Vermont Medical Society

Notes and Draft Recommendations
VMS Meeting with Commissioner of Mental Health
Waiting times for Psychiatric Inpatient Beds
December 19, 2014

Attendees:
Cindy Bruzzese – Executive Director, Vermont Ethics Network
Mark Depman MD – Director, Emergency Department, Central Vermont Medical Center
Rob Duncan MD - Psychiatrist, Central Vermont Medical Center
Paul Dupre, Commissioner of Mental Health
David Fassler MD – Psychiatrist, Vermont Psychiatric Association
Marilyn Hart MD – Internist, VMS Council
Tobey Horn MD - Psychiatrist, University of Vermont Medical Center Hospital
Justin Knapp MD – Psychiatrist, Central Vermont Medical Center
Judy Lewis MD – Psychiatrist, University of Vermont Medical Center Hospital
David McKay MD – Psychiatrist, Veterans Administration
Madeleine Mongan, VMS Staff
Bill Nowlan MD – Porter Hospital Emergency Department, VMS Council
Allison Richards MD – Psychiatrist, University of Vermont Medical Center Hospital
Jesse Rilvo MD – Psychiatrist, Central Vermont Medical Center
Sarah Swift MD – Director Hospitalist Service, Central Vermont Medical Center
Jonathan Weker MD – Psychiatrist, VMS Council, Vermont Psychiatric Association

Meeting with Commissioner of Mental Health December 19, 2014
A working group of VMS member physicians is charged with leading the VMS' work on the 2014 VMS resolution expressing concern about acutely ill patients waiting in emergency rooms for admission to Level I inpatient psychiatric beds. As a first step, VMS convened a meeting with the Commissioner of Mental Health, which was held at the VMS office on December 19, 2014. Members of the working group attended along with other VMS members interested in this issue and representatives of the Vermont Ethics Network and the Vermont Psychiatric Association. It is VMS policy that no patient should wait more than 24 hours in an emergency department for a psychiatric placement. In addition, physicians believe that patients with the highest acuity should be prioritized for immediate placement.

The meeting and associated discussions about patients waiting for placements in Level I inpatient psychiatric beds resulted in the following six draft recommendations:

- **VMS recommends that the Department of Mental Health work with stakeholders to develop a contingency plan as soon as possible to care for patients so that no patient in custody of the Department waits for longer than 24 hours for an Inpatient bed.**
- **VMS recommends identifying, quantifying, and tracking patients with high acuity in order to ensure that the system has the capacity to care for them.**
- **VMS recommends identifying funding to support the creation of a psychiatric resource plan for Vermont.**
- **VMS recommends tracking the capacity, usage, length of stay and readmissions at all levels of the inpatient and outpatient mental health system.**
• VMS recommends that psychiatric patients with the highest acuity be prioritized for immediate placement.

• VMS recommends that the Department of Mental Health provide all emergency departments the criteria for admission to, continuing stay at, and discharge from all services in the continuum of care. In addition, emergency departments with waiting patients should be able to access the Department’s web-based bed board and directly contact the Department’s clinical management coordinators to identify placements for their patients.

• VMS recommends monitoring the timeliness of applications for involuntary treatment and the use of the new expedited commitment and involuntary medication provisions to determine whether these changes in the law have improved timely access to care.

Background – VMS 2014 and 2013 Resolutions and Act 192 (2014)
At the 2014 VMS Annual Meeting, VMS members adopted a resolution that expressed concern about acutely mentally ill patients waiting in emergency rooms without recourse to psychiatric care, and charged VMS with assessing the current status of access to Level One inpatient psychiatric care and urging the State to adopt further measures to enhance level one inpatient treatment resources. http://www.vtmd.org/sites/default/files/files/2014TimelyAccess.pdf

This resolution succeeded a resolution adopted by VMS in 2013 that charged VMS with working to ensure that the mental health system includes sufficient overflow capacity to ensure that no acutely psychiatrically ill patient waits for a Level 1 Acute Involuntary Psychiatric bed at an emergency department or correctional facility for more than 24 hours. The 2013 resolution also charged the VMS with working to assess the mental health workforce needs and developing an approach to address unmet needs. http://www.vtmd.org/sites/default/files/files/VMS_Council_Policy_Inpatient_Mental_Health_Services_adopted_02-8-14.pdf

In 2013, VMS formed a multi-specialty working group that included three psychiatrists, two primary care physicians, two emergency department physicians, a surgeon and a physician who is a clinical ethicist. The working group proposed and supported the resolutions adopted by VMS and reviewed legislative policies. Last year, VMS worked with the Vermont Association of Hospitals and Health Systems (VAHHS) to support passage of Act 192 which improved the commitment and involuntary medication process.

Meeting with Commissioner of Mental Health December 19, 2014
The VMS working group continues to lead the VMS’ work on the 2014 resolution. As a first step in this process, VMS convened a meeting with the Commissioner of Mental Health, which was held at the VMS office on December 19, 2014. Members of the working group attended along with other VMS members interested in this issue and representatives of the Vermont Ethics Network and the Vermont Psychiatric Association.

Waiting times
The meeting began with a discussion of waiting times for acutely psychiatrically patients being held in emergency departments or the correctional system pending availability of Level 1 Psychiatric Inpatient beds. In October 2014, on average, 8 patients were waiting inpatient placements in emergency
departments every day. These patients included patients held for Emergency Examination and patients held for Forensic Observation.

In September, the Department’s data shows that emergency examination patients waited 45 hours on average for admission to Level 1 beds, while forensic observation patients waited 412 hours on average. In September, 18 patients waited more than 24 hours for a bed.


David McKay, MD summarized the opinion of the physicians at the meeting: there is still a problem with acutely ill patients waiting in the emergency departments in Vermont for Level 1 Psychiatric Inpatient beds. In addition, Mark Depman, MD reported that sheriffs are only available to assist with safety about 40% of the times that they are requested. The group expressed concern that the system does not have a place where Level 1 patients can go as a last resort, a place that operates as a relief valve for the system. The Vermont State Hospital (VSH) performed this role, but in the new system, the hospitals with Level 1 beds, including the Vermont Psychiatric Care Hospital, do not appear to serve this function. Patients may end up waiting because the system balances the needs of patients on the unit with the needs of patients waiting for placements and does not have the ability to accept all comers. VMS is concerned that requiring psychiatric patients to wait in emergency departments without appropriate psychiatric treatment raises clinical, safety, and potential ethical issues.

VMS recommends that the Department of Mental Health develop a contingency plan as soon as possible to care for patients so that no patient in custody of the Department waits for longer than 24 hours for an Inpatient bed.

In November of 2013, the Mental Health Oversight Committee and the Health Care Oversight Committee recommended to the Joint Fiscal Committee that, “the General Assembly should develop contingency plans in case the need for overflow beds in the level I system arises.”


VMS concurs with this recommendation and believes that currently there is at least a temporary need for overflow beds, and there may be a need for permanent overflow beds in the level I system.

Reasons for Lack of Level 1 Psychiatric Inpatient Capacity in Vermont

At the meeting, Commissioner Paul Dupre explained some of the issues he believes are causing the lack of capacity to accommodate Level 1 patients in the system. Overall he believes that there are enough Level 1 beds in the system. There are currently 45 planned Level 1 beds – 25 at the Vermont Psychiatric Care Hospital (VPCH), 6 at the Rutland Regional Medical Center (RRMC) and 14 at the Brattleboro Retreat. (Rutland and the Retreat, however, frequently exceed their planned Level 1 capacity - Rutland
by about 2 to 4 beds and the Retreat by about 3 to 8 beds in any given month in 2014.) In the year before it closed (August 2010 to 2011), the census at the Vermont State Hospital (VSH) ranged from approximately 36 to 51 patients. The Vermont Psychiatric Care Hospital (VPCH), which opened on July 1, 2014, is only at 75% to 80% of capacity with 3 to 5 of their 25 beds not occupied on any given day. This is due to primarily to the difficulty the Department has experienced in hiring and training staff. It is also due to the extreme acuity of patients. According to the Commissioner, there are 90 new staff who have a learning curve and more need to be hired. At the same time a number of “heavy duty folks” were admitted to the hospital. Forensic patients are treated at the VPCH along with involuntarily committed patients which adds to the complexity and challenges for the hospital.

In a presentation to the House Human Services Committee on Thursday, January 15, 2015, Jeff Rothenberg, the CEO of the VPCH updated the Committee on the current status of the VPCH. About 34 patients were admitted to the VPCH since July 2, 2014 and 24 patients have been discharged. The current length of stay was 72 days as of 12/31/14. Most of the patients (65%) were admitted through the civil commitment process; 35% were admitted through the criminal justice process. The presentation also included data about aggressive actions against employees and the degree of harm. There have been more aggressive actions against patients at VPCH per 1000 patient hours than there were at VSH in the last six months of its operation, but there have been fewer emergency involuntary procedures per 1000 hours. Dr. Isabelle Desjardins MD, Executive Medical Director of the VPCH described the challenges and complexity of balancing safety for all (patients and staff) with recovery and the tension between the legal regulations which generally do not permit involuntary medication for about 20 to 30 days and the need to treat patients, provide safety for all, and maximize utilization of the hospital. Because of the acuity of the patients already in the hospital, it is not always possible to admit the next patient from an emergency room.

Vermont Psychiatric Care Hospital presentation to the House Human Services Committee; 1/15/15

**VMS recommends identifying, quantifying, and tracking patients with high acuity in order to ensure that the system has the capacity to care for them.** It is unclear what is causing the increased acuity of psychiatric patients. It could be caused by the lack of capacity and flow in the system, or it could be due to other factors, such as trauma, substance abuse, genetics, or environmental causes. If acuity is increasing separate and apart from the lack of capacity in the system, Vermont needs to plan for these patients.

**VMS recommends identifying funding to support the creation of a psychiatric resource plan for Vermont.** In collaboration with the Department of Mental Health, the Vermont Psychiatric Association (VPA), the Vermont Association of Hospitals and Health Systems (VAHHS), and the designated agencies, the VMS Education and Research Foundation (VMSERF) will develop consensus recommendations for a psychiatric resource plan based on analyses and predictions of future need. Recommendations will:

- Identify Vermont needs for psychiatric services, programs, and facilities;
- Understand what resources are required to meet those needs; and
Develop priorities for addressing those needs on a statewide basis.

Developing the decentralized mental health system in Vermont
Commissioner Dupre explained that a new and decentralized mental health care system is in the process of being built out across Vermont. In theory, as other parts of the system come on line there will be increased step-down capacity that will allow patients in Level 1 beds to move out enabling waiting patients to move into Level I beds. Increased capacity in the community outpatient system should also take the pressure off the demand for Level I inpatient beds. Soteria House will open 5 community beds in 2015, primarily for patients seeking to avoid medication. The Department of Mental Health is working on developing a permanent 14-bed secure residential facility that will replace the current 7-bed secure residential facility in Middlesex. Planning is underway for the permanent facility as is a search for an appropriate site. This facility will cost about $12 million, and the Department of Mental Health will need help advocating for this funding. This facility is still in the planning phase and will not be online for several years. The Department is also investigating the possibility of opening a sub-acute program where patients could be held involuntarily for 23 hours. Arizona and Delaware have these programs.

VMS recommends tracking the capacity, usage, length of stay and readmissions at all levels of the inpatient and outpatient mental health system.

Centralized Triage System for Level 1 patients
At the meeting, the group discussed the possibility of creating a centralized triage system that could identify available inpatient and outpatient services throughout the system and find placements for patients. Currently the Department of Mental Health emergency team and care managers work on allocating beds and other resources, and the screeners from the designated agencies are also calling the inpatient hospitals seeking placements. The screeners on duty can change every day which reduces continuity. Jonathan Weker, MD noted that a bed board system existed in the past.

The Commissioner observed that hospitals may want to work on the placements for the patients in their emergency departments. Similarly, the hospitals and other programs, including the VPCH, may wish to evaluate patients for admission that they can serve in their milieu. It appears that, in some cases, patients with higher acuity may wait longer for placements than patients with lower acuity.

VMS recommends that psychiatric patients with the highest acuity be prioritized for immediate placement.

Act 79 (2012) required the Department of Mental Health, in consultation with providers such as the designated agencies, to establish a clinical resource management system to coordinate “the movement of individuals across the continuum of care to the most appropriate services.” Act 79 requires

- State-employed clinical resource management coordinators to work with community partners, including designated agencies and hospitals, to ensure access to services for individuals in need;
- Coordinators to be available 24/7 to assist emergency service clinicians in the field;
- The system to include “an electronic, web-based bed board to track in real time the availability of bed resources across the continuum of care;” and
• The Department to create level-of-care descriptions, including criteria for admission, continuing stay, and discharge.


At the Mental Health Oversight Committee meeting on October 3, 2014, the Department of Mental Health reported that the Department’s care management services are available during the weekend. The care management team meets weekly with hospitals to review all involuntarily hospitalized patients, monitors voluntary and involuntary patients waiting for inpatient beds, and facilitates transitions between levels of care. DMH has established a web-based bed board and has established criteria for Level 1 patients.

*VMS recommends that the Department of Mental Health provide all emergency departments contact information for the Department’s clinical resource management coordinators, and the criteria for admission to, continuing stay at, and discharge from all services in the continuum of care. In addition, emergency departments with waiting patients should be able to access the Department’s web-based bed board to identify potential placements for their patients.*

**Cultural change needed in the mental health system**

Part of the problem identified by the Commissioner is that the entire mental health system is still adjusting to the new decentralized system and this requires a culture change. In the past once a patient was admitted to the Vermont State Hospital, there was no urgency to move them to a lower level of care. Now, with patients waiting in emergency departments, it has become important to discharge patients from Level 1 beds as soon as it is clinically appropriate in order to open Level 1 beds for patients who are waiting in emergency departments. In the past, discharges could be delayed for reasons not related to clinical care, such as holidays.

**Use of new legal tools**

The commissioner noted that another part of the cultural change that is needed is to increase use of the available legal tools, such as outpatient orders of non-hospitalization, and early filing for involuntary medication. Clinicians, facilities, designated agencies and the legal system are all becoming more familiar with the new rules and timeliness of decisions for involuntary treatment created in Act 192 and outlined below. Dr. Desjardins testified that the time patients wait for involuntary medication is still too long and that the definitions of “acute” and “imminent” harm are still too narrow, although it is helpful in the small number of cases when commitment and medication cases are combined.

**Act 192 – Improvements to Commitment and Involuntary Medication Court Processes**

1. Effective November 1, 2014, the involuntary commitment process can begin in the emergency department, if that is where the patient is being held, instead of waiting until a Level 1 bed is found before filing for commitment. An examination by a psychiatrist is required within 24 hours after the patient arrives involuntarily in the ED, and an application for involuntary
treatment must be filed by the Commissioner of Mental Health within 72 hours after the emergency examination even if the patient is still in the emergency department.

2. Patients are deemed to be in temporary custody of the Commissioner of Mental Health when the psychiatrist certifies that the person needs involuntary treatment — within 24 hours of arrival. The commissioner is required to ensure that patients receive temporary care and treatment in the least restrictive manner necessary to protect their safety and the public's safety and that respects their privacy and prevents physical and psychological trauma.

3. Expedited review of commitment cases may be ordered by the court for patients who demonstrate a risk of causing serious bodily injury and for patients who received involuntary medication in the past two years if it unlikely that delay will lead to a therapeutic relationship of restoration of competence. In expedited cases, hearings must be held in 10 days, although the law permits limited continuances.

4. Applications for involuntary medication may be filed prior to commitment orders in cases that are expedited due to risk of serious bodily injury and in cases where the case has been pending for 26 days without a hearing. In these cases the court must consolidate the commitment and medication hearings and hold a hearing within 10 days.

Link to Summary of Act 192:

VMS recommends monitoring the earlier filing of applications for involuntary treatment and the use of the new expedited commitment and involuntary medication provisions to determine whether these changes in the law enable patients to access care in a timely manner.