Vermont's Mental Health System of Care

HOUSE COMMITTEE ON HEALTH CARE
JANUARY 24, 2019

Presentation Overview

- Statutory Principles
- Components of Vermont's Mental Health System
  - Existing System
  - Proposed Changes
- Overview of Involuntary Admission and Treatment

System Principles (18 V.S.A. § 7251)

- 2012 Acts and Resolves, No. 79 adopted the following principles as a framework for the State's mental health 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)

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

Clinical Resource Management System

(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.

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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

Implementation of the Clinical Resource Management System

- DMH Care Management Team
  - Daily discussions with hospitals, DAs, IRRs and any other relevant community partners
- Director and 4 staff:
  - One staff member focuses exclusively on involuntary triage
  - Three staff members follow clients through the entirely of their custody - inpatient, IRR, and community

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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

Community Services: Implementation & Updates

- Crisis Beds:

Alyssum (Rochester)	**2**
Howard Center (Chittenden County)	6
Northeast Kingdom Mental Health (Caledonia)	2
Northwestern Counseling & Support Services (Franklin & Grand Isle Counties)	2
Washington County Mental Health (Washington County)	4 Home Intervention & 1 Maple House
Clara Martin (Orange County)	2
Lamoille County Mental Health (Lamoille County)	2
United Counseling Services (Bennington County)	6
Counseling Services of Addison County (Addison County)	1
Health Care and Rehabilitation Services (Windham & Windsor Counties)	4 Alternatives & 2 Commissioner beds
Rutland Mental Health (Rutland)	4

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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

Intensive Residential Recovery Facilities: Implementation & Updates

Second Spring North (Westford)	**8**
Second Spring South (Williamstown)	16
Maplewood (Rutland)	4
Meadowview (Brattleboro)	6
Hilltop (Westminster)	8
Pathways Vermont – Soteria House (Burlington)	5
Middlesex Secure Residential (Middlesex)	7

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

Secure Residential Recovery Facility

- Act 79 required 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.

Secure Residential Recovery Facility: Implementation & Updates

- Middlesex Therapeutic Community Residence
  - 7 Bed (temporary) Facility
  - Only secure (locked) intensive residential
  - Individuals on ONHs specific to MTCR
  - Inability to perform EIPs limits admissions
- Future Plans
  - AHS Facilities Plan includes funding to continue to search for and find a replacement site for up to 16 beds
  - Due to IMD concerns, CVMC is unable to build enough beds to replace VPCH beds and allow VPCH to become the new secure residential
  - Working with DAIL to consider allowing EIPs in the new facility

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

Acute Inpatient (Level 1) 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)*

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

Acute Inpatient (Level 1) Hospitals: Southeastern and Southwestern Units

- Initial contract terms for the 14-bed and 6-bed units required participation in the no refusal system for 4 years, meaning that the hospitals were 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

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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 was responsible for supervising the construction of the hospital with a goal of completing the project in 24 months

Components of Vermont's Mental Health System as Established by 2012 Acts and Resolves, No.79

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) for individuals between 18-65 years of age
  - Inpatient psychiatric 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
  - *In 2018, CMS advised Vermont that it would not longer waive the IMD exemption; State is financially responsible in part beginning in 2021 and fully by 2025

- 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

2018 Acts and Resolves No. 200: Legislative Response to Status of IMD Waiver

Reports; Institutions of Mental Disease

- The Secretary of Human Services was required to submit the following reports regarding the Agency's progress in evaluating the impact of IMD spending on persons with serious mental illness or substance use disorders:
  - (1) a status update, including possible solutions considered as part of the State's response to the CMS requirement to begin reducing federal Medicaid spending due on or before November 15, 2018; and
  - (2) on or before January 15 of each year from 2019 to 2025, a written report evaluating:
    - (A) the impact to the State caused by the requirement to reduce and eventually terminate IMD spending;
    - (B) the number of existing psychiatric and substance use disorder treatment beds at risk and the geographical location of those beds;
    - (C) the State's plan to address the needs of Vermont residents if psychiatric and substance use disorder treatment beds are at risk;
    - (D) the potential of attaining a waiver from CMS for existing psychiatric and substance use disorder services; and
    - (E) alternative solutions, including alternative sources of revenue, such as general funds, or opportunities to repurpose buildings designated as IMDs.

Acute Inpatient Hospital Units: Current System

- System spread across 7 Designated Hospitals
- 45 Level 1 Beds:
  - VPCH – 25 Beds
  - RRMC – 6 Beds
  - BR – 14 Beds
- General Inpatient Beds (Voluntary and Involuntary)
  - BR: 75
  - RRMC: 17
  - UVMMC: 28
  - CVMC: 14
  - Windham Center: 10*
  - VA: 12

Total Beds in the Inpatient System

Brattleboro Retreat Osgood 2 (LGBT)	**15**
Brattleboro Retreat Osgood 3 (Emerging Adults)	14
Brattleboro Retreat Tyler 1 (co-occurring)	22
Brattleboro Retreat Tyler 2 (Acute Adults)	24
Brattleboro Retreat Tyler 4 (Level 1 Adults)	14
Rutland Regional Medical Center PSIU (general adult unit)	17
Rutland Regional Medical Center South (Level 1 Adults)	6
Central Vermont Medical Center (general unit)	14
University of Vermont Medical Center Shep 3 (general unit)	12
University of Vermont Medical Center Shep 6 (Acute unity)	16
Windham Center (General unit)	10
Veterans Affairs (General unit)	12
Vermont Psychiatric Care Hospital (Level 1 Adults)	25

Acute Inpatient Hospital Units: Proposed Changes and Other Updates

- Brattleboro Retreat
  - Building an additional 12 Level 1 beds
  - Will amend current contract to include these beds
  - ~Early 2020
- University of Vermont Health Network
  - Currently evaluating number of beds that can be built on the CVMC campus, initial thinking there is a need for 29-35 beds. Need to consider IMD issues – won't be able to build all needed beds
  - Will not be enough beds to convert VPCH into the new secure residential

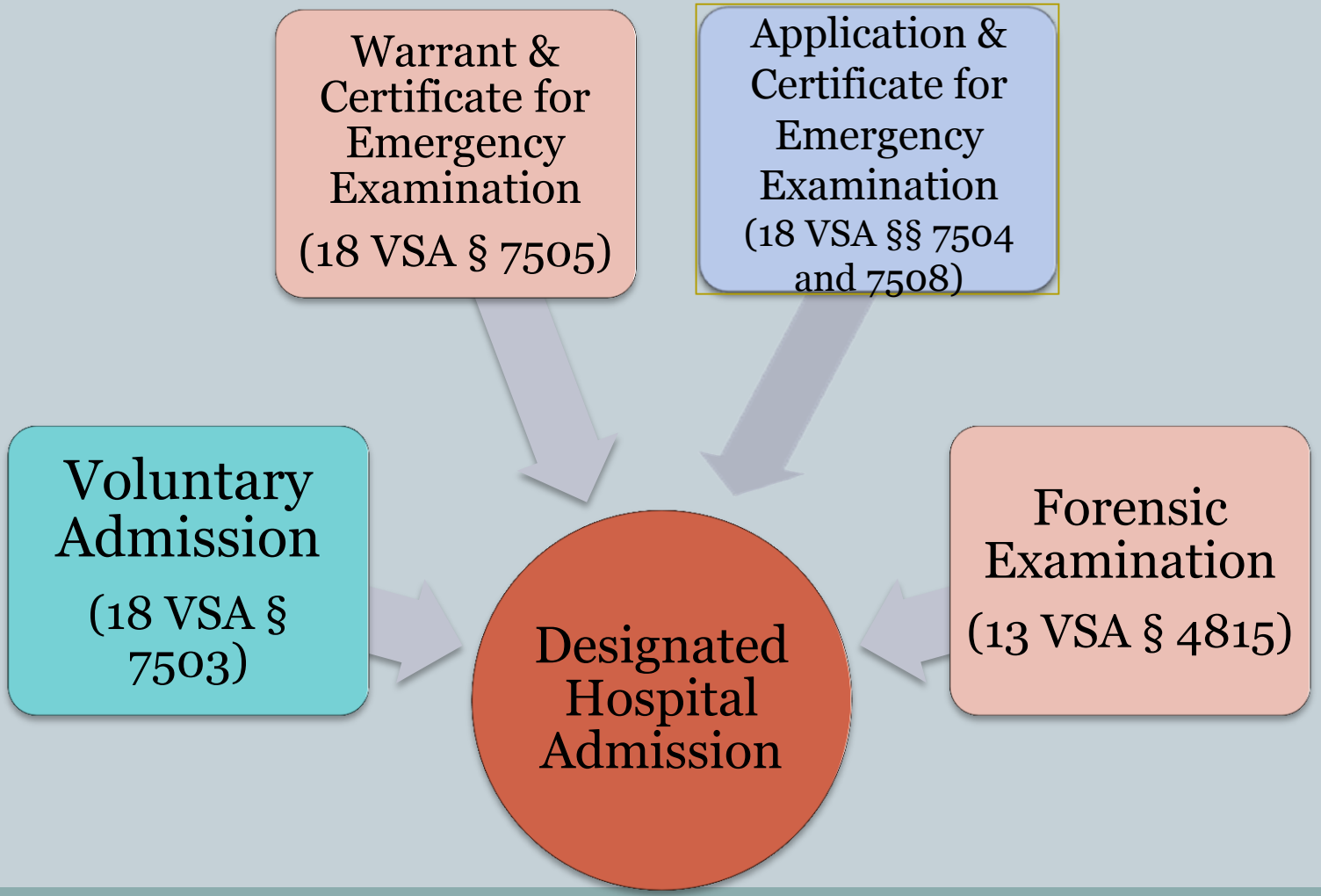
Secure Transport

- 18 V.S.A. §7511:
  - State Policy: "…restraints are not routinely used on persons subject to this chapter unless circumstances dictate that such methods are necessary."
  - Commissioner has authority to designate professionals or law enforcement officers who may authorize the method of transport of patients within the Commissioner's custody
  - When a professional or law enforcement officer decides an individual is in need of secure transport with mechanical restraints, the reasons must be documented
- Most recent legislation pertaining to secure transport:
  - 2017 Acts and Resolves No.85, § E.314
  - 2018 Acts and Resolves No. 200, § 6

Secure Transport: Implementation & Updates

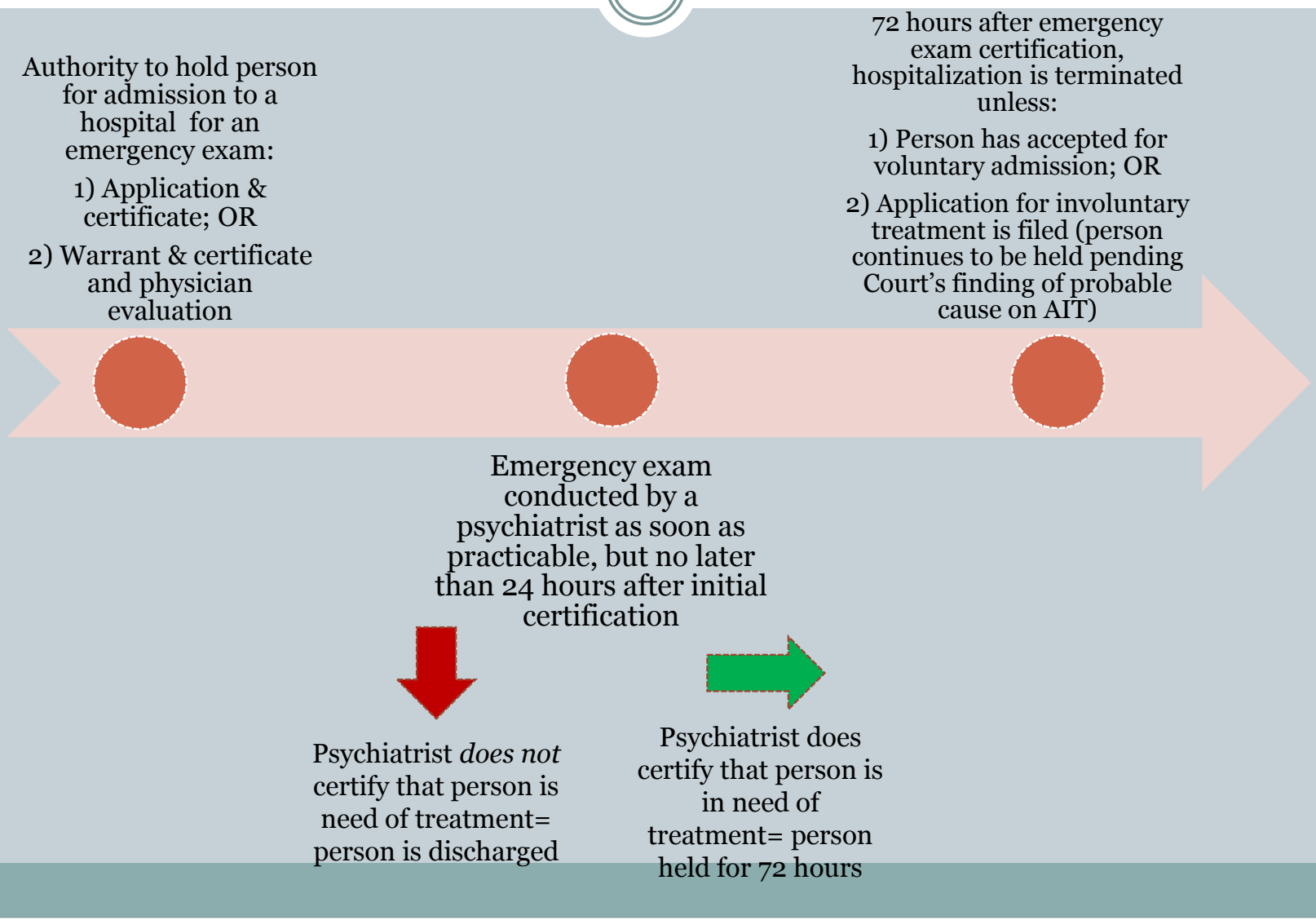
- Policy on Use of Restraints for Involuntary Transport of Individuals in the Care and Custody of the Commissioner of the Department of Mental Health
  - The transport and escort for individuals in the custody of the Commissioner of Mental Health ("Commissioner") shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the individual while ensuring the safety and security of deputies, transport specialists, healthcare staff, and the public
  - No or soft restraints, unmarked cars, plain clothes
  - Special training
  - Flushed out by the Involuntary Transportation Manual and Standards
- DMH, since ~2012, has contracted with Windham and Lamoille to provide transports pursuant to this policy and has provided them with special training
- New AHS contracts include DMH contract language and have been signed by all departments except Chittenden

Hospital Admissions



Emergency Examination

(i.e. "Second Certification")



Emergency Examination: Implementation

- Screening - Qualified Mental Health Professionals
  - DMH training provided by DMH AAGs and DMH Care Management to review the legal and clinical aspects of screening
- First Certifications
  - Can be a physician or APRN
  - DMH created online training and test
- Second Certifications
  - Must be a psychiatrist and done within 24 hours of the First Cert
  - Generally done by psychiatrist at the hospital. If there is not a psychiatrist available, as part of UVMMC contract for services DMH has included additional monies for second certifications done via telemedicine by VPCH psychiatrists

Application for Involuntary Treatment

Application

- Application must contain:
  - Written application filed by interested party; AND
  - One of the following:
    - Physician's certification that s/he examined person within 5 days of date AIT is filed and believes person is in need of treatment; OR
    - Applicant's written statement that person refused physician's exam

Counsel; Notice; Exam

- Once AIT is filed, the Court is responsible for:
  - Appointing counsel to the person;
  - Transmitting copies of the application, physician's certification (if any), and notice of hearing to the person, counsel, guardian, State's attorney, etc.
- As soon as practicable after notice, Court may authorize exam of patient by a psychiatrist other than certifying physician (§7614)

Hearing Date

- Hearing must be held:
  - 10 days from date of AIT's receipt by Court; OR
  - 20 days from date of AIT's receipt by Court if psychiatric exam is ordered under §7614
- Court can grant either party a 7 day continuance for good cause
  - It can grant one or more additional 7 day continuance if certain conditions are met

Application for Involuntary Medication

CMH may file an application for involuntary medication of a person refusing to accept psychiatric medication, IF one of the following conditions is met:

Person is in the care and custody of CMH pursuant to an OH or order for continued treatment in a hospital	Person previously received treatment under an OH and is currently receiving treatment under an ONH	Person is in the custody of the Commissioner of Corrections as a convicted felon; Person is held in a designated correctional facility; AND Departments of Corrections and Mental Health have jointly determined that involuntary medication is appropriate	Person has an AIT pending for which court has granted a motion to expedite	Person has AIT pending; Person waives right to hearing on AIT until a later date; and Person agrees to proceed with IM hearing without a ruling on whether s/he is a person in need of treatment	Person has AIT pending for 26+ days w/o hearing; Treating psychiatrist certifies there is good cause to believe additional time will not result in person establishing therapeutic relationship with providers or regaining competence; AND Serious deterioration of person's mental condition is occurring

- Unless consolidated with AIT, hearings on IM must be held within 7 days of filing the application
- If the requirements of #6 are established, court consolidates AIT & AIM and hears both within 10 days of date of AIM being filed

AIM Findings and Outcomes

- A hearing on a application for involuntary medication has 2 possible outcomes:

Court finds person is incompetent to make decision on proposed treatment

AND

that involuntary medication is supported by factors

- Application granted in whole or part with reference to supporting factors
  - Order specifies medication type, permitted dosage, length and method of administration
  - Order requires provider to review use of IM weekly

Court finds person is competent to make decision on proposed treatment

OR

that involuntary medication is *not* supported by factors

- Application for IM is denied

- If the person subject to the order for IM becomes competent, the order is no longer in effect

Questions?