state identify and implement strategies to build and strengthen the mental health workforce.

State Responses

The State acknowledges the reverse trends of the target direction of the aforementioned metrics associated with this milestone. The performance reported on each of these metrics highlights the

recommendation for the need to improve care coordination activities between inpatient psychiatric hospitals and emergency departments with outpatient providers, specifically Designated Agencies and Specialized Service Agencies. One ongoing initiative that the State plans to complete in the upcoming fiscal year is having DAs and SSAs sending and receiving data via the VHIE. Presently, agencies have connected their respective EHRs to the VHIE, but have not yet begun sending or receiving production data. The State anticipates that these data will begin transmission within the next 3-6 months, which will drastically improve care coordination activities for all providers. Subsequently, the State foresees the trends of these measures to align with the identified targeted directions.

4.3 Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services

We assign SMI/SED Milestone 3 an overall risk rating of low. The state met the target for the critical monitoring metric associated with this milestone, maintaining an average length of stay in IMDs under 30 days. The total number of members with SMI/SED treated in an IMD did not change between 2020 and 2022, but the average length of stay in IMDs (for all IMDs and populations) declined by almost two days. Notably, the variation in length of stay between the two IMD facilities is significant. The average length of stay at the Brattleboro Retreat was eight days, while the average length of stay for the Vermont Psychiatric Care Hospital was 110 days. Together, the average length of stay for all inpatients at an IMD is 15 days.[xix] Documents and interviews with hospital leaders highlighted factors contributing to longer hospital stays including a state law enforcing a waiting period before commencing involuntary medication and hospitals' efforts to avoid discharging patients to homelessness.[xxiv]

No action was needed by the state on three of the five action items associated with this milestone. The action item associated with implementation action item 3d (state requirement that providers use a widely recognized, publicly available patient assessment tool to determine the appropriate level of care and length of stay) was completed in January of 2022 with an update to the Vermont Department of Health's Hospital Licensing rule. Finally, the state has made progress on implementation action item 3e (other state requirements/policies to improve access to a full continuum of care including crisis stabilization) through two key initiatives: the River Valley Therapeutic Residence expanded community-based mobile crisis intervention services. Finally, while workforce shortages and a lack of available inpatient and crisis stabilization beds are contributing to access challenges in the state, most provider organizations reported offering a variety of crisis stabilization services for patients with SMI/SED, as well as several strategies to connect individuals to appropriate levels of care and enable ongoing treatment in outpatient settings.

4.4 Milestone 4: Earlier Identification and Engagement in Treatment

We assign an overall risk rating of medium to Milestone 4. The state did not demonstrate progress on the three critical metrics under this milestone, though one metric (Metric 26, Access to Preventative/ Ambulatory Health Services for Medicaid Beneficiaries with SMI), remained consistent. While the implementation plan reported no actions were needed for the four action items under Milestone 4, Vermont has continued to employ several strategies intended to better identify and engage individuals in treatment earlier, such as increasing integration of behavioral health in non-specialty settings, and expanding access and capacity to community-based mental health services, particularly for young people with SMI/SED. Provider organizations reported using screening tools to identify patients in need of treatment for mental health conditions as well as other clinical needs. However, feedback also indicated that workforce shortages affect access to these services and contribute to increased wait times. Designated Agencies reported struggling to meet the demand for services, which may in part be driving the lack of progress on critical metrics under this milestone.

Recommendations

- **Develop specific action items with target dates to achieve this milestone by outlining key steps to achieve increased integration of behavioral healthcare.** While the state is engaged in a number of initiatives designed to quickly and efficiently identify and engage members with SMI/SED, we encourage AHS to identify specific implementation action items to facilitate progress towards this milestone.

State Response

As aforementioned in the “State Response” section to recommendations pertaining to Milestone 2, the State acknowledges the need for action items to have target dates with associated key steps to ensure achievement of earlier identification and engagement in treatment through increased integration for its SMI/SED population. The State has a number of ongoing mental health integration-related initiatives that include:

- Mental Health Payment Reform
  - This initiative has a Value-Based Payment component with quality measures that assess the performance of Designated Agencies and Specialized Service Agencies on access to care, screening for mental health and substance use issues, and adoption of standardized assessment tools. This ongoing, CMS-approved reform initiative was instituted on January 1, 2019.
- Certified Community Behavioral Health Clinics (CCBHCs)
  - In March 2023, the State received a CCBHC State Planning Grant from SAMHSA. The State received a No Cost Extension for this grant, which extends the period of performance until March 2025.

- The State is currently studying the feasibility of implementing a CCBHC program in Vermont, as one does not currently exist. CCBHCs are required to meet federal and state standards for the range of services and provide timely access to individuals seeking care, including those with SMI/SED. Other requirements include 24/7 crisis services that has mobile crisis, providing routine outpatient care within 10 business days after an initial contact to prevent people from languishing on waiting lists, ensuring access to a comprehensive range of services, providing care coordination when needed and incorporating evidence-based practices and other supports based on a community needs assessment. Finally, CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age, including developmentally appropriate care for children and youth.
- CCBHCs provide a model to improve the integration of mental health care within Vermont that focuses on whole person health. The State applied for acceptance into the next round of CCBHC Demonstration and expects to be notified of whether it will be accepted by mid-June 2024.

Overall, these initiatives will enhance the State's ability to meet the associated targets of this milestone and improve care integration for individuals with SMI/SED.

Attachment 1: Independent Assessor

In May 2023, AHS selected NORC at the University of Chicago (NORC) as the Independent Evaluator for the Global Commitment to Health 1115 Demonstration via a competitive procurement process. The statement of work included a MPA on progress toward goals described in the state's SMI/SED Implementation Plan. In accordance with CMS guidance on the MPA, NORC signed a "No Conflict of Interest" statement, included here.

NORC CONFLICT OF INTEREST STATEMENT & COMPLIANCE PROCESS

Overview

NORC has robust policies and procedures for avoiding and mitigating potential conflicts of interest on programs such as this. For this solicitation, ***Evaluation of the Vermont Global Commitment to Health 1115 Waiver,*** NORC has no known actual or potential conflict of interest. NORC has no known organizational or personal conflicts of interest that might cause biased judgment. NORC does not have access to nonpublic information that will provide an unfair competitive advantage.

Introduction

National Opinion Research Center ("NORC") is a prominent not-for-profit research firm that is well known for its scientific excellence, independence, and integrity. The majority of NORC's business is performed through contracts and grants with the federal government. Given the importance of NORC's reputation for successful business activity and its position as a federal contractor, a robust and well-proven Conflict of Interest ("COI") regime is in place to ensure (1) the prevention of COIs from developing in the first place, and (2) the identification and remediation of any COIs effectively and immediately in the rare cases they do occur. NORC has developed COI procedures described herein to fulfill the requirements set forth in ***Evaluation of the Vermont Global Commitment to Health 1115 Waiver***. We provide details on our tailored COI processes in the remainder of this document.

NORC Compliance Officer

A NORC Vice President and senior Institutional Review Board ("IRB") member, Kathleen Parks, serves as NORC's Conflicts Compliance Officer. Due to her role on the IRB and her position on NORC's senior management team, Ms. Parks is independent and impartial. In addition to being a senior member of NORC's IRB, Ms. Parks is also responsible for administrative oversight of the IRB and is a member of NORC's Conflicted Transactions Committee which oversees the administration of NORC's Financial Conflict of Interest policies and procedures. The Conflicts Compliance Officer reports directly to NORC's Board of Trustees for all compliance and conflicts matters. NORC's Conflicts Compliance Officer reviews and has auditing authority for all business and contractual relationships and activities of NORC.

Independent and Impartial

NORC is an independent 501 (c) 3 not-for-profit organization. NORC has its own Board of Trustees (16). NORC is affiliated with the University of Chicago in that the President of the University can nominate 51% of NORC's Trustees. However, all of NORC's Trustees have a fiduciary responsibility to act in NORC's best interest while making decisions as Trustees of NORC. The University of Chicago has its own independent Board of Trustees which is required to make decisions in the best interest of the University.

Conflicts Policies and Procedures

NORC maintains policies and procedures for organizational conflicts of interest and personal conflicts of interest, each described in turn below. Each item below describes the particular conflicts oversight process including how conflicts are identified and resolved.

1. Organizational Conflicts

All staff are required to identify potential conflicts of interest on an ongoing basis. All NORC staff receive annual conflicts and ethics training that includes a series of self-administered training modules and exams supplemented by regularly conducted training sessions. NORC's Conflicts Compliance Officer reviews all existing and potential new business for NORC and its staff, subcontractors, consultants, and vendors to determine if there are any actual, potential, or apparent conflicts. Any actual, potential, or apparent conflicts are categorized into any or all of the following conflict types: unequal access to information, biased ground rules, or impaired objectivity. If any of the aforementioned conflicts exist as determined by the Conflicts Compliance Officer, the Conflicts Compliance Officer works with the project team and NORC's Contracts department to create a mitigation plan for submission to the cognizant awarding agency's conflicts officer and/or the program's assigned Contracting Officer along with any other information that may be useful in assisting the review of NORC's proposed solution to mitigate or neutralize the conflict.

Additionally, the Conflicts Compliance Officer has full authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. NORC maintains a reporting hotline where anyone can call in to report an issue. Issues reported to the hotline are resolved by the Conflicts Compliance Officer and Board of Trustees members that participate in NORC's Conflict Transactions Committee. All such reported issues are treated seriously and investigated thoroughly.

2. Personal Financial Conflicts

NORC also adheres to a robust Personal Financial Conflict of Interest (FCOI) Policy. This is a federally mandated policy by certain agencies of the government including HHS. Under this policy, all principal investigators, and other staff who can influence the results of an affected government contract, are required to at least annually complete a certificate identifying potential conflicts of interest with the work they are performing on the affected contract (Personal Conflicts disclosures are also completed on per project and/or per proposal basis as required by individual sponsors). These employees are also required to undergo specific training on how to identify a potential conflict of interest and the requirements to disclose it. FCOI compliance is overseen by the NORC FCOI Committee, of which the Conflicts Compliance Officer is a member. All personal conflict disclosures are evaluated by the Conflicts Compliance Officer. Under the direction of NORC's Conflicts Compliance Officer, the Contracts department administers the annual certifications and trainings required to satisfy the organization's compliance obligations for FCOI. If an FCOI disclosure is identified, it is immediately sent to the FCOI Committee for review, discussion, and further remediation by other cognizant NORC officers, if necessary. The Conflicts Compliance Officer ensures a mitigation plan is created and

submitted to the appropriate governing agency for review where any actual, potential, or apparent conflict has been identified. Conflicted and/or potentially conflicted individuals are prohibited from participating in any component of the program or work that gave rise to the conflict until the conflict has been neutralized and cleared by the governing agency.

Authority, Audits and Remediation

NORC's Conflicts Compliance Officer has independent authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. In coordination with NORC's Contracts department, Accounting and Finance, and other stakeholders within the organization, the Conflicts Compliance Officer conducts regular random audits of project and personnel activities to ensure compliance with NORC's conflicts policies and procedures. Additionally, NORC contracts with an independent external auditor to conduct an independent audit of any mitigation plans as directed. The findings and recommendations of any external audit including any corrective action plan developed by NORC will be shared with our client for review and approval.

NORC maintains a third-party administered Hotline for reporting conflicts, fraud, misconduct, and illegal or unethical practices. Staff, contractors, sponsors, or interested parties can anonymously call this third-party administrator and report any suspected wrongdoing including conflict of interest at any time. The third-party administrator reports directly to the Board of Trustees Chairman of the Audit and Finance Committee and NORC's Conflicts Compliance Officer. All such reported issues are treated seriously and investigated thoroughly. In accordance with FAR 52.203-14, the Conflicts Compliance Officer works with NORC's Human Resources and Facilities Departments to ensure these conflicts policies and hotline number are posted in locations that are accessible to all staff including hard copy posters in common areas of office sites and on NORC's intranet. NORC routinely prompts staff to review these policies.

Violation of NORC's conflicts policies and procedures are handled in a manner commensurate to the nature of the violation. Violations may range from corrective action by a supervisor, termination of employment/contractor, referral to authorities, as well as civil and criminal prosecution where warranted or necessitated by law.

Vice President and COI Compliance Officer

Attachment 2: Vermont Mental Health Care Provider Survey

NORC at the University of Chicago ("NORC"), a non-partisan research organization, is under a contract with the State of Vermont Agency of Human Services to evaluate the Vermont's Global Commitment to Health Demonstration ("the Demonstration") as approved by the Centers for Medicare & Medicaid Services (CMS) (contract number 45956). As part of the evaluation, NORC is conducting a one-time survey of mental-health care organizations in Vermont.

Thank you very much for your assistance with this important effort!

What is the purpose of this survey?

The purpose of the survey is to learn more about your organization's efforts to provide and coordinate care across the care continuum for patients with serious mental health conditions.

Who will respond to this survey?

Participation in this survey is voluntary. We shared the survey link with the person identified as the primary contact at each organization. We are only requesting one survey from each organization. We anticipate that others within your organization may have information needed to answer some of the survey questions within a specific area (e.g., care coordination, access to care). You may consult with colleagues at your organization, and the instrument is designed so you may pause, save your responses, and continue at a later date.

At the end of the survey, you have the option to download a copy of your responses.

How is your confidentiality and data protected in this survey?

Your responses will be kept private. We will use unique survey identifiers, instead of respondent or organization names, to store the data that we collect through this survey. Your responses will not be shared with anyone outside of the NORC research team. CMS and the State of Vermont will not have access to any identifiable information from this survey about you/your organization. This study has received approval from the NORC and Agency of Human Services Institutional Review Boards and can be contacted at irb@norc.org and Shawn.Skaflestad@vermont.gov with any questions related to research ethics.

How long will the survey take to complete?

This survey is expected to take approximately 15-20 minutes to complete.

Whom do I contact for assistance?

Contact the NORC evaluation team at VTWaiverEval@norc.org if you need assistance with this survey. If you have questions about your rights as a participant in this evaluation, you may contact the NORC Institutional Review Board Manager toll-free at (866) 309-0542 or by e-mail irb@norc.org.

INSTRUCTIONS

Please use the "Continue" and "Previous" survey buttons **on the bottom of the screen** to navigate through the questions in the survey. **" Please do not use your browser buttons to navigate through the questions in the survey.** You can simply close your internet browser window to exit the survey and any responses completed before closing will be saved.

We greatly appreciate your time and participation! Let's get started.

I. Organization Characteristics

Q1. What is the name of your organization? *[Forced Response]*
- [**TEXT BOX**]

Q2. What is the zip code of your primary site? *[Forced Response]*
- [**TEXT BOX**] *[5-digit validation]*

Q3. Approximately how many of the following types of staff are employed by your organization? Your best estimate is fine. Please indicate '0' for none.

Staff Type	Number of Staff
Staff providing clinical mental health and/or substance use care (includes psychologist, psychiatrist, primary care provider, therapist/counselor, clinical social worker)	
Nursing team members providing mental health and/or substance use care	
Staff providing peer support/recovery services	
Staff providing care coordination/care management services	
Other staff providing mental health and/or substance use care, please specify: [**TEXT BOX**]	

II. Care Coordination and Transitions

Q4. Is your organization involved in care transition activities, including discharge planning, for patients being discharged from any of the following:

- Involuntary ED admissions
- Voluntary ED admissions
- Psychiatric hospitals
- Residential care delivery sites

- ○ Yes, please specify [**TEXT BOX**]
- ○ No
- ○ Don't know

Q5. *[If Q4 = yes]* **Has your organization adopted any systems, processes, or policies to improve care transition activities?**

- ○ Yes, please specify [**TEXT BOX**]
- ○ No
- ○ Don't know

Q6. Please indicate the frequency at which your organization conducts these care coordination activities for patients with serious mental health conditions. Select one response per row.
[Randomize response options]

	Often	Sometimes	Seldom	Never	Don't know
Outreach to engage and monitor patients' care coordination	○	○	○	○	○
Provide care coordination services for patient panels	○	○	○	○	○
Create shared care plans and community among care team members	○	○	○	○	○
Participate in shared care planning and/or care conferences to facilitate the patient's goals of care	○	○	○	○	○
Support effective care transitions (e.g., ED follow-up calls, post hospital discharge visits)	○	○	○	○	○
Partner with continuum of care and other family and youth-serving systems, such as education, child welfare, housing, and economic supports, as applicable	○	○	○	○	○
Other, please specify [**TEXT BOX**]	○	○	○	○	○

Q7. Please indicate the frequency at which your organization screens patients with serious mental health conditions for these clinical and/or social service needs. Select one response per row. *[Randomize response options]*

	Often	Sometimes	Seldom	Never	Don't know
Co-morbid physical health conditions	O	O	O	O	O
Co-morbid SUD	O	O	O	O	O
Housing assistance	O	O	O	O	O
Transportation	O	O	O	O	O
Safety	O	O	O	O	O
Food assistance	O	O	O	O	O
Education to enhance wellness and resiliency skills	O	O	O	O	O
Other, please describe the population [**TEXT BOX**]	O	O	O	O	O

Q8. Please briefly describe any challenges in transition planning and care coordination for patients with serious mental health conditions.
[OPEN END]

III. Access

Q9. We are interested in how your organization identifies patients in need of treatment for serious mental health conditions, including inpatient and crisis stabilization. Please indicate which screening tool(s) your organization frequently uses. Select all that apply.

- Locus
- CASII
- InterQual/McKesson
- SBINS
- Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)
- Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)
- SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)
- Don't know
- We do not currently use a screening tool
- Other [**TEXT BOX**]

Q10. Please indicate the frequency at which your organization provides these <u>services</u> for patients with serious mental health conditions. Select one response per row. *[Randomize response options]*

	Often	Sometimes	Seldom	Never	Don't know
Call centers, such as a mental health or suicide prevention hotline	O	O	O	O	O
Emergency/crisis units	O	O	O	O	O

Intensive outpatient services	○	○	○	○	○
Crisis bed alternative programs	○	○	○	○	○
Embedded mental health professionals within local and state law enforcement	○	○	○	○	○
Telepsychiatry	○	○	○	○	○
Peer-to-peer support services	○	○	○	○	○
Screening, Brief Intervention, and Navigation to Services (SBINS)	○	○	○	○	○
Other, please specify: [**TEXT BOX**]	○	○	○	○	○

Q11. Please briefly describe any challenges providing these services for patients with serious mental health conditions.
[OPEN END]

Q12. Is there anything else that you would like to share related to your organization's services or care coordination efforts for patients with serious mental health conditions?
[**OPEN END**]

We thank you for your time spent taking this survey. Your responses have been recorded. (Your respondent's response summary will appear here)

Attachment 3: Provider Survey Response Tables

Exhibit A3.1. Provision of Care Coordination Services to Patients with SMI

	N (17)	Overall	Hospital (n=6)		Non-hospitals (n=11)	
	#	%	#	%	#	%
Outreach to engage and monitor patients' care coordination						
Often	12	70.6%	4	66.7%	8	72.7%
Sometimes	3	17.6%	1	16.7%	2	18.2%
Seldom	1	5.9%	1	16.7%	0	0.0%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	1	5.9%	0	0.0%	1	9.1%
Provide care coordination services for patient panels						
Often	12	70.6%	4	66.7%	8	72.7%
Sometimes	2	11.8%	1	16.7%	1	9.1%
Seldom	2	11.8%	1	16.7%	1	9.1%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	1	5.9%	0	0.0%	1	9.1%
Create shared care plans and community among care team members						
Often	9	52.9%	4	66.7%	5	45.5%
Sometimes	6	35.3%	2	33.3%	4	36.4%
Seldom	2	11.8%	0	0.0%	2	18.2%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%

	N (17)	Overall	Hospital (n=6)		Non-hospitals (n=11)	
	#	%	#	%	#	%
Participate in shared care planning and/or care conferences to facilitate the patient's goals of care						
Often	13	76.5%	4	66.7%	9	81.8%
Sometimes	3	17.6%	2	33.3%	1	9.1%
Seldom	1	5.9%	0	0.0%	1	9.1%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%
Support effective care transitions (e.g., emergency department follow-up calls, post-hospital discharge visits)						
Often	12	70.6%	4	66.7%	8	72.7%
Sometimes	4	23.5%	2	33.3%	2	18.2%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	1	5.9%	0	0.0%	1	9.1%
Partner with continuum of care and other family and youth-serving systems, such as education, child welfare, housing, and economic supports, as applicable						
Often	14	82.4%	4	66.7%	10	90.9%
Sometimes	1	5.9%	1	16.7%	0	0.0%
Seldom	1	5.9%	1	16.7%	0	0.0%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	1	5.9%	0	0.0%	1	9.1%

Exhibit A3.2. Provision of Screening for Patients with SMI for Clinical and Social Service Needs

	N (16)	Overall	Hospital (n=6)		Non-hospitals (n=10)	
	#	%	#	%	#	%
Clinical Needs						
Co-morbid physical health conditions						
Often	12	75.0%	6	100.0%	6	60.0%
Sometimes	1	6.3%	0	0.0%	1	10.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	2	12.5%	0	0.0%	2	20.0%
Co-morbid substance use disorder(s)						
Often	14	87.5%	6	100.0%	8	80.0%
Sometimes	0	0.0%	0	0.0%	0	0.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	2	12.5%	0	0.0%	2	20.0%
Social Services						
Housing Assistance						
Often	10	62.5%	3	50.0%	7	70.0%
Sometimes	4	25.0%	3	50.0%	1	10.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Transportation						
Often	10	62.5%	3	50.0%	7	70.0%
Sometimes	4	25.0%	3	50.0%	1	10.0%
Seldom	0	0.0%	0	0.0%	0	0.0%

	N (16)	Overall	Hospital (n=6)		Non-hospitals (n=10)	
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Safety						
Often	14	87.5%	5	83.3%	9	90.0%
Sometimes	1	6.3%	1	16.7%	0	0.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	0	0.0%	0	0.0%	0	0.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Food assistance						
Often	10	62.5%	4	66.7%	6	60.0%
Sometimes	4	25.0%	2	33.3%	2	20.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Education to enhance wellness and resiliency skills						
Often	10	62.5%	3	50.0%	7	70.0%
Sometimes	3	18.8%	3	50.0%	0	0.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	2	12.5%	0	0.0%	2	20.0%

Exhibit A3.3. Service Provisions to Patients with SMI

	N (16)	Overall	Hospital (n=6)		Non-hospitals (n=10)	
	#	%	#	%	#	%
Call centers, such as a mental health or suicide prevention hotline						
Often	6	37.5%	1	16.7%	5	50.0%
Sometimes	2	12.5%	1	16.7%	1	10.0%
Seldom	2	12.5%	2	33.3%	0	0.0%
Never	5	31.3%	2	33.3%	3	30.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Emergency/crisis units						
Often	11	68.8%	3	50.0%	8	80.0%
Sometimes	0	0.0%	0	0.0%	0	0.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	5	31.3%	3	50.0%	2	20.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%
Intensive outpatient services						
Often	4	25.0%	2	33.3%	2	20.0%
Sometimes	5	31.3%	2	33.3%	3	30.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	7	43.8%	2	33.3%	5	50.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%
Crisis bed alternative programs						
Often	5	31.3%	0	0.0%	5	50.0%
Sometimes	4	25.0%	2	33.3%	2	20.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	7	43.8%	4	66.7%	3	30.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%

	N (16)	Overall	Hospital (n=6)		Non-hospitals (n=10)	
	#	%	#	%	#	%
Embedded mental health professionals within local and state law enforcement						
Often	4	25.0%	0	0.0%	4	40.0%
Sometimes	3	18.8%	2	33.3%	1	10.0%
Seldom	1	6.3%	0	0.0%	1	10.0%
Never	7	43.8%	4	66.7%	3	30.0%
Don't Know	1	6.3%	0	0.0%	1	10.0%
Telepsychiatry						
Often	9	56.3%	3	50.0%	6	60.0%
Sometimes	5	31.3%	3	50.0%	2	20.0%
Seldom	1	6.3%	0	0.0%	1	10.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%
Peer-to-peer support services						
Often	9	56.3%	3	50.0%	6	60.0%
Sometimes	5	31.3%	3	50.0%	2	20.0%
Seldom	1	6.3%	0	0.0%	1	10.0%
Never	1	6.3%	0	0.0%	1	10.0%
Don't Know	0	0.0%	0	0.0%	0	0.0%
Screening, Brief Intervention, and Navigation to Services (SBINS)						
Often	6	37.5%	4	66.7%	2	20.0%
Sometimes	1	6.3%	0	0.0%	1	10.0%
Seldom	0	0.0%	0	0.0%	0	0.0%
Never	4	25.0%	0	0.0%	4	40.0%
Don't Know	5	31.3%	2	33.3%	3	30.0%

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