THE LEGISLATIVE BULLETIN

A publication of the Vermont Medical Society

Week of February 24, 2014

S. 287 – Mental Health – Involuntary Medication

Consistent with the VMS Policy on Acute Inpatient Mental Health Care adopted at the February 2014 VMS Council meeting, VMS is working to pass S. 287, a bill that would ensure that acutely ill patients receive treatment in a timely manner. VMS has joined the Vermont Association of Hospitals and Health Systems (VAHHS), the Department of Mental Health, FAHC and others in an effort led by Jill Olson of VAHHS to gain legislative support to pass this bill. S. 287 has now been voted out of the Senate Health and Welfare Committee and the Senate Judiciary Committee favorably, clearing the first two hurdles for this bill, which will next be debated on the Senate floor and then reviewed by the House Judiciary and Human Services Committees.

Delayed treatment for acutely ill patients with psychiatric illness is a serious problem in Vermont. Data from the Vermont Department of Mental Health found that the average time from a patient's admission to a medication order that permits a physician to administer or prescribe medication for the patient over their objection was 72 days.

Similarly, a national survey of Mental Health Commitment Laws, done by the Treatment Advocacy Center (http://tacreports.org/state-survey) found that Vermont was one of a very few states where there were significant delays in delivering medication over objection: "In Vermont and New Hampshire, the typical delay in providing medication over objection to individuals in psychiatric crisis who were unable to recognize their need for treatment was found to be more than two months."

Expedited Review of Applications for Involuntary Medication
The amended version of the bill expressly permits the court to authorize an expedited review. If the court grants the expedited review, a hearing would be required to be held within seven to 10 days after the expedited hearing is ordered. Medication cases that are not expedited may take up to 20 days and even longer if continuances are granted when they are requested by the attorneys for the patient or the state.

The expedited review would be permitted for patients who, even when hospitalized, demonstrate a risk of causing "serious bodily injury" to self or others, if other clinical interventions have failed to reduce that risk. The term "serious bodily injury" is narrowly defined as injury that creates a substantial risk of death, impairment of function, impairment of health, or disfigurement. Expedited reviews are also available for patients who have received involuntary medication in the past two years and experienced significant clinical improvement as a result of the treatment.

Timing of an Application for Involuntary Medication - Consolidated Hearings for Commitment and Medication
Currently, an application for involuntary medication cannot be filed to start the process until after the court orders involuntary commitment and in Vermont it takes an average of 51 days to obtain a commitment order. Because the involuntary medication order takes an additional 21 days on average, patients who need medication can end up waiting more than 10 weeks before their clinicians are permitted to prescribe or administer medication for them. S. 287 would permit an application for involuntary medication to be filed at any time after an application for involuntary commitment is filed. The bill also allows the court to combine the hearings for commitment and medication if consolidation would be in the interests of the patients, but the commitment order would be required to precede the medication order.

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S. 295 Office-Based Opioid Treatment

S. 295 started out as a bill intended to require risk assessments and screenings for persons cited for certain offenses related to substance abuse and to create treatment alternatives to the criminal justice model for these individuals, such as pre-charge programs. After hearing concerns about diversion and abuse of buprenorphine, particularly in the correctional system, the Senate Judiciary Committee amended the bill to include additional provisions to address those concerns.

List of Approved Prescribers of Buprenorphine
S. 295, as voted out of the Senate Judiciary Committee, requires the Department of Health to create a list of prescribers of buprenorphine, licensed in Vermont and outside of Vermont, who prescribe to Vermont residents. To be added to the list, prescribers would be required to receive a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA), to have a special DEA number, and to meet other standards established by the Vermont Department of Health by rule. A physician would have to notify the Commissioner of Health in writing of his or her intent to be included on the list. The list of approved prescribers would be provided to pharmacies and pharmacies would only be authorized to dispense buprenorphine if the prescription was written by a physician on the approved list.

Querying the Vermont Prescription Monitoring System
The bill requires a physician participating in Vermont Medicaid who prescribes buprenorphine for a Medicaid patient to query the Vermont Prescription Monitoring System (VPMS). This provision applies to physicians licensed in or outside of Vermont. Checking the VPMS is already required by the Department of Health Access (DVHA) for Medicaid patients, but S. 295 would require the Secretary of Human services to address this formally in rules.

Counseling for Patients Receiving Medication Assisted Treatment
The bill requires the Department of Health to adopt rules for physicians treating fewer than 30 patients receiving medication–assisted therapy for opioid dependence. The rules would be required to include a requirement addressing substance abuse counseling.

Several provisions of concern to VMS were removed in the Senate Judiciary Committee. Earlier versions of the bill would have required physicians prescribing Buprenorphine to 10 or more patients to comply with the Department of Health's 24-page Medication Assisted Therapy Rules, which now only apply to methadone clinics and to buprenorphine prescribers with 30 or more patients in their practice. The bill also would have required the Department of Health to post a list of buprenorphine prescribers on its public website with names and addresses and would have prohibited any physician who had been the subject of licensing board discipline related to prescribing, from prescribing Buprenorphine.

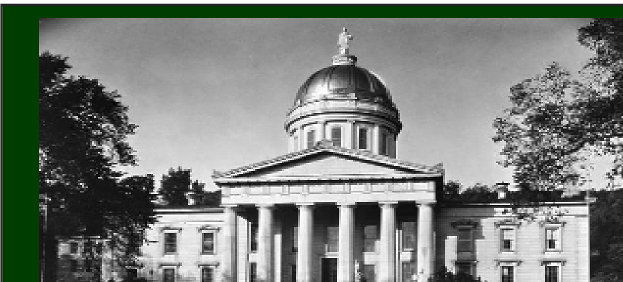
The bill is now in the Senate Health and Welfare Committee and VMS will work with the committee as it marks up the bill to reduce administrative burdens for physicians.

Link to the bill: *http://bit.ly/N3s5o5*

H.62 – Prohibiting the Handheld Use of a Portable Electronic Device while driving

This bill would prohibit the handheld use of a portable electronic device to engage in voice communications while operating a moving motor vehicle. The bill passed the house last week with an amendment to allow activation or deactivation of hands-free use as long as the device is in a cradle or otherwise securely mounted in the vehicle.

At its 2011 Annual Meeting VMS passed a resolution urging the Vermont General Assembly to enact a law banning the use of hand-held communication devices while driving. VMS testified in both the House Judiciary and Transportation committees, as well as the Senate Transportation committee.



The Vermont Medical Society is the leading voice of physicians in the state and is dedicated to advancing the practice of medicine by advocating on behalf of Vermont's doctors and the patients and communities they care for.

H.762 – The Adverse Childhood Experience Questionnaire

This bill as originally introduce would have required a patient's Blueprint for Health medical home to use the Adverse Childhood Experience (ACE) Questionnaire in assessing the patient's health risks. It also would have made Medicaid reimbursement of primary care practitioners' contingent upon the use of the questionnaire.

The ACE Questionnaire contains ten questions pertaining to abuse, neglect and family dysfunction. It is used to measure childhood exposure to traumatic stressors. Based on a respondent's answers to the questionnaire, an ACE Score is calculated, which is the total number of categories of ACEs reported by a respondent.

According to the Centers for Disease Control and Prevention, the greater the number of ACEs experienced by a respondent, the greater the risk for the following health conditions and behaviors: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, obesity, illicit drug use, Ischemic heart disease, liver disease, intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, and unintended pregnancies.

VMS, the American Academy of Pediatrics Vermont Chapter and the Vermont Academy of Family Physicians testified that while this work is very exciting, and we look forward to future publications on the work that is being conducted now, it does not appear that we yet have evidence to support mandating the use of the ACE tool by primary care providers, nor tying primary care reimbursement to its use.

Rather than proposing to mandate use of a screening tool whose real value and meaning is still under investigation, we would encourage to look for every opportunity to use supportive means to encourage medical practice according to national standards, to incorporate this topic into the education of health and human services professionals, and to promote the voluntary use of guideline-based care using quality improvement methodology such as that conducted by the Vermont Child Health Improvement Program. In the child health arena, this translates to support for application of what we know works: early and continuous developmental screening according to the Bright Futures Guidelines, and greater investment in a child- and family-centered system of care that is focused on primary prevention and early intervention.

Testimony also focused on the lack of a clear path to appropriate follow-up interventions that have yet to be defined and the availability of resources for patients.

Last week the House Health Care Committee dramatically amended the bill to include:

- An additional per member, per month payment to each health care provider participating in the Blueprint for Health that uses the Adverse Childhood Experience Questionnaire;
- Creation of a family wellness coach pilot program, in at least five community health teams, using the Vermont Center for Children, Youth and Families' Vermont Family Based Approach;
- Creation of a pilot program within at least five school districts using the Vermont Center for Children, Youth and Families' Vermont Family Based Approach;
- Creation by the Agency of Human services of a Trauma-Informed Care Coordinator;
- Creation by the Commissioner of Health of a director of Adverse Childhood Experience, Treatment and Prevention;
- Asking the University of Vermont's College of Medicine and School of Nursing to consider including in its curriculum information on the ACE Study; and,
- Directing the Vermont Board of Medical Practice in collaboration with VMS and the VMS Foundation to develop educational materials pertaining to the ACE study.

VMS will continue to advocate that evidence to support mandating the use of the ACE tool by primary care providers is not there and more information, education and resources are needed.

To read the full text of the bill go to *http://bit.ly/1hg4yeu*.

Involuntary Medication

(Cont'd from pg. 1) **Stay of Involuntary Medication Order**
S. 287 will amend the court rules to remove an automatic 30-day stay for involuntary medication orders, and allow medication orders to go into effect as soon as they are issued by the court. Stays could still be authorized in some cases, if medication orders are appealed to the Vermont Supreme Court, and certain conditions are met.

Adequate Number of Psychiatrists to Perform Independent Evaluations
Section 9 directs the Agency of Human Services to determine if funding to the Mental Health Law Project (MHLP) may be made contingent on the MHLP contracting with a sufficient number of psychiatrists to conduct psychiatric examinations in the time frames established in law.

Link to VMS Council Policy: *http://bit.ly/1gOYqZP*
Link to bill as approved by Senate Judiciary: *http://bit.ly/1cQeXMq*
Link to Senate Health & Welfare Amendment: *http://bit.ly/1hoXRGl*

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