Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Work Group # 1: Service System Structure and Financing

Meeting #5 Summary

Wednesday, October 26, 2016
4th Floor East Conference Room
Capitol Building, Richmond, Virginia

Work Group #1: Service System Structure and Financing (the Work Group) of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) held its fifth meeting of the 2016 interim on Wednesday, October 26, 2016, at the Capitol Building in Richmond. Members present included Senator Hanger (Chair), Senator Deeds, and Delegate Farrell. Materials from the meeting can be found on the Joint Subcommittee's website at http://dls.virginia.gov/interim_studies_MHS.html.

Update on Activities of the Expert Advisory Panel

Dr. Richard Bonnie provided an update on the activities of the Service System Structure and Financing Expert Advisory Panel (the Panel).

Report on Core Services

Dr. Bonnie presented the Panel's Interim Report on Core Services, noting the fragmented nature of the service system, inconsistent availability of services due to variability among community services boards (CSBs), and lack of clear accountability and oversight. He noted that the Commonwealth needs a clear vision of what the behavioral health system should look like and a road map to reach that goal. The Panel has studied the System Transformation, Excellence and Performance in Virginia (STEP-VA) plan developed by the Department of Behavioral Health and Developmental Services (DBHDS) and believes that it meets these needs. The STEP-VA plan lays out 10 core services that should be provided by the behavioral health system. DBHDS has identified same day access, primary health screening and referral, and outpatient mental health and substance abuse services as priorities and has developed a multiyear, multiphase plan for financing and implementing STEP-VA.

Staff presented a Preliminary Report on Services that set out service descriptions for the 10 services envisioned in the STEP-VA model and the estimated costs of implementing each of those services. Following some discussion of the need to develop a more complete plan for implementation of STEP-VA moving forward, the Work Group agreed that the STEP-VA model represented a good blueprint for the Commonwealth's behavioral health system moving forward and agreed to support both the model and the implementation of same day access and primary health screening and referral as priorities for the 2017 Session of the General Assembly.

Report on Hospital Bed Utilization

Dr. Richard Bonnie and Jim Martinez presented the Panel's Proposal on Managing State Hospital Utilization. They reported that since Virginia's "last resort" legislation took effect in July 2014, admissions to Virginia's nine state hospitals have increased 54% over FY 2013. Admissions to

state hospitals of individuals under temporary detention orders (TDOs) have increased 157% over the same time period. Simultaneously, the proportion of temporary detention admissions going to private or community hospitals statewide has decreased significantly. In addition, as many as 150–180 individuals on any given day are clinically ready for discharge from Virginia state hospitals but continue to occupy much-needed beds, often well beyond the necessary period of hospitalization and at great expense to the Commonwealth. State hospitals are consistently operating at utilization levels of 95% or higher, while best practices indicate that patient and staff safety is reduced at utilization levels over 85%. At times, several state hospitals have been at 100% of operating capacity, causing delayed admissions for some individuals, as well as the use of temporary beds. In addition, there has been regular diversion of individuals from their home catchment areas to state hospitals much farther away, which causes transportation challenges for law enforcement and creates additional care coordination problems for care providers. The above has occurred amid declining budgets over the last decade and has contributed to increased staff turnover.

At a recent Panel meeting, DBHDS reported that it had begun an ongoing dialogue with Virginia CSBs and state hospitals in May, with the goal of raising awareness of the inherent risks and liabilities of the current situation, and to explore strategies that would reduce and stabilize state hospital utilization of CSBs at safer levels (e.g., 90%), build community program capacity, and ensure that CSBs within each state hospital's region would have necessary access to acute beds. A number of strategies have been implemented, and the Department has also set aside $8.7 million in one-time funds from existing budgets to allocate to regions and CSBs for system capacity-building.

The Panel strongly supports these DBHDS and CSB initiatives. The Panel also recognizes, however, that excessive demand on state hospital beds has been an ongoing challenge for the behavioral health system for decades and that the current initiatives are limited in scope and funded with one-time dollars. The Panel is also convinced that permanent and lasting change will not be achieved without permanent and lasting support, including funds and other resources as well as leadership commitment. Moreover, these initiatives do not address the structural incentives built into the system that are almost certainly producing or exacerbating the increased pressure on state hospitals. These structural incentives include the "last-resort" laws, the bias toward involuntary (versus voluntary) care in the provision of short-term treatment for temporary detention and in transportation, the "free care" provided by state hospitals to CSBs, and the discretion granted to private hospitals regarding all admissions. The Panel believes that these and possibly other structural incentives warrant further study in the upcoming year, which may yield important keys to achieving a more balanced and accountable community based system of care for Virginia in the long term.

In light of these issues, and based upon extensive discussion, the Panel offered four recommendations:

1) That DBHDS, CSBs and state hospitals implement the agreed upon FY 2017 census reduction initiatives and periodically (upon request) report on the progress and impact of these initiatives on the Extraordinary Barriers List and overall state hospital use to the Panel, Work Group, and Joint Subcommittee.

2) That DBHDS and CSBs develop budget request(s) for FY 2018 to support continued targeted CSB and regional interventions to stabilize and maintain state hospital utilization at no more than 90% of the January 1, 2017, operating capacity of each DBHDS state hospital.
3) That the Panel and Work Group continue to study the statutory, policy, financing, and administrative elements of the current behavioral health system that are not aligned with strategic and operational objectives, or that create impediments to efficient and effective care, and recommend solutions to the Joint Subcommittee by October 30, 2017, including the use of financial risks and incentives to achieve targeted performance objectives.
4) That DBHDS, in cooperation with the Department of Medical Assistance Services (DMAS), shall study the potential use of the Involuntary Mental Commitment Fund (IMCF) for both voluntary inpatient treatment and involuntary temporary detention, in order to create an incentive to reduce the use of involuntary treatment statewide. The two agencies shall also study the possible transfer of the IMCF fund from DMAS management to DBHDS control and any other strategies for improving the use of these funds.

Report on Telemental Health

Dr. Bonnie described recent efforts to increase the use of telemental health services in the Commonwealth. Telemental health is the use of electronic information and telecommunications technologies to support the delivery of behavioral health services at a distance. This includes clinical care, patient and professional health-related education, public health, and administration. A variety of modalities can be used to deliver these services, including live interactive videoconferencing, remote monitoring, and mobile applications. Providers of telemental health include psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and licensed professional counselors.

Significant challenges to access to and provision of mental health services exist in the Commonwealth. Resources available to local and regional CSBs and behavioral health authorities have not kept pace with the increasing number of persons in need of services. This is particularly true in rural and other underserved communities. Multiple reviews of the telemental health literature regarding its efficacy for diagnosis and assessment across a variety of populations (adult, child, geriatric) and for a variety of disorders and settings have largely shown that it is comparable to in-person care. Telehealth-enabled new models of care (e.g., remote monitoring/hovering, interprofessional collaborative care teams, mobile health) have also demonstrated very positive outcomes. Telemental health is therefore not only a viable but an essential tool for bridging the existing care gap. However, despite its demonstrated utility, telemental health has not been widely adopted within the Commonwealth.

During the 2016 interim, the Expert Panels on System Structure and Financing and Mental Health Crisis Response and Emergency Services jointly established a Telemental Health Work Group to develop policy proposals to remove impediments to greater use of telemental health services. Specifically, the Telemental Health Work Group was asked to identify barriers to greater use of telemental health services in the Commonwealth and to identify policy options for overcoming those barriers.

In October 2016, the Telemental Health Work Group reported on 30 policy options to address six specific barriers to greater use of telemental health services. The Telemental Health Work Group also provided 12 specific recommendations for immediate consideration. These

recommendations addressed provider barriers, workforce barriers, financial barriers, patient/client barriers, and policy barriers. Despite the thorough work of the Telemental Health Work Group, additional analysis and evaluation of policy options may be required. Therefore, the Telemental Health Work Group recommends that the Joint Commission on Health Care (JCHC) be asked to review the Report of the Telemental Health Work Group on Policy Development, established by the Joint Subcommittee, study the issues and proposals set forth in the report, and develop recommendations for increasing the use of telemental health services in the Commonwealth. The JCHC should report its findings and recommendations to the Joint Subcommittee by December 1, 2017.

Report on Data Sharing Challenges

Dr. Bonnie noted that the Panel had identified data sharing challenges as a major barrier to the transformation of the behavioral health system. One specific challenge relates to the sharing of data regarding temporary detention orders and outcomes between the Supreme Court of Virginia's data systems and the and the data systems of DBHDS. To address this issue and allow for greater sharing of data, the Panel proposed a revision to § 37.2-818 of the Code of Virginia that would require district courts to transmit records and information pertaining to proceedings, hearings, and orders provided for pursuant to Chapter 8 of Title 37.2 of the Code (dealing with emergency custody, temporary detention, and involuntary commitment, including identifiable information) to DBHDS upon request for the purpose of enabling DBHDS to maintain statistical archives, conduct research, and otherwise carry out its responsibilities.

Comments on Recommendations of Other Expert Advisory Panels

Dr. Bonnie provided a brief overview of proposals developed in the other Expert Advisory Panels, including several proposals related to housing for individuals with serious mental illness, alternative transportation, and developing alternative service models for emergency services to take pressure off hospital emergency departments.

Discussion of Final Recommendations for 2017 Session

Following the update on activities of the Panel, the Work Group discussed recommendations for the 2017 Session. Recommendations identified as priorities included implementation of same day access to screening and outpatient primary care screening and monitoring services included in the STEP-VA model, expansion of telemental health services, amendments to § 37.2-818 of the Code of Virginia to encourage data sharing, and recommendations to address utilization of state hospitals. Senator Deeds noted that the Joint Subcommittee will need to finalize its recommendations at the December 6, 2016, meeting.