

**VERMONT'S INPATIENT PSYCHIATRIC SERVICE SYSTEM**

Care Management System; System Description Sub-Committee

09/29/2006

**ENTITIES PROVIDING FEEDBACK:**

Care Management System Committee  
Docking Station Project – in conjunction with statewide CRT directors  
VSH Medical Staff  
Designated Hospitals Meeting  
Statewide Inpatient Medical Directors Meeting  
Hospital & Community Psychiatrists Meeting  
Statewide Standing Committee on Mental Health

**SYSTEM FUNCTION REPRESENTED:**

Vermont's Inpatient Psychiatric Service System

**CURRENT LOCATION:**

Vermont State Hospital (VSH)  
Fletcher Allen Health Care/UVM (FAHC/UVM)  
Brattleboro Retreat (BBR)  
Rutland Regional Health Care (RRHC)  
Central Vermont Hospital (CVH)  
Wyndham Center (WC)

**FUTURE LOCATION:**

Fletcher Allen Health Care/UVM (FAHC/UVM)  
Brattleboro Retreat (BBR)  
Rutland Regional Health Care (RRHC)  
Central Vermont Hospital (CVH)  
Wyndham Center (WC)

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SECTION A: LEVELS OF SERVICE & THE CARE MANAGEMENT SYSTEM

There shall be three (3) levels of inpatient psychiatric service provided in Vermont:

I. *General Inpatient Psychiatric Services*

II. *Specialized Inpatient Psychiatric Services*

III. *Intensive Inpatient Psychiatric Services*

I. CVH, WC, RRHC, BBR, and FAHC/UVM will provide *General Inpatient Psychiatric Services* (see below)

- CVH and WC will work with patients whom they determine they can be safely manage
  - If CVH and/or WC determine they cannot safely care for a patient, they will be transported to the closest Specialized Inpatient Psychiatric Services hospital
- *All five (5) Designated Hospitals (DHs) are able to apply for commitment; this is therefore not a basis for transfer*
  - *Patients who are treatment resistant/refractory with sustained prominent symptoms and/or low level of functioning may be transferred to Specialized Care Hospitals*
- Qualified Mental Health Professionals (QMHPs) will initially present a potential admission to the geographically most proximate hospital
  - Lack of ability to pay is not a reason for admission outside a DH catchment area
- All five (5) DHs accept warrants
  - *Emergency Examinations certified by a non-psychiatrist when it no psychiatrist is available in the community may go to the local DH*

II. In addition to providing *General Inpatient Psychiatric Services*, RRHC, BBR, and FAHC/UVM will also provide *Specialized Inpatient Psychiatric Services* (see below) on a limited basis

- RRHC and BBR shall take all persons in need of admission from the southernmost 4 counties (name them)
  - Ability to safely contain “intensive” level patients on a time-limited basis
  - RRHC and/or BBR may determine that they are not able to provide adequate care needed for highly acute patients after an initial period of evaluation.
    - In such instances, patients will be transported to FAHC/UVM
  - The only reason for transfers to occur from RRHC and BBR will be for patients that cannot be safely managed (including complex non-psychiatric medical conditions) in an ongoing manner or for assistance with complex diagnostic procedures
- FAHC/UVM shall take all persons in need of admission from the remaining 10 counties (name them)
- RRHC, BBR, and FAHC/UVM shall operate on a “no decline” policy

III. In addition to providing *General Inpatient Psychiatric Services* and *Specialized Inpatient Psychiatric Services*, FAHC/UVM will provide *Intensive Inpatient Psychiatric Services* (see below) on a non-limited basis

- FAHC/UVM will take referrals from RRHC and BBR who are determined to need *Specialized Inpatient Psychiatric Services* admitted from one of the southernmost 4 counties (name them) after an attempt has been made to assess and manage them.

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SECTION B: GENERAL INPATIENT PSYCHIATRIC SERVICES

*Admission Criteria for General Inpatient Psychiatric Services:*

1. Client must have a diagnosed or suspected mental illness.
2. Client is determined to be one of the following:
  - a. danger to self;
  - b. danger to others;
  - c. unable to care for self;
  - d. unable to care for others in his/her care;
  - e. in need of 24 hour medical supervision for the treatment of a mental disorder and a complicating medical factor;
  - f. in need of rapid evaluation and there is significant risk of deterioration;
  - g. in need of medication trials which involve significant risk;
  - h. unable to be managed at a lower level of care;
  - i. appropriate for lower level of care but no less intensive alternative is available.

*Roles Provided By General Inpatient Psychiatric Services:*

**a) Role #1: Emergency Evaluations (Civil) and Misdemeanants (Forensic)**

- i) Meets criteria for hospitalization*
- ii) Assessed not to be too disruptive for the milieu*
- iii) Likely no prominent history of violence*

**b) Role #2: Ongoing Treatment (Civil)**

- i) Acute Stabilization*
- ii) Meets criteria for hospitalization*
- iii) Not assessed to be too disruptive to the milieu*
- iv) Likely no prominent history of violence*
- v) Likely not a prominent elopement risk*
- vi) Medication acceptance, or application for involuntary medication pending*
- vii) Treatment responsive with improved level of functioning*
- viii) No prominent aftercare placement issues*

**c) Role #3: Court-ordered evaluations (Forensic)**

- i) Not a prominent public safety risk*
- ii) Not a prominent elopement risk*

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**SECTION C: SPECIALIZED & INTENSIVE INPATIENT PSYCHIATRIC SERVICES**

***Admission Criteria for Specialized Inpatient Psychiatric Services:***

1. Meets Generalized Inpatient Psychiatric Services admission criteria and one or more of the following:
  - a. risk of harm such that there is current suicidal or homicidal behaviors with intention or repeated episodes of violence and/or harmful behavior toward self or others with pattern of nearly continuous attempts;
  - b. no natural or community supports available;
  - c. multiple recent hospitalizations or prolonged (greater than 30 days) hospitalization;
  - d. severe inability to function as demonstrated by:
    - i. inappropriate or unintelligible communication
    - ii. threatening behaviors with little or no provocation
    - iii. total withdrawal from all social interactions
    - iv. inability to attend to the most basic daily needs such as personal hygiene, appearance, or nutrition, extreme weight change and extreme sleep disruption causing serious harm to physical/mental health;
    - v. evidence of complete inability to maintain any aspect of personal responsibility in the community;
  - e. no employment is likely without support;
  - f. homeless except for emergency shelter;
  - g. significant substance use;
  - h. significant involvement with the criminal justice system;
  - i. significant medical co morbidity requiring medical monitoring;
  - j. stressful community environment as evidenced by traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
    - i. ongoing injurious and abusive behaviors from family members;
    - ii. witnessing or being a victim of extremely violent incidents;
    - iii. persecution by a dominant social group;
    - iv. sudden or unexpected death of loved one;
    - v. unavoidable exposure to drug use and active encouragement to participate in use
    - vi. sustained inability to meet basic needs for physical and material well being;
    - vii. chaotic and constantly threatening environment;
  - k. poor to negligible response to treatment;
  - l. rarely able to accept reality of illness or any disability which accompanies it, has no desire to adjust behavior, relates poorly to treatment and treatment providers with extremely narrow ability to trust, avoids contact with and use of treatment resources if left to own devices, does not accept any responsibility for recovery.

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*Admission Criteria for Intensive Inpatient Psychiatric Services:*

1. Meets Specialized Inpatient Psychiatric Services admission criteria and poses a risk of harm to self or others requiring 1:1 staffing or more intensive intervention(s) to maintain safety.

*Roles Provided By Specialized & Intensive Inpatient Psychiatric Services:*

**a) Role #1: Conduct Emergency Examinations (EEs) (civil)**

- i) No room at Generalized Inpatient Psychiatric Services*
- ii) Too acute for Generalized Inpatient Psychiatric Services*
- iii) Prominent history of violence*

**b) Role #2: Provide Ongoing Treatment (Civil)**

- i) Too Acute for Generalized Inpatient Psychiatric Services*
- ii) Prominent history of violence*
- iii) Requires court-ordered involuntary medications.*
- iv) Treatment resistant/refractory with sustained prominent symptoms and/ or low level of functioning.*
- v) Aftercare placement issues.*

**c) Role #3: Court Ordered Evaluation (Forensic)**

- i) Significant danger to self and/ or others*
- ii) Significant public safety risk*
- iii) Felony or misdemeanor charges*

**d) Role #4: Ongoing treatment (Forensic)**

- i) As ordered by the court*
- ii) Transfers from corrections*

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*Emergency Involuntary Procedures Available at Hospitals Providing Specialized & Intensive Inpatient Psychiatric Services:*

- Emergency Involuntary Medication.....YES
- Seclusion:
  - Locked Door Seclusion in a seclusion room.....YES
- Restraints:
  - 4-Point.....YES
  - 5-Point.....YES
  - Belt & Wristlets.....YES
  - Posey Vest Chair for behavior management during a psychiatric emergency.....YES
  - Posey Vest Bed for behavior management during a psychiatric emergency.....YES

*Non-Emergency Involuntary Procedures Available at Hospitals Providing Specialized & Intensive Inpatient Psychiatric Services:*

- Non-Emergency (Court-Ordered) Involuntary Medication.....YES

*Treatment Considerations Provided Through Specialized & Intensive Inpatient Psychiatric Services:*

Characteristics of serious mental illness that are important to emphasize because of their crucial impact on treatment include:

1. **Chronicity.** Although not all patients with schizophrenia and affect psychosis develop a chronic course, many do. Chronicity implies that the illness, or the risk of relapse, persists, to some degree, for a longtime-often for the patient's entire life.
2. **Potential for Deterioration.** While people with schizophrenia and affect psychosis can be treated successfully and can make progress, in a deteriorating if the disease is untreated, or if they are repeatedly non-adherent with treatment.
3. **Denial.** Denial is a common characteristic of chronic mental illnesses that may be related, at least in part, to the cognitive deficits associated with the psychotic process. The chronically psychotic patient who cannot accurately perceive the severity of his or her illness is likely not to comply with treatment, and consequently to have a poor outcome.
4. **Disability.** Even when these illnesses are stabilized with medication, significant disability often remains. This disability may be primary, resulting from continuation of symptoms or ongoing deficits in cognitive processing due to the illness; secondary, due to lack of motivation or demoralization resulting from persistent symptoms; and/or tertiary, due to social rejection or stigma as a consequence of exhibiting illness related behavior. All three types of disability or a direct result of the biological disorder and must be addressed for treatment to proceed.

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***Elements of Care for Specialized & Intensive Inpatient Psychiatric Services:***

- ❖ Disease Model: Treating the Biological Illness
  1. Make an accurate diagnosis.
  2. Stabilized symptoms pharmacologically.
  3. Assessed baseline functioning.
  4. Relieve patient and family of responsibility for causing the illness.
  5. Mobilize patient and family as allies in managing the illness.
- ❖ Psychosocial Component: Treating the Person
  1. Perform a multidimensional, longitudinal assessment.
  2. Educate the patient and family to overcome denial.
  3. Implement a plan to prevent treatment non-adherence.
  4. Help patient and family develop new coping skills.
- ❖ Long-term Program of Rehabilitation and Recovery
  1. Maintain long-term stabilization and treatment compliance.
  2. Define attainable "next step" goals and objectives.
  3. Develop a long-term treatment plan to attain these goals.
  4. Address ongoing feelings of impatience and frustration to maintain proper pace of progress.
  5. Help patient and family to maximize self-acceptance, autonomy, and dissatisfaction with life despite persistence of the illness.

**In order to create and maintain a system that can meaningfully provide the *Elements of Care for Specialized & Intensive Inpatient Psychiatric Services*, all hospitals providing these levels of care shall:**

- a) participate in the creation and maintenance of a shared information system in order to facilitate the availability of relevant medical records to inform clinical decision-making;
- b) participate in a care management system (outlined in Section A);
  - i. participate in the creation and maintenance of a bed management system
- c) maintain staffing ratios which permit the use of 1:1 and 2:1 staff to patient coverage when clinically indicated;
- d) maintain availability of psychiatrists such that
  - i. a covering psychiatrist shall be physically present on the participating unit no longer than 30 minutes after being called, 24 hours a day/365 days per year;
  - ii. a covering psychiatrist shall be available to assess and admit (if indicated) new patients 24 hours a day/365 days per year;
- e) use common treatment documentation templates including but not limited to
  - i. the treatment planning system developed at the Vermont State Hospital & Fletcher Allen Health Care

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- f) use common clinical protocols including but not limited to
  - i. medication formularies
  - ii. maximum dose levels
  - iii. clinical practice guidelines
  - iv. LOCUS scales on all admissions and discharges
  - v. LOCUS risk scale as a daily level of risk indicator
- g) use common clinical programs including but not limited to
  - i. the UCLA social skills training modules
- h) use a common Quality Improvement/Utilization Review system

additional notes to be addressed:

>United Health Consortium (UHC) benchmarks for LOS. Bob justifies this to FAHC.

-can this be adjusted for public pts?

-new edits beyond Medicaid?

>Economic viability of unit, certain % of "non-paying pts" or newly created funding stream for public pts.

-how does Medicaid reimbursement rate factor in?

-what is % of Medicaid-eligible public patients?

>legal system is not organized to help-turnaround time for court proceedings-

-compare all states/ave length of time to medicate