Agency Legislative Proposal - 2021 Session

Document Name: 10012020_DMHAS_HealthCareEntity

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: DMHAS

Liaison: Mary Kate Mason
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Lead agency division requesting this proposal: Commissioner's Office

Agency Analyst/Drafter of Proposal: Mary Kate Mason

Title of Proposal: An Act Designating the Department of Mental Health and Addiction Services as a Single Health Care Entity

Statutory Reference: 17a-450

Proposal Summary:
Designating DMHAS as one health care entity would allow the use of one electronic medication record with an order entry and prescribing system that all clinical staff can use for consistent documentation across all DMHAS clinics and hospitals. Digitalization of Personal Health Information in an electronic medical record has been shown to have many advantages. DMHAS patients could benefit from safe care and the Department could realize an increase in efficiency and cost savings.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

Without this legislation DMHAS is unable to implement an agency wide EHR that allows holistic, efficient care. A single electronic health record (EHR) used by all DMHAS facilities would all DMHAS patient health information to be shared in real time. Patients at DMHAS often transfer their services between the facilities run by the agency. Currently statutory interpretation has been that DMHAS facilities are separate entities. As separate entities each facility would be required to purchase their own EHR. Individual EHR's do not allow for real time sharing of information including: diagnosis, medication trails, allergies, laboratory reports etc. A common EHR would eliminate the cost of the electronic prescribing system currently utilized by DMHAS to comply with state statute (21a-249(b). Work flow can be streamlined by prescribers immediately placing orders or prescriptions and medical records can be

securely shared with multiple DMHAS providers throughout the system. Complete documentation can be done at point of service which can improve coding and billing. Costs can be reduced through Decreased use of paper and storage of record and employee time spent printing and filing. A single EHR would improve patient care and safety can improve by reducing errors and avoiding reduplication of tests and enhancing care coordination

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share: *(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* *(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?* *(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?* *(4) What was the last action taken during the past legislative session?* This proposed legislation passed out of committee but was not taken up for a vote in the Senate due to the curtailed legislative session.

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: **Agency Contact (*name, title, phone*):** **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* n/a
State n/a

Federal n/a
Additional notes on fiscal impact n/a

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Designating DMHAS as one health care entity would allow the use of one electronic medication record with an order entry and prescribing system that all clinical staff can use for consistent documentation across all DMHAS clinics and hospitals. Digitalization of Personal Health Information in an electronic medical record has been shown to have many advantages. DMHAS patients could benefit from safe care and the Department could realize an increase in efficiency and cost savings.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs. N/A- this is not a program proposal.

Insert fully drafted bill here

Sec. 17a-450. (Formerly Sec. 17-207b). Department of Mental Health and Addiction Services. Functions and duties. (a) There shall be a Department of Mental Health and Addiction Services headed by a Commissioner of Mental Health and Addiction Services, appointed by the Governor with the advice of the Board of Mental Health and Addiction Services established pursuant to section 17a-456.

(b) For the purposes of chapter 48, the Department of Mental Health and Addiction Services be organized to promote comprehensive, client-based services in the areas of mental health treatment and substance abuse treatment and to ensure the programmatic integrity and clinical identity of services in each area. The department shall perform the functions of: Centralized administration, planning and program development; prevention and treatment programs and facilities, both inpatient and outpatient, for persons with psychiatric disabilities

or persons with substance use disorders, or both; community mental health centers and community or regional programs and facilities providing services for persons with psychiatric disabilities or persons with substance use disorders, or both; training and education; and research and evaluation of programs and facilities providing services for persons with psychiatric disabilities or persons with substance use disorders, or both. The department shall include, but not be limited to, the following divisions and facilities or their successor facilities: The office of the Commissioner of Mental Health and Addiction Services; Capitol Region Mental Health Center; Connecticut Valley Hospital, including the Addictions Division and the General Psychiatric Division of Connecticut Valley Hospital; the Whiting Forensic Hospital; the Connecticut Mental Health Center; Ribicoff Research Center; the Southwest Connecticut Mental Health System, including the Franklin S. DuBois Center and the Greater Bridgeport Community Mental Health Center; the Southeastern Mental Health Authority; River Valley Services; the Western Connecticut Mental Health Network; and any other state-operated facility for the treatment of persons with psychiatric disabilities or persons with substance use disorders, or both, but shall not include those portions of such facilities transferred to the Department of Children and Families for the purpose of consolidation of children's services. All department divisions and facilities shall provide their patient records to the electronic health record system established pursuant to subdivision (7) of subsection (c) of this section. Disclosures of patient information from the electronic health record system outside of the department shall be in accordance with applicable federal and state law.

(c) The Department of Mental Health and Addiction Services may

(c) The Department of Mental Health and Addiction Services may:

(1) Solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services or property from the federal government, the state or any political subdivision thereof or any private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for any grant;

(2) Keep records and engage in research and the gathering of relevant statistics;

(3) Work with public or private agencies, organizations, facilities or individuals to ensure the operation of the programs set forth in accordance with sections 17a-75 to 17a-83, inclusive, 17a-450 to [17a-484] 17a-488a, inclusive, 17a-495 to 17a-528, inclusive, 17a-540 to 17a-550, inclusive, 17a-560 to 17a-575, inclusive, 17a-580 to 17a-603, inclusive, and 17a-615 to 17a-618, inclusive;

(4) Hold hearings, issue subpoenas, administer oaths, compel testimony and order production of books, papers and records in the performance of its duties;

(5) Operate trustee accounts, in accordance with procedures prescribed by the Comptroller, on behalf of inpatient and outpatient department clients;

(6) Notwithstanding [any] the provisions of sections 4-101 and 17b-239 [to the contrary,] establish medical reimbursement rates for behavioral health services including, but not limited to, inpatient, outpatient and residential services purchased by the department; and

(7) Establish and utilize an electronic health record system that allows authorized department personnel to have access to patient health information, including psychiatric records from any of the department's divisions and facilities set forth in subsection (b) of this section for purposes of (A) providing diagnosis and treatment, and (B) improving the department's health care operations, as defined in 42 CFR 164.501.

[(7)] (8) Perform such other acts and functions as may be necessary or convenient to execute the authority expressly granted to it.

(d) The Department of Mental Health and Addiction Services is designated as the lead state agency for substance abuse prevention and treatment in this state, and as such is designated as the state methadone authority. As the designated state methadone authority, the department is authorized by the federal Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration within the United States Department of Health and Human Services to exercise responsibility and authority for the treatment of opiate addiction with an opioid medication, and specifically for: (1) Approval of exceptions to federal opioid treatment protocols in accordance with the Center for Substance Abuse Treatment, (2) monitoring all opioid treatment programs in the state, and (3) approval of Center for Substance Abuse Treatment certification of all opioid treatment programs in the state. The Commissioner of Mental Health and Addiction Services may adopt regulations in accordance with chapter 54 to carry out the provisions of this subsection.

Agency Legislative Proposal - 2021 Session

Document Name: 10012020_DMHAS_Whiting Forensic Hospital

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: CT Department of Mental Health and Addiction Services

Liaison: Mary Kate Mason
Phone: (860) 418-6839
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Lead agency division requesting this proposal: Forensic Division

Agency Analyst/Drafter of Proposal: Mary Kate Mason

Title of Proposal: An Act Concerning Whiting Forensic Hospital

Statutory Reference: 17a-548 and 17a-565

Proposal Summary:
This proposal allows patients in the maximum security building at Whiting Forensic Hospital to be present during routine searches of personal belongings. It requires the appointment of a person with lived experience to the Whiting Advisory Board.

PROPOSAL BACKGROUND

◊ **Reason for Proposal**

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
(3) Have certain constituencies called for this action?
(4) What would happen if this was not enacted in law this session?

The DMHAS and the DMHAS Advocacy community believe strongly in patient and client rights. This proposal addresses areas where the statute does not include the voice of people with behavioral health disorders.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share:

(1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
(4) What was the last action taken during the past legislative session?

This proposal was submitted last session but did not receive a hearing due to the curtailed legislative session

PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: N/A **Agency Contact (*name, title, phone*):** **Date Contacted:** Approve of Proposal ☐ **YES** ☐ **NO** ☐ **Talks Ongoing**
Summary of Affected Agency's Comments
Will there need to be further negotiation? ☐ **YES** ☐**NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)*
State Two additional FTS staff for 1 shift per day (1 to do search, 1 to observe patient and maintain safety). Starting FTS salary is $51,000, two FTS would be $102,000
Federal
Additional notes on fiscal impact

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

Changes to 17a-548 may require increased staffing to allow staff to support clients during patient searches

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

N/A

Insert fully drafted bill here

Section 1. Section 14a-548 is repealed and the following is substituted in lieu thereof (Effective October 1, 2021):

Sec. 17a-548. (Formerly Sec. 17-206i). Patient's rights re clothing, possessions, money and access to records. List of rights to be posted. (a) Any patient shall be permitted to wear his or her own clothes; to keep and use personal possessions including toilet articles; to be present during any search of his or her personal possessions, except a patient hospitalized in the maximum security service of Whiting Forensic Hospital when such search is conducted by police officers and probable cause exists that contraband or hazardous items are hidden in the patient's living area; to have access to individual storage space for such possessions; and in such manner as determined by the facility to spend a reasonable sum of his or her own money for canteen expenses and small purchases. These rights shall be denied only if the superintendent, director or his or her authorized representative determines that it is medically harmful to the patient to exercise such rights. An explanation of such denial shall be placed in the patient's permanent clinical record.

(b) In connection with any litigation related to hospitalization, or at any time following discharge from the facility, any patient or his or her attorney shall have the right, upon written request, to inspect all of such patient's hospital records, and to make copies thereof. Unless the request is made in connection with any litigation related to hospitalization, a mental health facility, as defined in subdivision (5) of section 52-146d, may refuse to disclose any portion of a patient's record which the mental health facility determines: (1) Would create a substantial risk that the patient would inflict life-threatening injury to self or to others or experience a severe deterioration in mental state; (2) would constitute an invasion of privacy of another person; or (3) would violate an assurance of confidentiality furnished to another person, provided only such portion of the record the disclosure of which would not constitute an invasion of privacy of another person or violate an assurance of confidentiality furnished to another person shall be disclosed. Any patient aggrieved by a facility's refusal to disclose under this subsection may petition the Superior Court for relief in the same manner as a patient proceeding under section 4-105, except that in addition to notice and a hearing, the court may conduct an in camera review of the record. The court shall order disclosure of the record by such facility unless the court determines that the disclosure (A) would create a substantial risk that the patient would inflict life-threatening injury to self or to others or experience a severe deterioration in mental state, or (B) would constitute an invasion of privacy of

another person, or (C) would violate an assurance of confidentiality furnished to another person, provided if the court orders disclosure of the record, only such portion of the record the disclosure of which would not constitute an invasion of privacy of another person or violate an assurance of confidentiality furnished to another person shall be disclosed.

(c) A list of all in-hospital rights shall be prominently posted in each ward where mental health services are provided. Such list shall include, but not be limited to, the right to leave, as afforded by subsection (a) of section 17a-506, the right to a hearing, as afforded by subsection (d) of section 17a-502, and the right to file a complaint, as afforded by the hospital's complaint procedure.
(d) Nothing in subsection (b) of this section shall limit a patient's right of access to his records under section 4-104.

Section 2. Section 17a-565 is repealed and the following is substituted in lieu thereof (*Effective from passage*):

There shall be an advisory board for Whiting Forensic Hospital, constituted as follows: The Commissioner of Mental Health and Addiction Services, two people with psychiatric disabilities, at least one of whom has received inpatient services in a psychiatric hospital, three physicians licensed to practice in this state, two of whom shall be psychiatrists, two attorneys of this state, at least one of whom shall be in active practice and have at least five years' experience in the trial of criminal cases, one licensed psychologist with experience in clinical psychology, one licensed clinical social worker, and one person actively engaged in business who shall have at least ten years' experience in business management. Annually, on October first, the Governor shall appoint a member or members to replace those whose terms expire for terms of five years each. The board shall elect a chairman and a secretary, who shall keep full and accurate minutes of its meetings and preserve the same. The board shall meet at the call of the chairman at least quarterly. Members of the board shall receive no compensation for their duties as such but shall be reimbursed for their actual expenses incurred in the course of their duties. Said board shall confer with the staff of the hospital and give general consultative and advisory services on problems and matters relating to its work. On any matter relating to the work of the hospital, the board may also confer with the warden or superintendent of the affected Connecticut correctional institution.