

SJ 47 Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

October 2016 Advisory Panel Report to Work Group #3: Mental Health Crisis Response and Emergency Services

Background

In prior meetings of the Advisory Panel, held in May, June and August, the panel members reached consensus on the four highest priorities for action in regard to mental health emergency services in Virginia: (1) the creation of a regional Psychiatric Emergency Services (PES) unit that could more effectively address and resolve mental health crises and relieve current pressures on hospital Emergency Departments (EDs) and psychiatric hospitals; (2) the increased use of tele-mental health services to make more efficient and effective use of increasingly scarce psychiatrists, in both the outpatient and emergency setting; (3) the increased use of non-law-enforcement transport of persons in mental health crisis, to reduce the trauma and stigma experienced by individuals in crisis and to enable law enforcement officers to more quickly return to their normal public safety duties; and (4) the establishment of a “core set of emergency mental health services that would be available equally in every Virginia community.

Sub-group activities and reports

The Panel formed four subgroups to work independently on the Panel’s agreed priorities: Alternative Transportation, Tele-Mental Health Services, the PES unit model, and Core Emergency Services. Each subgroup met separately throughout the summer and into the fall. Their progress to date, and their current recommendations, are set out below.

I. Alternative Transportation

The Interim Report of the Alternative Transportation subgroup is attached.

A. Some key points and findings:

1. *There are four distinct transports that are involved in responding to a person in mental health crisis in the community:* (1) transport from the site of the crisis to the hospital ED or other assessment site (often under the authority of an Emergency Custody Order (ECO); (2) transport from the assessment site to a mental health treatment facility under a Temporary Detention Order (TDO) (and possible transports between facilities during the effective period of the TDO; (3) transport to a mental health facility following entry of an involuntary commitment order (or a person’s voluntary admission at the time of the commitment hearing); (4) transport from a mental health facility to the community.

2. ***Virginia’s statutes require that transportation be provided by law enforcement*** for the first three transports unless the magistrate, special justice or judge specifically authorizes alternative transport. The fourth transport – from facility to community – is unaddressed in the Virginia Code, though the nature and appropriateness of this transport can have a significant effect on the person involved.

3. ***The driving concern behind Virginia’s requirement for law enforcement transport is to ensure safety***, including the safety of the person involved, the safety of service providers and the safety of the public.

4. ***Law enforcement transport imposes significant costs***: (1) it “criminalizes” a mental health crisis, resulting in trauma and stigma for the individual that has lasting impact and potentially compromises not only the outcome of the person’s treatment but also the willingness of the person and family to seek help in the event of a subsequent crisis; (2) it could endanger some individuals, as a percentage of mental health crises involve an underlying medical problem that law enforcement officers are not trained to identify or treat; (3) the demands on officers to respond to their regular public safety duties can result in delays in officers being available to provide transport, resulting in delays in treatment and deterioration in the person’s condition; (4) these cases can end up consuming many hours of officers’ time, especially if transport to a state hospital is required, thereby reducing the number of officers “on the street” and able to respond promptly to other emergencies – a problem that can be particularly acute in rural communities served by small law enforcement staffs.

5. ***The safety of alternative transport has been established in Virginia and elsewhere.*** A DBHDS grant funded pilot project in the Mt. Rogers CSB service area, which utilizes CIT trained staff of a private security company driving unmarked vehicles equipped with a safety partition, has completed over 300 transports over a ten month period without incident. Initially, the magistrate authorized alternative transport for a third of the total transports (with the Sheriff’s Office providing the rest), but that has now increased to half, and is expected to increase further. The Valley CSB’s CIT program has developed a transport program in which CIT-trained off-duty staff of the Middle River Regional Jail (MRRJ) provide transport in unmarked cars owned by the MRRJ. Between October 5, 2015 and June 30, 2016, the program saved law enforcement agencies over 1,600 hours of duty time. In North Carolina, the G4S private security company has been providing similar transport for individuals in various communities in North Carolina. To date, the program has transported over 8,000 individuals and covered over 500,000 miles, without incident. Both the Mt. Rogers and the G4S programs report high rates of customer satisfaction, with reduced trauma and stigma (the Valley CSB’s program, to the group’s knowledge, has not evaluated this aspect of its program).

6. ***An unresolved issue regarding alternative transport models is cost.*** The per-trip costs of alternative transport in the Mt. Rogers CSB Pilot Project are high. This is due in part to the fact that this project had to be created from scratch, including the establishment of a 24/7 dispatch office and a dedicated set of drivers. Other existing models of alternative transport suggest that alternative transport can be affordable, and

even provide cost-savings over law enforcement transport. Average costs for alternative transport by the private security firm G4S in North Carolina ranges between \$88 and \$140 per trip (though G4S noted that costs are often very much driven by local conditions and requirements). Minnesota's Medicaid program has a category termed "protected transport" under which it compensates approved vendors for non-emergency medical transport (NEMT) for individuals experiencing mental health crises, with a \$75.00 base fee and \$2.40 per mile compensation rate. The Valley CSB's grant-funded program has been very cost effective, due largely to the participation of the Middle River Regional Jail, as described above. The primary added cost is the hourly payment to drivers (currently \$45.00 per hour). DBHDS is currently looking for a financially sustainable model to allow ongoing funding of alternative transport in the Mt. Rogers Pilot Project.

7. A medical model for transporting people in mental health crisis from the community to the health care setting has been successfully established in other jurisdictions.

Programs in California, North Carolina and elsewhere utilize CIT-trained Emergency Medical Services (EMS) staff to respond to mental health crises, treating them as a type of medical emergency. These programs note that a number of mental health crises involve other medical conditions which police officers are not trained to recognize. These programs also report that this model of transport has not resulted in safety problems for them. This model warrants consideration in Virginia.

B. Recommendations

1. Continue the successful Southwest Virginia/Mount Rogers pilot project for another year with the goal of making the project financially sustainable. Consider, among other things, re-initiating the competitive bidding process; expanding the area served, thereby spreading overhead costs across a greater population area; identifying a more cost-effective dispatch system (perhaps utilizing the public dispatch system since these transports are carrying out the order of the magistrate); or reallocating staffing by using "on call" as opposed to "on duty" staff.

2. Develop a second pilot project in a denser population area, such as Tidewater, utilizing a combination of EMS as the primary transport from the community (unless specific safety concerns call for law enforcement transport) and secure alternative transportation for TDO and post-commitment hearing transports, unless a person's other medical conditions indicate a medically higher level of transport is appropriate.

3. Involve the Department of Health/Emergency Medical Services system in all studies and discussions related to alternative transportation. Ensure that emergency medical services technicians receive adequate training in responding to and screening mental health emergencies.

4. Request guidance from the Department of Medical Assistance Services on when Medicaid reimbursement will be provided for medical transport in the case of mental health crises, and review other insurance coverage standards regarding such transport

and whether they comply with parity requirements for coverage of treatment of mental health conditions.

II. Tele-Mental Health

The report of the TeleMental Health sub-group is attached.

A. Scope of work

Notably, the mandate given to the Tele-Mental Health Group by Professor Bonnie was a broad one, encompassing all aspects of mental health care: “to develop a blueprint for policy proposals designed to remove impediments to greater use of telemental health services”. Accordingly, the recommendations from the group are comprehensive, addressing the barriers to effective use of telemental health services in prevention, outpatient treatment, emergency response and inpatient treatment.

B. Prescribing controlled substances via telepsychiatry

The group recognized and deferred to the work of the Telehealth-Telepsychiatry Stakeholders Group led by State Sen. Dunnivant and coordinated by C. Scott Johnson, Esq., and the Medical Society of Virginia. That group has been reviewing how federal Drug Enforcement Administration (DEA) regulations on the prescribing of Schedule II-V drugs via telemedicine (established primarily to stop the increasing use of the internet for inappropriate prescribing of controlled substances - opioids in particular) impact the capacity of Virginia programs to effectively utilize telemental health to reach people needing services. Recent amendments to Virginia Code Section 54.1-3303 placed limits on the prescribing medications that parallel the DEA regulations. The result has been that most planned telepsychiatry initiatives have been put on hold until there is clearer guidance on when such prescribing is allowed.

Following Stakeholder Group meetings in the summer and fall, in which there was participation by DEA representatives, a plan of action was developed along several fronts. As set out by Mr. Johnson in an email to the group, the plan included the following: (1) developing a coordinated set of standards and process among the supervising state agencies involved for enabling local community services boards (CSBs) to apply for and obtain a “controlled substance registration” from the Board of Pharmacy (BOP) (which DEA representatives indicated was key requirement for a site to host telepsychiatry sessions in which controlled substances could be prescribed); (2) obtaining DEA recognition of those standards and process as sufficient for the DEA to recognize approved CSBs as sites for prescribing controlled substances via telepsychiatry; (3) seeking legislative action to confirm the authority of the BOP to issue a controlled substance registration to CSBs; (4) seeking guidance and interpretation from the DEA regarding the nature and extent of the DEA’s requirement for “face-to-face” interaction between a provider and patient as a condition for prescribing a Schedule II-V drug via telemedicine; (5) consulting with the Virginia Attorney General’s office on whether it’s possible to publish a “revised guidance document” on Virginia Code Section 54.1-3303

“to clarify that practitioners can prescribe Schedules II-V via telemedicine if they satisfy the federal requirements”; (6) if such a revised guidance document is not an option, seeking amendment of that Code section.

The Stakeholders Group will be meeting with Work Group #3 on October 26 to present a report on progress, and review what legislative and non-legislative action should be supported to “maximize the use of telemedicine and in particular telepsychiatry”.

C. The documented value of and need for telemental health services

As set out in the presentation made to Work Group #3 at its August 22, 2016 meeting by Anita Clayton, M.D., and Larry Merkel, M.D, Ph.D. (available on the Division of Legislative Services website and linked [here](#)), the clinical effectiveness, and cost savings, of telemental health care are well established. Moreover, there are a variety of “models of care” in which telemental health can be used, including inter-professional collaborative care team, mobile health, and monitoring/hovering services. At the same time, the funding for mental health services has not kept up with the growing need for those services. The gap in services has been particularly acute in rural areas, where distances between people compound the service gaps and where the devastation of the current opioid abuse epidemic make the need for additional services all the more acute. Unfortunately, there has been little funding for the expansion of telemental health capacity.

D. Recommendations of the telemental health group and the potential for immediate action

1. The big picture

The group identified six major “problem” areas constituting barriers to the effective implementation of telemental health services statewide: (1) provider barriers, (2) workforce barriers, (3) financial barriers, (4) patient/client barriers, (5) policy barriers, and (6) preventive care barriers. The group identified a set of policy initiatives or options to address each of these areas, and then made a total of twelve recommendations for action.

2. Recommendations for study and possible action by the Joint Commission on Healthcare and the Secretary of Health and Human Services

A number of the group’s recommendations call for specific study, recommendations and possible action by the Joint Commission on Healthcare (including: a costs/benefits study of different models for telemental health services on improving outcomes and reducing financial burdens in regard to care in emergency services, corrections, hospitals and state psychiatric facilities; and a study of the current behavioral health care workforce and how to better engage and leverage the full continuum of that workforce in Virginia), and for action by the Office of the Secretary of Health and Human Resources (including: developing standards and guidance on key unresolved issues in tele-mental practice,

such as liability/malpractice, privacy and security requirements, standards of care, and standards for technology and interoperability; and that the Secretariat develop a plan with the Office of Public Safety for effective use of telemental health care and prevention services in the correctional setting, and work with the Office of Technology to leverage existing broadband expansion initiatives in rural communities to make telemental health services more available to under-served rural areas.) A number of these recommended actions will take some time to implement, but they provide necessary groundwork for establishing an effective statewide telemental health system.

2. Matters that are urgent and deserve executive and legislative attention in the 2017 session

- a. **Recommendation: that the Commonwealth leverage Appalachian Regional Commission and Virginia Tobacco Region Revitalization Commission funding to implement a pilot telemental health network to address the mental health needs of the counties within their respective footprints.**

As the report submits, “the pilot telemental health network should prioritize addressing the opioid epidemic that is having devastating human costs and hindering economic and workforce development in these communities. The pilot telemental health network should engage and leverage the full continuum of the mental/behavioral health workforce and also include Project ECHO clinics to provide front-line clinicians with the knowledge and support they need to manage patients with opioid addictions.” Grant funding from these two commissions could be obtained to serve the needs of a number of localities in Southwest Virginia, with additional “leveraging” funds from the General Assembly enabling a wider service area for this work.

- b. **Recommendation: that the Commonwealth appropriate \$300,000 per year to establish statewide Project ECHO (Extension for Community Healthcare Outcomes) clinics focused on mental/behavioral health issues such as pain management, behavioral health disorders, opioids, substance abuse, and other addictions.**

As Dr. Wibberly, the group’s chair, has written: “Project ECHO is a collaborative model of medical education and care management that has been established in several states and has proven efficacy and cost effectiveness. The ECHO model™ does not actually provide care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing clinicians who are in the community with direct access via telemedicine services to the knowledge and support they need to manage patients with complex conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub.”

- c. **Recommendation: that the Commonwealth appropriate \$50,000 per year to the Virginia Telehealth Network to establish and manage a referral network of Virginia-licensed telemental health providers.**

In explaining the value of this initiative, Dr. Wibberly has noted the following: “One of the greatest challenges for most areas is the ability to quickly identify a mental health provider who is available to take referrals. This would be similar to the problem the state has had for several decades related to being able to find available bed-space for patients in in-patient facilities. An online/mobile directory of providers who have been trained in using telemental health would allow someone needing to refer a patient to identify providers by specialty, identify what type of insurance they accept, and be able to identify whether they have openings to take new referrals. It would also allow some basic monitoring regarding if a patient actually followed through with a referral. This could potentially allow patients to be referred and be able to be seen immediately (or at least the same day they are referred).”

Dr. Wibberly noted that some CSBs in urban areas have established a program of “same day access” to services. Rural CSBs simply do not have the numbers of mental health providers on site to provide such access to services. Access via tele-mental health services could help them to overcome that problem and offer faster care by quickly linking individuals to available therapists. The proposed Network is the infrastructure needed to enable those CSBs to identify available providers.

These three recommended initiatives involve modest amounts of money but could leverage services of tremendous value to the communities they serve.

III. Psychiatric Emergency Services (PES) unit

The PES unit group currently does not have a written report. The group has worked with the Virginia Hospital and Healthcare Association (VHHA) in developing and distributing a survey to hospitals statewide to better capture the extent of, and costs resulting from, “psychiatric boarding” in hospital Emergency Departments. There is a consensus among the Panel members that the extent of psychiatric boarding in Virginia is not adequately understood or appreciated, and that it is likely far more significant and far more costly than many in the health field (and elsewhere) may assume. Getting firmer numbers and a better understanding of ED experiences statewide will be an important step forward.

It also remains the case that, while the state hospitals continue to function as guaranteed safe placements for individuals in crisis who are brought into custody under an ECO and are then found to meet the criteria for a TDO, those hospitals often remain above capacity – sometimes substantially so – and this compromises care and care outcomes. Members of the PES unit group have held conference calls with the staffs of two programs in North Carolina – the WakeBrook Campus in Raleigh, operated by UNC Healthcare, and the Recovery Response Center in Durham, operated by RI International – that provide the services envisioned by the Panel for a PES unit. In addition, review of the services of some of Virginia’s CIT Assessment Centers show that a few of them have many of the characteristics of a PES unit. It may be possible, through some infrastructure improvements and added mental health staff and services, to enable these Centers to operate not merely as assessment centers, but as active treatment centers, with the

potential of enabling more people who are in crisis to obtain needed help without having to enter either a hospital ED or a psychiatric facility. The potential for recommending and providing cost estimates for “pilot” sites for such PES units will be explored in the coming weeks.

IV. Core Emergency Services

The fourth priority – the establishment of a “core” set of emergency mental health services that would be available equally in every Virginia community – is currently being addressed largely through the establishment of the Virginia STEP (System Transformation, Excellence and Performance) program by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). That program, which grew out of DBHDS’s response to a federal grant program encouraging the establishment of model Certified Community Behavioral Healthcare Centers (CCBHCs), is adopting the “9 + 1” model of services for CCBHCs (nine core services plus coordination among those services) set out by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) as a requirement for the grant program. While DBHDS has recently decided not to pursue the grant, it is maintaining the CCBHC model, and is merging it with the recommendations that came out of the Transformation initiative started by former DBHDS Commissioner Ferguson. Those recommendations have been consistent with the CCBHC model. The Advisory Panel’s subgroup on Core Emergency Mental Health Services is following the progress of the DBHDS Virginia STEP initiative, to see whether it reflects the service concepts and values that the Advisory Panel has agreed upon as being necessary parts of an effective mental health emergency services system. Until such time as there are clear differences between the Virginia STEP proposal for emergency mental health services and the position of the Advisory Panel on those services, the Panel will defer to the Commissioner’s presentations regarding the STEP program.