Meeting Summary

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

October 7, 2019, at 1:30 p.m.

Pocahontas Building, Senate Committee Room A

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The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Joint Subcommittee) met in Richmond with Senator R. Creigh Deeds, chair, presiding.[1] The meeting began with introductions and opening remarks followed by presentations and discussion. Materials presented at the meeting are accessible through the *Joint Subcommittee's website*.

Presentation: Virginia's Behavioral Health System: Community Hospitals' Perspective

Jennifer Wicker, Director of Intergovernmental Affairs, Virginia Hospital and Healthcare Association

Ms. Wicker presented to the members on the community hospitals' perspective on Virginia's behavioral health system and, specifically, the state hospital bed shortage. She stated that, at first blush, it may seem like an easy solution for community hospitals to take more temporary detention orders (TDO) in response to this shortage but she said she would explain why that is not an easy solution, nor the only solution.

Ms. Wicker noted that the "bed of last resort" legislation was passed into law in 2014 in order to ensure that individuals who needed inpatient care received the care they needed and were not "streeted." She stated the legislation has been successful in that effort; however, it has also revealed some weaknesses in our behavioral health system. Ms. Wicker suggested that some of those weaknesses include an overreliance on inpatient care and a tendency to focus on the needs of behavioral health patients when they are in crisis. She said the changes and development of community services through STEP-VA and the full continuum of care that has been imagined through the Behavioral Health Redesign will help meet those challenges. Ms. Wicker reported that the Virginia Hospital and Healthcare Association (VHHA) remains committed to being part of the solution and optimizing the role of community hospitals.

Ms. Wicker noted that Virginia's behavioral health system serves people who are under a TDO and showed that, in fiscal year 2015, community hospitals admitted 90% of TDOs, and in fiscal year 2018, they admitted 80%. She reported that there has been an overall decrease of 2,477 TDO admissions by community hospitals. Virginia's behavioral health system also serves people who meet the criteria for inpatient care and are willing to do so voluntarily. Ms. Wicker added that, currently, community hospitals admit 100% of the voluntary patients. In fiscal year 2015,

[1] **Members Present:** Senator R. Creigh Deeds, Senator Emmett W. Hanger, Jr., Delegate Robert B. Bell, Delegate Patrick A. Hope, Delegate Vivian E. Watts

Members Absent: Senator George L. Barker, Senator John A. Cosgrove, Jr., Senator Janet D. Howell, Delegate Lashrecse D. Aird, Delegate T. Scott Garrett, Delegate Todd E. Pillion, Delegate Margaret B. Ransone, Delegate L. Nick Rush

there were 25,526 voluntary admissions, and in fiscal year 2018, there were 29,278 voluntary admissions, meaning an overall increase of 3,752 voluntary admissions. Asked by members about the average length of stay for voluntary admissions, Ms. Wicker reported that the average at a community hospital is between seven and 10 days, but she did not have the specifics for voluntary admissions. She concluded that, even considering the decrease in TDO admissions from fiscal year 2015 to fiscal year 2018, because of the increase in voluntary admissions, community hospital admissions increased by 1,275 patients between fiscal year 2015 and fiscal year 2018.

Ms. Wicker advised that, as of fiscal year 2018, community hospitals are meeting 90% of Virginia's behavioral health needs, including involuntary and voluntary admissions. Members noted that the number of TDOs have remained steady for the last four cycles, but it appears there has been an increase in voluntary admissions and asked why that is. She explained that there are no concrete answers, but she cited more people receiving insurance through Medicaid and thus more people having access to services, as well as the work being done to reduce the stigma of mental illness and increased awareness of mental illness. Looking at the Department of Behavioral Health and Developmental Services (DBHDS) Crisis Report from 2018, she remarked that, between fiscal year 2015 and fiscal year 2018, the number of emergency evaluations increased by over 8,000. She stated this is indicative of more people seeking services and the increasing need for mental health services. Members asked whether the increase in behavioral health needs is unique to Virginia; Ms. Wicker stated that the trend is nationwide.

She reported that 70% of emergency evaluations do not become TDOs. The final disposition varies and the individual may be voluntarily admitted, admitted in a crisis stabilization unit (CSU), discharged, or jailed. Ms. Wicker also listed the top reasons a bed may not be available for a person who is subject to a TDO: staffing, bed blocks, longer lengths of stay for many patients, and anti-ligature renovations. She said hospitals are licensed for a certain number of beds but not all are operating at their fully licensed capacity because of staffing difficulties, adding that community hospitals make up 1,799 of the licensed psychiatric beds in Virginia and that, out of 43 facilities, six operate at full licensed capacity. Ms. Wicker stated that the industry standard for psychiatric bed occupancy is 85%. In Virginia, 54% of community hospitals are operating at or above that standard and 69% are operating at or above 80% occupancy.

Asked by members about how community hospitals are using the term "voluntary admissions," Ms. Wicker explained that they cover an array of patient types. She noted that just because someone is a voluntary admission does not necessarily mean they require a lower level of care compared to a patient who is under a TDO. She added that whether a person decides to become a voluntary patient might change throughout the process. She did not have specific information about the population of voluntary admissions, but told members she can work to get more concrete data.

In looking at the psychiatric bed discharges by payor mix from 2018, Ms. Wicker showed that about 43% came from Medicaid and Medicare, 29% were from commercial insurers, and close to 16% were self-paid and uninsured.

Ms. Wicker talked to the members about VHHA's short-term and long-term opportunities and goals. For short-term opportunities, VHHA will work with its membership to come up with a plan to increase admissions to facilities operating below the 85% occupancy rate. She stated that VHHA is also currently working with the Virginia Association of Community Services Boards

(VACSB) to improve access to CSUs and identify shared patients/clients with high rates of readmissions for intervention. Regarding long-term opportunities, Ms. Wicker talked about VHHA working with DBHDS to increase admissions for special populations in community hospitals, increasing community supports to reduce reliance on inpatient services, and increasing community supports to improve safe discharges for geriatric patients, which would alleviate some pressure from inpatient settings. Ms. Wicker also reported the following proposals VHHA presented to DBHDS and the Secretary of Health and Human Resources: reduce inpatient admissions by establishing a Medicaid benefit for mental health partial hospitalization (PHP) and intensive outpatient (IOP), improve access to crisis services for patients with a substance use disorder, and a hospital/CSB collaborative for intellectual disabilities and developmental disabilities (ID/DD) Dually Diagnosed Beds. Members inquired about more specifics about the various alternatives that would be provided for ID/DD and geriatric patients. Ms. Wicker reported that 159 additional inpatient beds have come or will be coming online between fall 2018 and the middle of 2022.

Members told Ms. Wicker they would like more information on the total number of psychiatric bed days from 2013 to present to see if there has been a significant change, and they requested a breakdown of the numbers of TDOs versus voluntary admissions, including the length of stay for each. Members also asked if she had any data on whether the number of readmissions was related to patients being released too soon. She stated that hospitals are experiencing denials for extended admission stays from insurance partners, so it is an issue and something that needs to be discussed. They have reached out to DMAS to have a conversation about this issue.

Presentation: Hospital Census Update

The Honorable Daniel Carey, Secretary of Health and Human Resources

Secretary Carey discussed the current hospital census status, the need for temporary beds at Catawba Hospital, and the extraordinary barriers list (EBL). He explained that the sustained operation of facilities at 96-97% capacity is unsafe and leads to staff burnout, which is the main reason for DBHDS initiating action to add temporary beds to Catawba in order to meet its legal obligations under the "bed of last resort" requirement pursuant to § 37.2-809. There will be 56 beds added in total: 28 in FY2020 and 28 in FY2021. DBHDS will use $4.15 million of special funds in FY2020 and will request additional general funds of $9.3 million in FY2021 and $10.3 million in FY2022 to operate the beds. Secretary Carey explained that Catawba was chosen because there are already beds there, so almost all of the money will be going toward operational needs such as staffing. Members noted that if the goal is to reduce money spent, then why not focus on speeding up the redesign and providing wraparound services rather than adding more beds to Catawba? Secretary Carey explained they are in agreement with the long-term goal of moving moneys allocated to inpatient hospitals into the community; however, it became apparent to them they needed to provide temporary beds in order to meet their statutory requirement.

Secretary Carey said adding beds at Catawba is temporary and the beds would be in place until the state hospital census decreases through STEP-VA, mobile crisis, additional step-down levels of care and diversion alternatives such as IOP and PHP, and crisis stabilization units, and other short- and long-term actions recommended by the SB 1488 workgroup.

Members asked whether DBHDS considered speeding up redesign and advancing money for intensive outpatient and PHP rather than creating temporary beds. Secretary Carey reported that the state hospital census meant they needed a solution as quickly as possible to take care of

people. He stated they could not wait to build out those things with the emergent need for more beds. Members noted that it is going to take nine months to build out 28 beds and another year to build out the other 28 beds and inquired about an estimate for how long the beds will be open. Secretary Carey stated the beds will be open only as long as they are needed. Members also asked whether the temporary beds at Catawba will be enough to lower the state hospital census or if it is just the first step. Secretary Carey responded that it is difficult to make predictions, but they anticipate they will be adequate.

Regarding the EBL, Secretary Carey explained that an individual is placed on the EBL 14 calendar days after they are clinically ready for discharge, but they are not able to be discharged due to the lack of needed residential programs, supports, and services. He presented that the EBL is a result of the need to build a comprehensive community-based system to prevent and divert inpatient admissions and reduce the overall need for inpatient care in state hospitals. It is also related to the growing number of people admitted to state hospitals. The SB 1488 Work Group is addressing these issues.

Presentation: Development of an Information Sharing Process between Jails and Community Services Boards (SB 1644)

Michael Schaefer, Ph.D., Assistant Commissioner-Forensic Services, Department of Behavioral Health and Developmental Services

Dr. Schaefer discussed the development of an information sharing process between jails and community services boards (CSBs). During the 2019 Session, SB 1644 (Boysko) became law, which required DBHDS to convene a workgroup, study the issue of information sharing between CSBs and jails, develop a plan for the sharing of protected health information (PHI) for individuals in jails who have previously received treatment from a CSB, and provide a status report to the Governor and General Assembly by October 1, 2019. Dr. Schaefer explained that information sharing with jails is critical because national research shows that 70% of offenders have a substance use disorder, 17-34% of inmates have some form of mental illness, and the prevalence rate for serious mental illness at a point in time in the community is 4.5%. In Virginia, 19.84% of inmates are known or suspected of having a mental illness and 10.42% are known or suspected of having a serious mental illness. He explained that jails admit new individuals year-round, 24 hours a day, and many of those admitted are in crisis. He advised that jails are not generally staffed to assess and respond to behavioral health disorders all the time, so access to prior treatment records is critical.

Dr. Schaefer spoke of some cautions to keep in mind when talking about information sharing, such as being mindful of the expectation of privacy in patient/health care provider relationships, the rule of sharing the minimum information necessary to accomplish the desired task, the stigma surrounding mental illness, the potential unintended consequences of keeping individuals away from treatment, and the possible differential treatment of individuals who access the public behavioral health treatment system versus those who access private services.

He also pointed out the laws currently regulating health information sharing. The applicable federal laws include the Health Insurance Portability & Accountability Act (HIPAA) and 42 C.F.R. § 2.2. Dr. Schaefer noted that HIPAA does allow for some sharing without signed release to other providers involved in an individual's care when it is in the patient's best interest. There are other exceptions, but they generally do not apply to individuals in jails. He noted that the law concerning sharing of information with other providers is permissive, not obligatory, and there

are often differing interpretations of HIPAA. He stated that, in general, a health provider in a jail is viewed as a provider involved in an individual's care, but a jail superintendent is not. Dr. Schaefer also highlighted 42 C.F.R. § 2.2, which covers health records related to substance abuse treatment and prohibits sharing without a signed release. The applicable Virginia laws include § 53.1-133.03, which provides that a person in charge of a jail is entitled to obtain medical and mental health information and records even without consent. He noted it does not address the community provider's obligation to release information. Dr. Schaefer also pointed out that § 37.2-804.2, which requires community providers to release, upon request, prior treatment records, only applies to individuals subject to involuntary commitment pursuant to Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 and is not applicable to jails.

Dr. Schaefer shared with the members the process DBHDS went through to develop a plan for information sharing. They explored already existing information-sharing platforms, including the Emergency Department Care Coordination (EDCC) Program; however, not all CSBs are currently using EDCC and it would only contain information on a subset of CSB clients, he said. To use such a platform, they would have to broaden the user pool to include jail medical providers. He told the members they also consulted with Texas, which has a robust information-sharing system. Dr. Schaefer explained that all CSBs in Texas utilize one electronic health record (EHR) system and the state's jails all utilize the same jail management system. That is not the case in Virginia. Thus, he explained, DBHDS could not use Texas's system as a model because the state does not currently have the right data systems. Dr. Schaefer advised that DBHDS also researched publicly available data-matching systems, but they would have to build such a system from scratch, which would be expensive, enter into a Business Associate Agreement (BAA), and write code from each EHR to be able to get data into such platform.

Next, Dr. Schaefer presented the option of using existing systems for a new purpose. He explained that DBHDS has a data warehouse, which can match datasets. DBHDS already receives data from the CSBs about clients served (CCS3) and receives data from the State Compensation Board about individuals in jail (LIDS). They could write an inquiry to match these two data systems to identify individuals in jail who have previously received services from the CSB. There are several limiting factors, such as a two-month delay in CCS3 data being downloaded into the data warehouse and the fact that DBHDS only receives the LIDS download once a month. Additionally, he noted that the data warehouse does not currently have the ability to push data out to multiple sources. They would have to hire someone to send notifications to the CSBs. In addition, he stated this approach would only identify CSB consumers and not those who received services from a private provider.

Dr. Schaefer shared that the work group had differing opinions about how much data to share, but the prevailing opinion was to share information concerning clients who have been receiving case management services or psychiatric services, who have been pre-screened for hospital admission/crisis services, or who have received services within the last year. The work group also discussed what type of information to share, such as diagnoses, current medications, incidents of self-injury, and types of services being provided.

Dr. Schaefer talked about how such a system would work. He stated DBHDS would run cross-matching intervals and that the data warehouse would identify individuals in jail who have previously received services from a CSB and who meet the specified criteria. DBHDS would then notify respective CSBs of clients who are currently in jail and who received the identified types of services within the last year. The CSB would either share information with the jail,

and/or go see the client, and/or get the client to sign a release. DBHDS would then follow up with the CSBs to ensure such action was taken. In order to accomplish such a system, DBHDS would need one-time funds of approximately $144,000 to write computer code to facilitate the automatic download of LIDS data to allow for more frequent downloads and would need ongoing funds of about $65,000 for one full-time employee at DBHDS to perform the notifications to CSBs and follow up. He told the members that the work group suggested a "pilot" of this process to determine if the information shared is useful and to work out any issues. Dr. Schaefer noted that the alternative would be to build out a new platform, which would likely better meet needs but would be more costly and challenging to do.

Dr. Schaefer concluded by submitting to the members that, regardless of which system is used, the differing interpretations of HIPAA will continue to be a barrier to information sharing and that the members may want to consider amending § 53.1-133.01 to address such issues or codify DBHDS's responsibility to cross-match and the responsibility of CSBs to share information. Members inquired about the price estimate of building out an entirely new data platform. Members also asked about the percentage of inmates who received services from CSBs versus private providers. Dr. Schaefer said he would work to get that information for the work group.

Public Comment

Several citizens and advocates addressed the Joint Subcommittee and expressed various concerns including the money going toward the temporary beds at Catawba.

For more information, see the *Joint Subcommittee's website* or contact the Division of Legislative Services staff:

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