2012 ACTS & RESOLVES, NO.79
AN ACT RELATING TO REFORMING VERMONT'S MENTAL HEALTH SYSTEM

Senate Committee on Health and Welfare
January 12, 2017

Act Overview

- Principles
- Clinical Resource Management System
- Mental Health Care System Components
- Adverse Event Reporting
- System Evaluation
- Additional Provisions

Principles

(Sec. 1a – 18 V.S.A. § 7251)

- Act 79 adopts the following principles as a framework for reforming the state's mental system:
  - Best practices/highest standard of care
  - Long-term planning responsive to changes over time
  - Services coordinated across the continuum of care
  - Integration with health care system
  - Geographically and financially accessible
  - Protection of legal rights
  - System oversight and accountability
  - Adequately funded and financially sustainable
  - Rights and protections reflect evidence-based best practices aimed at reducing the use of emergency involuntary procedures (as amended in 2015)

Clinical Resource Management System

(Sec. 1a – 18 V.S.A. § 7253)

- The purpose of the clinical resource management system is two-fold:
  - To coordinate the movement of individuals to appropriate services throughout the continuum of care; and
  - To perform ongoing evaluations and improvements of the mental health system.

Clinical Resource Management System:
Coordinated Movement of Individuals

- Ensures that individuals with a mental health condition obtain the most appropriate services
  - Develops a process for receiving patient input on treatment opportunities and services
  - Coordinators available 24/7 to assist emergency service clinicians in the field access services
  - Electronic bed board to track available bed space
  - Coordinates transportation resources
  - Mental health patient representative accessible to individuals in the custody of the Commissioner

Clinical Resource Management System:
Evaluation and Improvement

- Ensures the continued integrity and effectiveness of the system
  - DMH to designate a team of clinical staff to review patient treatment and progress
  - Internal coordination within AHS
  - Coordinate service delivery with health care reform initiatives
  - Measure individual outcomes and system performance using quality indicators and manageable data requirements
  - Involve stakeholders/providers in oversight
  - Mechanisms for dispute resolution

Mental Health Care System Components

- Peer Services
- Community Services
- Intensive Residential Recovery Facilities
- Acute Inpatient Hospitals
- Secure Residential Recovery Facility

System Components:

Peer Services

- Peer: Individual who has a personal experience of living with a mental health condition or psychiatric disability
- Commissioner shall contract for peer services that help individuals with mental illness achieve recovery through improved physical and mental health, increased social and community supports, and avoidance of crises and hospitalizations, including:
  - Peer-run warm line
  - Peer-run transportation services

System Components:
Community Services

- DAs, with support from DMH, shall improve:
  - emergency responses
  - noncategorical case management
  - mobile support teams
  - adult outpatient services
  - alternative residential opportunities
- DMH shall provide:
  - At least 4 short-term crisis beds
  - Voluntary 5-bed residence for reduced reliance on medication for initial episode of psychosis
  - Housing subsidies

System Components:
Intensive Residential Recovery Facilities

- Intensive Residential Recovery Facility: licensed program providing safe, therapeutic, recovery-oriented residential environments to care for individuals in need of intensive clinical interventions in anticipation of returning to the community
  - 15 beds located in northwestern Vermont
  - 8 beds located in southeastern Vermont
  - 8 beds located in central or southwestern Vermont

- Placement of facilities is subject to a certificate of approval process, which shall take into consideration recommendations from a panel of stakeholders

System Components:
Acute Inpatient Hospitals

- Long-Term Hospital Units:
  - 14-bed unit in southeastern Vermont (Brattleboro Retreat)
  - 6-bed unit in southwestern Vermont (Rutland Regional Medical Center)
  - 25-bed State-run hospital in Central Vermont
- Temporary Hospital Units:
  - 7 to 12 beds at Fletcher Allen Health Care
  - 8 beds at temporary hospital (Morrisville)

Acute Inpatient Hospitals:
Southeastern & Southwestern Units

- Initial contract terms for the 14-bed and 6-bed units require participation in the no refusal system for 4 years, meaning that the hospitals are required to admit any individual for care if s/he meets the eligibility criteria established by the Commissioner in contract

- Contracts for these units shall contain several conditions, including:
  - Funding based on hospitals' ability to treat patients with high acuity levels
  - State reimbursement that covers reasonable actual costs
  - Maintenance of a stakeholder advisory group with non-exclusionary membership
  - State option to renew the contract upon the expiration of the initial term

Acute Inpatient Hospitals:
State-Owned and -Operated Hospital

- 25-bed hospital, proximate to an existing "medical" hospital
- Hospital shall maintain:
  - adequate capacity for individuals receiving a court order of hospitalization
  - a private room used for judicial proceedings
- BGS is responsible for supervising the construction of the hospital with a goal of completing the project in 24 months

State -Owned and -Operated Hospital:
IMD Status

- Federal Framework:
  - Medicaid reimbursements are not permitted for medically necessary services provided in Institutions for Mental Diseases (IMDs)
  - Inpatient mental hospitals containing more than 16 beds are considered IMDs
  - Now and at the time Act 79 was passed, Vermont's Global Commitment waiver allowed licensed hospitals to receive Medicaid reimbursements even if they were considered an IMD

- Addressing IMDs in Act 79:
  - If the new hospital is not eligible to receive Medicaid reimbursements after December 31, 2013, the Commissioner must cease use of 9 beds and reduce the hospital's license from 25 to 16 beds
  - At that time the Commissioner must develop a transition plan that:
    - Addresses the acute inpatient bed deficit by expanding capacity elsewhere in the system (if necessary)
    - Repurposes the 9 decommissioned beds in a manner that does not jeopardize federal matching funds for the hospital's remaining 16 beds
  - Transition plan shall be approved by various members of the General Assembly

Acute Inpatient Hospitals:
Temporary Hospital Units

- Commissioner has the authority to contract for temporary inpatient hospital units that shall be used until the State-owned hospital is operational:
  - 7-12 beds at Fletcher Allen Health Care
  - 8 beds at setting identified by the Commissioner and licensed by the Department of Health

- If the latter facility is located in Morrisville:
  - It may not operate after September 1, 2015
  - Requires permission from the host community to expand the number of beds at the facility

System Components:
Secure Residential Recovery Facility

- Act 79 requires the commissioner to establish and oversee a secure seven-bed residential recovery facility owned and operated by the state.

- The facility shall be used to care for individuals no longer requiring acute inpatient services, but who remain in need of treatment within a secure setting for an extended period of time.

- The opening of a secure residential recovery facility was contingent upon the passage of statutory amendments authorizing judicial orders for commitment to such a facility. Act 160, an act relating to permitting the use of secure residential recovery facilities for continued involuntary treatment, was signed into law on May 17, 2012.

Adverse Event Reporting

(Sec. 1a – 18 V.S.A. §§ 7257-58)

- Adverse events are reported as both isolated incidents and as part of systematic reviews:
  - Acute inpatient hospitals, designated agencies, and secure residential facilities are required to report to the DMH instances of death or serious bodily injury to individuals receiving treatment who are within the custody of the commissioner
  - DMH must establish a system to review any death or serious bodily injury occurring outside an acute inpatient hospital when the individual causing or victimized by the death or serious bodily injury is or recently has been within the custody of the commissioner

System Evaluation:
Annual Reporting Requirements

- DMH to report on the overall effectiveness of the mental health care system, including:
  - the utilization of services within the system
  - the adequacy of the system's capacity
  - individual experience
  - the performance of the system as compared to national standards

System Evaluation:
One-Time Reporting Requirements

- DMH to report on the decentralization of inpatient mental health care, including:
  - any statutory changes needed to preserve rights afforded to patients at the former VSH
  - the development of a process to ensure public involvement with policy matters
  - the development of consistent definitions of seclusion and restraint
  - and the efficacy of housing subsidy programs
- DMH to report on its efforts to implement and its recommendations to improve the new mental health system
- DMH to report on its plan to streamline overlapping state and federal reporting requirements for providers in the mental health care system
- DMH to report to the Joint Fiscal Committee by September 2012 regarding whether its hospital cost reimbursement methodology reflects reasonable actual costs

System Evaluation:
Independent Consultant

- Special committee to contract with an independent consultant who has expertise in mental health and psychiatric hospital services
- Consultant tasked with evaluating and reporting on the structure, services, and financial implications of Vermont's mental health care system by December 2012
- Consultant's report shall:
  - Address whether the proposed mental health system serves the needs of Vermonters, and if there are any needs unmet by the system, how they should be addressed
  - Establish a list of data and evaluation mechanisms necessary to manage and improve the quality of care and outcomes for individuals with a mental health condition

Additional Provisions

- Former VSH Employees
  - RIF Rights
  - Private Sector Positions Posted by DHR
  - Retirement Incentives
- Rulemaking required regarding:
  - the use and reporting of seclusion or restraint on individuals within the custody of the commissioner
  - the training/certification of personnel performing emergency involuntary procedures
- Sunset date of the Advisory Council for Mental Health Services Transformation extended until Sept. 2015
- Transfer of funds to the Attorney General's Office for continuation of a law enforcement training program on officer interactions with persons exhibiting mental health conditions