

**Joint Subcommittee to Study Mental Health Services
in the Commonwealth in the 21st Century
Work Group #3: Crisis and Emergency Services
Meeting Summary
Monday, August 22, 2016
House Room 2, The Capitol, Richmond, Virginia**

Work Group #3: Crisis and Emergency Services (the Work Group) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) held its second meeting of the 2016 interim on Monday, August 22, 2016, at the Capitol in Richmond. Work Group members Delegate Garrett (chair), Senator Barker, and Delegate Yost were present.

Presentation: Dr. Anita Clayton and Dr. Richard Merkel, Department of Psychiatry and Neurobehavioral Sciences, University of Virginia School of Medicine

Following the call to order and opening remarks, Dr. Clayton and Dr. Merkel presented an overview of telepsychiatry and the telepsychiatry experience at the University of Virginia (UVA). They noted that the practice of telepsychiatry is as effective and reliable as in-person psychotherapy and health care management. Dr. Merkel explained that patients are seen at 31 UVA telepsychiatry partner sites throughout the Commonwealth. He noted that the practice began 18 years ago at UVA and that, over that time period, 19,069 child and adolescent encounters, 6,907 adult encounters, and nearly 7.4 million miles of travel have been saved by the practice. The practice is most commonly used for individuals in the Commonwealth experiencing post-traumatic stress disorder, anxiety, depression, and substance abuse issues. Nationwide, he explained, the practice has been predominantly used in outpatient settings, correctional institutions, and emergency rooms, but its use is increasing in inpatient and home health care settings.

Dr. Merkel then delineated the differences between two main models of telepsychiatry: the Consultation Care Model (Consultation Model) and the Collaborative Care Model (Collaborative Model). He explained that, in the Consultation Model, a local clinic identifies a patient who is then referred to UVA's telepsychiatry center for consultation. After the consultation, UVA makes recommendations to the patient and local provider; the local provider is then responsible for acting on the recommendations. Further contact between UVA and the local provider, or between UVA and the patient, is possible but is not required. Dr. Merkel then explained that, in a Collaborative Model, a local clinician is identified and oversees the mental health care, acting more as a behavioral health consultant. The local clinician serves as a bridge between local providers and the UVA team, facilitating frequent contact between the provider and UVA team. By one measure of comparison, Dr. Merkel noted, the rate of failure of patients to show up for their telepsychiatry appointments is 20 percent lower where the Collaborative Model is utilized.

Dr. Merkel then discussed the results of a telepsychiatry survey given to some patients who utilized the practice at UVA. He pointed out that, on average, individuals rated their anxiety

level prior to an appointment at 2.71 on a scale of 1 to 4, with 1 indicating "not at all" and 4 indicating "very much." The average reported anxiety level after the telepsychiatry appointment dropped to 1.85. The average satisfaction rate with the practice was 3.57 out of 4, and the average likelihood of making another appointment with UVA was 3.92 out of 4.

Dr. Merkel explained some of the problems with the practice, including (i) long waits for follow-up appointments in many cases, (ii) low reimbursement rates for providers, (iii) lack of psychiatric provider availability, (iv) a high no-show rate, (v) difficulty in identifying cases for referral by a primary care physician, (vi) stigma attached to seeking care, and (vii) that the telepsychiatry structure may be confusing for a patient. He also pointed out some limitations of the practice, noting (a) communication barriers between local providers and staff and the telepsychiatrist, particularly in the Consultation Model; (b) insurance coverage issues; and (c) complexity of medications, dosages, and combinations.

Finally, Dr. Merkel pointed out a few potential solutions to the problems and limitations explained above, including (1) increased use of the Collaborative Model, (2) robust development of local mental health networks and divisions of outreach to increase knowledge and understanding of the practice, and (3) dedicated effort to understand the cultural context of the population being served to examine any stigmatization associated with treatment and to appreciate the situation from the perspective of the local provider. He concluded by saying that the telepsychiatry practice is effective but that additional investment is needed to increase mental health provider availability and support the more effective Collaborative Model.

Presentation: Dr. Stephanie Loveridge and Ted Stryker, Centra Health

Mr. Stryker began the presentation by explaining the need for psychiatric services generally. He noted that one in five adults experiences some form of illness. Though there has been a significant decrease in early deaths due to many physical diseases, the suicide rate has remained largely unchanged over time, currently the third leading cause of death in youths ages 10–24 and the tenth leading cause of death for adults in the United States. He reported that in Centra's 2016 Community Health Needs Assessment for Lynchburg and Farmville, two areas Centra serves, mental health and substance abuse needs ranked very high.

Despite the need for psychiatry services, he noted, there is a national shortage of psychiatrists, particularly in specialty areas such as child and adolescent psychiatry. Asked by Delegate Yost why that was the case, Mr. Stryker responded that, among other things, the nature of mental illness is very complex and challenging, lacking a hard-proof diagnostic tool. He added that the reimbursement rate for psychiatrists is low compared to that for other medical specialties.

Mr. Stryker noted that early intervention is key in aiding those experiencing a mental health crisis and that early intervention is a more prevalent focus in preventing physical diseases than in treating mental illness. He noted that the use of telepsychiatry could aid in such early intervention.

Dr. Loveridge then explained the chief barriers to advancing telepsychiatry in Virginia. She first noted that state law currently requires the establishment of a bona fide practitioner-patient relationship before prescribing certain Schedule II–IV medications; in such cases, the Code of Virginia requires that the practitioner perform, or has performed, appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic

equipment through which images and medical records may be transmitted electronically. Since many psychiatric drugs are in the Schedule II–IV classes, requiring an initial face-to-face evaluation poses a large barrier to the use of telepsychiatry, particularly in remote areas of Virginia.

Dr. Loveridge then noted another barrier relating to sites where the practice takes place. She explained that Medicaid does not cover telepsychiatry uses in the home or school but that private insurance has no restrictions surrounding such sites. With respect to the school setting, Dr. Loveridge noted that allowing telepsychiatry would enable parents to have their child evaluated without requiring them to take time off from work to transport the child to a doctor's office and that, by involving the school system, school nurse, and the parents, a psychiatrist would be able to provide a better consultation and treatment plan based on a more holistic picture of the child.

Presentation: Stephanie Lynch, Virginia Association of Health Plans, and Dr. Renee Miskimmin, Virginia Premier Health Plan, Inc.

Ms. Lynch began the presentation by noting that there is a lack of routine care for mental illness in the Commonwealth, incentivizing a very reactionary, crisis-response-based system. She noted that an increased use of telepsychiatry may enable better access to early intervention and routine care for the mentally ill.

Dr. Miskimmin then noted that Virginia Premier Health, Inc., reimburses for 10 different specialties in telehealth but that the most commonly used form is telepsychiatry. She noted that the biggest challenges in psychiatry generally, and where the biggest advances and savings could be made, are in the areas of child psychiatry and the nursing home setting. As to the nursing home setting, she explained that it can be difficult for a psychiatrist to travel to a nursing home and that the psychiatrist's visit itself can stigmatize the elderly person being treated. She noted that telepsychiatry can improve a physician-patient relationship in some instances, explaining that some individuals are more comfortable sharing concerns with their doctor when there is a smaller chance they will see the doctor in the community.

Dr. Miskimmin also explained that telepsychiatry enables services to be provided in an appropriate, convenient setting and with less delay.

Final Comments and Next Meeting

Following the presentations, Delegate Garrett asked the presenters to provide data as to the cost efficiencies of the practice of telepsychiatry.

The next Work Group meeting is scheduled to take place on October 26, 2016, at 10:00 a.m.

Materials

Presentations and materials from the meeting can be found on the website of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century at http://dls.virginia.gov/interim_studies_MHS.html.