

## **Summary of June 8, 2016 Meeting of Advisory Panel on Mental Health Crisis Response and Emergency Services (our third meeting)**

Thanks again to the panel for an excellent conference call meeting on June 8. In that meeting we explored in more depth the three “priority” issues that we identified in our prior meeting: (1) the development of a regional Psychiatric Emergency Services (PES) unit to provide a local treatment setting where individuals in mental health crisis would have more time, support and treatment services available to work through their crisis before a decision about hospitalization had to be made; (2) the increased use of tele-psychiatry to improve the timeliness of access to needed consultation with and treatment by a psychiatrist during a crisis; and (3) the development of a medical model for transport of persons in mental health crisis, in place of the current law enforcement model. We also talked about addressing the need to identify a set of “core” emergency services that every locality should provide, and a set of “core” community treatment and prevention services that every locality should provide in order to enable people to avoid falling into mental health crisis. (We recognized the need to identify where this work might duplicate work on other panels.) We firmed up membership in the subcommittees that will study and make recommendations to the larger group regarding each of these issues.

### **DISCUSSION SUMMARY**

Below is a summary of our discussions in regard to each of these issues:

#### **1. The concept of a regional Psychiatric Emergency Services (PES) Unit**

*The experience of the hospital ED: Alison Land, Vice President for Behavioral Health Services, Sentara Healthcare:* Alison reported that, as part of its current strategic planning process, the Sentara system is looking at how best to help people who come into Sentara’s hospital Emergency Departments (EDs). She noted that the HB 2368 report on CSB responses to EDs did not provide a complete picture of what EDs are experiencing in regard to patients in mental health crisis, and that, in fact, “psychiatric boarding” is an increasing problem in the ED. While, as the HB 2368 report found, CSB responses to persons in the ED who are under an Emergency Custody Order (ECO) meet the time requirements of statute, those persons are only a portion of the patients in the ED who are there primarily because of mental health issues. EDs currently are not designed, equipped, or staffed to treat individuals whose primary treatment need is mental health care, so ED staff attempt to refer these individuals to appropriate places for treatment. Currently, there appear to be no outpatient mental health treatment services available for immediate referral for individuals who are in crisis but who do not need inpatient or residential care. For those deemed appropriate for a Crisis Stabilization Unit, the average wait for the required pre-screening and placement is currently over two *days*. People waiting for hours and days in the ED for referrals and placements elsewhere sometimes experience deterioration in their condition while waiting, requiring more intensive intervention than what would have been sufficient earlier.

People with a primary need for mental health care constitute an increasing percentage of the people in the ED. The Sentara Norfolk General ED built behavioral health pods to provide places for individuals experiencing behavioral health problems to remain while waiting for transfer, but they have proved insufficient, so that increasing numbers of persons in mental health crisis are in the general ED area. Some of these individuals require one-on-one supervision by ED staff who otherwise would be treating patients who are in the ED for other medical emergencies. On a number of occasions, in order to provide a more appropriate environment for the individual and to relieve the ED, Sentara has transferred patients in mental health crisis from the ED to Sentara’s

psychiatric hospital ward for care, even though Sentara could not obtain compensation for providing that care because the patients did not meet the criteria for psychiatric hospitalization.

Alison noted that some of the individuals who come to the ED in mental health crisis could benefit from treatment with medication early in their stay, but that it is difficult to staff an ED with a psychiatrist specializing in emergency psychiatric care (contributing to Sentara's interest in tele-psychiatry in the urban ED setting as well as in rural ED settings).

Sentara is interested in working collaboratively with other private and public health care entities to find a regional solution to the continuing "psychiatric boarding" problem. A regional PES unit is seen as a potential answer, especially with the capacity to provide active treatment.

In our panel discussion about how best to capture the costs of this psychiatric boarding in the hospital ED, Kurt Hooks, who works at Chesapeake Regional Medical Center, noted that various studies place the revenue loss to the EDs at anywhere between \$300 and \$1200 per hour.

***The hospital ED and the CIT assessment center: Kurt Hooks, Director of Behavioral Healthcare Services, Chesapeake Regional Medical Center (CRMC):*** Kurt reported that, under a grant provided by the DBHDS, the CRMC has established an assessment center in the hospital complex near the ED. Police officers who have a person in custody due to a mental health issue – either because of a magistrate-issued ECO or the officer's own observations – bring that person first to the assessment center, which can manage two individuals at a time. (If the center is at its two-person capacity, then the person is taken to the ED.) The center includes an office for CSB staff, a waiting area and an assessment space. Individuals can be referred for alternative treatment, or processed for issuance of a TDO for inpatient hospitalization. Approximately 50 people are seen each month in the assessment center.

Kurt reported that while he does not yet have specific figures on the impact of the assessment unit on psychiatric boarding in the ED at CRMC, he does expect the figures will show a significant impact. He noted, however, that individuals at the center are only being assessed; they are not receiving concurrent treatment, and he expressed his view that a regional PES unit, based on a 23-hour admission model, could provide significant benefit to individuals in crisis by providing active treatment services in a local and less restrictive setting.

In the discussion that followed, it was noted that there are other CIT assessment centers in the state, and some are reported to be working well. The one in Harrisonburg was cited as a good model. We also noted the issue of the "medical clearance" that is required by some inpatient mental health facilities before a person can be placed there. This issue remains on our "to do" list.

***A vision of integrated medical care:*** Becky Sterling urged the ideal of a wellness center offering care for the whole person, providing care for physical and mental health needs under the same roof and eliminating the stigma that attaches to providing mental/behavioral health care in a separate setting. We did discuss how there are also specialty trauma centers in physical health care to deal with certain kinds of physical emergencies, and that the PES unit might be seen as more analogous to such a center.

## **2. Tele-psychiatry**

***The current statutory impediment:*** Jane Hickey reported that, following the last meeting, she did some research on the issue of what statutory impediments currently exist to the use of tele-

psychiatry. She confirmed that amendments to the Virginia Code in 2015 that were intended to address problems with online pharmacy operations providing opioids that were being abused had the unintended consequence of preventing the prescribing of psychotropic medications by a psychiatrist following a tele-psychiatry session unless the psychiatrist has previously met with the patient in-person. That, unfortunately, defeats the whole purpose of tele-psychiatry, particularly during a crisis. Jane reported that UVA had been providing tele-medicine services, including tele-psychiatry, to a number of rural communities in western Virginia, and through UVA's efforts the 2016 General Assembly restored its ability to carry out tele-medicine services. Unfortunately, the General Assembly's authorization to UVA was not extended to anyone else. The DBHDS Commissioner is aware of this problem and legislation to fix it is in the works.

There was some discussion as to whether there was a "work-around" in regard to this – for example, having a physician doing the in-person exam and then a tele-psychiatry consultation with a psychiatrist – but concerns were noted about the viability of such a plan. Derek Curran noted that the Hampton/Newport News CSB's planned tele-psychiatry program (another example of an urban-based tele-psychiatry program reflecting the scarcity of providers everywhere) has been put "on hold" until the statutory problem is resolved.

### **3. Medical Transport**

There was complete agreement on the need for us to pursue a medical model for transport. I apparently stopped taking notes at that point, but will note the following as my recollection of our consensus: (1) the stigma felt by individuals who experience transport by law enforcement during a mental health crisis is strong, and the extent of the negative impact on people is not sufficiently recognized by policy makers; (2) the costs to law enforcement in providing this transport is high, not only in terms of actual time and resources devoted by law enforcement to carry this out, but also in terms of reduced officer time in more standard public safety functions; (3) other jurisdictions are already using a medical model (New Jersey and California were noted), and North Carolina has been experimenting with a non-law enforcement model for transport; (4) the pilot project in the Mt. Rogers CSB service area – which does not involve the initial emergency transport of people in crisis, but provides for non-law enforcement transport for subsequent transportation, is working well; notably, it is not medical transport, but instead "civilian" transport in cars that do not have distinguishing identification (Becky Sterling was involved in the training of drivers for this work); (5) there is currently no provision in Virginia Medicaid (or, to our knowledge, other insurance plans) to provide compensation for the costs of medical transport of persons in mental health crisis.

(Follow-up note: Robert Tucker at the Valley CSB advises me that they have had an alternative transport model in effect since the fall of 2015, and that it is working very successfully. We will want to follow up on that.)

### **4. A standardized set of "core" services**

In this discussion, it was noted that the "Certified Community Behavioral Healthcare Center" model, developed by SAMHSA for a federal grant program to fund "demonstration projects" for effective community-based mental health care, sets out a comprehensive set of services that characterize an effective services system – including prevention, treatment and emergency services. This model, which DBHDS adopted for its STEP VA initiative in seeking that federal funding, is based upon consensus in the field as to what constitutes "best practices" in community-based mental health care. In addition, the DBHDS Transformation Teams on services also set out consensus-based listings of core services.

## **PANEL PLAN**

We agreed that we would have our next panel conference call meeting on August 3, 2016 at 3 p.m. In the meantime, our four subcommittees (I'm going to call them "groups" because that's a shorter word) would meet and work to develop information, ideas, and recommendations that will be shared at the August meeting.

### **The Regional PES Unit group**

Members: Alison Land, Ted Stryker, Kurt Hooks, Derek Curran, and Dr. Lo

Key tasks: (1) research and develop data to provide numbers demonstrating the current crisis in psychiatric boarding in the ED and the costs incurred by the EDs and their hospital systems as a result (and illustrating, if possible, the resulting impacts on the persons in crisis because of the delays in treatment)

(2) research models for a regional PES unit already operating in other jurisdictions, including any data that may help to demonstrate the efficacy of those models, both in terms of costs incurred and outcomes experienced by patients.

(3) describe a possible regional PES unit model for Virginia, and what changes in Virginia statutes, regulations, policies and practices, and what appropriations, might be needed to make such a unit possible.

### **Tele-psychiatry group**

Members: Alison Land (along with a Sentara physician chosen by Ms. Land), Melissa Lucy, and Jane Hickey

Key tasks: (1) research and develop data to provide numbers demonstrating the need for tele-psychiatry in both the rural and urban settings

(2) research models for tele-psychiatry, with a particular emphasis on the model developed by UVA

(3) describe a possible model for the use of tele-psychiatry in both the rural and urban setting, and what changes in Virginia statutes, regulations, policies and practices, and what appropriations, might be needed to implement tele-psychiatry in each setting.

### **Medical/alternative transport group**

Members: Jane Hickey, Becky Sterling, and Dean Barker

Key tasks: (1) research and develop data demonstrating the costs of the current law enforcement transport system

(2) research existing alternative transport models in other states and the pilot projects currently being carried out in Virginia

(3) describe a possible model for medical/alternative transport in Virginia, and what changes in Virginia statutes, regulations, policies and practices, and what appropriations, might be needed to implement medical and other alternative transport as the "default" transport for persons in mental health crisis

### **Core Services model**

Members: Jim Martinez and Janet Lung

Key tasks: research and review and report on the proposed "core" services set out in the CCBHC demonstration project, STEP VA, and the Transformation Team recommendations to identify the current consensus in the field on the core services that identify an effective community-based behavioral healthcare system, with a particular focus on emergency response services.