

1 S.133

2 Introduced by Committee on Health and Welfare

3 Date:

4 Subject: Health; mental health; access to care; care coordination

5 Statement of purpose of bill as introduced: This bill proposes to examine
6 various aspects of the mental health system in order to improve access to care
7 and care coordination throughout the system.

8 An act relating to examining mental health care and care coordination

9 It is hereby enacted by the General Assembly of the State of Vermont:

10 * * * Findings * * *

11 Sec. 1. FINDINGS

12 The General Assembly finds that:

13 (1) The State's mental health system has undergone substantial
14 transformations during the past ten years, with regard to both policy and the
15 structural components of the system.

16 (2) The State's adult mental health inpatient system was disrupted after
17 Tropical Storm Irene flooded the Vermont State Hospital in 2011. The
18 General Assembly, in 2012 Acts and Resolves No. 79, added over 50 long- and
19 short-term residential beds to the State's mental health system, all of which are
20 operated by the designated and specialized service agencies. It also

1 strengthened existing care coordination with in the Department of Mental
2 Health to assist community providers and hospitals in the development of a
3 “system” that fosters the movement of individuals with psychiatric conditions
4 between appropriate levels of care as needed.

5 (3) Due to hospital flow and other system pressures, Vermont has seen a
6 gradual increase in the number of individuals with a psychiatric condition held
7 in emergency departments awaiting a hospital bed. Currently, hospitals
8 average 90 percent occupancy while crisis beds average just under 70 percent
9 occupancy, the latter largely due to understaffing. Issues related to hospital
10 discharge include inadequate staffing in community programs, insufficient
11 community programs, and inadequate supply of housing.

12 (4) Individuals presenting in emergency departments with acute
13 psychiatric care needs often remain in that setting for many hours or days
14 under the supervision of hospital staff, peers, crisis workers, or law
15 enforcement officers until a bed in a psychiatric inpatient unit becomes
16 available. Many of these individuals do not have access to a psychiatric care
17 provider and the emergency department does not provide a therapeutic
18 environment. Some of these individuals’ conditions worsen while waiting for
19 an appropriate placement. Hospitals also struggle under these circumstances
20 because their staff is demoralized that they cannot care adequately for
21 psychiatric patients and consequently there is a rise in turnover rates. Many

1 hospitals are investing in special rooms for psychiatric emergencies and hiring
2 mental health technicians to work in the emergency department.

3 (5) Care provided by the designated agencies is the cornerstone upon
4 which the entire mental health system balances. Approximately two-thirds of
5 the psychiatric patients admitted to emergency departments are not clients of
6 the designated or specialized service agencies and are meeting with the crisis
7 response team for the first time. Many of the individuals presenting in
8 emergency departments are assessed, stabilized, and discharged to return home
9 or to supportive programming provided by the designated and specialized
10 service agencies.

11 (6) There is a shortage of psychiatric care professionals both nationally
12 and statewide. Psychiatrists working in Vermont have testified that they are
13 distressed that individuals with psychiatric conditions are boarded in
14 emergency departments and that there is an overall lack of health care parity
15 between physical and mental conditions.

16 (7) In 2007, a study commissioned by the Agency of Human Services
17 substantiated that designated and specialized service agencies face challenges
18 in meeting the demand for services at current funding levels. It further found
19 that keeping pace with current inflation trends, while maintaining existing
20 caseload levels, required annual funding increases of eight percent across all
21 payers to address unmet demand. Since that time, cost of living adjustments

1 appropriated to designated and specialized service agencies were raised by less
2 than one percent annually.

3 (8) Evidence regarding the link between social determinants and healthy
4 families has become increasingly clear in recent years. Improving an
5 individual's trajectory requires addressing the needs of children and
6 adolescents in the context of their family. This means Vermont must work
7 within a two-generational framework. While these findings primarily focus on
8 the highest acuity individuals within the adult system, it is important to also
9 focus on children's mental health. Social determinants when addressed can
10 improve an individual's health, therefore housing, employment, food security,
11 and natural support must be considered as part of this work as well.

12 (9) Before moving ahead with changes to refine the performance of the
13 current mental health system, an analysis is necessary to take stock of how it is
14 functioning and what resources are necessary for evidence-based or best
15 practice and cost-efficient improvements.

16 * * * System Coordination and Patient Flow * * *

17 Sec. 2. PROPOSED ACTION PLAN

18 On or before September 1, 2017, the Secretary of Human Services shall
19 submit an action plan to the Senate Committee on Health and Welfare and to
20 the House Committee on Health Care containing recommendations and

1 legislative proposals for each of the evaluations, analyses, and other tasks
2 required pursuant to Secs. 3–9 of this act.

3 Sec. 3. OPERATION OF MENTAL HEALTH SYSTEM

4 The Secretary of Human Services, in collaboration with the Commissioner
5 of Mental Health and Green Mountain Care Board, shall conduct an analysis of
6 child and adult patient movement through Vermont’s mental health system,
7 including voluntary and involuntary hospital admissions, emergency
8 departments, intensive residential recovery facilities, secure residential
9 recovery facility, crisis beds, and stable housing. The analysis shall identify
10 barriers to efficient, medically-necessary patient transitions between the mental
11 health system’s levels of care and opportunities for improvement. It shall also
12 build upon previous work conducted pursuant to the Health Resource
13 Allocation Plan described in 18 V.S.A. § 9405.

14 Sec. 4. CARE COORDINATION

15 (a) The Secretary of Human Services, in collaboration with the
16 Commissioner of Mental Health, shall develop a plan for and an estimate of
17 the fiscal impact of implementation of regional navigation and resource centers
18 for referrals from primary care, hospital emergency departments, inpatient
19 psychiatric units, and community providers, including the designated and
20 specialized service agencies and private counseling services. The goal of the
21 regional navigation and resource centers is to foster a more seamless transition

1 in the care of individuals with mental health conditions or substance use
2 disorders. The Commissioner shall provide technical assistance and serve as a
3 statewide resource for regional navigation and resource centers.

4 (b) The Secretary of Human Services, in collaboration with the
5 Commissioner of Mental Health, shall evaluate the effectiveness of the
6 Department's care coordination team and the level of accountability among
7 admitting and discharging mental health professionals, as defined in 18 V.S.A.
8 § 7101.

9 Sec. 5. INVOLUNTARY TREATMENT AND MEDICATION

10 (a) The Secretary of Human Services, in collaboration with the
11 Commissioner of Mental Health and the Chief Administrative Judge of the
12 Vermont Superior Courts, shall conduct an analysis of the role that involuntary
13 treatment and psychiatric medication play in hospital emergency departments
14 and inpatient psychiatric admissions. The analysis shall examine the interplay
15 between staff and patients' rights and the use of involuntary treatment and
16 medication. The analysis shall also address the following policy proposals,
17 including the legal implications, the rationale or disincentives, and a cost-
18 benefit analysis for each:

19 (1) a statutory directive to the Department of Mental Health to prioritize
20 the restoration of competency where possible for all forensic patients
21 committed to the care of the Commissioner;

1 (2) enabling applications for involuntary treatment and applications for
2 involuntary medication to be filed simultaneously or at any point that a
3 licensed independent practitioner believes joint filing is necessary for the
4 restoration of the individual's competency;

5 (3) enabling a patient's counsel to request only one evaluation pursuant
6 to 18 V.S.A. § 7614 for court proceedings related to hearings on an application
7 for involuntary treatment or application for involuntary medication, and
8 preventing any additional request for evaluation from delaying treatment
9 directed at the restoration of competency; and

10 (4) enabling both qualifying psychiatrists and psychologists to conduct
11 patient examinations pursuant to 18 V.S.A. § 7614.

12 (b) On or before October 1, 2017, Vermont Legal Aid and Disability Rights
13 Vermont shall jointly submit an addendum addressing those portions of the
14 Secretary's proposed action plan submitted pursuant to Sec. 2 of this act that
15 relate to subsection (a) of this section. The addendum shall be submitted to the
16 Senate Committee on Health and Welfare and to the House Committee on
17 Health Care and shall identify any policy or legal concerns implicated by the
18 analysis or legislative proposals in the Secretary's action plan.

19 (c) As used in this section, "licensed independent practitioner" means a
20 physician, an advanced practice registered nurse licensed by the Vermont

1 Board of Nursing, or a physician assistant licensed by the Vermont Board of
2 Medical Practice.

3 Sec. 6. PSYCHIATRIC ACCESS PARITY

4 The Agency of Human Services, in collaboration with the Commissioner of
5 Mental Health and designated hospitals, shall evaluate opportunities for and
6 remove barriers of implementing parity in the manner that individuals
7 presenting at hospitals are received, regardless of whether for a psychiatric or a
8 physical condition. The evaluation shall examine: existing processes to screen
9 and triage health emergencies; transfer and disposition planning; stabilization
10 and admission; and criteria for transfer to specialized or long-term care
11 services.

12 Sec. 7. GERIATRIC AND FORENSIC PSYCHIATRIC SKILLED
13 NURSING UNIT OR FACILITY

14 The Secretary of Human Services shall assess existing community capacity
15 and evaluate the extent to which a geriatric or forensic psychiatric skilled
16 nursing unit or facility, or both, are needed within the State. If the Secretary
17 concludes that the situation warrants more home- and community-based
18 services, a geriatric or forensic nursing home unit or facility, or any
19 combination thereof, he or she shall develop a plan for the design, siting, and
20 funding of one or more units or facilities with a focus on the clinical best
21 practices for these patient populations.

1 Sec. 8. UNITS OR FACILITIES FOR USE AS NURSING OR
2 RESIDENTIAL HOMES OR SUPPORTIVE HOUSING

3 The Secretary of Human Services shall consult with the Commissioner of
4 Buildings and General Services to determine whether there are any units or
5 facilities that the State could utilize for a geriatric or forensic psychiatric
6 skilled nursing or residential home or supportive housing.

7 Sec. 9. 23-HOUR BED EVALUATION

8 The Secretary of Human Services, in collaboration with the Commissioner
9 of Mental Health, shall evaluate potential licensure models for 23-hour beds
10 and the implementation costs related to each potential model. Beds may be
11 used for patient assessment and stabilization, involuntary holds, diversion from
12 emergency departments, and holds while appropriate discharge plans are
13 determined. At a minimum, the models considered by the Secretary shall
14 address psychiatric oversight, nursing oversight and coordination, peer support,
15 and security.

16 * * * Workforce Development * * *

17 Sec. 10. MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND
18 SUBSTANCE USE DISORDER WORKFORCE STUDY
19 COMMITTEE

20 (a) Creation. There is created the Mental Health, Developmental
21 Disabilities, and Substance Use Disorder Workforce Study Committee to

1 examine best practices for training, recruiting, and retaining health care
2 providers and other service providers in Vermont, particularly with regard to
3 the fields of mental health, developmental disabilities, and substance use
4 disorders. It is the goal of the General Assembly to enhance program capacity
5 in the State to address ongoing workforce shortages.

6 (b)(1) Membership. The Committee shall be composed of the following
7 members:

8 (A) the Secretary of Human Services or designee, who shall serve as
9 the Chair;

10 (B) the Commissioner of Labor or designee;

11 (C) a representative of the Vermont State Colleges; and

12 (D) a representative of the Vermont Health Care Innovation Project's
13 (VHCIP) work group.

14 (2) The Committee may include the following members:

15 (A) a representative of the designated and specialized service
16 agencies appointed by Vermont Care Partners;

17 (B) the Director of Substance Abuse Prevention;

18 (C) a representative of the Area Health Education Centers; and

19 (D) any other appropriate individuals by invitation of the Chair.

20 (c) Powers and duties. The Committee shall consider and weigh the
21 effectiveness of loan repayment, tax abatement, long-term employment

1 agreements, funded training models, internships, rotations, and any other
2 evidence-based training, recruitment, and retention tools available for the
3 purpose of attracting and retaining qualified health care providers in the State,
4 particularly with regard to the fields of mental health and substance use
5 disorders.

6 (d) Assistance. The Committee shall have the administrative, technical,
7 and legal assistance of the Agency of Human Services.

8 (e) Report. On or before September 1, 2017, the Committee shall submit a
9 report to the Senate Committee on Health and Welfare and the House
10 Committee on Health Care regarding the results of its examination, including
11 any legislative proposals for both long-term and immediate steps the State may
12 take to attract and retain more health care providers in Vermont.

13 (f) Meetings.

14 (1) The Secretary of Human Services shall call the first meeting of the
15 Committee to occur on or before July 1, 2017.

16 (2) A majority of the membership shall constitute a quorum.

17 (3) The Committee shall cease to exist on September 30, 2017.

18 Sec. 11. OFFICE OF PROFESSIONAL REGULATION; INTERSTATE
19 COMPACTS

20 The Director of Professional Regulation shall engage other states in a
21 discussion of the creation of national standards for coordinating the regulation

1 and licensing of mental health professionals, as defined in 18 V.S.A. § 7101,
2 for the purposes of licensure reciprocity and greater interstate mobility of that
3 workforce. On or before September 1, 2017, the Director shall report to the
4 Senate Committee on Health and Welfare and the House Committee on Health
5 Care regarding the results of his or her efforts and recommendations for
6 legislative action.

7 * * * Designated and Specialized Service Agencies * * *

8 Sec. 12. 18 V.S.A. § 8914 is added to read:

9 § 8914. RATES OF PAYMENTS TO DESIGNATED AND SPECIALIZED

10 SERVICE AGENCIES

11 (a) The Secretary of Human Services shall have sole responsibility for
12 establishing rates of payments for designated and specialized service agencies
13 that are reasonable and adequate to meet the costs of achieving the required
14 outcomes for designated populations. When establishing rates of payment for
15 designated and specialized service agencies, the Secretary shall adjust rates to
16 take into account factors that include:

17 (1) the reasonable cost of any governmental mandate that has been
18 enacted, adopted, or imposed by any State or federal authority; and

19 (2) a cost adjustment factor to reflect changes in reasonable cost of
20 goods and services of designated and specialized service agencies, including
21 those attributed to inflation and labor market dynamics.

1 (b) When establishing rates of payment for designated and specialized
2 service agencies, the Secretary may consider geographic differences in wages,
3 benefits, housing, and real estate costs in each region of the State.

4 Sec. 13. PAYMENTS TO THE DESIGNATED AND SPECIALIZED
5 SERVICE AGENCIES

6 The Secretary of Human Services, in collaboration with the Commissioners
7 of Mental Health and of Disabilities, Aging, and Independent Living, shall
8 develop a plan to integrate multiple sources of payments to the designated and
9 specialized service agencies. In a manner consistent with section 12 of this
10 act, the plan shall implement a Global Funding model as a successor to the
11 analysis and work conducted under the Medicaid Pathways and other work
12 undertaken regarding mental health in health care reform. It shall increase
13 efficiency and reduce the administrative burden. On or before January 1, 2018,
14 the Secretary shall submit the plan and any related legislative proposals to the
15 Senate Committee on Health and Welfare and the House Committee on
16 Health Care.

17 Sec. 14. INTEGRATION OF PAYMENTS; ACCOUNTABLE CARE
18 ORGANIZATIONS

19 (a) Pursuant to 18 V.S.A. § 9382, the Green Mountain Care Board shall
20 review an accountable care organization's (ACO) model of care and
21 integration with community providers, including designated and specialized

1 service agencies, regarding how the model of care promotes seamless
2 coordination across the care continuum, business or operational relationships
3 between the entities, and any proposed investments or expansions to
4 community-based providers. The purpose of this review is to ensure progress
5 toward and accountability to the population health measures related to mental
6 health and substance use disorder contained in the All Payer ACO Model
7 Agreement.

8 (b) In the Board's annual report due on January 15, 2018, the Green
9 Mountain Care Board shall include a summary of information relating to
10 integration with community providers as described in subsection (a) of this
11 section received in the first ACO budget review under 18 V.S.A. § 9382.

12 (c) On or before December 31, 2020, the Agency of Human Services, in
13 collaboration with the Green Mountain Care Board, shall provide a copy of the
14 report required by Section 11 of the All-Payer Model Accountable Care
15 Organization Model Agreement, which outlines a plan for including the
16 financing and delivery of community-based providers in delivery system
17 reform, to the Senate Committee on Health and Welfare and the House
18 Committee on Health Care.

1 Sec. 15. HEALTH INSURANCE; DESIGNATED AND SPECIALIZED
2 SERVICE AGENCY EMPLOYEES

3 On or before September 1, 2017, the Commissioner of Human Resources
4 shall consult with Blue Cross and Blue Shield of Vermont and Vermont Care
5 Partners regarding the operational feasibility of including the designated and
6 specialized service agencies in the State employees' health benefit plan and
7 submit any findings and relevant recommendations for legislative action to the
8 Senate Committees on Health and Welfare, on Government Operations, and on
9 Finance and the House Committees on Health Care and on Government
10 Operations.

11 Sec. 16. PAY SCALE; DESIGNATED AND SPECIALIZED SERVICE
12 AGENCY EMPLOYEES

13 The Secretary of Human Services shall allocate to designated and
14 specialized services agencies an appropriation as specified in Sec. 17 of this act
15 with the goal of implementing a pay scale by July 1, 2017 that:

16 (1) provides a minimum hourly payment of \$15.00 to direct care
17 workers; and

18 (2) increases the salaries for employees and contracted staff to be at
19 least 85 percent of those salaries earned by equivalent State, health care, or
20 school-based positions with equal lengths of employment.

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* * * Appropriations * * *

Sec. 17. APPROPRIATION; DESIGNATED AND SPECIALIZED
SERVICE AGENCY EMPLOYEE PAY

(a) In fiscal year 2018, a total of \$30,240,000.00 from the Global
Commitment Fund is appropriated to the Agency of Human Services as
follows:

(1) \$30,000,000.00 for the purposes of carrying out the provisions of
Sec. 16 of this act; and

(2) \$240,000.00 for the purpose of expanding staffing of the existing
peer-run warm line by eight hours a day.

(b) In fiscal year 2018, a total of \$13,995,072.00 from the General Fund
and \$16,224,928.00 in federal funds is appropriated to the Agency of Human
Services Global Commitment for funding the appropriations made in
subsection (a) of this section.

* * * Effective Date * * *

Sec. 18. EFFECTIVE DATE

This act shall take effect on passage.