S.3 Act 57 Report to the Vermont Legislature
Inventory and Evaluation of Mental Health Services

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Submitted to: House Committees on Corrections and Institutions, on Health Care, and on Judiciary and to the Senate Committees on Health and Welfare and on Judiciary

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I. Introduction

S.3 Act 57

S.3 Act 57 makes several changes to criminal proceedings related to the insanity defense and a criminal defendant's competency to stand trial. The act also requires the Department of Corrections (DOC) and the Department of Mental Health (DMH) to jointly submit to the General Assembly an inventory and evaluation of the mental health services provided by the entityDOC contracts with for health care services.

The specifics of the joint report are found in Section 5 of the Act which reads as follows:

Sec. 5. CORRECTIONS; ASSESSMENT OF MENTAL HEALTH SERVICES

(a) On or before January 1, 2022, the Departments of Corrections and of Mental Health shall jointly submit an inventory and evaluation of the mental health services provided by the entity with whom the Department of Corrections contracts for health care services to the House Committees on Corrections and Institutions, on Health Care, and on Judiciary and to the Senate Committees on Health and Welfare and on Judiciary.

(b) The evaluation shall include:

(1) a comparison as to how the type, frequency, and timeliness of mental health services provided in a correctional setting differ from those services available in the community, recognizing that comparison to currently available community services does not necessarily establish the standard of care for best practices;

(2) a comparison as to how the type, frequency, and timeliness of mental health services differ among Vermont correctional settings, including between men's and women's facilities, and from those mental health services provided to individuals under the care and custody of the Department of Corrections incarcerated in an out-of-state correctional facility;

(3) an assessment as to how the use of a for-profit entity with whom the Department of Corrections contracts for health care services affects costs or quality of care in correctional settings;

(4) an assessment as to whether the Department of Mental Health should provide oversight authority for mental health services provided by the entity with whom the Department of Corrections contracts for health care services; and

(5) information as to how the memorandum of understanding executed by the Departments of Corrections and of Mental Health impacts the mental health services provided by the entity with whom the Department of Corrections contracts for health care services and whether it is adequately addressing needs of those individuals with severe illness or in need of inpatient care

(c) In conducting the work required by this section, the Departments of Corrections and of Mental Health shall ensure that social and racial equity issues are considered, including issues related to transgender and gender nonconforming person.

II. Report Methodology

In response to # 1 & 2 inclusive of 5 (c). The DOC and DMH developed a table that details the inventory, evaluation, and comparison of mental health and substance use disorder services provided by the DOC and DMH. This table indicates how the type, frequency, and timeliness of these services differ between Vermont correctional settings, including in-state male and female facilities and the out-of-state correctional facility, and the DMH designated agency (DA) system. See response in Section III.

In response to #3. The DOC assessed how the use of a for-profit entity with whom the DOC contracts for health care services affects costs or quality of care in correctional settings. Previous reports such as the CGL Report (2.16.2019); the COCHS Report (August 2013) the VPQHC Report (2011); and current financial data and contract language were included in the analysis. The summary findings are within this report. See response in Section IV.

In response to #4. The DOC and DMH assessed independently and together whether the DMH should provide oversight authority for mental health services provided by the entity with whom the DOC contracts for health care services. The independent and joint responses are included within this report. See response in Section V.

In response to #5. The DOC and DMH assessed independently and together how the memorandum of understanding executed by the DOC and DMH impacts the mental health services provided by the entity with whom the DOC contracts for health care services and whether it is adequately addressing needs of those individuals with severe illness or in need of inpatient care. The joint response is included within this report. See response on Section VI.

Appendices:

Appendix 1: TABLE 1 - S.3 ACT 57 INVENTORY AND EVALUATION OF DOC AND DMH MENTAL HEALTH SERVICES
Appendix 2: NCCHC Mental Health Standards

III. DOC and DMH's inventory, evaluation, and comparison of mental health services.

See Appendix 1 (TABLE 1 - S.3 ACT 57 INVENTORY AND EVALUATION OF DOC AND DMH MENTAL HEALTH SERVICES)

IV. The DOC assessment of how the use of a for-profit entity affects costs or quality of care in correctional settings.

Since 2011, there have been at least three assessments completed by third party entities to determine how the cost and quality of care is affected by the current model used within the DOC to provide Comprehensive Correctional Health Services. These assessments include:

- CGL Report – February 16, 2019
- COCHS Report – August 2013
- VPQHC Report – 2011

The CGL report entitled "Vermont Department of Corrections: Assessment of Health Care System Costs" was published in February 2019 and noted that, "[l]ike many states, Vermont has determined that contracting out the management and delivery of correctional healthcare offers the best opportunity to achieve system goals. These goals typically include:

- Improving overall system performance
- Filling vacant staff positions in a timely manner
- Enhancing staff accountability and responsiveness
- Reducing system costs
- Professionalizing healthcare management
- Reducing state liability."

The CGL report concluded, "…the most significant factor that diminishes the potential ability of a private vendor to improve performance and cost efficiency for the VDOC […] is quite simply the size of the system relative to potential cost risks" and "The contract model developed by the VDOC, is probably the most effective means to attract multiple bidders and generate meaningful competition, and is thereby most likely to balance the VDOC's goals for performance while remaining cost-effective."

In addition, the DOC offers the following information regarding how the use of a for-profit entity affects the cost and quality of Comprehensive Correctional Health Services:

- The DOC is not strictly seeking for-profit companies to contract with; however, since the move from State positions to a contract, all RFP bidders have been for-profit entities.
- The Comprehensive Correctional Health Services contract language is designed to minimize the financial risk to the State of Vermont and maximize the State's ability to monitor the quality of services provided. For example, the contract includes language that:
    - Identifies a specific profit percentage to eliminate the concern of a for-profit entity providing subpar care to maximize profits.
    - Identifies a total annual cost, but allows for transfer between cost categories to minimize any additional costs to the State.

    - Allows for the State of Vermont to re-coup funds in the case that the cost of providing services is less than the overall budgeted total per year.
    - Allows for holdbacks and liquidated damages in the case that the Contractor is not meeting contract expectations.
    - Uses a pay-for-performance model for a percentage of the overall reimbursement to incentivize the contractor to provide a high quality of care.

- The current Contractor, VitalCore Health Strategies (VCHS), set profit percentage of six percent, which is well below the previous contractor and the industry standard. In addition, for the first year of the current contract (July 1, 2020 through June 30, 2021), VCHS received zero profit as a result of the higher than predicted costs of staffing. In comparison to the model used by the DMH, the DAs, while not-for-profit, include a percentage (up to 3%) that is built-in to the cost structure as an expense above the actual service costs.
- This highest driver of cost related to Comprehensive Correctional Health Services in Vermont is the structure of the system. Multiple facilities housing very small populations of people require additional staffing, including medical leadership at each site, duplication of costs for equipment, space, and many other overlaps. No cost efficiency or any ability to scale exists with the current structure.

V. Assessment as to whether the DMH should provide oversight authority for mental health services provided by the entity with whom the Department of Corrections contracts for health care services. (DMH response below is non italicized – *DOC response below is italicized.)*

DMH response:
.. The Department of Mental Health finds it most appropriate for oversight authority for mental health services remain within the Department of Corrections. t is important to note that, other than the Vermont Psychiatric Care Hospital (VPCH) and the Middlesex Therapeutic Community Residence (MTCR), DMH does not directly oversee the provision of mental health services in Vermont. Rather, DMH works to set policies, procedures, requirements, and guidance for the provision of mental health services in hospitals and Vermont communities, including those under our care and custody. Relevant to this question, DMH has no subject matter expertise regarding the provision of mental health services, or any services in general, in correctional settings.

By contrast, DOC is staffed with subject matter experts (SME) in these areas and these SME provide mental health and substance use disorder contract oversight. Is it also important to note that mental health care is one part of a vast array of services provided to inmates at DOC, and not something that could be easily parsed out and assigned to another department. In addition, it would be ineffective and worst case, potentially dangerous, to attempt to separate out mental health care from the rest of the care provided inmates. While intentions are good, realistically there is no way to have two departments, two leaders, two independent staffs, all with intense, demanding, and complex jobs to do, attempt to manage the same population differently. Both Departments have great concerns that should mental health oversight authority be separated out of the provision of whole health care, that care coordination and communication would be even more difficult, and these challenges would create even more obstacles to provision of good care – not because anyone was at fault or meant badly, but because it just is not possible to do it all.

While AHS works hard to be "an agency of one" and strives to assure that the left hand is speaking with the right, there is a reason there are six different departments within the agency, and that each one is independently staffed according to their different missions and goals. The people of Vermont benefit from this departmental approach to subject matter focus and expertise on their needs.

***DOC response**:*
As indicated above, we, the DOC also do not believe oversight authority for mental health services should rest with DMH but instead remain with DOC.

As previously stated by DMH, DOC agrees that it is already staffed with SME who provide integrated mental health and substance use disorder contract oversight. Additionally, these positions also provide subject matter expertise on many other DOC operations and patient care- all of which is informed by providing oversight of the contracted mental health services and whole contract.

Providing contract oversight is not just monitoring the individual needs of the incarcerated population, it is also monitoring at the systemic level, interdepartmental level, policies and procedures, clinical guidelines, responding to grievances, and working with family members, community providers and advocates and other states (informs practice). Simply put, mental health oversight of the DOC contract intersects with so many other functions – DOC does not believe it is advisable to delegate that authority to another AHS Department.

To provide more detail, DOC believes that separating DOC mental health contract oversight as a singular activity would undermine the integrity of many other DOC SME activities which include but are not limited to: Contract CQI processes which impact care at the systems and individual levels; Individual monitoring of the most vulnerable and special populations (e.g. incarcerated individuals who are designated (as having/ being identified as) Serious Functionally Impairment (SFI), Delayed Placement Persons (DPP), Traumatic Brain Injury (TBI), comorbid complex chronic care, Medication Assisted Treatment (MAT), Transgender and nonconforming); Monitoring/Coordinating care to ensure that stipulation conditions and requirements are met and reported appropriately; Responding to grievances and monitoring trends across the system; Coordinating with DOC Program Services – risk needs responsivity (RNR) to address criminogenic risks and needs; ADA accommodations; Clinical support to Field/Probation and Parole offices and facility security staff; Department wide Subject Matter Expertise (SME) on related policies and procedures and intersection with operations; Management of complex cases at release; Management of complex cases in the field; Participating in case staffings; Liaising with other AHS Departments (VDH, DMH, DAIL,DCF and DVHA) at individual case and systems level; Liaising with internal and external stakeholders/advocates; and Constituency services responses.

The proposal that DMH provide oversight of the mental health part of the "whole health" contract is also suboptimal practice because mental health is integrally connected to substance use disorders and physical health. Management of chronic comorbid illnesses and clinical guidelines/pathways is best done in a coordinated multidisciplinary team. Some screening and assessment functions are completed by nursing clinical pathways that then handed off to mental health clinical pathways. The workflows are braided and blended and trying to separate out a discrete part will neither be efficient or effective. Just as it would not be evidence based to silo these pathways by having different entities deliver them, it would be sub optimal to have different entities providing oversight as well. DOC also believes that separating mental health oversight and delegating to DMH would increase time and efforts needed for even more complex system collaboration. Working in this already complex multidisciplinary system is challenging and making it more complex will create unnecessary burdens.

Additional DMH response:

DMH, however, clearly has subject matter expertise in best practices regarding the provision of mental health care and is well equipped to act in a supporting role to DOC, as it already does. DMH, and in particular our Care Management Team, is always available to consult with DOC and does so on a regular basis. DMH and DOC have a strong partnership built on trust and mutual respect, and part of the foundation for that is understanding and respecting each department's unique missions, expertise, and roles.

In addition to the regularly occurring communications between DMH and DOC, Act 78 and its associated MOU and appendices, which has been in place since July 1, 2017, provide specific written guidance for accessing psychiatric hospital level of care for inmates in DOC custody, replicating and modifying the community process. It is important to note that, just as in the community, only an individual who meets the statutory and clinical criteria for inpatient hospitalization can be admitted to an inpatient unit. Vermont does not have a general fund forensic unit, only CMS accredited and Joint Commission certified hospital.

VI. How the MOU executed by the DOC and DMH impacts the mental health services and whether it is adequately addressing needs of those individuals with severe illness or in need of inpatient care.

(Joint DMH and DOC response and opinions are in bold)

Act 78, enacted on June 13, 2017, directed both DOC and DMH to create an MOU by July 1, 2017, codifying the collaboration between the two departments to serve the needs of vulnerable criminal justice involved individuals. ACT-78, specifically Section Sec. 9. Titled: DEPARTMENT OF CORRECTIONS; DEPARTMENT OF MENTAL HEALTH; FORENSIC MENTAL HEALTH CENTER; MEMORANDUM OF UNDERSTANDING FOR MENTAL HEALTH SERVICES; REPORTS states:

(a)(1) On or before July 1, 2017, the Department of Corrections shall, jointly with the Department of Mental Health, execute a memorandum of understanding regarding mental health services for inmates prior to the establishment of a forensic mental health center as required by subdivision (c) of this section. The memorandum of understanding shall:
(A) establish that when an inmate is identified by the Department of Corrections as requiring a level of care that cannot be adequately provided by the Department of Corrections, then the Department of Mental Health and the Department of Corrections will work together to determine how to augment the inmate's existing treatment plan until the augmented treatment plan is no longer clinically necessary; and
(B) formally outline the role of the Department of Mental Health Care Management Team in facilitating the clinical placement of inmates coming into the custody of the Commissioner of Mental Health pursuant to Title 13 or Title 18 and inmates voluntarily seeking hospitalization who meet inpatient criteria

The MOU and associated appendices that address the requirements in Section 9 (above) can be reviewed here.

DOC and DMH both believe the MOU has met the intent of the legislation, positively impacted the mental health services provided by DOC contractors and does adequately address those individuals in DOC custody in need of inpatient care. Just as in the community, when someone meets inpatient criteria, the MOU outlines the process for DOC/their contractor to work with the DMH Care Management Team to find an appropriate bed for the individual and to help monitor their hospitalization and eventual discharge. Without a forensic facility, however, there does remain a gap in services for those individuals who do not meet criteria for an inpatient level of care but would benefit from more services than can be provided in the traditional correctional setting.