

# Vermont Legislature's Consulting Group on the Future of VSH and Systems of Care Interim Report: Preliminary Issues

August 21, 2007

Vermont is facing a serious set of decisions regarding the future of the treatment for persons with severe mental illness – especially those who may need acute care and extended treatment. The Legislature, Administration and people of good will from all sides have produced options for how to proceed. The Consulting Group was charged with considering those options and determining if there are additional options that should be explored.

In that regard, The Consulting Group (Richard Surlles, Con Hogan & Tom Moore) has undertaken a comprehensive review of all available reports and minutes of the past three years. They met with the Secretary of Human Services; the Commissioner and Medical Director of the Department of Corrections, held multiple meeting with the DMH Commissioner and leadership team; met with VSH, Fletcher Allen, the Brattleboro Retreat and the VSEA leaders. In addition, the Group reviewed materials provided by the Department of Buildings and General Services and the VSEA regarding capital cost for a variety of options; met with the Court Administrator, the Chair of the Corrections Oversight Committee and had informal discussions with numerous non-governmental parties of interest.

From these activities, seven policy issues have emerged that the Group recommends be discussed prior to drafting a final report. These policy issues will form the foundation of our discussions on August 21 and 22 with legislators and members of the administration.

**1. Should Vermont substantially revise its state laws governing the emergency detention and involuntary treatment and medication of persons who represent a danger to self or others?**

There is wide spread recognition of the difficulty of reopening this issue. But the fact that involuntary medication may currently only occur at the VSH calls into question the advisability of adding any new acute care capacity without first addressing the issue of the need to extend the coverage of the current act. More important is the fact that the administration of current provisions of the statute appears to require long periods of involuntary detention when a person refuses to comply with clinical recommendations of the responsible physician. Once a person refuses treatment at a community hospital, most are transferred to VSH within 72 hours. At VSH, because of the legal framework and related rules that have the force of law, a person can wait months before a court hearing occurs thus remaining actively psychotic and untreated. There are some actions that might improve the administration of the current law - expanded court hearings and expedited clinical reviews – but retaining a person without active treatment raises significant issues especially in an acute hospital setting.

This concern is primarily a problem of law and of administrative rule and not practice. The problem becomes even a more serious barrier if there are multiple sites for acute care in Vermont. Multiple sites are deemed as a preferred policy for rapid access and providing less stigmatizing treatment environments.

**2. How many inpatient beds are needed to replace the functions of VSH?**

VSH provides less than 200 admissions per year with an average length of stay (LOS) of about 70 days. This LOS is distorted by the fact that those awaiting a court decision on treatment (typically 7-8 cases) can be detained well beyond that average and because about 20% of all beds are occupied by persons who have been waiting for a community based placed for more than a year. Vermont must first address the issue of “what kind of beds” before a final decision is made about the VSH. For example, the need for high cost acute care beds can be lessened if sub-acute beds (also known as “step down beds”) are available in a non-hospital setting. Beds of this type could well be provided by private sector contractors at less cost and in quicker time than traditional institutional acute care facilities. Acute inpatient care is best reserved for rapid evaluation, medical stabilization and referral to an appropriate level of care. Only in a small percentage of cases would tertiary care be needed but immediate access is also critical.

Significantly expanding the number of psychiatric beds in acute hospital settings could, in the long run, lead to an over supply of high cost acute inpatient capacity while not addressing the immediate need for intermediate or “step down” beds and extended residential care.

Acute care hospitals must always address the requirement of “medical necessity” and LOS for acute psychiatric treatment is usually less than 10 days. So theoretically, the current 50 beds that VSH provides for less than 200 annual admissions could be replaced with a 50 bed acute capacity of more than 1800 annual admissions. This “over capacity” would occur if the new 50 beds are used for “medically necessary” acute care with an LOS of 10 days rather than the full functional use of VSH for acute, sub-acute and extended residential care.

Answering the question of how many beds (acute, step down and extended residential) requires a fresh look at the type of beds and the state wide distribution of inpatient capacity. The answer should take into account the potential use of existing designated beds and clarify the intended use of new beds to meet a comprehensive mixture of acute, sub-acute and extended residential beds.

**3. What role should existing acute inpatient capacity play in the VSH Futures Plan?**

Four community hospitals have been designated as psychiatric inpatient units for acute care – Central Vermont (14), FAHC (28), Rutland Regional (19) and Springfield (10). The Brattleboro Retreat is certified for 52 beds but is not an acute care facility for Medicaid adults since it is an Institution for Mental Disease (IMD) and not eligible for federal financial participation (FFP). Thus 71 acute inpatient beds are designated for emergency treatment and those hospitals qualify for FFP. However, about 25% of these beds are not currently used due to facility and staffing problems. Nevertheless, these hospitals provide about 2000 admissions per year with Medicare being the largest payor at 40%. Vermont Medicaid currently pays for less than 30% of the annual acute inpatient bed days. Addressing the facility and staffing needs of these existing hospitals could provide some “new” capacity for patients now using VSH and could reduce the number of new acute beds needed to replace VSH.

**4. Why is it critical to get the number of acute care beds right?**

Once Vermont has designated an acute inpatient bed as certified to participate in the state’s Medicaid program, the designated hospital is required to provide access to all Medicaid eligible persons. Currently only 30% of the designated acute psychiatric beds bill for Medicaid reimbursement. In many states, Medicaid is a more prominent payor since private payors are aggressively diverting admissions and limiting LOS. Modeling varying assumptions about the future potential use of current acute inpatient beds and expansion beds may prove helpful in planning. Vermont’s requirement to pay for Medicaid acute inpatient care may vary dramatically in future years based on the total number of beds located in medical hospitals, especially if Medicaid were to become the predominate payor. Our preliminary modeling is telling us that an excess number of acute care beds, over time, can drive costs beyond reason at the expense of the community based system, which is so critical to the well being of the overall mental health system and that limiting the number of Medicaid funded acute care beds is essential. Private organizations that may be able to move quickly to provide ‘step down’ and extended residential levels of care and need to be factored into the long term plan for setting limits on acute capacity.

**5. What are the significant concerns of hospital administrators in replacing the acute capacity of VSH?**

Medical centers are designed to do rapid evaluation, provide an initial diagnosis and begin critical medical treatment as soon as possible. They are also required by payors and accreditation agencies to provide medically necessary care and appropriate discharges. Shifting all emergency evaluations and initial acute hospitalization to a full service medical center is the emerging standard of care throughout the US. While hospitals are concerned about the adequacy of reimbursement and their ability to recruit and retain staff, of critical importance is the right to begin treatment and assure the existence of an appropriate placements for discharge. Community hospitals will want assurance that Vermont has established a comprehensive array of discharge

options including outpatient referrals, sub acute settings and residential living arrangements – including setting that have a capacity for supervision and security.

**6. What should be the future role of the VSH?**

Retaining the physical plant at VSH, or building of a new state hospital, for acute care services does not appear a logical option given not only cost, but the emerging expectation that acute care initially occur in a medical hospital with full capacity for CAT scans, full medical evaluations and rapid diagnosis and treatment. The major function of VSH is to provide extended residential rehabilitation to a patient population that requires long term supportive therapy. This function must be a part of a comprehensive mental health system. Therefore, building a rehabilitation and recovery center should be considered and could be state or privately operated. If such a facility is over 15 beds it will be treated as an IMD and no federal funds can be used for residential services. However, the operation of such a facility may cost less than state match for a medically certified, non-IMD.

The existing staff represents hundreds of years of experience. The capabilities and experience of the VSH staff does not currently exist any place else in Vermont. A transitional plan with the flexibility for employment at any level in the statewide mental health system, but particularly in the treatment of person with severe mental disability, should be developed. Even though the current staff at VSH has done extraordinary work in up-righting the facility, the current State Hospital should not be used in future for treatment purposes. It is beyond any useful future use in this regard. At the same time, it must be more than adequately resourced during an upcoming and difficult transition.

**7. What capacity should exist for the treatment of the population involved in the criminal justice system who need inpatient psychiatric hospitalization?**

The same standards for acute hospitalization and medication management should exist for persons in the state corrections systems as for other persons who currently utilize VSH. A review of the Milliman Report provided to the Department of Health in June, 2006 concluded that Vermont's Corrections population had "a higher level of mental health treatment than all but a few states" and that the "current level of mental health inpatient services delivered to the Corrections population appears to be appropriate." In interviews with Mental Health and Corrections, the consultants were told that the same standards for commitment to VSH were applied to Corrections inmates as to other Vermont citizens. The consultants did not find any evidence to dispute the Milliman Report or the representations of the two Departments. However, the consultants did hear from key contacts that significant concerns exist about the adequacy of access to care within the inmate population.

A recent report on the use of psychotropic medications in the prison population (almost 50% of inmates are said to be medicated) adds to that concern. A more careful study of that recent report could provide insight into the degree of severity of illness

within the correctional population. Simply knowing the classes of medications being used, the dosing levels and duration of medication treatment would provide useful information. If findings indicate that most medications were prescribed for mild depression and anxiety, such medication use would seem appropriate and humane. However, if one found long term use of antipsychotic medications at a high dosing range, then the inference would be that persons with severe mental illness, requiring active treatment, were prevalent in the general correction's population.

The resolution of these seven fundamental policy issues both precedes and informs the capital and operating options.

Respectfully submitted by,

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