Vermont Agency of Human Services (AHS)
Challenges for Change Integrated Family Services
Progress Update - October 2010
Last Update – July 2010

The AHS Challenges for Change (C4C) web site will provide quarterly updates on all the C4C work as well as additional information:
http://humanservices.vermont.gov/challenges-for-change

An Integrated Family Service Director has been hired. Melissa Bailey has been in the position since September 13, 2010. You can contact her at Melissa.bailey@ahs.state.vt.us or 802-241-4045.

Enhanced Family Treatment including Reduction in Hospitalizations and Out-of-Home Placements

On September 20, 2010 AHS hosted a statewide planning process that included all 12 regions and over 85 participants including providers and family members. We spent ½ a day focusing on 4 topics:

- Intake and eligibility
- Assessment and Family Support and Service Plan
- Re-balancing the system from out-of-home to more in-home supports and services
- Next Steps – the best thinking on how to roll this out statewide

There was good work completed around these topics and a lot of similar thinking and some creative ideas. The summary of the notes are posted on the web site. We will now move to a more condensed planning session over the next few weeks converging with a 2 day compression planning session. This process will also involve all 12 regions who will work on a specific topic more intensively creating a model that could be replicated and implemented statewide. Then on Nov 9 and 10 the regions will send one provider and one parent to present their design and we will spend some time refining that planning to 2-3 options for statewide implementation. The intent is to identify some early adopters who will begin to make the necessary changes at the local level in conjunction with the necessary changes at the state level to implement by March 2011 with statewide implementation July 2011.

Documentation and Administrative Tasks

Tasks associated with administrative burden and/or consumption of indirect time in the designated agency system were reviewed with a interagency group led by the Deputy Secretary of AHS. Several areas of concern were streamlined to reduce administration and indirect time in the system of care. Savings associated with these activities for the children's services system amounted to approximately 600k, leaving a 400k in administrative reductions to meet the original challenges for change IFS target. A children's "administrative streamlining" workgroup is inventorying all intake

and referral and treatment planning forms from programs, divisions and departments within AHS to identify a core universal set of documentation and data elements common to all AHS programs. This would eliminate the need for local providers' maintaining separate system requirements for each of the various divisions within the agency dealing with children and families.

Repurpose Woodside as Secure Residential

The Woodside Juvenile Rehabilitation Center is focused on repurposing Woodside as a residential psychiatric treatment facility, under CMS regulations; serving youth ages 10 to 17. In keeping with national trends in youth detention, Woodside has been undergoing significant transformation for the past 3 years, including changes in policy and practice, and changes in oversight and accreditation. Currently, with the help of a contracted CARF surveyor, Woodside is reviewing all existing policies and operational procedures, engaging in a mock CARF survey, and developing new policies and procedures in keeping with treatment and regulatory requirements. Staff are being trained in these policies and procedures, and in best treatment practices including Cognitive Behavioral Therapies (CBT). Discussions have been occurring with the Judiciary and other stakeholders and recommendations to the general assembly are being developed by DCF recommending statutory language changes for the repurposing of the facility.

Best Practices in Psychotropic Medication Use

A stakeholder meeting was held on 10/13/10. DVHA, AHS, UVM, and DMH presented to the group the C4C draft recommendations which included $300,000 in savings which will be established by curtailing the off label use of Seroquel for sleep in adults. The feasibility of using the ADAP prescription monitoring system was explored by this committee with VDH and rejected because the credibility between the VDH and physicians was based on monitoring the abuse of controlled substances by patients and not a review of physician prescription practices. Additionally, the system would need significant changes in order to be used in a new manner.

In order to promote best practices for prescribing child psychotropic meds, all agreed that we need to look at the individual cases and the diagnoses. Gross numbers of meds used do not give us the information as to whether they are used properly or not. Discussions with UVM have begun related to academic detailing project on ADHD and/or anxiety/depression. These proposals were generally well received and our committee will work to operationalize them. We will meet again with the stakeholder committee on December 8th.

CHASS – Children's Health and Support Services
Integrated Intake and Program Operation Between DAIL and VDH Programs for Children

Client Cross-Match between CSHN respite and DAIL CPCS showed that 50% of CSHN Respite recipients receive CPCS. The team identified an opportunity for greater efficiency by contracting with ARIS to serve as fiscal agent for CSHN respite program. Currently CSHN staff processes 1500 to 2000 paper invoices manually which are submitted to VDH Business Office for entry into VISION system. Jennifer Garabedian and Steve Brooks will meet with ARIS representative to discuss necessary process changes at CSHN and the cost-benefit of utilizing ARIS.

With significant background work now completed, the team has met with Vermont Family Network and formulated a plan for family input; and has a meeting planned with the Assistant Director of the Vermont Federation of Families for Children's Mental Health -- to engage families as integral partners in the further development of CHASS:

- Overall access to CHASS which includes CPCS, Children's Hi-Tech Nursing, CSHN services, Bridge Case Management and Flexible Family Funds for children
- Development or selection of new assessment/reassessment tool for CPCS
- Development of criteria for periodicity of reassessment for CPCS and Hi-Tech (?)
- Identification of a cadre of assessors, focusing on partners with most relevant knowledge of the children and families who seek CHASS services
- Development of training materials and protocols for assessors

The CHASS team developed and implemented a plan whereby we will forego CPCS re-assessments scheduled for December 2010 through June 2011. This week approximately 1400 CPCS recipients received a memo indicating that services would be automatically extended for another year. This has enabled us to exceed our target C4C savings of $100,000 by almost $40,000. Family requests for reassessment will be honored. Once new periodicity criteria and schedules have been established beginning July, 2011, we anticipate meaningful ongoing savings. These savings are less predictable, but we anticipate that a significant number of children will be deemed eligible for reassessment at 3 and 5 year intervals as opposed to the current 1-year interval for all children.

We have every expectation that families will find improved assessment and reassessment tools and protocols to their liking. We are equally certain that reassessment intervals that reflect children's health and developmental status will be well received.

Children's Integrated Services: ages 0-6 – Karen G

The 3 regional pilots have been identified **-** Lamoille (Lamoille Family Center), Rutland (Rutland Area VNA) and Franklin/Grand Isle (NCSS) and will be implementing full CIS integration on November 1, 2010. We plan to phase in the remaining nine regions over the next 15 months, with statewide implementation by January 1, 2012. Phase 1

contractors will be responsible for meeting contract performance expectations, which include:

All Contractors:

1. Percentage of those served by CIS who achieve one or more plan goals by the annual review or transition (which ever is earliest);
2. Percentage of those served by CIS receiving services within the timelines outlined in these work specifications;
3. Percentage of those served by CIS who have no further need for immediate related supports upon exiting CIS services;
4. Percentage of those served by CIS reporting satisfaction with CIS services, based on surveys administered annually or at exit, (which ever is earliest). The survey used for this measurement will be developed by the CIS State Team.

Phase 1 Contractors:

1. Number of referrals that are triaged by the CIS Intake Coordinator
   - Rationale - The CIS goal is to have all referrals come through the CIS Coordinator (except for urgent referrals)
2. Percentage of performance measures that are met
   - Rationale - Are we achieving better performance (as measured by meeting performance expectations) from the fully integrated model?
3. Number of service professionals interacting directly with families.

Rationale - Does the use of a consultation team to maximize multidisciplinary views decrease the number of providers servicing an individual family?

IFS Workgroups originally identified in March 2010 will continue to be on hold as we try and determine if the topics identified for these workgroups - Intake, Screening and Assessment (workgroup 1) and Care Coordination (workgroup 2) have a clear charge that is different from the work being completed in the above mentioned IFS initiatives. There is a lot of overlap in each of those initiatives in connection with these 2 workgroups and it appears, for now, that continuing to develop these topics within each of the initiatives and identify where and how they fit together is the best course. For example EFT is focusing on intake that will potentially be applied to the broader system and not just as the EFT "door". As that becomes more solidified we will identify other groups that may want to offer feedback or have questions. If you were identified to participate in one of these groups and feel that you have not had an opportunity in the other initiatives to be heard please let Melissa Bailey know so that she can help determine the best mechanism to get your voice and ideas included.