

Vermont System of Care Report 2020

Submitted by State Interagency Team (SIT)

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State Interagency Team Members

Karen Bielawski-Branch, DCF, Child Development Division
Danielle Bragg, Department of Vermont Health Access
Diane Bugbee, DAILE, Developmental Disabilities Services Division
Morgan Cole, DCF, Child Development Division
Melanie D'Amico, DCF, Family Services Division
Brenda Gooley, DCF, Family Services Division
Alicia Hanrahan, Agency of Education
Sandi Hoffman, Department of Vermont Health Access
Suzanne Legare Belcher, AHS, Field Services Division
Amy Lincoln Moore, Vermont Federation of Families for Children's Mental Health
Pam McCarthy, Vermont Family Network
Monica Ogelby, VDH, Maternal Child Health
Laurel Omland, DMH, Child, Adolescent and Family Unit
Karen Price, Vermont Family Network
Dana Robson, DMH, Child, Adolescent and Family Unit
Amy Roth, DAILE, Developmental Disabilities Services Division
Cindy Tabor, Vermont Federation of Families for Children's Mental Health
Auburn Watersong, AHS, Secretary's Office
Cheryle Wilcox, Department of Mental Health, Commissioner's Office

For any questions related to this report, please direct them to the SIT Co-chairs:

Cheryle A. Wilcox, LICSW
Interagency Planning Director
AHS-Department of Mental Health
802-760-9171
Cheryle.Wilcox@vermont.gov

Diane Bugbee, LICSW
Children's Services Specialist
DAILE-DDSD
802-241-0154
Diane.Bugbee@vermont.gov

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Introduction and Executive Summary

This system of care report is in response to the Act 264 statutory requirement as outlined in 33 VSA § 4302 which requires the State Interagency Team (SIT) to *submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.*

In 2005, an interagency agreement was established which expanded the scope of the statute in the following way: This interagency agreement outlines the provision of services to students who are eligible for both special education and services provided by AHS and its member departments and offices including Department of Health (VDH), Department for Children and Families (DCF, formerly Social and Rehabilitation Services), Department of Mental Health (DMH), Department of Disabilities, Aging and Independent Living (DAIL), Department of Corrections (DOC), Office of Vermont Health Access (now DVHA-Department of Vermont Health Access), and the Department of Education (now AOE-Agency of Education). It is intended that the agreement will provide guidance to human services staff and school personnel in the coordination and provision of services for students with disabilities.

The priorities outlined in this report are the result of ongoing feedback and dialogue from a number of stakeholders including the 12 Local Interagency Teams (LIT), the Act 264 Advisory Board Annual System of Care recommendations, data analysis from the departments of the Agency of Human Services and the Agency of Education and discussion at monthly State Interagency Team meetings. Feedback and input about the Children's System of Care comes in a variety of manners—through face-to-face meetings, annual LIT surveys, electronic communications and phone calls.

I define connection as the energy that exists between people when they feel seen, heard and valued; when they can give and receive without judgment; and when they derive sustenance and strength from the relationship.

~ Brene Brown

System of Care Recommendations for 2020



- 1. Support statewide services in being more streamlined and coordinated.**
 - a. SIT Chair(s) will continue to attend monthly Act 264 Board Meetings to closely coordinate between the two bodies.
 - b. Disseminate the System of Care on an annual basis to all Local Interagency Teams and ensure there is commitment to move the plan forward at the local and state level.
 - c. Continue to collaborate with our education and community mental health partners to ensure that the Act 264 mission is being implemented as intended, especially considering the increased number of children struggling with trauma in educational settings.
 - d. SIT will create a family-friendly guide to explain the Case Review Committee process.

- 2. Increase the number of children, youth and families served in community settings by investing in community-based supports and focusing on mobile response efforts in Vermont.**
 - a. Continue to provide regional and statewide data on a quarterly basis to maintain a focus on the trend lines in residential care.
 - b. An interagency team is focusing on moving mobile response efforts in Vermont forward as a way to support children, youth and families earlier on to prevent higher levels of care from being needed. This team submitted a formal proposal outlining the need for MRSS in Vermont in the Fall, 2019.
 - c. Coordinate with early childhood services to address the need for high-quality early care and learning, grow access to Early Childhood and Family Mental Health, and support evidence-based practices.

- 3. Support funding structures that are coordinated and streamlined to the highest extent possible across AHS departments, move away from fee-for-service funding and toward value-based payments.**
 - a. DMH and DAIL representatives have been meeting for over a year and continue to do so to work towards better coordination between mental health and developmental disabilities so services to children and families can be as streamlined as possible in communities.
 - b. DAIL is undergoing payment reform work to re-tool the funding system for Medicaid developmental disabilities Home and Community Based Services in order to ensure increased equity and accountability.
 - c. The Child Development Division has been engaged in working with the DVHA Payment Reform team to update the Children's Integrated Services (CIS) payment model, to ensure the model is data-informed and equitable across all CIS regions of Vermont.
 - d. Support funding for family and youth partnership to be a shared responsibility of all AHS Departments and the Agency of Education.
 - e. Highlight the apparent inequities and lack of parity created by different insurance coverage and make recommendations about possible solutions.
 - f. Support mechanisms that enhance the various AHS departments' ability to think about funding and budgets as a whole system of care, despite the siloed budgets they each operate within.

- 4. Support transitions in the system of care that streamline service delivery for children, youth and families.**
 - a. Coordinate a transition-aged youth summit that highlights best practice, supports more streamlined approaches, and bridges the children and adult system.

System of Care Accomplishments During 2019



1. SIT hosted the 5th annual statewide gathering of Local Interagency Teams with representation from all 12 regions of the state.
2. SIT created two practice guidance documents for LITs:
 - a. Overview of statutory mandate, responsibilities, membership requirements, and LIT activities
 - b. Facilitating a family-centered LIT meeting
3. SIT provided four consultations involving systems' issues with recommendations to local teams.
4. SIT created training videos as a resource for Local Interagency Teams that model best practice for having families at LITs.
5. SIT provided input and feedback to the Vermont Federation of Families for Children's Mental Health. in their development of a family-friendly introduction to Coordinated Services Plan (CSP) video.
6. SIT received feedback from the field to inform a more streamlined and family friendly CSP. [The revised version](#) was released in September 2019.
7. SIT created a companion [facilitator's guide to completing a CSP](#).
8. SIT collaborated with stakeholders to create a brochure for families who have a child in crisis in the emergency department, which can be viewed on the [DMH website](#). The brochure was distributed to all Designated Agency Emergency Services teams, hospital emergency departments, and other stakeholders.
9. SIT continued to coordinate with the MRSS interagency workgroup and participate in monthly affinity calls regarding Mobile Response and Stabilization Supports (MRSS). A formal proposal was created outlining the need for [MRSS in Vermont](#).
10. January 1, 2019 DMH and DVHA moved all designated agencies out of fee-for-service funding and into case rates for mental health services.
11. SIT began another cycle of in-person meetings with all 12 LITs to learn about regional challenges, successes and work towards greater System of Care consistency in implementation of Act 264. These discussions will be completed during the 2020 calendar year.
12. In January 2019, the SIT became co-chaired by DMH and DAIL-DDSD.

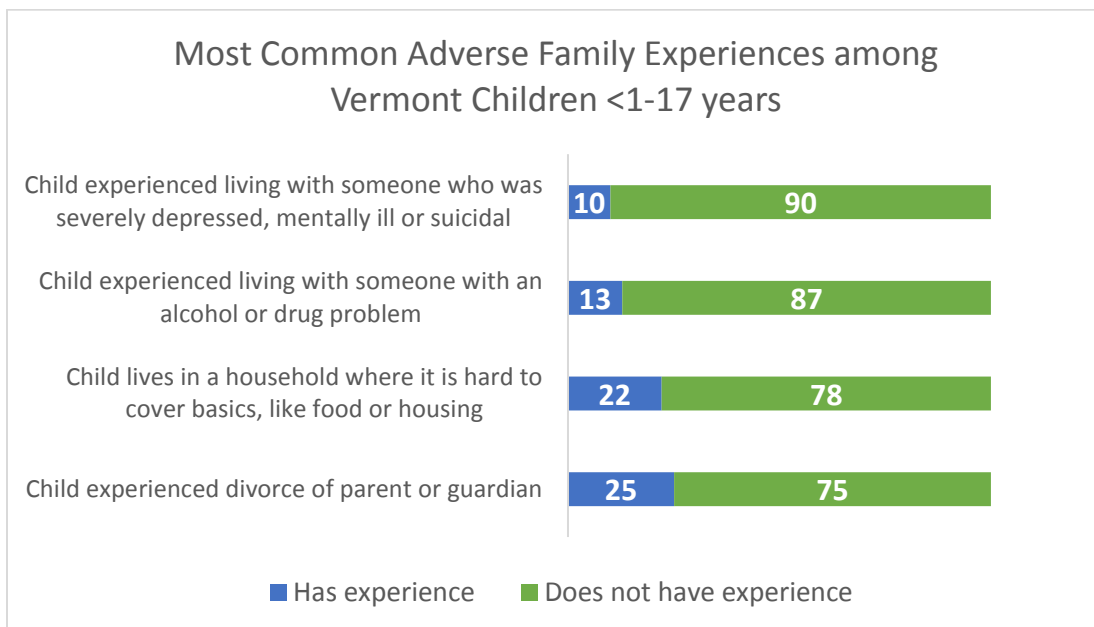
Acuity of Need and the Hope Resiliency Brings



What we know about Vermont's children and youth related to Adverse Family Experiences (AFE) and the Adverse Childhood Experiences (ACE) Study

Adverse Family Experiences¹ and Adverse Childhood Experiences² are phrases used to describe types of abuse, neglect, and traumatic experiences occurring to individuals during their childhood and within their families. We care about this information because research has shown a relationship between adverse childhood experiences and reduced health and well-being later in life.

Figure 1: Vermont AFE Data³



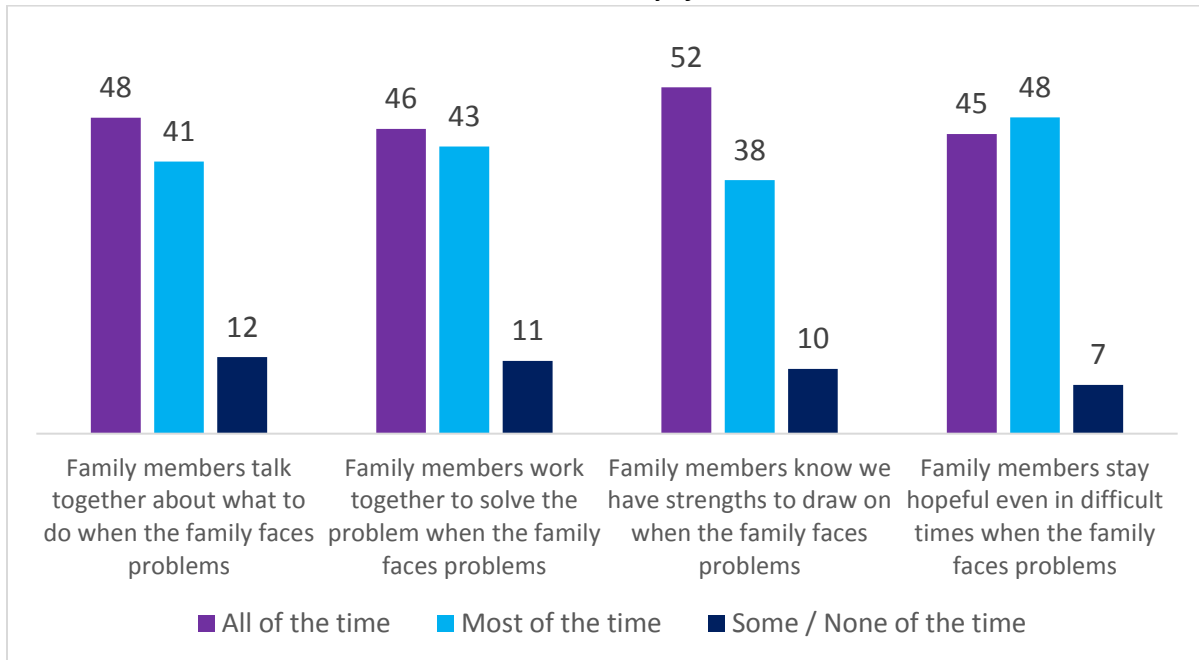
¹ United States Census Bureau. (2016-2018). National Survey of Children's Health. Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

² Felitti, V.J., et al., Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med, 1998. 14(4): p. 245-58.

³ Kasehagen, L., System of Care Plan, October 21, 2019 Vermont Departments of Health & Mental Health, Senior MCH Epidemiologist/CDC Assignee to VDH & VDMH.

We also know people have incredible resilience and the ability to overcome adversity. Therefore, Figure 2 shows data about children in Vermont and the rate of children/youth who engage in resiliency-building dialogue/activities.

Figure 2: Markers of Family Strengths among Vermont Children <1-17 years
2016-2018 National Survey of Children's Health



Youth Risk Behavior Survey, 2019 Report

Family Connectedness:

- More than three quarters of students (75%) ate dinner at home with at least one of their parents on at least four days during the previous week, **significantly less than in 2017**.
- Eating dinner with a parent at least four times during the past week did not differ by sex.
- Younger students are significantly more likely than older students to report eating dinner with a parent at least four times during the past week.
- White, non-Hispanic students are significantly more likely than students of color to eat dinner with a parent at least four times during the past week.
- Heterosexual/cisgender students are significantly more likely than LGBT students to eat dinner with a parent at least four times during the past week.

School Connectedness:

- About three quarters of students (78%) have at least one teacher or adult in their school that they can talk to if they have a problem; 11% are not sure or do not have an adult at their school they could talk to if they had a problem.
- In 2019 **significantly fewer students** reported having at least one teacher or other adult in their school that they could talk to if they had a problem compared to those in 2017.
- Female students are significantly more likely than male students to report having at least one teacher or other adult they can talk to if they had a problem.
- Having at least one adult or teacher in the school they could turn to if they had a problem significantly increases with each grade level.
- White, non-Hispanic students are significantly more likely than students of color are significantly to have an adult in their school they could talk to if they had a problem.
- Heterosexual/cisgender students are significantly more likely than LGBT students to have at least one adult or teacher in the school they could turn to if they had a problem.

Population of Children 0-18 in Vermont

2010: 139,094
 2011: 136,451
 2012: 134,023
 2013: 132,714
 2014: 131,199
 2015: 129,512
 2016: 128,060
 2017: 126,307

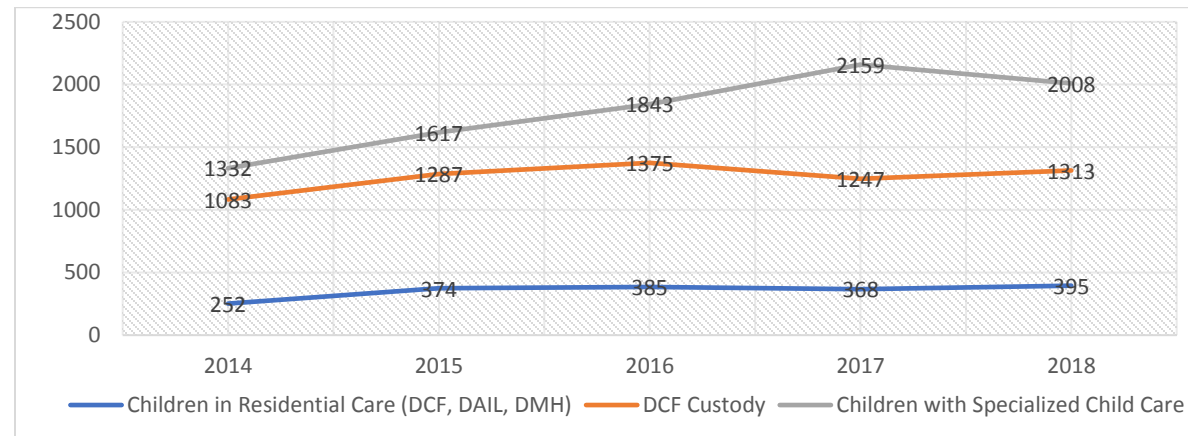
Difference 2010 to 2017: -12,787

Source: Vermont Department of Health, Population of Vermont Counties,

<http://www.healthvermont.gov/health-statistics-vital-records/vital-records-population-data/vermont-population-estimates>

Figure 3: Acuity of Need

There is no question there is a clear decline in the population of children 0-18 in Vermont (see sidebar), however, this does not correlate to a decline in acuity or need. The line graph below shows there has a rise in the need for supports and interventions to combat the growing social and economic needs of families in Vermont. Families are facing poverty, struggles with opiate addiction, limited employment opportunities, and the impacts Adverse Family Experiences have on children.



Youth Risk Behavior Survey, 2019 Report

Acuity of Need:

- Three in ten students felt so sad or hopeless almost every day for at least two weeks during the past 12 months that they stopped doing some usual activities.
- Feeling sad or hopeless has significantly increased over the past 10 years and since 2017.
- Overall, 19% of students reported hurting themselves without wanting to die, such as by cutting or burning on purpose, in the past 12 months.
- Self-harming behaviors significantly increased over the past decade and between 2017 and 2019.
- Just over one in ten students made a plan about how they would attempt suicide during the past 12 months.
- Following a decrease in the percent of students who reported making a suicide plan from 1995 to 2005, students making a suicide plan increased significantly over the past decade and increased between 2017 and 2019.
- During the past 12 months, 7% of students attempted suicide.
- Suicide attempts nearly doubled over the past ten years and significantly increased between 2017 and 2019.
- Two in five students have tried marijuana. While ever using marijuana has remained relatively stable over the past decade, marijuana use significantly increased between 2017 and 2019.

Prevalence of Children with an Emotional Disturbance in Vermont

The Vermont Department of Mental Health (DMH) had been reporting data to SAMHSA on the number of children served through the Designated Agency and Specialized Service Agencies (DA/SSA) system with severe emotional disturbance (SED), using the federal definition of SED identified by Global Assessment of Functioning (GAF) scores 50 and under. However, the most recent version of the DSM-5 removed the GAF. Since provider agencies are expected to comply with the most current version of the DSM, they are no longer using GAF scores. Therefore, until a different tool to measure functioning or a different marker of SED is determined, trend analysis is being utilized to determine SED numbers beginning in 2016.⁴ Over the last decade, Vermont has held steady with nearly 20% of children identified as SED.

Intervening early is critical, given that half of all lifetime cases of mental illness begin by age 14 and three-fourths by age 24. Research has shown that early identification and treatment improves outcomes. For example, early interventions conducted by comprehensive school-based mental health and substance treatment systems have been associated with enhanced academic performance, decreased need for special education, fewer disciplinary encounters, increased engagement with school, and elevated rates of graduation.⁵

In Vermont, about 14.4 percent were identified with an emotional disturbance, according to federal data⁶. That is more than twice the national average of 5.4 percent, however, due to the use of trend analyses to determine SED rates, this is likely an underrepresentation.

In 1992, Vermont started Success Beyond Six, an Agency of Human Services funding mechanism which allows school districts to use Medicaid match to support mental health services in the schools. Under the Medicaid-supported formula, federal dollars cover about 54% of the costs for providing mental health services in the schools with local school districts paying about 46%. The mental health services provided through the designated agencies in the schools have become more varied and individualized based on the identified needs of the students. The collaboration of Local Education Agencies and Designated Mental Health Agencies has created opportunities for a spectrum of services including school-wide mental health consultation, prevention and early intervention all the way to intensive individualized services. In the 2017-2018 school year, Success Beyond Six helped fund 585 full time equivalent behavioral interventionists, as well as 175 School Based Clinicians and 25 Board Certified Behavioral Interventionists with about \$69 million in Medicaid and local dollars supporting the program.⁷

⁴ Analysis based on Monthly Service Report data submitted to the VT Department of Mental Health by the designated agencies. Includes youth aged 9 to 17 with a primary program assignment of Children's Programs.

⁵ SAMHSA Bulletin, July 1, 2019, guidance to states and school systems on addressing mental health and substance use issues in schools, <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB20190701.pdf>

⁶ *Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services*

⁷ *Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services (with updated data from 2015)*

Coordinated Services Plans (CSP)

To organize information for this report, SIT looked at several data factors all with the goal to better understand the level of need that exists and current challenges arising for children and families. Designated Agencies resource LITs with children’s mental health staff (DAs do not receive additional financial resources to support this work) and they do not have a consistent way to track CSPs in their electronic health records. LIT coordinators estimate the number of CSPs that occur and believe it is likely an underestimate since teams may use the tool at any time it may benefit planning. SIT continues to work with and explore accurate data collection in collaboration with LITs and the Act 264 Board.

Figure 4: Number of Coordinated Services Plans Reported by Region (Estimated)

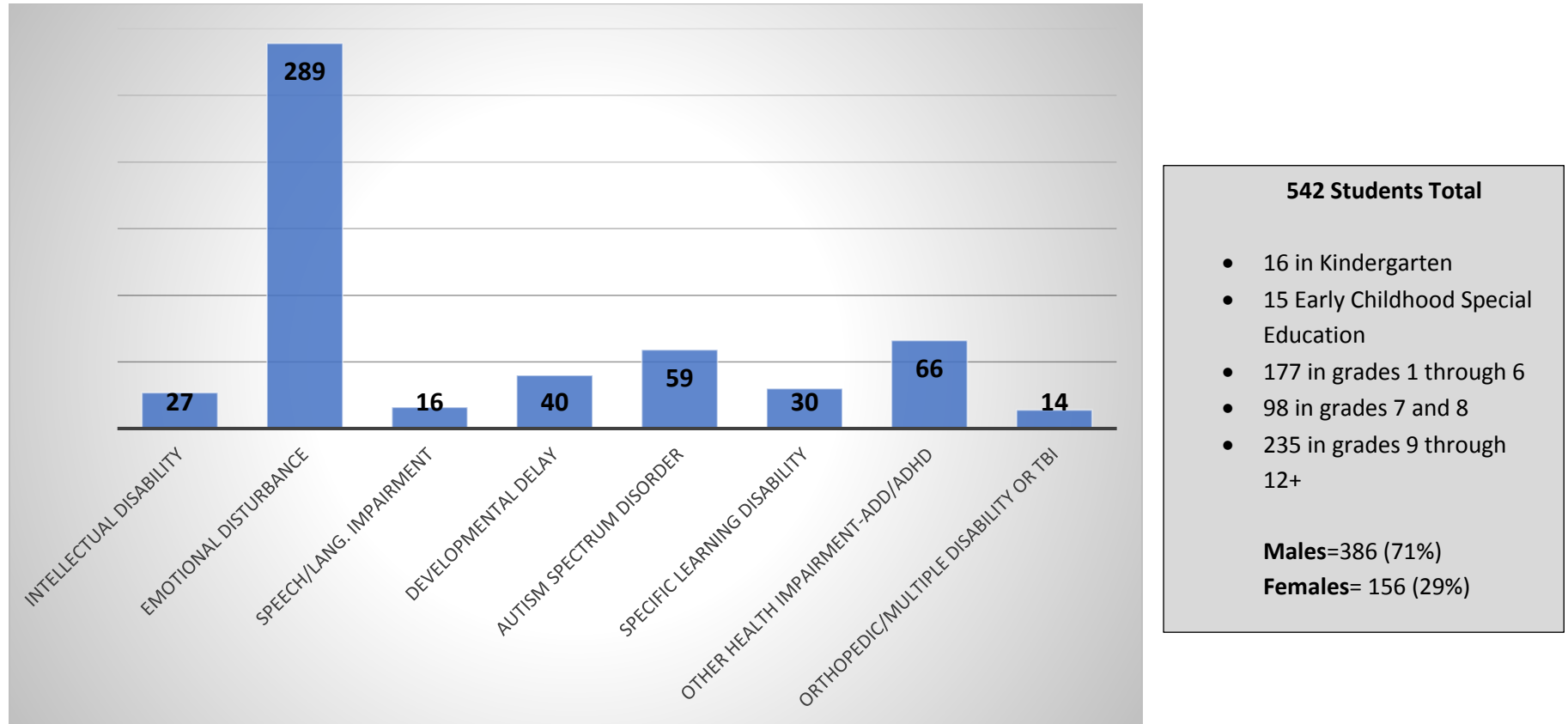
REGION	2013	2014	2015	2016	2017	2018	2019
Barre	79	59	60	50	60-80	75	80-90
Bennington	20				25-30	25	30-40
Brattleboro	41	50	40	40	40	75	45
Burlington	150-200	150-200	150-200	83	180	227	134
Hartford					75-80	★	87
Middlebury	88				60	63	67
Morrisville	43	51	50	40-60	50-60	50-70	62
Newport	25				17	45	26
Rutland	65	63		66	70+	60	★
St. Albans				100	100	125	150
St. Johnsbury	25				11	15	19
Springfield	8	42	38	29	28	28	46
TOTALS*	544	415	338	408	716	728	746

* When a range was identified, the lower end was utilized for this calculation

★ Data not reported

Educational Data

Through the Agency of Education's Special Education Child Count data⁸, there is data identifying children/youth who had a CSP **and** are receiving special education services. The data is unduplicated children; the primary disability is identified; secondary and tertiary disabilities are not included. It is important to note that not all students who access a CSP are eligible for special education. Some students have 504 Plans or Educational Support Team (EST) Plans.



⁸ Child Count Data for children ages 3-21 as of December 1, 2018

Focus on Addressing Trauma in Educational Settings

AHS and AOE recognize their shared responsibility in meeting the needs of children and families, especially given the increased acuity of need seen in educational and home-based settings. In November 2019, a group convened for a meeting to address the issue of schools not having enough supports to appropriately address the acute needs of the children they see on a daily basis. The group included the Secretaries of AHS and AOE, Commissioners from DCF, DAIL, and DMH, Prevent Child Abuse Vermont leadership, the Vermont Principals Association, school principals and the co-chairs of SIT. This group met to discuss Act 264 and to review whether the spirit and intent of the law was accomplishing the intended goals. There is clearly a need for continued focus on the coordination and streamlining of services and supports. There was a collective commitment by all members present to continue to collaborate to ensure that the Act 264 mission is being implemented as intended and to leverage all collective resources.

There continues to be a focus on increasing school staff knowledge about trauma. Below is a graph which shows the data from the Multi-Tiered Systems of Support Survey Summary.⁹ This data answers the survey question posed to schools asking, “What trauma informed training has your staff participated in within the past three years?”

Figure 5: Percent of Education Staff Trained in Trauma Informed Practices

<i>Percent of school staff trained in trauma informed practice</i>	2017-2018 School Year	2018-2019 School Year
0%	10%	3%
25%	24%	19%
50%	9%	9%
75%	25%	32%
100%	32%	37%

Response Rate:

2017-2018:
120 schools submitted responses

2018-2019:
283 schools submitted responses

⁹ Multi-tiered System of Supports (MTSS) Annual Survey, November 9, 2019

Mental Health Services

In FY 2018, Vermont’s Designated and Special Services Agencies (DA/SSA) child, youth and family mental health programs served 10,892 children and youth. ¹⁰

Figure 6: Children’s Mental Health Services

FY18	# of Children Served	Ages 0-6	Ages 7-12	Ages 13-19	Ages 20-34	Male	Female
Overall	10,892	21%	37%	39%	3%	56%	44%
Services Received through DA/SSA						# children	
				FY2015	FY2016	FY2017	FY2018
Therapies				4,349	4,003	3,839	3,812
Medication and consultation				1,257	1,344	1,337	1,352
Clinical interventions				6,523	6,322	6,291	6,688
Service Planning and Coordination				7,343	7,531	7,138	7,491
Community Supports				8,685	8,493	8,333	8,344
Crisis assessment, supports, and referrals				1,965	1,558	1,170	1,277
Respite				445	302	215	192

The Vermont DMH conducts annual perception of care surveys to monitor DA/SSA program performance from the perspective of service recipients and other stakeholders, alternating years to survey parents and youth. The most current available data (2017) from parents showed that 82% of parents of children served by child and adolescent DA/SSA mental health programs in Vermont rated the programs favorably. In addition, 79% of the surveyed youth evaluated the programs positively on the Overall measure of program performance.¹¹

¹⁰ DMH FY2018 Statistical Report

¹¹ DMH 2018 Consumer Evaluation of Children's Services Programs

Developmental Disabilities Services Division – Vermont Department of Disabilities, Aging, and Independent Living

In 1996, the Vermont Developmental Disabilities Act (DD Act) required that the Developmental Disabilities Services Division (DDSD) adopt a plan to provide services to Vermonters with developmental disabilities. The DDSD was required to develop a System of Care Plan which would outline eligibility, services, and funding priorities for Vermonters with Developmental Disabilities across the lifespan. When the DD Act went into effect, the Legislature made it clear that services would not be available to all Vermonters with Developmental Disabilities.

The System of Care Plan determined that a developmental disability is defined as having a diagnosis of intellectual disability OR an Autism Spectrum Disorder, AND significant deficits in adaptive functioning, AND onset of the disability prior to age 18. The primary funding mechanism for services through the DDSD is the Home and Community Based Services (HCBS) individualized budget (formerly known as a DS waiver). Depending on the needs of the child/youth, HCBS funding can be used to provide service coordination, home supports, respite, clinical, crisis, and/or accessible transportation. In addition to having a developmental disability, a person must also have Vermont Medicaid and meet a funding priority outlined in the DDSD System of Care Plan. At the time of the DD Act, and currently, HCBS individualized budgets are provided through the state's not-for-profit DAs and SSAs. There are also options for individuals and families to "self-manage" their services.

In 2001, because of budget constraints, DDSD had to restructure its funding priorities. The priority categories for children were reduced to two, making HCBS for children/youth under the age of 18 available only for those with the most intensive needs. These priorities are:

1. Preventing Institutionalization – Nursing Facilities: Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [This priority applies to both children and adults.]
2. Preventing Institutionalization – Psychiatric Hospitals and Intermediate Care Facilities (ICF/DD): Ongoing, direct supports and/or supervision needed to prevent, or end stays in inpatient public or private psychiatric hospitals or end institutionalization in an ICF/DD. [This priority applies to both children and adults.]

In addition, through a departmental Memorandum of Understanding, children with developmental disabilities who are in DCF custody may receive HCBS services if requested by DCF without being required to meet a funding priority. At the time of this report, 22 children with developmental disabilities who are in DCF custody receive HCBS.

Figure 7: Developmental Disabilities Services Data

The data in this figure was produced by DAIL-DDSD

Program	Number of Children/Youth Served			
	FY2015	FY2016	FY2017	FY2018
Home and Community-Based Services	64 children (0-18) 194 transition-age youth (18-22)	62 children (0-18) 216 transition-age youth (18-22)	58 children (0-18) 221 Transition-age youth (18-22)	65 children (0-18) 219 transition-age youth (18-22)
BRIDGE program: Care Coordination	300 children/youth up to age 22	323 children/youth up to age 22	391 children/youth up to age 22	391 children/youth up to age 22
Flexible Family Funding	750 children/youth up to age 18 201 transition-age youth (18-22)	725 children/youth up to age 18 220 transition-age youth (18-22)	729 children/youth up to age 18 211 Transition age youth (18-22)	742 children/youth up to age 18 220 transition age youth (18-22)
Family Managed Respite (FMR) (allocated to more families – the data only includes number who used it)	323 children/families statewide <ul style="list-style-type: none"> • 165 ID/ASD diagnosis • 123 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis 	384 children/families statewide <ul style="list-style-type: none"> • 197 ID/ASD diagnosis • 146 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis 	523 children/families statewide <ul style="list-style-type: none"> • 256 ID/ASD diagnosis • 226 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis 	416 children/families statewide <ul style="list-style-type: none"> • 200 ID/ASD • 181 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis
Vermont Crisis Intervention Network	95 total bed days were children, or 18% 7 individuals were children, or 20%	74 total bed days were children, or 12% 4 individuals were children, or 9.5%	91 total bed days were children (under 18) = 15.6% 5 individuals were children under 18 = 15.6%	115 total bed days were children (under 18) = 18.8% 5 individuals were children under 18 = 12.8%

Important information regarding Developmental Disabilities Services:

- Services provided with DDSD oversight are required to follow the rules and requirements of the Centers for Medicare & Medicaid Services (CMS), the Department of Labor, and the Collective Bargaining Agreement between the Agency of Human Services and Independent Direct Support Providers.
- Vermont Crisis Intervention Network (VCIN) is an emergency placement in a safe, calm environment for individuals with ID/DD who are experiencing a psychiatric, emotional or behavioral crisis (available on a limited basis for children).
- The following are supports and services that may be available to children who are not eligible for more intensive services such as HCBS:
 - Family Managed Respite is funding for families of children/youth who have a MH and/or ID/DD diagnosis
 - Flexible Family Funding is available to eligible children with a Developmental Disability (DD). This funding is available for respite or goods which the family deems to be supportive to their child with a DD
 - Bridge Case Management is care coordination for children with Developmental Disabilities

In Franklin/Grand Isle and Addison counties, services to children, regardless of disability type, are provided through an integrated approach and case rate. In addition, the Howard Center has developed a unique program, also using a case rate with funds included from DAIL and DMH, called ARCh (**A**ccessing **R**esources for **C**hildren) which provides service coordination, skills work and clinical support to 300 children/youth in FY19.

Post-Secondary Education Initiative

This initiative partners with several direct support programs which help young adults acquire two-year college certificates and degrees. SUCCEED, Think College Vermont, and College Steps work closely with DA and SSAs to help youth access careers and increase independent living skills via campus based post-secondary education. For ten years, this initiative has been demonstrating that youth with developmental disabilities can not only handle college but can excel in their coursework.

Each college support program matches students with internships based on the students' strengths. This contributes to high employment outcomes at graduation. Northern Vermont University, Southern Vermont College, Castleton University, American International College and University of Vermont (UVM) participate in this initiative.

Of thirty-three students who graduated in 2018, 94% were employed at graduation. Forty-two students remained enrolled and 62% of these students were employed while going to school. Two graduates enrolled in associate's and bachelor's degree programs at the Community College of Vermont and UVM. Full inclusion and participation in college campus life and customized academic supports fostered the growth, development, and success of these seventy-five students.

Applied Behavior Analysis (ABA) – Department of Vermont Health Access

The ABA benefit came into effect in 2014. During the first three years providers gave feedback to the DVHA Quality Unit that the billing process was complicated, and the required paperwork was cumbersome. Therefore, they reported that this limited their ability to serve more members. Given this feedback, the DVHA Quality Unit teamed up with the DVHA Payment Reform Unit on a payment reform project specific to ABA. After two years, the outcome of this project was a tiered case rate payment methodology for members who have Medicaid as a primary insurance and are eligible for ABA services. The goal of this payment reform project was to increase utilization and access to services and payment predictability for providers; since July 2019, 48 new members have begun receiving ABA services. There are currently 177 members statewide receiving ABA services through Medicaid. Initial data analysis has indicated that treatment hours for those receiving ABA services has increased, specifically with direct service treatment hours. The Quality Unit will continue to monitor claims data to look for patterns and trends associated with the case rate.

Children with Special Health Needs -- Vermont Department of Health



Children with Special Health Needs (CSHN) supports Vermont children and youth with special health needs by ensuring comprehensive, culturally sensitive, community-based and family-centered services. This is a free public health program for families, partially funded by Title V block grant funding from the Maternal Child Health Bureau and Medicaid. CSHN supports children with complex, chronic health conditions and/or developmental disorders, ages birth to-21, and their families, with flexible, experienced, and proactive services. Supports are provided by a team of medical social workers, nurses, and other specialty providers who are experienced and skilled in working with children, their families, and providers.

While the needs of a child are often what prompts a child to be referred to CSHN, the multidisciplinary team takes a holistic, family-centered approach. There are a variety of services and programs available depending on the needs of the child and family, including:

- Care Coordination
- Children's Personal Care Services

- Pediatric Hi-Tech Nursing
- Pediatric Palliative Care
- Child Development Clinic
- Community Nutrition Services

More specifically, CSHN focuses on the following which we know can be particularly challenging for children and families.

- Navigate the healthcare system
- Provide respite funding for parents and caregivers who need a break
- Coordinate care conferences with the various providers caring for a child
- Collaborate with schools and special educators to create meaningful and appropriate educational plans
- Access health insurance, medical care, and services
- Identify services and resources that may be helpful for a child and family
- Assist with transitions from services throughout a child's life
- Plan and prepare for adulthood
- Meet children and families in a setting that is most comfortable for them

In 2019, CSHN provided care coordination and/or consultation to approximately 700 individual families and countless community providers and partners. Nearly 2,000 children are enrolled in the three Medicaid Administrative programs we administer; Children's Personal Care Services, Pediatric Palliative Care Services, and Pediatric High-Tech Nursing. Approximately \$53,000 for respite was awarded to families in FY 2019.

In addition to providing direct care coordination to children and families, CSHN regional social workers are integrated with their local Children's Integrated Services, Building Bright Futures, Local Interagency Teams, and Transition (through VocRehab) teams.

This past year CSHN focused largely on systematically improving both the knowledge and application of EPSDT across Medicaid, as well as informed the implementation of newly updated Disabled Children's Home Care criteria. Improvement of the delivery of High-Tech Nursing services has been a primary focus in collaboration with DVHA and DAIL partners. This program cares for some of Vermont's most medically fragile Vermonters who often live with coexisting neurodevelopmental disabilities and thus access a wide breadth of services across the system.

Our federal funding encourages CSHN to focus energy on infrastructure building and population-based services in addition to direct and enabling services (see MCH Pyramid of Health Services, http://www.amchp.org/AboutTitleV/Documents/MCH_Pyramid_Purple.pdf). Thus, we initiated a body of work this past year to examine the system of care coordination for children with medical complexity and/or neurodevelopmental disabilities. This work was prompted by persistent confusion amongst the care coordination workforce about which

agency (designated agency, CSHN, Medical Home, specially provider, etc.) should take the lead in the coordination of care for children who do not squarely fall in to any one service category. More importantly, we understood from family/caregiver stakeholders that more care coordinators often did not reduce the burden of care, but rather created more individuals for parents and caregivers to organize and coordinate communication amongst. The conclusions from our work are as follows.

1. Care coordination provided by the medical home SW and CSHN SW is very similar, thus rarely is more than one social worker necessary.
2. There are a few, meaningful activities that differentiate medical home and CSHN care coordination.
3. Care and communication is improved both for the care coordinator themselves, the team, and the family, when there is one, clearly identified primary care coordinator.
4. The lack of services for certain high needs populations (mental health and autism) is stressing the care coordination delivery system as a whole.
5. There is a significant difference between the role of a nurse and social worker in the delivery of care coordination.
6. A partnership between a nurse and social work is necessary to provide optimal care coordination to clients who are medically complex.
7. Communication and coordination is significantly challenged by the lack of integrated technology.

These findings were shared with OneCare Vermont and informed the Pediatric Care Coordination Payment Model for 2020.

Most recently, an MOU was established between MCH Fostering Health Families Designees and DCF to ensure that children newly in custody have adequate and timely medical records shared with DCF, as well as prompt identification if they are known to CSHN so that additional supports may be provided to the foster family and DCF system around the child's unique needs.

Practice Highlight: The Difference Act 264 Can Make for a Family



A Coordinated Services Plan (CSP) meeting was convened for a youth who has autism and mental health challenges. This youth also experiences mobility and social challenges and was facing school truancy charges due to anxiety and depression. The mom of this youth is a single parent caring for two children with disabilities who was exhausted after years of trying to navigate services for both children. The team felt the following services were needed: ABA services, life skills, Physical Therapy, Occupational Therapy, in home family supports, sensory and therapeutic work, alternative school placement and resources/community support. The following were the successes as a result of the CSP:

- The Mom's voice about her children's needs were clearly defined and communicated to the team
- The Designated Agency, doctor and other service providers were there to back up the mother's voice and collaborate as a team
- Team clearly stated the challenges the youth was experiencing at school
- The school agreed to a special education evaluation
- The Vermont Family Network Family Support helped the mother at the IEP meeting that was scheduled as a result of the CSP
- An alternative school placement was achieved, and other community resources were offered to support family.
- The youth's sibling was offered additional services through community partners

Act 264 Board: Recommendations on Priorities for 2020

A statutory requirement of the Act 264 Board is to: advise the Agency of Education and Agency of Human Services (AHS) on the annual priorities for developing the System of Care. The following recommendations were submitted to SIT in December 2019.



1. **Demonstrate strong commitment to develop and implement an integrated approach for child and family programs and services across the state.**
 - a) Support the efforts of Building Flourishing Communities and statewide coordination across agencies with a focus on resiliency and trauma-informed services.
 - b) Support healthcare payment reform efforts away from ‘fee for service’ payment frameworks and towards accountability funding based on program performance measures and client outcomes.
 - c) Create a state database across AHS and AOE to track all in-state and out-of-state residential placements, including length of stay, performance measures, and client outcomes.
 - d) Communicate and coordinate with the Department of Vermont Health Access (DVHA) to support prevention services and reimbursement rates sufficient to ensure statewide availability of needed services.
 - e) AHS and the Act 264 Advisory Board will work together to provide state and local police officers brochures about contacts for Coordinated Service Plans to share with relevant Vermont families they encounter in their work.
 - f) Local Interagency Teams invite inclusion of healthcare representation with CSP process to assure holistic approach to avoid potential duplication of planning efforts.

2. **Strengthen direct and indirect strategies to improve staff recruitment and retention to assure timely access to needed quality services, particularly in Designated Agencies and in the Department for Children and Families’ Division of Family Services.**
 - a) Increase salary levels for line staff.
 - b) Try various methods to enhance the work culture and climate with non-monetary incentives.
 - c) Consider hiring family members with appropriate life experience equivalents for educational requirements.

3. Expand and align areas of service overlap within and beyond the Agency of Human Services (AHS) and the Agency of Education (AOE).

- a) Adjust services and funding within Success Beyond Six budget cap to promote better geographic accessibility.
- b) Work across public and private entities to offer engaging, affordable activities to all ages of children and adolescents, especially between 3:00 and 6:00 pm which is a critical time for the prevention of substance.
- c) Increase collaboration between the Department of Health (VDH) and education to:
 - 1) enhance school-based curriculum for the prevention of substance use.
 - 2) promote oral health in schools; and
 - 3) protect children's brain development by ensuring the removal of lead and other contaminants from schools.
- d) Increase the collaboration between the mental health system and education to reduce the use of restraint and seclusion in schools through focused effort on school-wide positive behavioral supports, and annually report the total numbers of restraint and seclusion to the Secretary of the Agency of Education.

4. Ensure all Agency of Human Services' departments, the Agency of Education, and families coordinate and implement system-wide changes that advance an integrated approach.

- a) Provide links to the Act 264 Advisory Board on the websites of the Department for Children and Families (DCF), the Department of Health (VDH), and the Department of Corrections (DOC).
- b) Ensure there is a Parent Representative on every Local Interagency Team, and families have knowledge of and access to Parent Representatives' services. Also, ensure Parent Representatives have access to technical support and orientation for their role, as well as adequate compensation for their responsibilities.
- c) Establish guidelines across all agencies and departments to assist linking children and families to needed basic services (e.g., housing, food, skills training, etc.), particularly for pregnant women and for children whose parents are involved with Corrections.
- d) Require that information on all applicable resources and services be made available to families involved in kinship placements.
- e) Support court decision makers with a goal of identifying the training, consultation, and coordination process with AHS departments to improve outcomes of court decisions that recognize current best-practice child development thinking and principles, including trauma-informed issues and services.

APPENDICES

Appendix A: Act 264 Statutory Language

Per 33 VSA § 4302: *The State Interagency Team shall have the following powers and duties:*

- 1. Submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.*
- 2. Develop and coordinate the provision of services to children and adolescents with a severe emotional disturbance.*
- 3. Make recommendations to the local interagency team for resolution of any case of a child or adolescent with a severe emotional disturbance referred by a local interagency team under subsection 4303(f) of this chapter.*
- 4. Recommend to the Secretaries of Human Services and of Education and the Commissioners of Mental Health and for Children and Families any fiscal, policy, or programmatic change at the local, regional, or State level necessary to enhance the State's system of care for children and adolescents with a severe emotional disturbance and their families. (Added 1987, No. 264 (Adj. Sess.), § 2; amended 1989, No. 187 (Adj. Sess.), § 5; 1995, No. 174 (Adj. Sess.), § 3; 2013, No. 92 (Adj. Sess.), § 295, eff. Feb. 14, 2014; 2013, No. 131 (Adj. Sess.), § 69, eff. May 20, 2014.)*

Appendix B: Vermont Federation of Families for Children’s Mental Health (VFFCMH) Act 264 Parent Representative Plan

Annual Goals

- Goal 1:** Provide two parent representative trainings per year
- Goal 2:** Increase # of stipend payments to parent representatives
- Goal 3:** Formalize a structured orientation and training for new parent representatives
- Goal 4:** Increase parent representative to all 12 AHS Regions.
- Goal 5:** Increase parent representative expanded role to all 12 AHS Regions

	FY 15/16		FY 16/17		FY 17/18		FY 18/19	
Region	CSP's	Cost	CSP's	Cost	CSP's	Cost	CSP's	Cost
Barre	98	\$ 4,248.14	116	\$ 5,050.96	60	\$ 2,563.93	45	\$ 2,563.81
Bennington	0	\$ 113.80	0		0		25	\$ 2,485.54
Burlington	20	\$ -	18	\$ -	14	\$ -	43	\$ -
Brattleboro	1	\$ -	1	\$ 223.30	8	\$ 771.00	21	\$ 1,865.16
Hartford	2	\$ -	0		0	\$ 26.36	4	\$ 491.98
Middlebury	23	\$ 1,768.17	0		3	\$ 554.87	5	\$ 439.74
Morrisville	39	\$ 2,705.98	26	\$ 2,129.63	44	\$ 3,485.31	49	\$ 3,868.26
Newport		\$ -	0		1	\$ 364.13	13	\$ 1,707.23
Rutland	60	\$ 3,514.27	117	\$ 5,268.31	135	\$ 6,286.29	112	\$ 6,045.59
St Albans		\$ -	0		1	\$ -	6	\$ 1,166.78
St Johnsbury	0	\$ 145.20	0	\$ 145.20	2	\$ 70.48	11	\$ 1,347.37
Springfield	0	\$ 463.06	6	\$ 463.06	0	\$ -	0	\$ -
Totals	243	\$ 12,958.62	284	\$ 13,280.46	268	\$ 14,122.37	334	\$ 21,981.46

HIGHLIGHTS FOR 2019

Outcomes:

- VFFCMH provided two Parent Representative (PR) Trainings: New CSP Form and the New LIT PR Reimbursement Process
- VFFCMH implemented a supportive screening process of LIT PR candidates for the LIT's
- VFFCMH in partnership with DMH & Vermont Center for Practice Improvement produced an informative video for families explaining the ACT 264 CSP Process.

Strengths:

- AOE has agreed to contribute \$15,000 annually starting in FY 2020.
- There was a 20% increase of families supported at a CSP by a LIT PR, from 268 to 334.
- All time high of nine regional LIT PR appointed by LIT's in FY 19, FY 20 begins with seven.

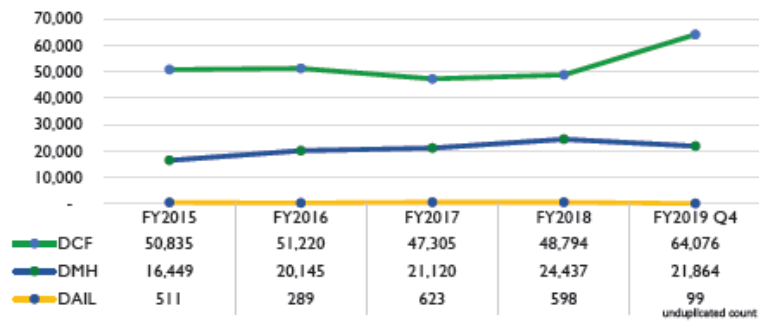
Challenges:

- We continue to have challenges recruiting parents with lived experience who are interested and qualified.
- A major barrier to recruitment is the high level of flexibility required and the low stipend reimbursement rate.
- As the number of families requesting a CSP and LIT PR support increases statewide the LIT PR reimbursement revenue must increase as well.

Appendix C: Children and Youth in Residential Care: Bed Days and Total Child Count

**Data compiled by Department of Mental Health*

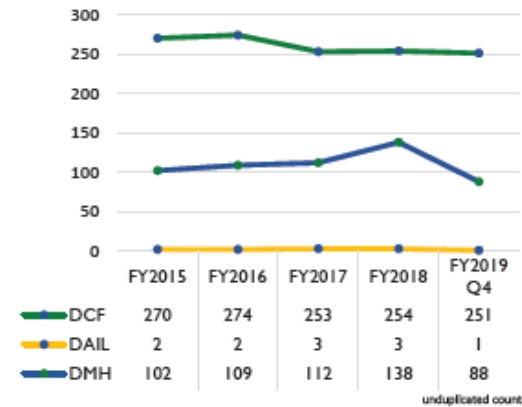
Total Residential Bed Days by Department per Fiscal Year Through FY19Q4



Total Bed Days

Total Bed Days is the total number of days a child/youth stays overnight in a residential program. For the Total Bed Days chart, children who were placed in more than one program during the fiscal year are represented more than once so that all bed days are calculated.

Total Child Count Residential by Department per Fiscal Year Through FY19Q4



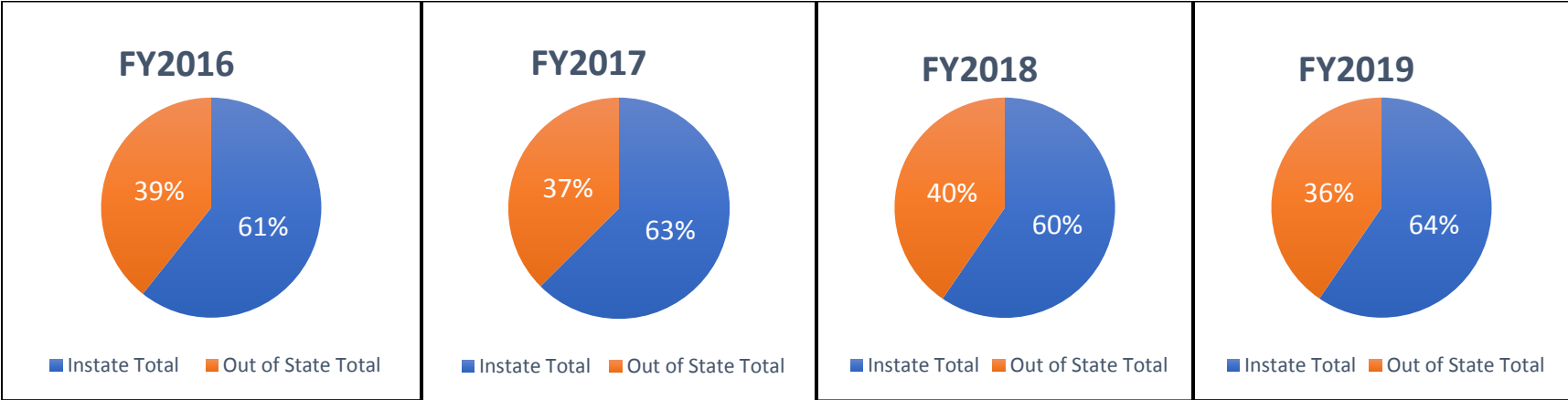
Total Child

For the Total Child Count in Residential by State fiscal year, the number of children/youth is unduplicated within the fiscal year, meaning if a child/youth was placed in more than one residential program during the fiscal year, the child/youth is only counted once.

Appendix D: Children and Youth in Residential Care: In-State and Out-of-State

**Data compiled by Department of Mental Health*

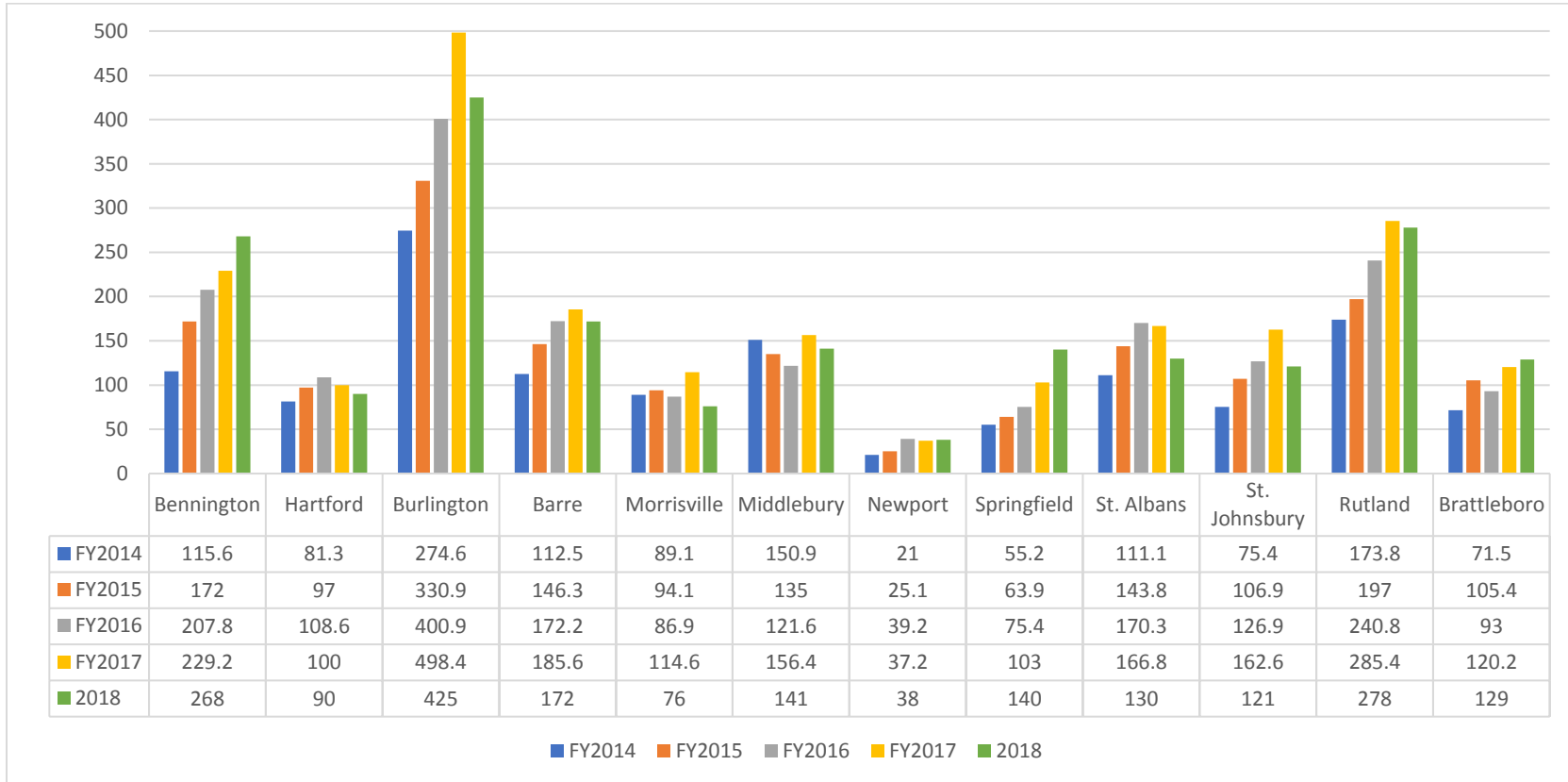
The following pie charts represent the breakdown of in-state placements compared to out-of-state placements. If a child was placed in more than one program in a fiscal year, they are represented more than once.



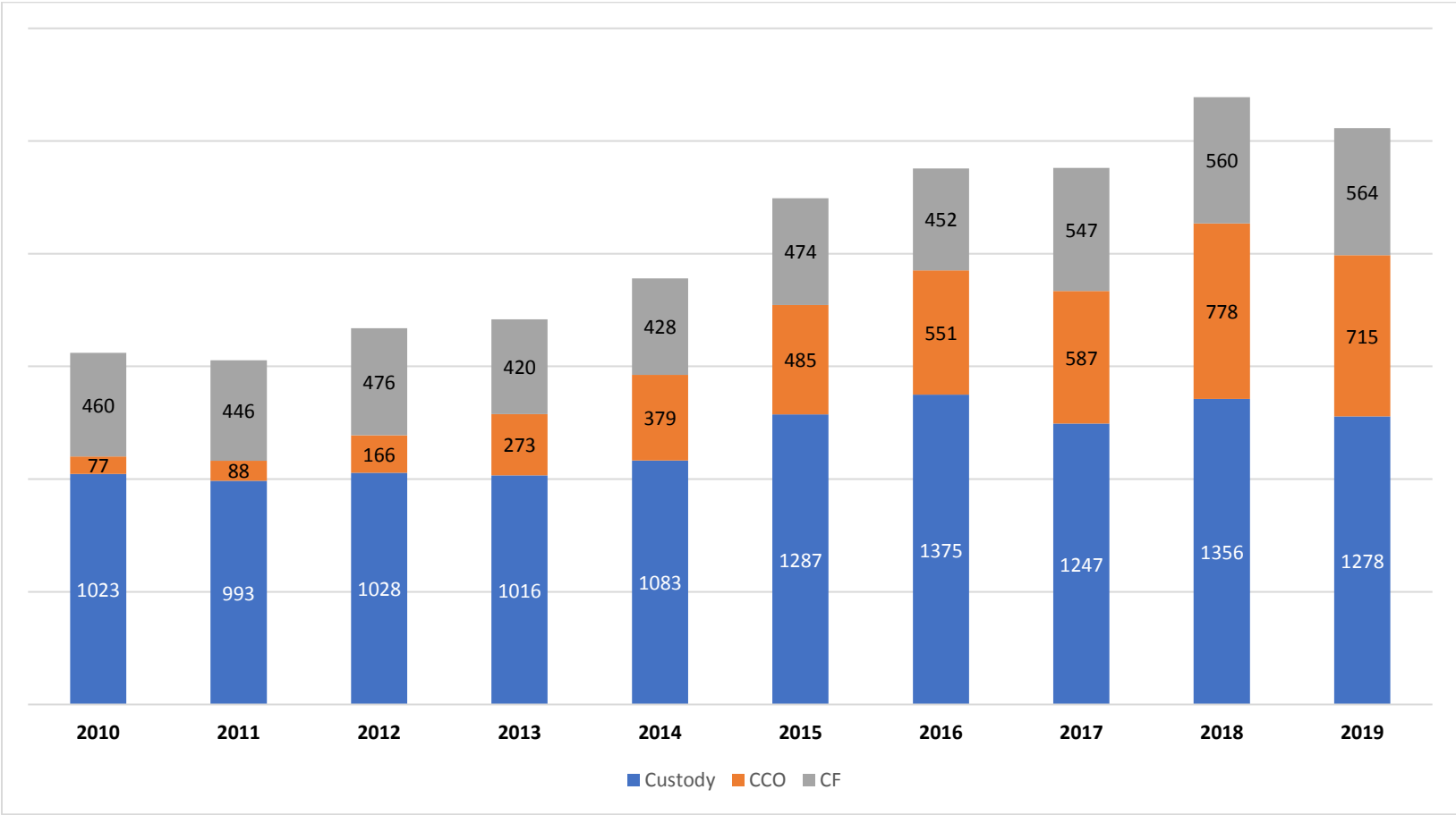
Appendix E: CIS Specialized Child Care Caseloads Data from FY2014 through FY2018

Specialized Child Care provides vulnerable children and high-risk families with quality childcare and specific supports that help meet their needs, strengthen their families, and promote their children's development.

*Data provided by DCF-Child Development Division



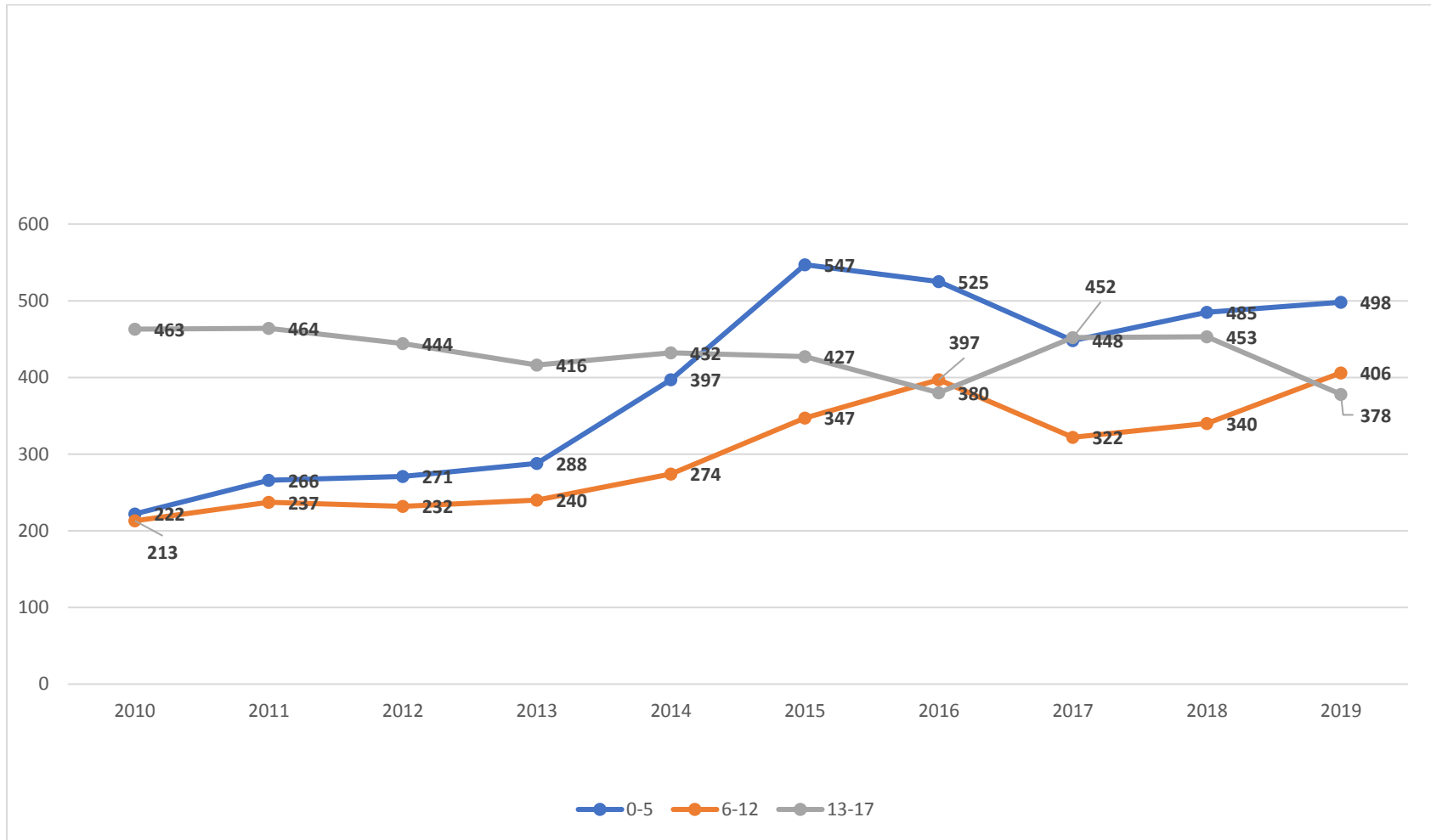
**Appendix F: Children/Youth involved with DCF
Custody, Conditional Custody Order (CCO) and Family Support Cases (CF)**



Data Source: FSD Quarterly Management Reports (2010-2019)-last day of Q2; FSD Report Catalog Full Caseload Report and CCO report for non-custody. Data note: non-custody case type reports are point-in-time and may not be reflective of the last day of Q2 each year

Appendix G: Number of Children/Youth in DCF Custody by Age Group

Data Source: FSD Quarterly Management Reports-last day of Q3.



Appendix H: References

Act 264 Statutory Reference: <http://legislature.vermont.gov/statutes/section/33/043/04302>

Act 264 Information and materials: <http://ifs.vermont.gov/docs/sit>

Agency of Education, Act 46 Report: <http://education.vermont.gov/documents/legislative-report-act46-sec46-special-education-funding>

Agency of Education, Special Education Website: <https://education.vermont.gov/student-support/special-education>

DAIL System of Care Plan for DS Services FY18-20:
<http://dail.vermont.gov/draft-care-plan-DS-services-FY18-20>

DCF-Family Services Performance Measures Dashboard: <http://dcf.vermont.gov/scorecard>

DCF-Family Services, 2018 Report on Child Protection in Vermont:
<https://dcf.vermont.gov/sites/dcf/files/Protection/docs/2018-CP-Report.pdf>

Developmental Disabilities Services State Fiscal Year 2018 Annual Report:
https://dail.vermont.gov/sites/dail/files//documents/2018_Full_Annual.pdf

DMH Stats Report, FY2018:
https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Reports/Stats/DMH-2018_Statistical_Report.pdf

Vermont Family Network: <http://www.vermontfamilynetwork.org/>

Vermont Federation of Families for Children's Mental Health: <http://www.vffcmh.org/>

Youth Risk Behavior Survey Report, 2019:
https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_YRBS_2019_HSReport.pdf