Brattleboro Retreat Contract for Level I Inpatient Psychiatric Care

Specification of Work to be Performed

Contractor (Brattleboro Retreat) agrees to continue to provide psychiatric intensive inpatient care services to patients (hereafter called "Level I"), as defined by the State, see Attachment G. The definition of Level I patients cannot be changed without a written agreement to this Contract signed by the State and Contractor. This Contract can be amended, by written agreement signed by both parties, if there are statutory or regulatory requirements resulting in higher operating costs not addressed through the annual cost reconciliation process outlined herein.

Contractor shall maintain compliance with all state and federal laws and regulations for licensed and certified psychiatric hospitals and for designated hospitals, and shall comply with the following requirements set by the State.

1. Bed Capacity: Contractor agrees to maintain 14 Level I emergency examination or court-ordered observation psychiatric inpatient beds on the renovated Tyler 4 Unit. For the purposes of this Contract, emergency examination beds means Level I beds that are available to patients who are admitted for an emergency examination pursuant to 18 V.S.A. § 7508(a) and meet the Level I definition outlined in Attachment G. Court-ordered observation psychiatric inpatient beds means Level I beds that are available to patients who are admitted for examination of competency and/or sanity pursuant to 13 V.S.A. § 4815(g) and meet the Level I definition outlined in Attachment G. Contractor's Level I beds shall be no-refusal beds as defined in Act 79. State may request the Contractor to provide additional Level I bed capacity beyond the no-refusal bed capacity. The decision to extend the capacity will be on a case-by-case basis and mutually agreed upon by both parties. Reimbursement will be made at the agreed-upon daily rate based on reasonable actual costs as defined in Attachment B. Should contractor refuse any referred admission to the Tyler 4 Unit, the Contractor's chief executive officer or designee shall contact the Department of Mental Health (DMH) and enter into an immediate review process to resolve issues which are preventing admission.

2. Inpatient Movement:

    a. During the course of each Level I inpatient admission, contractor agrees to regularly evaluate to determine whether patients continue to meet the Level I definition outlined in Attachment G or if they would be appropriate for transfer to a non-Level I unit. Such determination will be made in conjunction with the DMH Utilization Review process and clinical review with the inpatient treatment team during regularly scheduled review meetings. Potential disruption to patient treatment plan or relationship with the treatment team will be considered, but will not be the sole clinical determinant for remaining on PICU or being identified as a Level I patient.
    b. When the contractor desires to move patients between the Level I unit and a non-level I unit, the contractor will communicate with the Mental Health Services Director, or designee, to discuss the needs of the system as it relates to the use of the Level 1 bed. In the case of emergent clinical needs that require an immediate change in placement between the Level I and non-Level I unit, the Contractor will communicate with the Mental Health Services Director or designee as soon as practicable thereafter to discuss the change.

3. Within the 14 Level I emergency examination or court-ordered observation psychiatric inpatient bed capacity outlined in (1) above, Contractor shall provide 24 hour a day/7 day a week admission and discharge capacity for all patients in the care and custody of the DMH Commissioner.

4. The Contractor shall participate fully with the State in utilization and continued stay payment authorization and in any clinical care review processes outlined by the State.

5. The Contractor shall fully participate with the State's care management system to ensure that any patient is cared for in the appropriate setting and that patients are discharged to appropriate services and settings in a timely manner, when clinically appropriate. This participation shall include utilization review, including a determination, when clinically appropriate, that a person is no longer in need of Level I care and therefore should be considered for movement to a lower acuity unit.

6. The Contractor shall report to the State, in real time, the number of available inpatient beds via the electronic bed board reporting system made available to the Contractor by the State.

7. The Contractor shall minimize the use of restraints, both physical and chemical, and seclusion in compliance with Center for Medicare and Medicaid Services (CMS) standards. Contractor will continue participation in the Substance Abuse and Mental Health Services Administration (SAMHSA) Six Core Strategies for the Reduction of Seclusion and Restraint. The Contractor shall comply with the Rule Establishing Standards for Emergency Involuntary Procedures when promulgated. Occurrences of restraint, seclusion, and emergency involuntary medication shall be documented using a Certificate of Need (CON) form with core data elements and clinical content identified by the State. The CON forms shall be submitted to the state following the discontinuation of the emergency involuntary procedure or no later than twice per month on the 1st and 15th of each month.

8. The Contractor and/or the Contractor's legal counsel will maintain active communication with the DMH Legal Division in order to adhere to all legal requirements as required for any patient in the care and custody of the Commissioner of DMH. Legal requirements include, but are not limited to:

    a. Completion of all documentation required for Act 114 (court-ordered medication administration)
    b. 30 day reviews of involuntary medication orders
    c. Providing medical records to Assistant Attorneys General and Legal Aid attorneys in connection to involuntary treatment/medication admissions
    d. Seeking DMH approval for the discharge of patients in the custody of the DMH Commissioner
    e. Availability of physicians/staff who may be required to testify at involuntary treatment/medication hearings
    f. Notification of inability to admit patients sent for inpatient evaluation if no bed is available

9. Contractor shall be responsible for all escorts of patients within the facility and transports to any other treating facility for medically necessary care. All escorts/transports within the responsibility of Contractor shall be conducted in a manner that prevents physical and psychological trauma; respects the privacy of the individual; and represents the least restrictive means necessary for the safety of the patient given the medical condition and risk of danger or elopement of the patient at the time of the transport. All other transports shall be arranged by the State through the mutually agreed upon transportation protocol outlining duties of notification by each party (**Attachment I**).

10. Contractor, in accordance with the Designated Hospital Event Reporting Protocol, shall provide information to the State on any reportable event involving a patient cared for under this agreement. A verbal report shall be made to the DMH Commissioner during working hours and to the Vermont Psychiatric Care Hospital (VPCH) Admissions office during off hours and weekends. Such reports shall be followed by a report in writing within 24 hours of the occurrence in a format provided by the State and faxed to (802) 828-1715. An e-mail acknowledging receipt will be sent to the person completing the form.

11. The Contractor shall provide the State with all required reports identified herein. Contractor shall promptly notify the State when CMS or other regulatory or accrediting body appears for a survey/inspection visit. Contractor shall also provide timely notification to the DMH Commissioner of any initial exit visit findings as well as the formal findings of site visits. DMH will notify Chairs of the House Human Services and Senate Health and Welfare Committees. Reports of such visits, when received, shall be promptly submitted to the DMH Commissioner and, following necessary redactions of

identifying patient information wherein disclosure might jeopardize a patient's privacy or protected health information, DMH will provide same to the Chairs of the Legislative Committees of jurisdiction.

12. The State shall have full access to all records involving a patient in the custody of the DMH Commissioner or involving any patient admission requiring payment authorization by the State.

13. The Contractor is not a public agency and as such is not subject to Vermont's Access to Public Records law, 1 V.S.A. § 315 et. seq. To the extent records concerning the implementation of this contract maintained by the Contractor are subject to disclosure pursuant to Act. No. 79 (Adj. Sess.), § 9(2)(F), the records shall be provided to the state within 2 business days (unless otherwise agreed upon) and shall be in electronic format whenever possible. Records the Contractor determines are confidential by law shall not be produced. However, in the situation where the Contractor believes that the requested information is confidential by law, Contractor shall immediately submit to the State a written notice citing its legal basis for an exemption. DMH will review and discuss with Contractor.

14. The Contractor shall ensure that a patient representative is available to all Level I patients consistent with statutory requirements and is provided reasonable opportunity to conduct at least one monthly patient forum. The Contractor also shall ensure that the mental health ombudsman has access to all Level I patients.

15. The Contractor shall consistently participate in the inpatient quality workgroup convened by DMH and shall collaborate with DMH representatives regarding ongoing quality improvement measures and performance accountability outcomes. During this contract period, the contractor and DMH will finalize the documentation elements for de-briefing of patients. Such elements will be mutually developed and agreed upon as a statewide standard.

16. Contractor shall, as a component of current and future contract provisions, collaborate with DMH and other Designated Hospitals on the development of annual clinical outcome performance indicators. The Harbor Performance Initiative (HPI) will be specifically considered for future annual performance indicators. At a minimum for this contract period, annual indicators will include:

    <u>Hospital-Based Inpatient Psychiatric Services Core Measure Set (HBIPS)</u>

    a. HBIPS -1: Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed
    b. HBIPS-2: Hours of Physical Restraint Use
    c. HBIPS-3: Hours of Seclusion Use
    d. HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications
    e. HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
    f. HBIPS-6: Post Discharge Continuing Care Plan Created
    g. HBIPS-7: Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge

17. Contractor shall maintain an emergency preparedness plan for inpatient evacuation, transfer, and continuity of care of Level I patients in accordance with requirements set forth by State of Vermont, Department of Health, Board of hospital licensing standards.

ATTACHMENT G
"No Refusal System of Care" and "Level I" Intensive Care Patient Definitions and Utilization Review Protocol

Definition:

No Refusal System of Care

A 24/7 system of inpatient psychiatric hospitals under contract with the Department of Mental Health that admit patients identified as meeting Level I clinical eligibility criteria consistent with the purchased bed capacities at each facility. The collective "no refusal system of care" prioritizes any available Level I bed for utilization to minimize involuntary Level I wait time and address an emergent admission. When disagreement exists, the no refusal system of care includes a systematic next business day review of the admission and a commitment to mutual consensus by the Chief Executive Officers, or their designees, of the hospitals in determining the optimum available treatment environment and actively working to achieve transfer to that treatment setting at the earliest possible time.

"Level I" Intensive Care Patient

Patients admitted for involuntary psychiatric admission who meet the Clinical Eligibility and Severity criteria listed below will be considered "Level I" patients eligible for enhanced inpatient bed day payment by the Department of Mental Health. This determination will be completed by the DMH Utilization Review Care Manager within two (2) business days. An "exception" **may be** made for patients at other levels of inpatient care who require significant and more than usual resources.

Clinical Eligibility and Severity:

- Patients who are admitted under Emergency Examination or Warrants for Examination;
- Patients who are court ordered for inpatient evaluation;
- Patients in the custody of the Department of Corrections;
- Patients, who, following commitment hearing, are determined to need non-emergency involuntary medication until stabilized and discharged;
- **With prior DMH approval**, voluntary patients who require significant and more than usual resources

and who exhibit:

- significant danger to self (either imminent or strongly suggested by patient history) such that significant and more than usual resources are needed to manage the patient's care; or,
- significant danger to others (either imminent or strongly suggested by patient history) such that significant and more than usual resources are needed to manage the patient's care; or,
- significant disruptive behaviors such that significant and more than usual resources are needed to manage the patient's care; **or,**
- great difficulties caring or protecting for self that significant and more than usual resources are necessary to manage the patient's care.

"Significant and more than usual resources" means such interventions as extended and ongoing periods of additional staffing on the unit, including 1:1 and 2:1 staffing, or extra psychiatrist or other clinical staff time, repeated restraints or seclusions.

Care Management:

DMH Care Managers will be assigned to the Designated Hospital for collaborative care management and implementation of the Clinical Utilization Review Protocol outlined below. DMH Care Managers will actively

monitor and work with hospitals and community resources to identify patients appropriate for step-down facilities from inpatient care settings. Care Managers will perform on-site reviews up to one time per week at the facility in order to monitor clinical status and aftercare planning for involuntary care patients. On-site reviews will be coordinated with designated facility representative/s. The DMH Care Manager will:

- Provide information regarding previous treatment recommendations and system-wide treatment plans.
- Facilitate collaboration between care-givers who have been involved at all levels of care
- Coordinate with the Attorney General's office to facilitate legal processes for hearings, involuntary hospitalization, involuntary medication, adjudication, and/or other legal issues
- Facilitate aftercare coordination, including coordination of care between hospitals and relevant agencies
- Facilitate the coordination of system-wide treatment plans, for targeted individuals with complex treatment needs, across levels of care.

Clinical Utilization Review Protocol

Involuntary Care Notification, Admission Authorization, and Level I Assignment for Enhanced Payment:

Any involuntary admission must be reported to the VPCH Admissions Office. Designated agency (DA) screeners will provide emergency examination application information to VPCH admissions office prior to referral for involuntary care.

Any individual admitted involuntarily will be reviewed by DMH Utilization Review Care Manager. The DMH Utilization Review Care Manager, based on clinical evaluation provided at the time of admission, will determine if the admission is a Level I patient, based upon criteria above, and eligible for enhanced payment. This determination is only for immediate enhanced payment and does not preclude settlement of "real and actual" expenditures as part of the annual cost reconciliation process outlined in the payment provisions.

The DMH Utilization Review Care Manager in consultation with the DMH Medical Director or Psychiatrist designee will:

- certify the admission as Level I and identify the continued stay review periodicity; or
- certify the admission as acute involuntary and identify the continued stay review periodicity

Continued Stay Reviews:

Any involuntarily admitted individual will be reviewed by DMH Utilization Review Care Manager. Continued Stay Review periodicity will be determined by the DMH Utilization Review Care Manager. Designated Hospital's(DH) will provide clinical information requested by the care manager in order to authorize the period of inpatient care during the period of time under review. Any continued stay review that appears to no longer meet inpatient or Level I patient clinical eligibility criteria will be referred to the DMH Care Manager assigned to the DH for concurrent review. Only after consultation between the DMH Care Manager and review between the DMH Utilization Review Care Manager with the DH utilization review representative, a continued stay determination will be made.

The DMH Utilization Review Care Manager in consultation with the DMH Medical Director or Psychiatrist designee will:

- certify the continued stay as Level I involuntary

- certify the continued stay as acute, voluntary or involuntary, and identify the continued stay review periodicity; or
- certify the continued stay as "awaiting discharge" level of care and the basis for the determination; or
- certify no inpatient level of care being met and issue payment denial.

For DMH tracking purposes with Level I inpatient providers, and evaluation of Level I inpatient bed utilization for annual real, actual cost reconciliation, the afore mentioned certifications for Continued Stay Reviews will:

- Authorize Level I clinical eligibility criteria as being met and identify subsequent continued stay review date. Continuing Level I enhanced payment clinical eligibility criteria will consider intensity and duration of treatment services **and** routine documentation of:

  - The need for continued allocation of significant and more than usual resources to maintain the safety of the patient, other patients, or staff;
  - intractable mental illness symptomology, ongoing behavioral dysregulation and instability with demonstrated treatment plan modifications;
  - complex medication management that must occur in an acute inpatient setting;
  - active daily restorative interventions/services not available in alternate level of care settings.

  This authorization level maintains enhanced payment for inpatient billing and coding purposes; **or**

  - Authorize "acute" level of care (Level I patient remains acute, no longer requires additional level I resources, and internal transfer to other units is possible*) and effective date. This authorization level will be determined after having exhausted the clinical review process with the treatment team. (*If transfer to another unit cannot be mutually agreed to by both the Contractor and the DMH, the authorization level will be made and tracked by DMH, but enhanced payment will not be denied. Such determinations will be reviewed and any financial adjustments made during the annual cost reconciliation process.) The annual cost reconciliation process shall be the final determinant for any financial adjustment; or

  - Authorize "awaiting discharge" level of care (a former Level I patient is no longer acute and facility is actively working toward discharge) and effective date. Patients with complicated legal status or significant aftercare planning complexities may be in this level of care. This authorization level maintains payment for inpatient billing and will be tracked by DMH, but notifies providers of Level I units that acute clinical eligibility criteria is no longer met; or

  - Deny awaiting discharge clinical eligibility criteria as being met and level of care change effective date. This determination will only be made when transfer to an alternative level of care is appropriate and has been offered and declined by the inpatient facility. This determination will result in a denial of payment authorization for continued stay.

Patients in Level I unit beds, who continue to require psychiatric support services but are determined to be eligible for internal transfer or "awaiting discharge" as outlined above, are a priority group for aftercare coordination and movement to either alternate inpatient units or alternate care settings when clinically appropriate.

It is an expectation that hospitals will actively collaborate with DMH Care Managers to effect clinically appropriate inpatient movement or discharges to receiving facilities to expedite clinically appropriate level of care and aftercare when a patient does not meet Level I clinical eligibility criteria. Enhanced payment and inpatient level of care authorizations are contingent upon actively transitioning identified patients who no longer meet the level of care for Level I inpatient services to an available unit or facility that will accept a patient for admission.

Tracking and Verification:

The DMH Utilization Review Care Manager will track all enhanced payment and inpatient authorizations, changes in clinical status, and manage the flow of determinations within the parameters of the clinical utilization review protocol.

Enhanced Payment or Payment Denial and Appeal:

- **Enhanced payment denial will occur when an involuntary inpatient admission is denied an enhanced payment billing authorization at any point in the inpatient admission.**

Payment denial will only occur when a Level I patient is determined to be "awaiting discharge" and transfer to an alternative level of care has been offered and declined by the inpatient facility.
When disagreement occurs between DMH and the hospital regarding a decision to deny enhanced payment or payment, a clinical review will be initiated.

Clinical Review:

A **clinical review** is conducted by clinical representatives from a hospital and DMH clinical staff who are delegated by the DMH Commissioner to serve this function and review any materials submitted relevant to the decision. Delegated staff may issue a decision or request additional information from persons with knowledge of the issues prior to making a decision. The DMH Medical Director will render a determination regarding authorizing or denying the payment. If the DMH Medical Director believes additional consultation is needed to render a determination he may 1) informally consult with another psychiatrist, who has no vested interest in the determination, regarding medical/clinical necessity and the clinical review process or consult with the Department of Vermont Health Access Medical Director prior to making a determination.

In any instance of a denial at this level, the provider may request an appeal to the DMH Commissioner for reconsideration.

*In any instance when payment will be denied, the patient and his or her authorized representative will be notified of his/her right to appeal and the process by which he or she may do so. The hospital may only enter an appeal on behalf of the patient. The patient or his or her authorized representative must authorize this appeal.