Report of the Mental Health Oversight Committee
December 2014

Representative Ann D. Pugh, Chair
Representative Anne B. Donahue
Representative Mary S. Hooper
Representative Catherine Beattie Toll
Senator Claire D. Ayer, Vice Chair
Senator Norman H. McAllister
Senator John S. Rodgers
Senator Diane Snelling

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Table of Contents

I. Executive Summary

During the summer and fall of 2014, the Mental Health Oversight Committee (Committee) met four times to hear testimony on matters consistent with its charge of overseeing Vermont's mental health system. The Committee also focused on two topics in response to legislation enacted during the 2014 session relating to emergency involuntary procedures and the future oversight structure of the mental health system. The Committee makes the following recommendations for the 2015 legislative session:

- The committees of jurisdiction should reexamine legislative intent on emergency involuntary procedures with regard to who the rules on this topic should apply to, who can prescribe chemical restraint, and whether the person prescribing chemical restraint must personally observe the patient.
- The committees of jurisdiction should make children's mental health issues a priority in the next session.
- Funds currently designated for traveling nurse salaries should instead be used to train experienced Vermont nurses in psychiatric care. The Committee also recommends that the committees of jurisdiction review the Agency of Human Services' market analysis for nurses with psychiatric expertise.
- The committees of jurisdiction should monitor the status of elders in the mental health system, including the need for a new step-down facility specifically for elders and the basis on which elders with mental health needs are eligible for Choices for Care.
- The General Assembly should support the Agency of Human Services' coordinated efforts to transition from data collection to meaningful improvements within the mental health system. Additionally, DAIL should retain a surveyor with substantial expertise in psychiatric care, as well as refocus staff resources on visiting those facilities where the need for review is greatest.
- The committees of jurisdiction should seek clarification as to which information regarding adverse events is confidential by law.
- The committees of jurisdiction should continue to focus their attention on ensuring mental health care remains in the forefront of discussions on health care reform and integration.
- The committees of jurisdiction should review the State Auditor's report on designated agencies and monitor payment for services in the community mental health system.
- The Committee recommends that the General Assembly pass legislation reestablishing a time-limited and focused joint oversight committee whose sole charge is to monitor the ongoing development and implementation of Act 79 during adjournment and that the membership of the reestablished committee include diverse representation with more flexibility than its current charge allows.

II. Statutory Authority and Responsibilities of the Mental Health Oversight Committee

The General Assembly created the Committee in 2004 to oversee the development and implementation of the Vermont Mental Health Futures Plan and to ensure that Vermonters have

access to a comprehensive and integrated continuum of mental health services. (2004 Acts and Resolves No. 122, Sec. 141c.) The Committee's charge was amended in 2007 to focus on the State's mental health system more generally and to remove the Committee's sunset date. (2007 Acts and Resolves No. 65, Sec. 124b.) (*See* Appendix 1: Amended Charge of the Mental Health Oversight Committee.) In 2014, the General Assembly passed legislation repealing the Committee effective January 1, 2015. (2014 Acts and Resolves No.179, Sec. E.306.4.)

The Mental Health Oversight Committee is a bipartisan committee composed of senators who serve on the Committees on Health and Welfare, on Appropriations, and on Institutions, and representatives who serve on the Committees on Human Services, on Appropriations, and on Corrections and Institutions, as well as one member from each body chosen "at large." Since 2006, the General Assembly has required the Committee to provide an annual progress report to the represented standing committees. (2006 Acts and Resolves No. 215, Sec. 293a.) This is the ninth progress report of the Committee to date.

III. Summary of Committee Activities

After the General Assembly was adjourned in 2014, the Committee convened independently four times to hear testimony from a diverse array of stakeholders on a number of issues within its jurisdiction. (*See* Appendix 2: 2014 Witness List.) The Committee devoted much of its time to overseeing the implementation of Act 79, which authorized the construction of new mental health facilities, including the Vermont Psychiatric Care Hospital, and the operation of a clinical resource management system. (2012 Acts and Resolves No. 79.) During 2014, the General Assembly tasked the Committee with clarifying legislative intent pertaining to a rulemaking directive on emergency involuntary procedures. (*See* Appendix 3: 2014 Acts and Resolves No. 192, Sec. 23.) In addition, the Health Care Oversight Committee was directed to consult with the Committee as to the future oversight structure for issues related to health care and human services. (*See* Appendix 4: 2014 Acts and Resolves No. 179, Sec. E. 306.6.) The Committee also took testimony on the following subjects:

- Interdepartmental quality control and assurance practices
- Collaboration between the Departments for Children and Families, of Disabilities, Aging, and Independent Living, of Health, of Mental Health, and of Vermont Health Access around adverse event reporting
- Children's mental health services
- Staffing at the Vermont Psychiatric Care Hospital

IV. Mental Health System Overview and Status Update[1]

The Committee's charge is to "ensure that consumers have access to a comprehensive and adequate continuum of mental health services." (*See* Appendix 1.) Vermont's public mental health system alone provides services to over 28,000 adults and children, ranging from acute inpatient hospitalization to noncategorical case management and peer services. The system as a whole serves many additional Vermonters. The General Assembly refined its vision for the

[1] This section primarily refers to the adult mental health system.

system during the 2012 legislative session through its passage of Act 79 (An act relating to reforming the mental health system.) Prior to the start of that session, the Vermont State Hospital (VSH) was made uninhabitable by Tropical Storm Irene, leaving the State's mental health system in crisis. The General Assembly saw the devastation of VSH as an opportunity to expand the transition from a centralized system of care to a decentralized system that emphasizes community supports and services over institutionalized treatment.

Act 79 authorized the creation of several new facilities for the treatment and care of individuals with psychiatric disabilities, enhanced community services, and established a mechanism for coordinating the movement of individuals throughout the system. The Committee continued monitoring these services during the summer and fall of 2014. The Commissioner of Mental Health provided monthly updates to the Committee on facility usage and wait times for psychiatric hospital beds, as well as summaries of the system of care. The status of those facilities authorized by Act 79 is as follows:

- *Green Mountain Psychiatric Care Center* (Morrisville): The temporary eight-bed psychiatric hospital was closed in July 2014 when the Vermont Psychiatric Care Hospital opened in Berlin. Patients at the Green Mountain Psychiatric Care Center were transferred to the Vermont Psychiatric Care Hospital at that time.

- *Vermont Psychiatric Care Hospital* (Berlin): The 25-bed hospital began accepting patients into the first of its four level 1 units in July 2014. As of early October 2014, all but one 4-bed unit was admitting patients. DMH testified that it planned to open the final unit by the end of the month.

- *Secure Residential Recovery Facility* (Middlesex): Currently all of the beds at the temporary facility are occupied. The route to admission at the secure residential recovery facility is through previous level 1 hospitalization. Most residents at the facility no longer require treatment in a level 1 hospital, but still have issues involving public safety risks. DMH provided written testimony to the Committee that it is developing a plan with the Departments of Corrections and of Buildings and General Services for a permanent facility.

- *Brattleboro Retreat*: The Retreat was cited by the Centers for Medicare and Medicaid Services (CMS) this summer for its failure to comply with the federal Conditions of Participation in units that were not created by Act 79. This resulted in the Retreat developing a plan of correction with the assistance of DMH. CMS surveyors found this fall that the Retreat fell short of properly implementing its plan of correction, placing federal Medicare and Medicaid funds in jeopardy. Prior to the Retreat losing its federal certification in early October, CMS agreed to extend the termination date to November 5, 2014 to give the Retreat time to develop a Systems Improvement Agreement. Once executed, the Systems Improvement Agreement will allow the Retreat to continue to provide services paid for by Medicare and Medicaid.

- *Rutland Regional Medical Center*: The six-bed acute psychiatric unit has remained operating at full capacity since May 2013.

DMH also updated the Committee on the following community programs and supports:

- *Crisis Beds*: Crisis beds are usually used as a means of diverting individuals from hospitalization by providing a safe setting where they can be stabilized. Some crisis beds are also used post-hospitalization. Act 79 enabled each county to have at least two crisis beds.

- *Intensive Residential Recovery Facilities*: These facilities are often referred to as "step down beds" and are generally occupied by patients who are discharged from psychiatric hospital units. As a result of Act 79, there are eight intensive residential recovery beds at Hilltop Recovery Residence in Westminster, eight beds at Second Spring North in Westford, and four beds at Maplewood Recovery Residence in Rutland.

- *Facility for no or limited reliance on medication* (Soteria House): A director was selected for this facility and a location within Chittenden County was secured. The certificate of need and permitting processes were completed and renovations are currently under way. The facility is set to open at the beginning of 2015.

- *Peer services*: Expanded capacity for peer services is under way at Alyssum, Another Way, Pathways Vermont, Vermont Center for Independent Living, Vermont Psychiatric Survivors, Rutland Turning Point Recovery Center, and Vermont Vet-to-Vet.

- *Mobile crisis services*: While all areas of the State have developed some mobile capacity, the availability of 24-hour mobile crisis services is not consistent from county to county. Mobile crisis teams can often prevent trips to emergency departments by averting a crisis and stabilizing the situation.

As of the Committee's final meeting in 2014, the design and implementation of the clinical resource management system was under way. The electronic bed board does not yet function in "real time," although most hospitals are updating it one to two times per day. DMH's care managers are actively monitoring those individuals in need of beds in order to provide services where the need is greatest.

V. Findings and Recommendations

A. Rulemaking on Emergency Involuntary Procedures

In 2012, the General Assembly passed legislation requiring DMH to initiate a rulemaking process "…that establishes standards that meet or exceed and are consistent with standards set by the Centers for Medicare and Medicaid Services and the Joint Commission for the use and reporting of the emergency involuntary procedures of seclusion or restraint on individuals in the custody of the commissioner…." (2012 Acts and Resolves No. 79, Sec. 33a.) The same act included the principle that individuals in the custody of the Commissioner who receive treatment

in an acute inpatient hospital "shall be afforded at least the same rights and protections as those individuals cared for at the former Vermont State Hospital." (18 V.S.A. § 7251(9).)

DMH proposed a rule pertaining to the use of emergency involuntary procedures in adult psychiatric hospital units. These rules governed the use of physical restraint, chemical restraint, and seclusion. Ultimately, the Legislative Committee on Administrative Rules voted to object to the proposed rule on the grounds that it was arbitrary and contrary to the intent of the Legislature.

Consequently in 2014, the General Assembly tasked the Committee with identifying those policies that may require clarification of legislative intent prior to DMH proceeding with its rulemaking on emergency involuntary procedures. (*See* Appendix 3.) The Committee heard testimony from legislative counsel and various stakeholders in an attempt to identify those issues where legislative clarity is needed. It finds that there are three areas requiring further clarity of legislative intent and possible action by the committees of jurisdiction.

Recommendation

Though the Committee identified three policies pertaining to the use of emergency involuntary procedures where legislative intent is unclear so as to hinder rulemaking efforts, it cannot interpret legislative intent. The committees of jurisdiction are the appropriate legislative bodies to interpret intent. As a threshold question, the committees of jurisdiction should determine what the General Assembly meant by the phrase "rights and protections" in 18 V.S.A. § 7251(9). The Committee recommends that the committees of jurisdiction then clarify their intent on the following:

1. To whom do the rules on emergency involuntary procedures apply?

DMH was directed to adopt rules on emergency involuntary procedures that applied to individuals within the custody of the Commissioner. This group includes individuals on orders of hospitalization and orders of nonhospitalization, individuals in temporary custody prior to a commitment hearing, and individuals who a criminal court has ordered admitted to a hospital pending an evaluation of competency, sanity, or both. Although children can be in the custody of the Commissioner, they were not contemplated in the rule proposed by DMH.

2. Who can prescribe chemical restraint?

The emergency involuntary procedure policy in place at VSH allowed only a physician to prescribe chemical restraint. Conversely, regulations issued by CMS authorize either a physician or licensed independent practitioner (LIP) to prescribe emergency involuntary procedures, including chemical restraint.[2] While CMS regulations do not define "licensed independent practitioner," federal guidance on this topic states that "…a LIP is any individual permitted by

[2] CMS regulations pertaining to emergency involuntary procedures state "[t]he use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient…and authorized to order restraint or seclusion by hospital policy in accordance with State law." (42 CFR 482.13(e)(5).)

State law and hospital policy to order restraints and seclusion for patients independently, within the scope of the individual's license and consistent with the individually granted privileges." (71 FR 71393-71394.) The federal guidance further explains that CMS regulations are not meant to limit a physician's authority to delegate tasks to other qualified health care personnel, such as physician assistants and advanced practice registered nurses, where they are allowed to prescribe emergency involuntary procedures under State law and hospital policy. (*Id*. at 71394.)

The federal guidance is a bit circular in that it refers back to what advanced practice registered nurses and physician assistants are authorized to do under State law. In Vermont, prescription of emergency involuntary procedures is not specifically referenced in the scope of practice for either advanced practice registered nurses or physician assistants, although that authority may be implied. (26 V.S.A. §§ 1572 and 1732.) Advanced practice registered nurses do have the same signature authority as physicians. (26 V.S.A. § 1616.)

3. Must the prescriber personally observe the patient prior to prescribing chemical restraint?

At VSH, a physician was required to observe personally the patient prior to prescribing chemical restraint. The emergency involuntary procedure policy specifically stated that an order for chemical restraint could not be made telephonically. DMH's proposed rules on emergency involuntary procedures took a different approach in that they allowed a physician or LIP to order chemical restraint by telephone.

The Committee recommends that with regard to both this question and the two above that the committees of jurisdiction determine which policy outcomes provide the highest quality of care and protection of rights to individuals in the State's mental health system. With regard to the last question only, the Committee recommends that the committees of jurisdiction determine whether "personally observe" includes electronic observation or whether the prescriber should be physically present with the patient.

B. Children's Mental Health Care

Over the past several years, much of the focus on Vermont's mental health system has pertained to the needs of adults. Consequently, the Committee believes that issues regarding children's mental health care have been neglected. The Committee heard some testimony from the Administration and community providers on the topic of children's mental health, specifically with regard to the use of antipsychotic medications and the increasing number of children in out of State placements. It became clear to the Committee that an organizational divide exists between the management of adult and children's services at DMH, which does not seem to foster the best outcomes for individuals with psychiatric illness. The General Assembly needs to put the spotlight back on the children's mental health system.

<u>Recommendation</u>

Consistent with its recommendation from the previous year, the Committee continues to recommend that committees of jurisdiction make children's mental health issues a priority during

the legislative session. It particularly recommends that the committees of jurisdiction assess the following:

1. How does the Agency of Human Services' Integrated Family Services fit with 1988 Acts and Resolves No. 264 (An Interagency Coordinating Council for Handicapped Children)?

2. How will access to and coordination of children's mental health services be impacted by health care reform initiatives?

3. How can the Department of Vermont Health Access close the feedback loop with parents of children with a psychiatric illness as described by Kathleen Holsopple, Executive Director of the Vermont Federation of Families for Children's Mental Health, in her October 17, 2014 testimony?

C. Nursing at Vermont Psychiatric Care Hospital

There is a deficit in the mental health system with regard to attracting and retaining qualified health care providers. The Committee heard significant testimony on the staffing of the new Vermont Psychiatric Care Hospital. This included testimony that the Hospital was relying on the services of traveling nurses due to DMH's inability to recruit qualified nurses in the State who specialize in psychiatry. The Committee believes this is problematic because the cost of retaining traveling nurses is higher than the cost of hiring nurses from within Vermont. In addition, this practice does nothing to cultivate psychiatric expertise among experienced nurses in the State. With regard to patient care, the Committee is further concerned that the continual rotation of traveling nurses through the Vermont Psychiatric Care Hospital will limit the accumulation of institutional knowledge and compromise the stability and quality of care provided.

<u>Recommendation</u>

The Committee recommends using funds currently designated for traveling nurse salaries instead to train experienced Vermont nurses in psychiatric care. It believes this approach is more sustainable over time, ensures more consistent care at the Vermont Psychiatric Care Hospital, and cultivates a more skilled workforce within the State. The Committee further recommends that the committees of jurisdiction review the Agency of Human Services' market analysis for nurses with psychiatric expertise.

The Committee sent a letter with its recommendation regarding traveling nurses to the Commissioner of Human Resources. (*See* Appendix 5: Committee Letter to Commissioner Spellman.)

D. Services for Elders with Mental Health Needs

The Committee heard testimony that acute inpatient hospital units often struggle to place elderly patients in step-down facilities once hospital level care becomes unnecessary. Consequently, this

population of patients often remains in hospital beds for longer than necessary, and in turn prevents other potential patients with higher acuity needs from receiving timely care. DMH is currently considering whether the State should address this population by developing a step-down facility exclusively for elders, or instead serve them within the current system.

Recommendation

The committees of jurisdiction should monitor the status of elders in the mental health system, including the need for a new step-down facility specifically for elders. Since most elders receive their health care through Medicare, the State often overlooks their needs when discussing issues of parity. The fact that the mental health needs of older Vermonters is primarily within the purview of the Department of Disabilities, Aging, and Independent Living (DAIL) requires coordination and communication between the departments in the Agency of Human Services. The Committee further recommends that committees of jurisdiction assess the basis on which elders with mental health needs are eligible for Choices for Care.

E. Quality Oversight

The Committee spent a significant amount of time understanding how data were gathered and shared within the mental health system. Commissioners or designees from the Departments for Children and Families, of Disabilities, Aging, and Independent Living, of Health, of Mental Health, and of Vermont Health Access worked collaboratively to prepare testimony for the Committee on the relationship between data collection and quality improvement. The Committee found that while the Departments collect a significant amount of data—both generally and in response to specific events—it was not entirely clear how the data inform systematic improvements. It believes that the role of the General Assembly is to support and sustain the efforts of these Departments as they work to move beyond data collection to improving outcomes systemwide, particularly with regard to patient safety and treatment.

Committee members discussed their concern about the adequacy of State oversight around quality of care and patient safety at inpatient psychiatric units where patients in State custody receive care. Specific concerns include lack of clarity over which Departments have responsibility for such oversight and whether DMH is adequately involved in the hospitals it designates, especially given the CMS citations received by the Brattleboro Retreat this year. (*See Brattleboro Retreat* in Sec. IV for additional information.)

Another specific area of concern pertains to facility evaluations and investigations. The Committee heard testimony from DAIL that it maintained 16 nurse surveyors for the purpose of conducting CMS surveys. Of the 16 surveyors, three have some psychiatric expertise. The Committee believes that lack of psychiatric expertise among the surveyors is problematic as protocols at psychiatric facilities may differ from other settings. A surveyor with substantial psychiatric expertise could enhance the licensure process and bring more specific guidance and feedback to psychiatric facilities under review. Additionally, the Committee also heard testimony that State-regulated facilities only receive a visit from DAIL's Division of Licensing and Protection once every two years. While the Committee finds this less than adequate, current

resources dictate that DAIL instead focus its staff resources on visits to facilities where the need for review is greatest.

Recommendations

The General Assembly should continue to support the Agency of Human Services' coordinated efforts to transition from data collection to meaningful quality improvements within the mental health system. The Committee further recommends that DAIL retain a surveyor with substantial expertise in psychiatric care, as well as refocus staff resources on visiting those facilities where the need for review is greatest.

F. Reporting of Adverse Events

The Committee heard testimony regarding adverse events at the Brattleboro Retreat several weeks and months after these events occurred. This led to a larger conversation regarding transparency within the mental health system, particularly as to which entities know certain information about an event and when it is known. The Committee prefers that the Administration and providers share as much information as they can about adverse events in a timely fashion to ensure that both legislators and consumers are able to make informed decisions. It values the operating principle that all information be shared, unless there is a specific reason not to make certain information publicly available. To that end, the Committee would like more clarity as to what information is appropriate to share among departments in the Agency of Human Services, with legislators, and with the public.

Recommendations

With the help of the Office of Legislative Council, the committees of jurisdiction should seek clarification from the Agency of Human Services as to which information regarding adverse events is confidential by law. Specifically, the committees should determine which legislative members, if any, should receive reports of adverse events.

G. Integration of Mental Health in Health Care Reform

While the Committee took limited testimony on the integration of mental health and physical health as part of Vermont's health care reform initiative, it remains concerned that mental health will continue to be secondary to the rest of health care if current efforts and progress at achieving parity are absorbed once integration occurs. This concern is particularly significant with regard to individuals with highly acute mental health needs. When there is complete focus on delivery of care in the integrated system, there is a risk of losing focus on the fact that the medical model may not account for the numerous other mental health treatment modalities available to patients.

Recommendations

The committees of jurisdiction should continue to focus their attention on ensuring that mental health care remains in the forefront of discussions on health care reform and integration.

H. State Auditor's Report on Designated Agencies

Towards the end of the fall, the Vermont State Auditor's Office released a report entitled "Designated Agencies: State Oversight of Services Could Be Improved, But Duplicate Payments Not Widespread." The Committee could not organize testimony on this report on short notice, but recommends that the committees of jurisdiction review it and take testimony from the State Auditor and a representative of the designated agencies.

Recommendations

The committees of jurisdiction should review the State Auditor's report on designated agencies and monitor payment for services in the community mental health system.

I. Future of the Mental Health Oversight Committee

The Committee was originally established to plan the siting and financing of a new state hospital, and later to monitor the delivery of mental health care throughout Vermont. In the aftermath of Tropical Storm Irene, the Committee's focus again shifted to the implementation of a new geographically distributed inpatient mental health care system and expansion of community mental health services. In the course of its work during the summer and fall of 2014, the Committee determined that the mental health system had not yet emerged from the crisis that began with the flooding of VSH in 2011.

While significant progress has been made since that time, Committee members understand that there is still a great deal of work that must be accomplished to stabilize the system. MHOC remains concerned that not all of the individual components of the redesigned system as outlined in Act 79, which are meant to replace and improve the services provided at VSH, have been fully developed. The current quality, functioning, and integration of the various components necessary to create a comprehensive system are also of great concern to MHOC. The significant instability of the current mental health system has lead MHOC to the conclusion that focused oversight of this system cannot be done at this time within the context of overseeing health care and its reform, which is the Committee's ultimate goal.

The Committee shared this recommendation with the Health Care Oversight Committee, which was required to consult with the Committee prior to making a recommendation on future health care and human services oversight structures. (*See* Appendix 6: Committee Letter to the Health Care Oversight Committee.)

Recommendation

The Committee recommends that the General Assembly pass legislation reestablishing a time-limited and focused joint oversight committee whose sole charge is to monitor the ongoing development and implementation of Act 79 during adjournment. The Committee further recommends that the membership should be drawn from relevant policy committees without being so prescriptive that it limits flexibility based on member interest and expertise.

2014 Report of the Mental Health Oversight Committee to the Vermont General Assembly

Representative Ann D. Pugh, Chair	*Senator Claire D. Ayer, Vice Chair*
Representative Anne B. Donahue	*Senator Norman H. McAllister*
Representative Mary S. Hooper	*Senator John S. Rodgers*
Representative Catherine Beattie Toll	*Senator Diane Snelling*

VI. Appendices

Appendix 1: Amended Charge of the Mental Health Oversight Committee

THE MENTAL HEALTH OVERSIGHT COMMITTEE

(a) The mental health oversight committee is created to ensure that consumers have access to a comprehensive and adequate continuum of mental health services. The committee shall be composed of one member from each of the house committees on human services, institutions, and appropriations and a member-at-large to be appointed by the speaker of the house, not all from the same party, and one member from each of the senate committees on health and welfare, institutions, and appropriations and one member-at-large to be appointed by the committee on committees, not all from the same party. Initial appointments shall be made upon passage.

(b) Members of the committee shall serve as the liaison to their respective legislative standing committees with primary jurisdiction over the various components of Vermont's mental health system. The committee shall work with, assist, and advise the other committees of the general assembly, members of the executive branch, and the public on matters related to Vermont's mental health system.

(c) The committee is authorized to meet up to six times per year while the general assembly is not in session to perform its functions under this section.

(d) The commissioner of mental health shall report to the committee as required by the committee.

(e) Members of the committee shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(f) The legislative council, and the joint fiscal office shall provide staff support requested by the committee.

(g) The mental health oversight committee shall provide a progress report to each of the committees represented thereon no later than January 15 of each year.

Appendix 2: 2014 Witness List

Jay Batra, MD, Medical Director, Department of Mental Health

Charlie Biss, Director of the Children, Adolescent and Family Unit, Department of Mental Health

Clayton Clark, Director, Licensing and Protection, Department of Disabilities, Aging & Independent Living

Tracy Dolan, Interim Commissioner, Department of Health

Paul Dupre, Commissioner, Department of Mental Health

Nick Emlen, Mental Health Systems Coordinator, Vermont Council of Developmental and Mental Health Services

Dr. W. Gordon Frankle, Chief of Psychiatry, Rutland Regional Medical Center

Emma Harrigan, Chief of Research & Statistics, Department of Mental Health

Kathy Holsopple, Executive Director, VFFCMH, Nationally Certified Parent Support Provider

Mark Larson, Commissioner, Department of Vermont Health Access

Suzanne Leavitt, Director of Licensing and Protection, Department of Disabilities, Aging & Independent Living

Jim MacDonald, Executive Director, Second Spring

Carol Maloney, Interim Director of Integrated Family Services, Agency of Human Services

Jack McCullough, Director of Mental Health Law Project, Vermont Legal Aid

Jeffrey McKee, Psy.D, Director of Psychiatric Services, Rutland Regional Medical Center

Katie McLinn, Legislative Counsel, Office of Legislative Council

Amos Meacham, Project Director, Soteria House

Linda Nagy, Vice President of Clinical Services, Brattleboro Retreat

Nick Nichols, Policy Director, Department of Mental Health

Jill Olson, Vice President of Policy & Legislative Affairs, Vermont Association of Hospitals and Health Systems

Susan Onderwyzer, Program Services Executive, Department of Mental Health

Ed Paquin, Director, Disability Rights Vermont

Robert Pierattini, MD, Chair of Psychiatry, Fletcher Allen Health Care

Rep. Ann Pugh, Chair, Mental Health Oversight Committee

Frank Reed, Deputy Commissioner, Department of Mental Health

David Rettew, University of Vermont College of Medicine

Jeff Rothenberg, Director of Mental Health Services, Green Mountain Psychiatric Care Center

Stuart Schurr, Deputy Commissioner, Department of Disabilities, Aging & Independent Living

Catherine Simonson, Child, Youth and Family Services, Director, HowardCenter

Tom Simpatico, M.D., Chief Medical Officer, Department of Vermont Health Access

Dr. Geoffrey Sinner, Medical Director for the Adult Acute Care Unit, Brattleboro Retreat

Susan Wehry, Commissioner, Department of Disabilities, Aging & Independent Living

Appendix 3: 2014 Acts and Resolves No. 192, Sec. 23

Sec. 23. LEGISLATIVE INTENT; EMERGENCY INVOLUNTARY PROCEDURES

The Mental Health Oversight Committee shall identify and include in its 2014 annual report a list of policies that may require clarification of legislative intent in order for the Department of Mental Health to proceed with rulemaking pursuant to 2012 Acts and Resolves No.79, Sec. 33a. The Committee shall also make recommendations as to any legislation needed to clarify legislative intent for those policies identified by the Committee.

Appendix 4: 2014 Acts and Resolves No. 179, Sec. E.306.6

Sec. E.306.6 HUMAN SERVICE PROGRAMS OVERSIGHT PROPOSAL

(a) The fiscal year 2015 report required under 2 V.S.A. § 852(c) shall be made on or before December 31, 2014. In the report, the Health Care Oversight Committee shall, in consultation with the Mental Health Oversight Committee, recommend if a single oversight structure is needed to be the successor to the Health Care Oversight Committee and the Mental Health Oversight Committee.

Appendix 5: Committee Letter to Commissioner Spellman

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STATE OF VERMONT
MENTAL HEALTH OVERSIGHT COMMITTEE

September 25, 2014

Commissioner Maribeth Spellman
Department of Human Resources
110 State Street
Montpelier, VT 05620-3001

Dear Commissioner Spellman,

We are writing on behalf of the Mental Health Oversight Committee (MHOC) concerning testimony presented at our last meeting. The charge of MHOC is to oversee issues concerning mental health with a particular emphasis on achieving a sustainable and effective system of care throughout the State.

Commissioner Dupre recently testified before MHOC that the new Vermont Psychiatric Care Hospital (VPCH) was relying on the services of traveling nurses due to the Department of Mental Health's inability to recruit qualified nurses in the State who specialize in psychiatry.

The members of MHOC were alarmed by this testimony for several reasons. First, the cost of retaining traveling nurses is significantly higher than the cost of hiring nurses from within Vermont. Second, the nature of the traveling nurse model is that these nurses rotate through VPCH rather than obtain permanent employment. This practice limits the accumulation of institutional knowledge at VPCH and compromises the stability and quality of care provided there. Third, retaining traveling nurses does nothing to cultivate psychiatric expertise among experienced nurses in the State. Finally, the lack of experienced psychiatric nurses in the State contributes to the backlog of patients waiting in emergency departments with sheriff supervision for beds on a psychiatric hospital unit while beds remain unopened at VPCH.

MHOC instead supports a more sustainable and forward-thinking approach to the shortage of psychiatric-trained nurses in Vermont. The members of MHOC recommend using the considerable funds currently designated for traveling nurse salaries instead to attract and train

experienced Vermont nurses in psychiatric care. This approach is more sustainable over time, ensures more consistent care at VPCH, and cultivates a more skilled workforce within Vermont.

MHOC respectfully urges the Department of Human Resources to consider this proposal and assess its feasibility as soon as possible. We believe that it is fiscally prudent and improves care for Vermonters.

Sincerely,

Representative Ann Pugh, Chair
Mental Health Oversight Committee

Senator Claire Ayer, Vice Chair
Mental Health Oversight Committee

Appendix 6: Committee Letter to the Health Care Oversight Committee

115 STATE STREET
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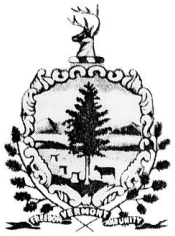

STATE OF VERMONT
MENTAL HEALTH OVERSIGHT COMMITTEE

October 7, 2014

Senator Virginia Lyons
Health Care Oversight Committee
115 State Street
Montpelier, VT 05633

Dear Senator Lyons,

I am writing on behalf of the Mental Health Oversight Committee (MHOC) concerning the future oversight of the mental health system while the General Assembly is adjourned. As you know, 2014 Acts and Resolves No. 179, Sec. E.306.6 requires the Health Care Oversight Committee (HCOC) to consult with MHOC as to whether "a single oversight structure is needed to be the successor to the Health Care Oversight Committee and the Mental Health Oversight Committee."

With that purpose in mind, MHOC met several times since the General Assembly adjourned in order to examine and evaluate the progress and stability of Vermont's restructured mental health system. At our most recent meeting, members specifically discussed whether or not, in addition to oversight by relevant standing committees during the legislative session, there is need for targeted oversight of Vermont's mental health system. The consensus was yes. There continues to be a need for formal legislative oversight focused solely on the mental health system when the General Assembly is not in session.

Based on the reports and testimony heard, MHOC determined that our State's adult mental health system has not emerged from the crisis that began with Tropical Storm Irene in August 2011. While significant progress has been made since that time, Committee members understand that there is still a great deal of work that must be accomplished to stabilize the system. MHOC remains concerned that not all of the individual components of the redesigned system as outlined in Act 79, which are meant to replace and improve the services provided at the Vermont State Hospital, have been fully developed. The current quality, functioning, and integration of the various components necessary to create a comprehensive system are also of great concern to MHOC.

Regrettably, the significant instability of the current mental health system has lead MHOC to the conclusion that focused oversight of this system cannot be done at this time within the context of overseeing health care and its reform, which is our ultimate goal. Therefore, MHOC recommends that the General Assembly enact a time-limited and focused joint oversight committee whose sole charge is to monitor the ongoing development and implementation of Act 79. Membership should be drawn from relevant policy committees without being so prescriptive that it limits flexibility based on member interest and expertise.

If you need any further information or elaboration of our recommendation, please feel free to contact me.

Sincerely,

Representative Ann Pugh, Chair
Mental Health Oversight Committee