Vermont Department of Mental Health

2017 Budget Proposal

Frank Reed, Commissioner

Proposed Agenda

Department Overview – 20 minutes
Results Based Accountability – 20 minutes
Departmental Budget – 60 minutes
Requested Items – 20 minutes

Departmental Overview

Central Office Organization
Provider Agencies
Departmental Programs

Central Office Organization

Overall Operations

- Administrative Support Unit
- Financial Services Unit
- Legal Services Unit
- Research & Statistics Unit
- Clinical Care Management Unit
- Policy, Planning & System Development Unit
- Quality Management Unit
- Children, Adolescent and Family Unit (CAFU)
- Adult Mental Health Services Unit

Designated Providers

Designated Agencies

- Clara Martin Center
- Counseling Services of Addison County
- Health Care and Rehabilitation Services of Southeastern Vermont
- Howard Center
- Lamoille County Mental Health Services
- Northwest Counseling and Support Services
- Northeast Kingdom Human Services
- Rutland Mental Health Services
- United Counseling Service
- Washington County Mental Heath Services

Specialized Service Agencies

- Pathways Vermont
- Northeastern Family Institute

Designated Hospitals

- Brattleboro Retreat
- Central Vermont Medical Center
- Rutland Regional Medical Center
- University of Vermont Medical Center
- Windham Center

State Psychiatric Hospital

- Vermont Psychiatric Care Hospital

State Secure Residential

- Middlesex Therapeutic Community Residence

Provider Capacity

Designated Agencies

- Adult Crisis Beds : 38 beds
- Youth Crisis Beds : 12 beds
- Adult Intensive Residential : 42 beds

Peer Services Agencies

- Adult Crisis Beds : 2 beds
- Adult Intensive Residential : 5 beds

Designated Hospitals

- Adult - Level 1 : 20 beds
- Adult - Non-Level 1 : 143 beds
- Children and Youth : 33 beds

State Psychiatric Hospital

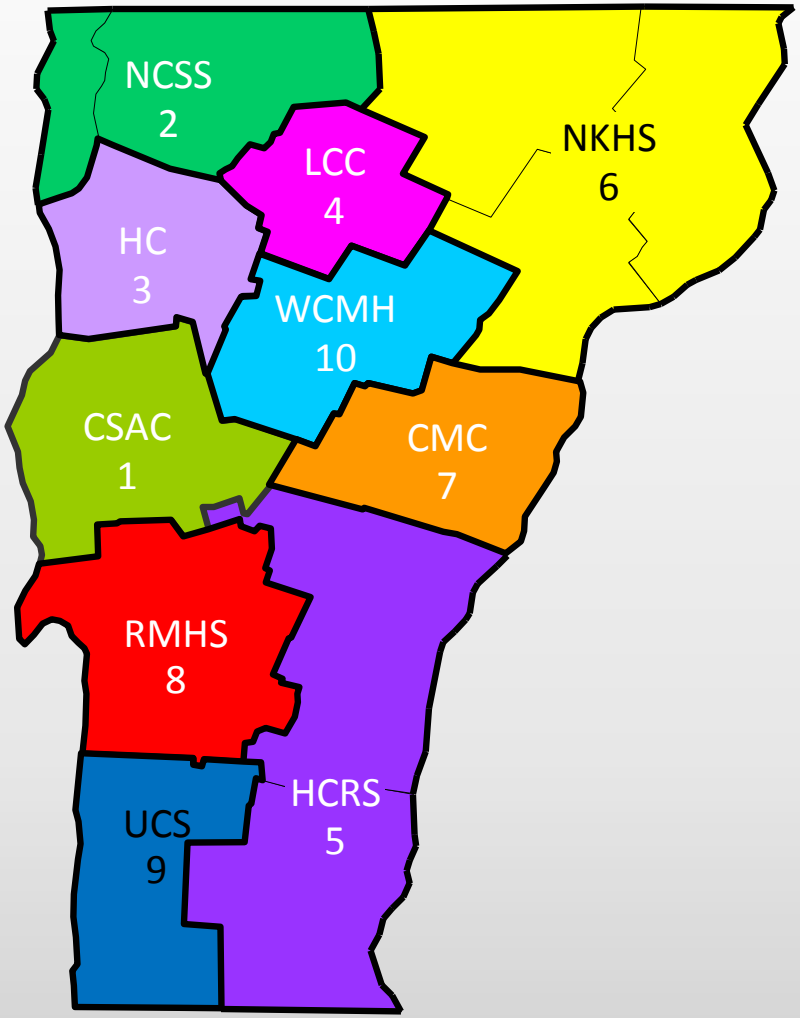
- Level 1 : 25 beds

State Secure Residential

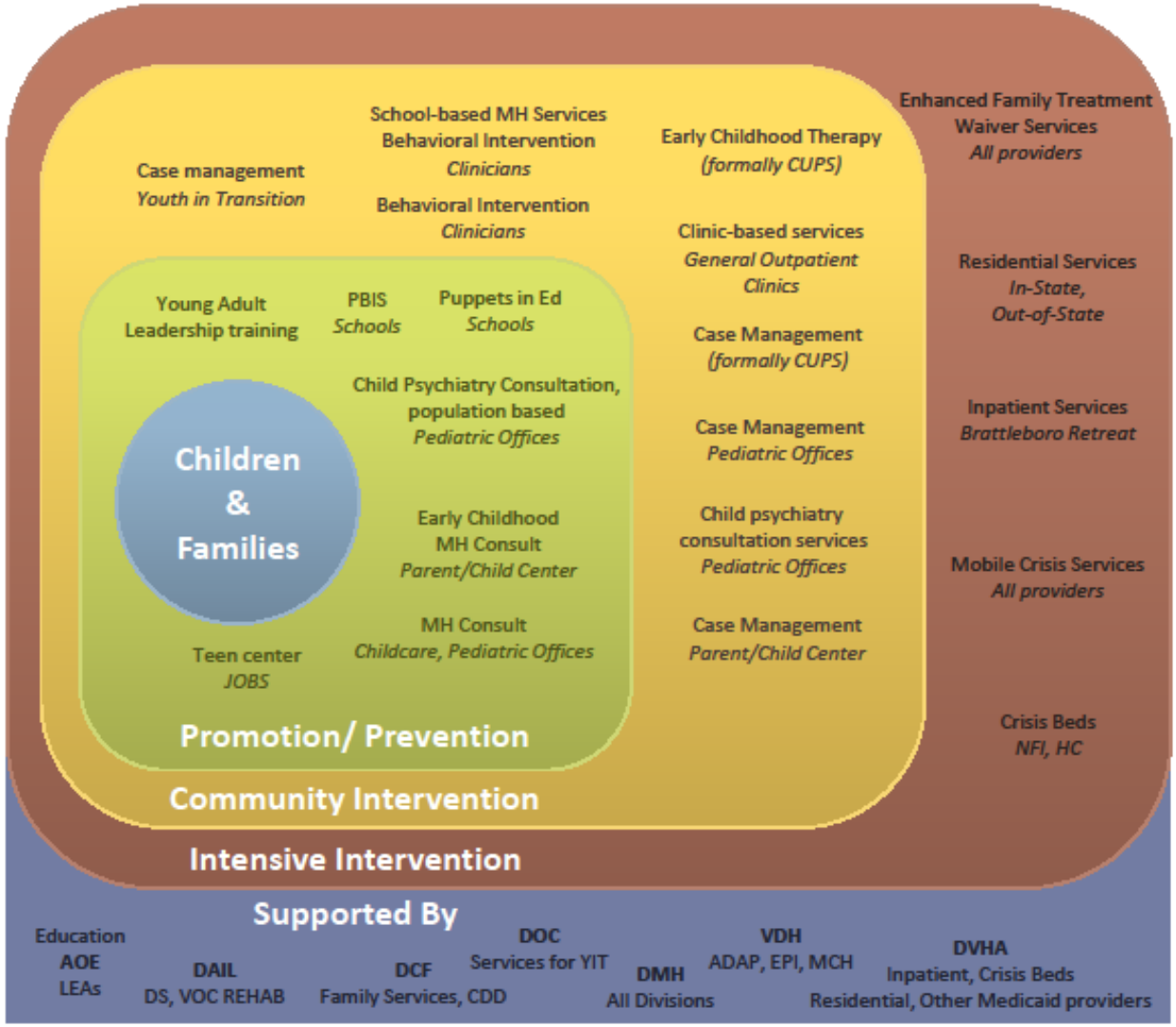
- Middlesex Therapeutic Community Residence : 7 beds

As of July 2015

Designated Providers



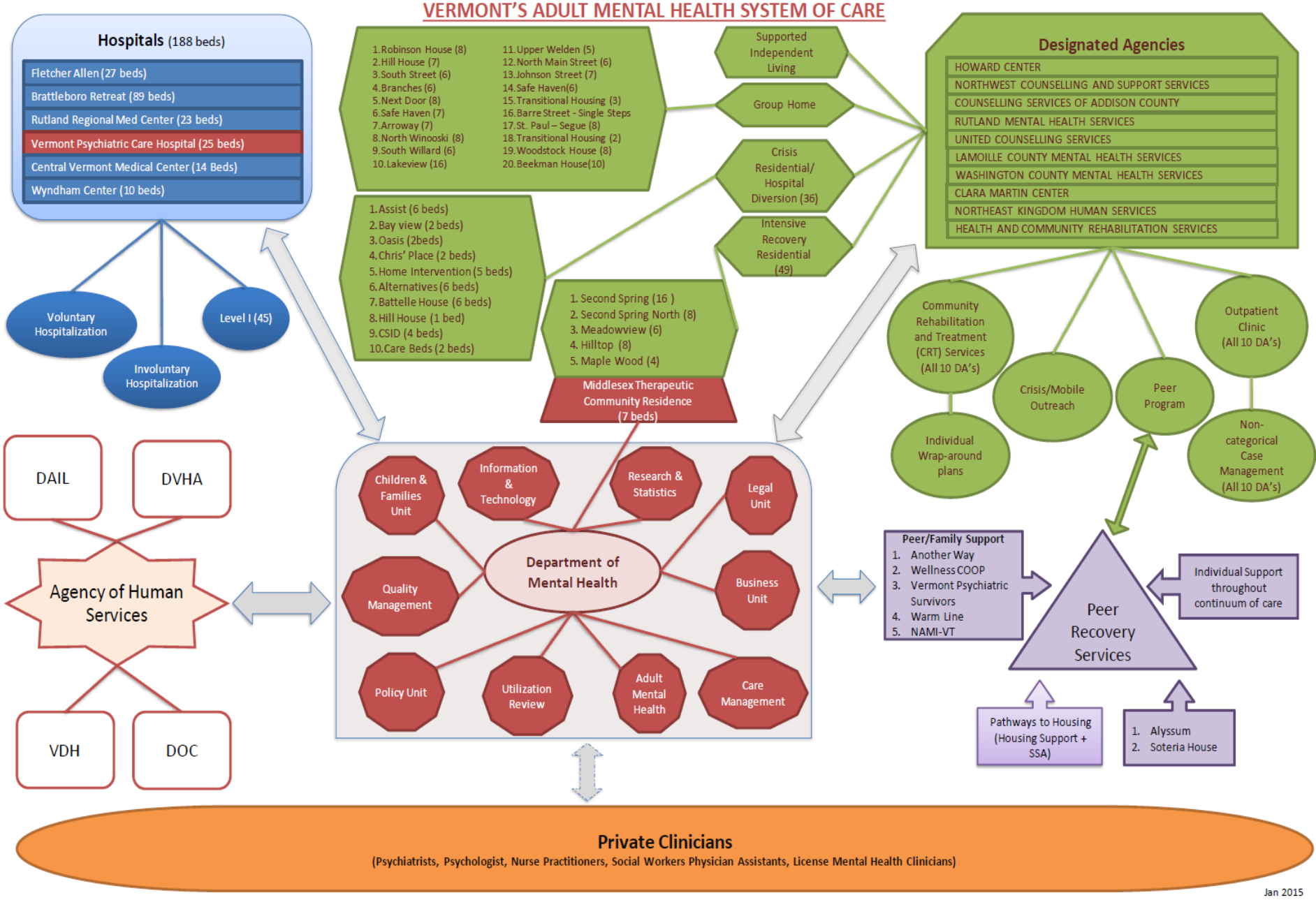
(CMC)	Clara Martin Center
(CSAC)	Counseling Services of Addison County
(HCRS)	Health Care and Rehabilitation Services of Southeastern Vermont
(HC)	Howard Center
(LCMH)	Lamoille County Mental Health Services
(NCSS)	Northwest Counseling and Support Services
(NKHS)	Northeast Kingdom Human Services
(RMHS)	Rutland Mental Health Services
(UCS)	United Counseling Service
(WCMH)	Washington County Mental Heath Services
(NFI)	Northeastern Family Services (SSA)
(PV)	Pathways Vermont (SSA – provisional)



Providers

- 10 Designated Agencies
- 1 Specialized Service Agency (NFI)
- 1 Designated Hospital (BR)

VERMONT'S ADULT MENTAL HEALTH SYSTEM OF CARE



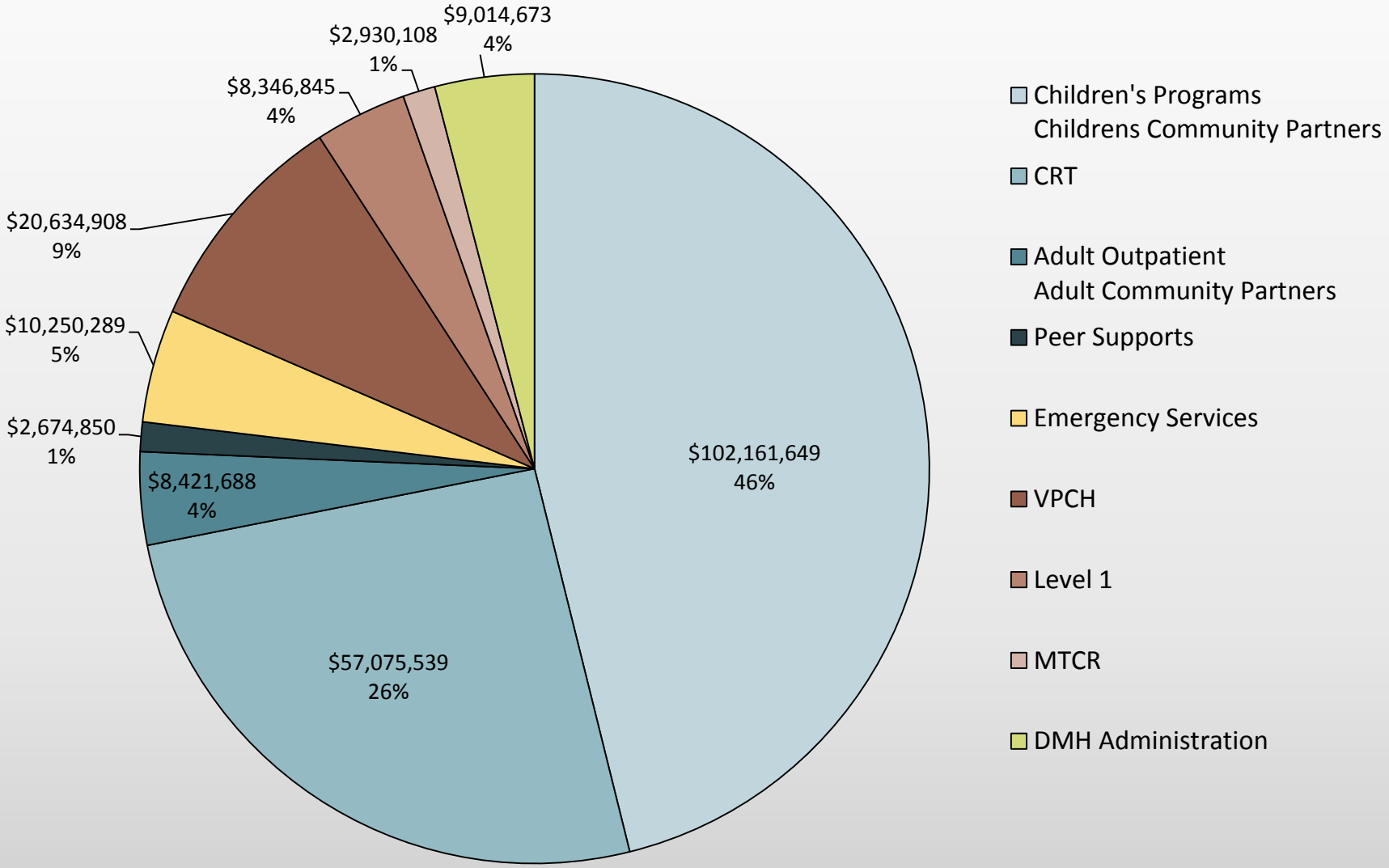
Jan 2015

Community Programs

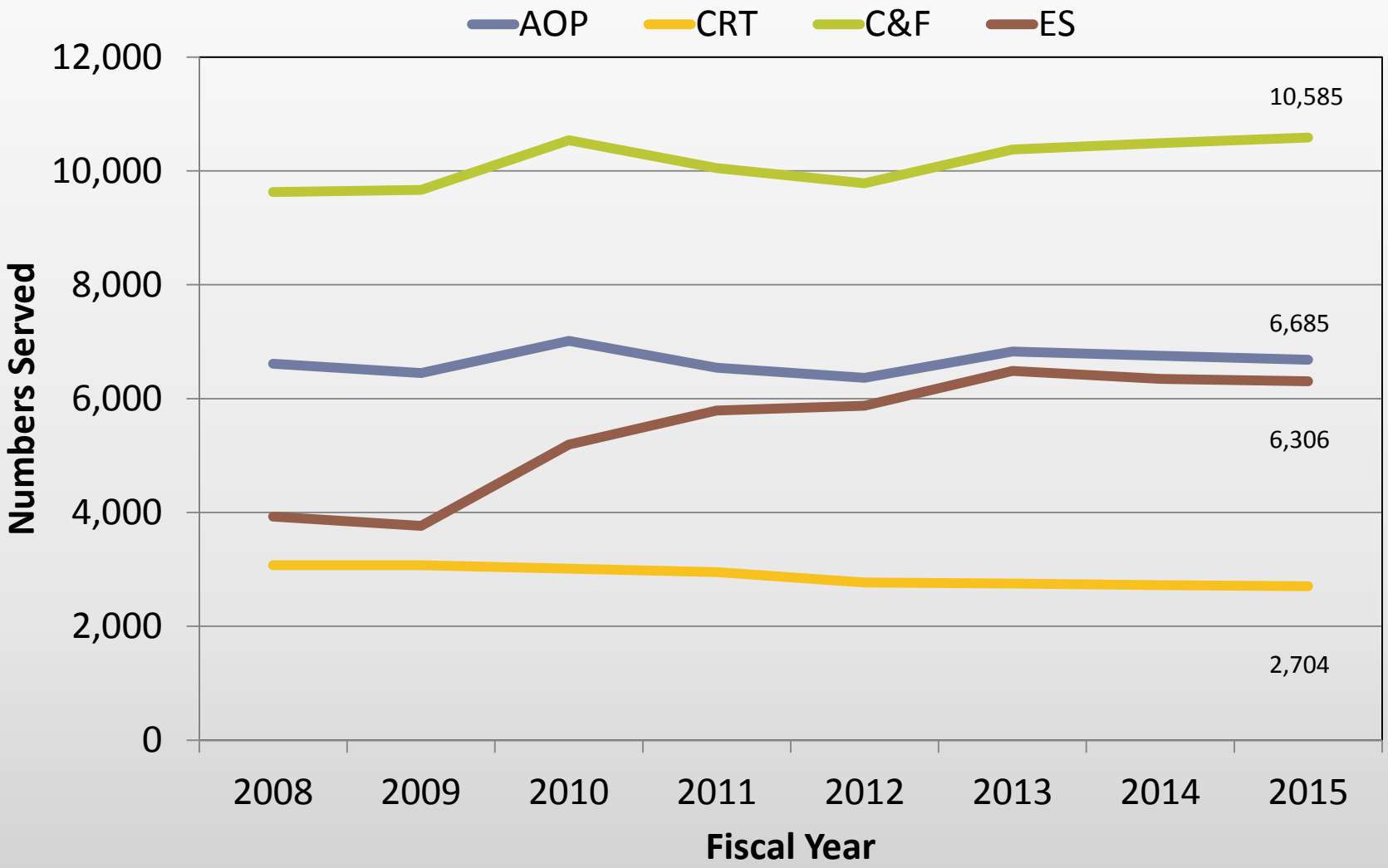
Program	Description
Adult Outpatient (AOP)	Provides services for adults who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention
Community Rehabilitation and Treatment (CRT)*	Provides services for adults with severe and persistent mental illness
Children and Families (C&F)*	Provide services to children and families who are undergoing emotional or psychological distress or are having problems adjusting to changing life situations.
Emergency Services	Serves individuals who are experiencing an acute mental health crisis. These services are provided on a 24-hour a day, 7-day-per-week basis with both telephone and face-to-face services available as needed.
Advocacy and Peer Services	Broad array of support services provided by trained peers (a person who has experienced a mental health condition or psychiatric disability) or peer-managed organizations focused on helping individuals with mental health and other co-occurring conditions to support recovery

*mandated service population

FY17: Proposed Expenses



People Served by Primary Program



Performance Measures

Adult Outpatient (AOP)

P AOP Adult Outpatient (AOP)		Time Period	Actual Value	Current Trend
PM	How_Much # of people served in AOP	SFY 2015	6,685	↘ 2
PM	How_Much # of non-categorical case management services	SFY 2015	15,066	↗ 6
PM	How_Well # of Medicaid AOP hospitalizations	FYQ2 2016	58	↘ 1
PM	Better_Off % improved upon discharge from AOP	SFY 2015	44%	↘ 2

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Performance Measures

Community Rehabilitation and Treatment (CRT)

P CRT Community Rehabilitation and Treatment (CRT)		Time Period	Actual Value	Current Trend
PM How_Much	# served in CRT	SFY 2015	2,708	↘ 7
PM How_Much	# of new CRT enrollees	FYQ2 2016	93	↘ 1
PM How_Well	# of inpatient psychiatric bed days for CRT clients	FYQ2 2016	3,471	↗ 1
PM How_Well	% of CRT clients receiving follow up services within 7 days of psychiatric hospitalization discharge	SFY 2015	93%	↘ 1
PM Better_Off	% of working age CRT clients who are employed	SFY 2015	22%	→ 1
PM Better_Off	% of CRT clients reporting positive outcomes	SFY 2014	73%	↘ 1

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Performance Measures

Children, Youth, and Family Services

P	C&F Children, Youth & Families (C&F)		Time Period	Actual Value	Current Trend
PM	How_Much	# of children and youth served by C&F	SFY 2015	10,585	↗ 3
PM	Better_Off	% of students receiving intensive school based behavioral interventionist services showing improvement	SFY 2014	45%	↘ 3
PM	Better_Off	% of children and youth receiving respite services who remain in their homes	SFY 2013	81.5%	↗ 1
PM	Better_Off	# of youth engaged in JOBS who achieve 90 days in competitive employment	SFY 2014	134	↗ 3
PM	Better_Off	% of adolescents reporting positive outcomes	SFY 2013	66%	↗ 1

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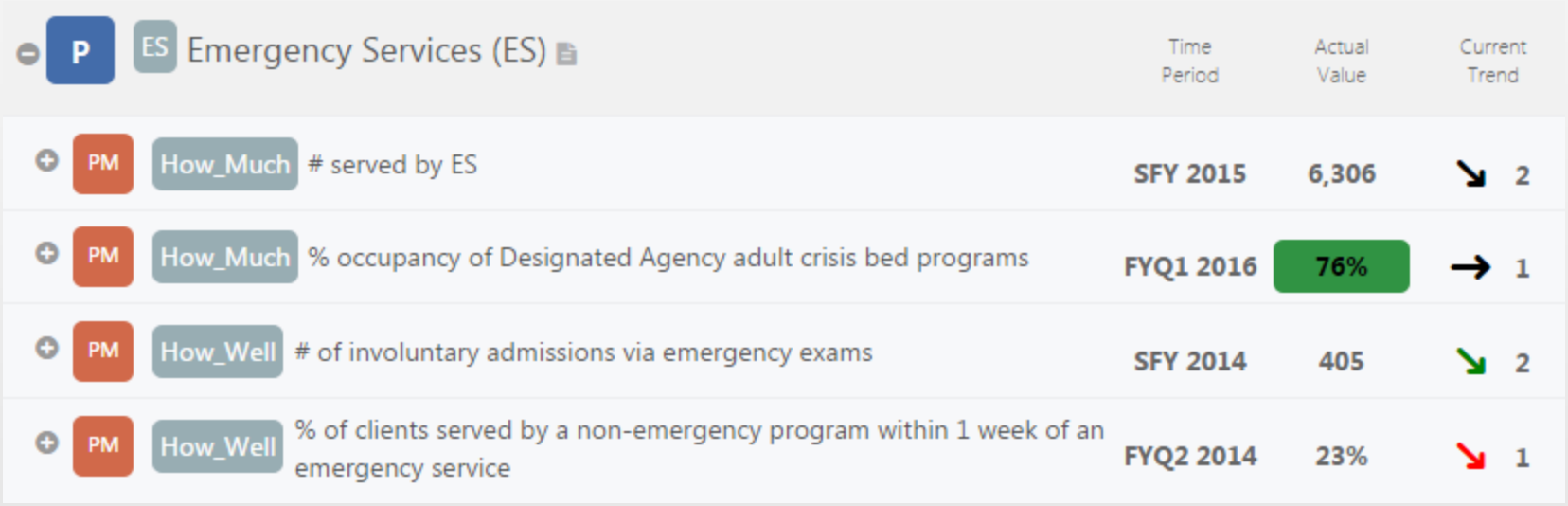
Performance Measures

Emergency Services



P	ES	Emergency Services (ES)		Time Period	Actual Value	Current Trend
PM	How_Much	# served by ES		SFY 2015	6,306	↘ 2
PM	How_Much	% occupancy of Designated Agency adult crisis bed programs		FYQ1 2016	76%	→ 1
PM	How_Well	# of involuntary admissions via emergency exams		SFY 2014	405	↘ 2
PM	How_Well	% of clients served by a non-emergency program within 1 week of an emergency service		FYQ2 2014	23%	↘ 1

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Performance Measures

Vermont Psychiatric Care Hospital (VPCH)

P	VPCH	Vermont Psychiatric Care Hospital (VPCH)	Time Period	Actual Value	Target Value	Current Trend
PM	How_Well	Average length of stay in days for discharged patients	SFY 2015	72	50	↘ 1
PM	How_Well	% of discharges readmitted involuntarily within 30 days of discharge	SFY 2015	9%	10%	↘ 1
PM	How_Well	# hours of seclusion and restraint per 1,000 patient hours	SFY 2015	1.00	1.30	↘ 1
PM	How_Well	% of patients with no emergency involuntary procedures during their stay	FYQ2 2016	74%	80%	↗ 1
PM	How_Well	% of medication errors reaching the patient (of all medications administered)	Dec 2015	0.18%	5.00%	↗ 2
PM	How_Much	# hours of mandated overtime in nursing department	FYQ2 2016	531	—	↘ 1
PM	How_Much	# of employee injuries (moderate severity or greater)	FYQ2 2016	4	—	↗ 1

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VPCH Staffing Update

Vermont Psychiatric Care Hospital

- Hospital has been open for 17 months.
- VPCH is both CMS certified and TJC accredited
- VPCH is operating at full bed capacity over the past 6 weeks
- VPCH is fully staffed, but still relies on permanent and temporary/traveler personnel at present

VPCH Performance Measures related to staffing

- # hours of mandated overtime in nursing department
  - Mandated overtime has decreased by 50% in the last quarter (Q2 FY 2016)
- # of employee injuries (moderate severity or greater)
  - Less than 4 moderate employee injuries each quarter, since start of measurement
- Working to develop numbers for VSH FY2011 as baseline comparison

VPCH Staffing Update

VPCH Nursing Personnel

- VPCH continues to operate ~50% of nursing positions filled by traveling nurses
- instituted nursing recruitment, retention, and sign-on incentives in late summer and early fall
- reinstituted PN I nursing positions (new graduates)
- flexibility to hire new, qualifying nurses up to Step 15 in the nursing pay grades
- AHS/DHR work group has been working on upgrading nursing positions to be more competitive in the marketplace over the past year
- AHEC prioritizing loan forgiveness for psychiatric nursing positions at VPCH
- Two Job Fairs have been conducted to recruit nurses in late fall
- An external nursing consultation report was commissioned to provide recommendations to DMH/VPCH on nurse staffing and retention opportunities. Action plan on recommendations being developed.

Results Based Accountability

Common Language
Performance to Population
Programmatic Performance Budget FY17

Results Based Accountability (RBA)

RBA is a framework that helps programs improve the lives of children, families, and communities and the performance of programs because RBA:

- Gets from talk to action quickly
- Is a simple, common sense process that everyone can understand
- Helps groups to surface and challenge assumptions that can be barriers to innovation
- Builds collaboration and consensus
- Uses data and transparency to ensure accountability for both the well-being of people and the performance of programs

http://resultsleadership.org/what-is-results-based-accountability-rba/

Results Based Accountability (RBA)

2 – kinds of accountability

- Population accountability > Population Indicators
  - Whole populations: Communities – Cities – Counties – States – Nations
- Performance accountability > Performance Measures
  - Client populations: Programs – Agencies – Service Systems

3 – kinds of performance measures

- How much did we do?
- How well did we do it?
- Is anyone better off?

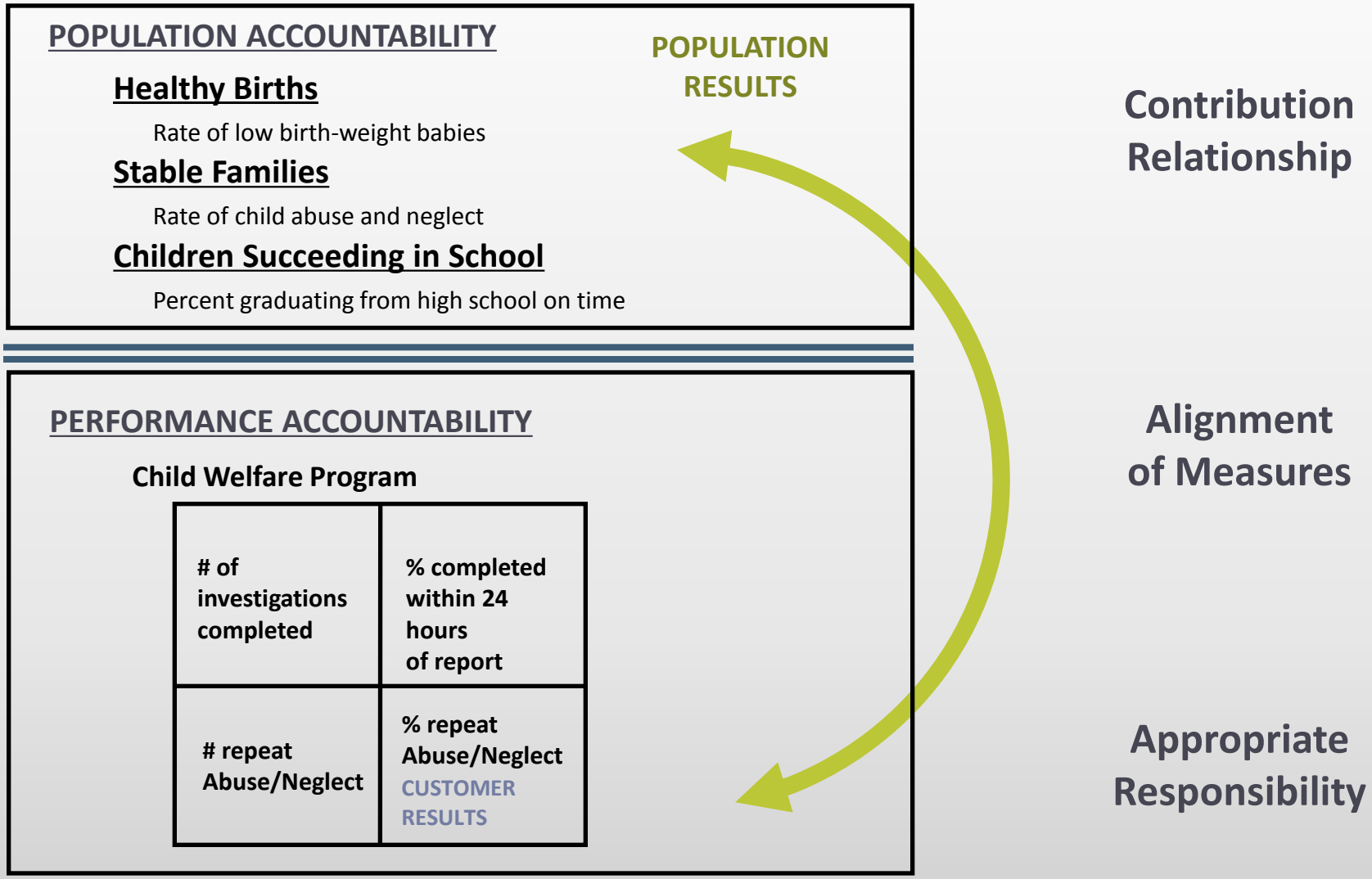
7 – questions, from ends to means

- Turning the curve

Common Language

	Term	Framework Idea
Population Accountability	**Outcome**	A condition of well-being for children, adults, families, or communities (a whole population)
	Indicator	A measure that helps quantify the achievement of an outcome
	Strategy	A coherent set of interventions that has a reasoned chance of working (to improve an outcome)
Performance Accountability	Goal	The desired accomplishment of staff, strategy, program, agency, or service system
	Performance Measure	A measure of how well a program, agency, or service system is working
	Quantity	*How much are we doing?* Measures of the quantity or amount of effort, how hard did we try to deliver service, how much service was delivered
	Quality	*How well are we doing it?* Measures of the quality of effort, how well the service delivery and support functions were performed
	Impact	*Is anyone better off?* Measures of the quantity and quality of effect on customer's lives

Performance to Population



Programmatic Performance Budget FY17

		Time Period	Actual Value	Target Value	Current Trend
O Act186	Vermonters are healthy.				
I AHS	Rate of suicide per 100,000 Vermonters	2013	16.9	11.7	↗ 1
I Act186	% of Vermont adults with any mental illness	2014	20.46	–	↗ 3
I Act186	% of Vermont adults with any mental illness receiving treatment	2014	56.8	–	↗ 1
O Act186	Vermont's elders and people with disabilities and people with mental conditions live with dignity and independence in settings they prefer.	Time Period	Actual Value	Target Value	Current Trend
I Act186	# of people with mental conditions receiving State services living in institutions	SFY 2015	83	–	↗ 4
I Act186	# of people with mental conditions receiving State services living in residential or group facilities	SFY 2015	349	–	↘ 1
I Act186	# of people with mental conditions receiving State services living independently	SFY 2015	1,852	–	↗ 1

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Programmatic Performance Budget FY17

			Time Period	Actual Value	Target Value	Current Trend
P	AOA	Community Rehabilitation and Treatment (CRT)				
PM	How_Much	# served in CRT	SFY 2015	2,708	2,700	↘ 7
PM	Better_Off	% of CRT clients reporting positive outcomes	SFY 2014	73%	80%	↘ 1
PM	How_Well	% of CRT clients receiving follow up services within 7 days of psychiatric hospitalization discharge	SFY 2015	93%	95%	↘ 1
P	AOA	Vermont Psychiatric Care Hospital (VPCH)	Time Period	Actual Value	Target Value	Current Trend
PM	How_Well	# hours of seclusion and restraint per 1,000 patient hours	SFY 2015	1.00	1.30	↘ 1
PM	How_Well	Average length of stay in days for discharged patients	SFY 2015	72	50	↘ 1
PM	How_Well	% of discharges readmitted involuntarily within 30 days of discharge	SFY 2015	9%	10%	↘ 1

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Departmental Budget

Key Fiscal Year Issues and Highlights
FY17 Revenue and Expenses
FY17 Budget Request

Key Fiscal Year Issues and Highlights

- Implementing Health Care Reform and All Payer Waiver and implications for integrated care delivery across specialty care population and services
- Operationalizing Level 1 care and timely treatment to assure access the right level of inpatient care at the right time
- Maintaining capacity of the new 25 bed Vermont Psychiatric Care Hospital (VPCH)
- Medicaid Rate Increase
- Planning for permanent secure residential recovery
- Implementing Electronic Health Record at VPCH

FY17 Budget Request

Item	Gross	General Fund
Rescission Items	$258,650	$127,708
Salary and Fringe Increase	$682,602	$311,399
Retirement Incentives	$225,927	$104,461
Workers Compensation Insurance	$159,416	$72,833
VPCH Vacant Position Step Increases	$159,241	$72,741
VPCH Current Nurse Step Increases	$105,759	$48,311
VPCH UVM Contract Increase	$314,869	$143,832
Reductions to VPCH Contracts	$150,000	$68,520
Savings from Morrisville Rent	$85,860	$85,860
Fee For Space Charges	$96,031	$43,429
Internal Service Funds/Property Management Surcharge	$25,087	$11,371

FY17 Budget Request

Item	Gross	General Fund
Peer Services for Young Adults	$0	$137,040
Vermont Cooperative for Practice Improvement (VCPI)	$0	$26,494
Suicide Prevention Spectrum	$72,724	$33,220
Technical Adjustment to Federal Fund Spending Authority	$900,000	
PNMI Increase (3%)	$140,953	$64,387
HUD Funding Reduction Impact to preserve transitional housing	$90,000	$41,112
Respite DOL Impact	$378,803	$173,037

FY17 Budget Request

AHS Net Neutral

Item	Gross	General Fund
Transfer from DCF for IFS DAP program	$344,600	$157,413
Transfer from DCF for Therapeutic Child Care	$267,821	$122,341
Success Beyond Six	$3,000,000	$1,370,400
ABA Funding for NCSS from DVHA	$429,099	$196,012

SUMMARY

Item	Gross	General Fund
DMH Request	$494,692	$751,959
AHS Net Neutral	$4,041,520	$1,846,166
Balance of DMH Request	**$4,536,212**	**$2,598,126**

Requested Items

Unified Mental Health Implementation Plan

Court-Ordered Involuntary Medication

AHS: DMH & DVHA

Implementation of a Unified Inpatient Psychiatric Hospital Service and Financial Allocation

February 2016

VERMONT
AGENCY OF HUMAN SERVICES

Discussion Topics

- Act 58 Charge to DMH and DVHA
- Implementation Plan Elements
- Plan Goals and Principles
- Task One: Inpatient Psychiatric Hospital Services
- Task Two: DMH DA/SSA Financing & All Payer Model Alignment
- Task Three: Coverage and Payment Policy Review
- Summary of Implementation Milestones and Timelines

Act 58 Charge to DMH/DVHA

As part of their fiscal year 2017 budget presentation, the Departments of Mental Health and Vermont Health Access will present a plan for a unified a unified service and financial allocation for publicly funded mental health services as part of an integrated health care system.

The goal of the plan is to integrate public funding for direct mental health care services within the Department of Vermont Health Access while maintaining oversight functions and the data necessary to perform those functions within the department of appropriate jurisdiction. The plan shall contain a projected timeline for moving toward the goals presented therein.

Implementation Plan Elements

Task 1. Inpatient Psychiatric Services

Establish a unified service and financial allocation for in the DVHA appropriation for Inpatient Psychiatric Services

- Joint DMH/DVHA clinical group established to define operational details and joint oversight structure (children and adult services)

Task 2. DMH DA/SSA Finance Models & All Payer Model Alignment

AHS and Vermont Health Care Improvement Project have established a joint work group to explore payment reform options for the DA/SSA system to support excellence in mental health and promote the integration of mental and physical health care for all ages in Vermont

- Joint AHS/VHCIP/Provider work group established to examine options
- Joint AHS/Provider Performance measures work group

Task 3. Review Coverage and Payment Policies and AHS-wide Impact

AHS has established an internal operations committee with membership from all departments to review coverage and payment policies to mitigate any unintended consequences of proposed changes across departments

- Joint DMH/DVHA team will be established to define operational priorities and stakeholder engagement plan for adult and children's services
- Reviews will include alignment with the emerging All Payer Model, as necessary

Plan Goals and Principles

- Ensure Access to Care for Consumers with Special Health Needs
  - Access to Care includes availability of high quality services as well as the sustainability of specialized providers
  - Ensure the State's most vulnerable populations have access to comprehensive care
- Promote Person and/or Family Centered Care
  - Person and/or Family Centered includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
  - Service delivery should be coordinated across all systems of care (physical, behavioral and mental health and long term services and supports)
- Ensure Quality and Promote Positive Health Outcomes
  - Quality Indicators should utilize a broad measures that include structure, process and experience of care measures
  - Positive Health Outcomes include measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators)
- Ensure the Appropriate Allocation of Resources and Manage Costs
  - Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors
- Create a Structural Framework to Support the Integration of Mental and Physical Health Services
  - Any proposed change should be goal directed and promote meaningful improvement
  - Departmental structures must support accountability and efficiency of operations at both the State and provider level
  - Short and long term goals aligned with current Health Care Reform efforts

Task One – Inpatient Hospital Services

Inpatient Psychiatric Hospital Services are currently managed by both DMH and DVHA for differing purposes:

- DMH manages all admissions for adults affiliated with DA/SSA programs, Emergency Evaluations and all Level I clinical designations and hospital cost settlements; annually unallocated inpatient hospital funding is used to support CRT community services. DMH monitors the overall capacity within the Mental Health System of Care and supports placements between multiple levels of care (e.g. outpatient, inpatient, hospital diversion, step down and other peer-run community crisis beds)
- DVHA manages all non-DA/SSA affiliated adult admissions and all children's admissions. DVHA manages episodes of inpatient care and ensures discharge planning is timely and coordinated across providers.

Task One – Inpatient Hospital Services

1. Inpatient Services by the following funding categories			2014	2015	Utilization Analysis
A. Level 1 Inpatient Services		capacity	35	45	The increase in FY 15 is due to the opening of VPCH. Expenditures for each year represent paid claims on complete episodes of care. Expenditures for inpatient hospitalizations that are ongoing at the end of the fiscal year are listed in Level 1 VISION payments and settlements. Claims are also subject to revision and are point in time. Level 1 hospital beds typically have a 98-100% occupancy rate each month.
All DMH	CRT	caseload	57	51	
		expenditure	$4,154,736	$4,472,963	
	Non-CRT	caseload	102	134	
		expenditure	$14,467,207	$24,371,604	
	Level 1 VISION payments and settlements		$3,973,100	$2,043,534	
B. Non-Level I, Involuntary Inpatient Psychiatric Services		capacity	131	143	Non-Level 1 involuntary inpatient psychiatric services and voluntary inpatient psychiatric services are provided using the same hospital beds in the system. Non-Level 1 hospital beds typically have a 84% occupancy rate each month.
CRT is DMH Non-CRT is DVHA	CRT	caseload	29	44	
		expenditure	$1,130,415	$683,703	
	Non-CRT	caseload	59	103	
		expenditure	$1,178,916	$2,262,344	
D. Inpatient Psychiatric Services for Other Medicaid Patients (Voluntary)		capacity	131	143	
CRT is DMH Non-CRT is DVHA	CRT	caseload	174	170	
		expenditure	$2,581,292	$2,440,728	
	Non-CRT	caseload	1,612	1,900	
		expenditure	$14,536,282	$22,106,845	
E. Emergency Department Wait times for an acute inpatient psychiatric bed for minors and adults		capacity			These longer wait times do not reflect a system-wide experience; it is heavily skewed by a small number of individuals who wait much longer than others in their cohort. This is due to a variety of circumstances such as bed closures due to unit acuity, no bed being readily available, or due to the acuity of the person waiting. On average, a majority of people waiting for inpatient care during the month are placed within 24 hours.
	Minors	avg hrs.	30	31	
	Adults	avg hrs.	48	45	

Task One - Activities and Timelines

December 2015 – June 30, 2016

1. Continue monthly DMH/DVHA inpatient utilization review team meetings to:
   - Review and refine joint policy and clinical criteria for children's and adult services (e.g., voluntary versus involuntary stays; screening procedures; continued stay criteria; rates and payment guidelines, etc.)
   - Identify decision making hierarchy and conflict resolution processes for joint oversight structure
   - Determine best practices for involuntary admissions that balances : the State's obligation for payment; the client's clinical needs; and court orders
   - Assess data and clinical trends to identify options for community alternatives (e.g., community assisted treatment) to inpatient admission for children's and adult services
   - Identify options for a joint DMH/DVHA hospital review process
2. Establish joint DMH/DVHA fiscal team to determine:
   - Whether the Level 1 hospital cost settlement process needs to be reviewed and revised; if revised, determine if transfer of the settlement process to DVHA is appropriate
   - How to track savings in the CRT hospital allocation and divert unused funding to CRT community services
3. Establish the timing for a unified service and financial allocation in the DVHA appropriation for inpatient psychiatric services that aligns with Task Two and Three of this plan
4. Determine resources, data and infrastructure needed based on outcomes of steps 1-3 above.

Task Two –DMH DA/SSA Financing & All Payer Model Alignment

DMH Mental Health Services are delivered by 10 private, non-profit community service providers called “Designated Agencies” (DAs) and by two Specialized Service Agencies (SSA) located throughout the state. These agencies:

- Are largely funded through Medicaid (Approximately $260 million or 77% of their funding in SFY15)
- Cannot refuse to serve CRT, DS or Children who meet State criteria and who reside in their geographic catchment area
- Must ensure contracted services are available by providing services directly or contracting with other providers or individuals. They also are responsible for local planning, service coordination, and monitoring outcomes within their region.

In the case of a SSA, providers are responsible for specific specialized services across a region or statewide as designated by DMH.

DA/SSA providers also provide support to multiple Specialized Programs across AHS (i.e., Integrating Family Services, Traumatic Brain Injury, Developmental Services, Choices for Care, DCF Child Development Division, Family Services Division, VDH Alcohol and Drug Abuse Programs, Vocational Rehabilitation Services and DVHA)

Task Two –DMH DA/SSA Financing & All Payer Model Alignment

Because these providers support programs across AHS, changes in one area may have unintended consequences in other programs. Alignment with the All Payer Model and exploration of new finance models to support excellence in mental health and substance abuse treatment must be viewed in the full context of AHS Medicaid programs and services

Task Two - Activities and Timelines

December 1, 2015 – December 31, 2016

1. Establish AHS/DA/SSA/VHCIP All Payer Model Work Group
   - Assess provider readiness and risk tolerance
   - Analyze current financial methodology and program requirements
   - Identify targeted services and beneficiaries
   - Review options for new finance models
   - Identify quality measures and reporting requirements
   - Produce an implementation plan including subsequent phases of the project that would expand to additional services and providers.
2. Implement revised DA/SSA performance measures in July 1, 2016 provider master grant agreements
3. Determine if additional legislative or policy changes are needed to implement desired changes
4. Determine if new finance models and All Payer Model Alignments have stakeholder consensus and if so, finalize timelines for implementation in 2017

Task Three – Review Coverage and Payment Policies for Mental Health Services

Current coverage and payment policy is defined by both DMH and DVHA based on who provides the services and departmental budget allocations

DMH/DVHA Mental Health Providers			
Provider/Services	**Oversight Roles**		
	Policy	**Funding**	**Provider**
DA/SSA Specialized Programs	DMH	DMH	DMH
Designated Agency Outpatient Mental Health	DMH, DVHA	DMH, DVHA	DMH
Hospital Inpatient Psychiatric	DMH, DVHA	DMH, DVHA	DMH, DVHA
Independent Practice Outpatient Mental Health	DVHA	DMH, DVHA	DVHA
FQHC and Other Clinic Outpatient Mental Health	DVHA	DVHA	DVHA

Task Three Activities and Timelines

December 1, 2015 – June 30, 2016

1. Review of Medicaid coverage and payment policies for similar services provided across multiple AHS programs
   - Establish joint DMH/DVHA policy and operations work group
2. Determine if additional policy or funding alignments are appropriate given the findings of the review
3. Determine if policy and funding recommendations align with the All Payer Model
4. Determine if Value Based Purchasing Opportunities exist and prioritize those opportunities for design and development
   - Engage Stakeholders in review and discussion of options
5. Determine if policy or legislative changes are needed to implement desired changes
   - Engage Stakeholders in review and discussion of options
6. Prioritize coverage and payment policies for change in calendar year 2016 and 2017

Implementation Summary

January 1 - June 30, 2016

- ✓ Support integrate inpatient hospital service policy and determine timing of any final unified financial allocation recommendations

January 1 - June 30, 2016

- ✓ Review additional coverage and payment policies to determine if changes should be made and prioritize for SFY 2017 Budget Adjustment Act and SFY 2018

January 1 - Dec 31, 2016

- ✓ Work with DMH DA/SSA stakeholders and VHCIP to explore new models for financing the mental health system and optimal alignment with the All Payer Model
- ✓ Implement revised performance measures in July 1, 2016 master grant agreements

January 1, 2017

- ✓ Review any necessary legislative changes with General Assembly and committees of jurisdiction

July 1, 2017

- ✓ Implement consensus models for finance and policy reform to support:

  An integrated health care system that recognizes Mental Health as a cornerstone for Health and supports access in all settings to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn and participate fully in their communities.

Court Ordered Involuntary Medication

Data and Challenges

Studies and Proposed Solutions

Court-Ordered Involuntary Medication

How many applications during a year?

- 70-75 applications for Court-Ordered Medication (AIM) are filed annually
  - As compared to 475-500 involuntary admissions annually
  - 76% of AIM are granted
- Since September 2014, 16 filings for expedited AIM applications
  - 86% were granted
- 55 discharges in FY 15 for persons with AIM filings

Court-Ordered Involuntary Medication

How long do people wait?

- 68% of AIM are resolved in 90 days
- Average time from hospital admission to a AIM decision (2014-2015)
  - Standard AIM: 128 days
  - Expedited AIM: 47 days (almost 3 months faster)
- Average Length of Stay for FY15 Discharges
  - Single filing during stay: 155 days
  - Multiple filings during stay: 334 days

Court-Ordered Involuntary Medication

Challenges with Current Process

- There may be multiple filings for AIM delaying appropriate clinical treatment
  - Order expires, person stops medication
  - Person agrees after filing; court date suspended; person stops medication
  - First trial or dosage of medication not effective; new medication or dosage requested
- Increased likelihood of seclusion, restraint, or sedation when behaviors are escalate to an emergency intervention level with other patients or staff in a hospital setting
- Access to inpatient beds is decreased by longer LOS for individuals not receiving timely medication treatment when known to improve acute symptoms of illness

Court-Ordered Involuntary Medication

Studies on Delayed Treatment

- The longer the period of untreated psychosis, the smaller the level improvement that can be expected. (Norman & Lewis, 2005)
- Not only are clinical outcomes better when the duration of untreated psychosis (DUP) is short but that reducing the duration of untreated psychosis early in the course of psychosis yields better outcomes than later on in course of an illness. (Norman & Lewis, 2005)
- Treatment response is better with a shorter DUP across multiple clinical domains including; positive symptoms, negative symptoms, global pathology as well as functional outcomes. (Perkins & Gu, 2005)
- DUP is an independent predictor of the likelihood of recovery from schizophrenia. (Perkins & Gu, 2005)
- At least after the first episode of psychosis, there is significant body of evidence that clinical and functional outcomes are poorer with a longer DUP and that the potential for full recovery reduces with longer DUP. (Anderson & Rodrigues, 2014)

Court-Ordered Involuntary Medication

Proposed Solutions

Revise Timelines

- Require that hearings for Applications for Involuntary Treatment (AIT) occur within 7 days
- Remove language for expediting AITs
  - Removing timelines eliminates need for this provision
  - Legal threshold for “significant risk of causing harm and serious bodily injury” is extremely high and not consistently interpreted across court systems
- Require that hearings on AIM occur within 7 days of application
- If the AIM and AIT are both filed within 48 hours of one another, require that the hearings are consolidated

Court-Ordered Involuntary Medication

Proposed Solutions

Reduce the Potential for Delays

- Remove one of two probable cause review processes
- Limit the use of continuances that delay timely treatment
- Limit the timeframe and the number of psychiatric evaluations that may be requested
  - Multiple evaluations and long delays impact timely treatment

Clarifying Appropriate Use

- Clarify the statues to define medication refusal
  - Inconsistent interpretations amongst courts
- Ensure that a clinically trained treating provider determines timely treatment and appropriate medication

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