

Report of the Telemental Health Work Group on Policy Development

INTRODUCTION

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century was established through Senate Joint Resolution No. 47 in 2014. The Advisory Panel to the Joint Subcommittee's Work Group on Mental Health Crisis Response and Emergency Services (Work Group #3) identified increased availability of telemental health services in the emergency setting as a high priority. An Advisory Panel work group on telemental health was then formed to develop specific findings and recommendations. Professor Richard Bonnie, advisor to the Joint Subcommittee, asked Katharine H. Wibberly, Ph.D., Director of the Mid-Atlantic Telehealth Resource Center, to chair the telemental health work group, and, as discussed below, gave the group a broad mandate in its review of telemental health services.

Telemental health is the use of electronic information and telecommunications technologies to support 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, but are not limited to psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and licensed professional counselors.

Significant challenges impacting access to and provision of mental health services exist in the Commonwealth of Virginia. Resources available to local and regional community services boards 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 on 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, inter-professional collaborative care teams, mobile health) have also demonstrated very positive outcomes. Telemental health is therefore not only viable, but an essential tool for bridging the existing care gap. Despite its demonstrated utility (described in more detail in the presentation made by Anita Clayton, M.D., and Larry Merkel, M.D, Ph.D., at the August 22, 2016 meeting of Work Group #3, [available on the Division of Legislative Services website and linked here]), telemental health has not been widely adopted within the Commonwealth.

The telemental health work group on policy development was given the following task:

to develop a blueprint for policy proposals designed to remove impediments to greater use of telemental health services.

More specifically, the work group was asked to provide definition to the problem(s) that need to be addressed and to set forth a menu of policy initiatives or options for addressing the problem(s).

The work group is aware that in order to fully treat some patients, a provider may need to have the ability to prescribe, and that there have been some recent challenges with language in the Code of Virginia pertaining to the requirements of the Drug Control Act and whether a relationship entirely built via telehealth would be considered a valid means for establishing the type of relationship needed to prescribe controlled substances. Adding to the complexity is the federal Ryan Haight Act. The Act provides a definition for the practice of telemedicine and dictates very specific scenarios where the practice of telemedicine would be considered a valid means for the prescribing of controlled substances. Under the Act, the prescribing of controlled substances via telemedicine is allowed in the following scenarios:

- A patient is being treated and physically located in a hospital or clinic registered to distribute under the Controlled Substance Act
- A patient is being treated and in the physical presence of a practitioner registered to distribute under the Controlled Substance Act
- The practitioner is an employee or contractor of the Indian Health Service (IHS) or working for an Indian tribe or tribal organization under contract or compact with IHS
- The practitioner has obtained a special registration from the US Attorney General
- In an emergency situation (21 USC 802(54).)

Although challenges related to prescribing of controlled substances, including psychotropic medications via telemental health continue to exist, headway is being made and the deliberations and recommendations that follow were made under the assumption that impediments to prescribing will be soon resolved.

The following policy framework has been developed by the workgroup and brings definition to six problems. Within each identified problem is a set of policy initiatives or options for addressing the problem, followed by a subset of recommendations for consideration for the 2017 General Assembly Session.

POLICY FRAMEWORK

Problem 1: Provider Barriers: Providers are hesitant to use telemental health technologies to facilitate the delivery of care. This hesitancy is a result of several factors: 1) discomfort with the technology; 2) skepticism and uncertainty about the impact of technology on establishing rapport and building relationships with patients/clients; 3) concerns about clinical workflows (protocols, processes, and procedures); and 4) lack of clarity regarding policies (liability/malpractice, privacy and security).

Policy Initiatives/Options

- 1 Provide incentives for and/or require clinical mental/behavioral health training programs to offer coursework on telemental health.
- 2 Provide incentives for and/or require licensed clinical mental/behavioral health providers to obtain continuing education credit in telemental health.
- 3 Provide incentives for and/or require practicum/internship/residency programs for clinical mental/behavioral health providers to include a telemental health rotation.
- 4 Provide policy clarification and guidance regarding liability/malpractice; privacy and security requirements, standards of care, and standards for technology and interoperability.
- 5 Develop a state funded or supported telemental health network that connects public and private providers and facilities and facilitates the sharing of electronic health records. Telemental health networks have enormous potential to provide a wide range of mental health services, provider education, and administrative functions. Several states have developed very successful telemental health networks, including Arizona, South Carolina, North Carolina and Montana. The usefulness of telecommunications technology to enhance a mental health care system is in direct relationship to the extent that it is fully integrated with existing systems of care and coupled with a sustainable business model. This requires an organizational infrastructure that can provide leadership, engage a broad spectrum of stakeholders, deliver training, and assure timely technical assistance.

Problem 2: Workforce Barriers: Rural and underserved communities often suffer from limited access to mental health services due to difficulties recruiting and retaining mental health specialists. This shortage/maldistribution of the mental health workforce often places non-mental health providers in the position of serving patients with severe mental health problems with little or no specialty support.

Policy Initiatives/Options

- 1 Establish loan repayment or scholarship programs for mental/behavioral health providers who provide services to rural and other to-be-defined underserved populations via telemental health
- 2 Establish statewide Project ECHO (Extension for Community Healthcare Outcomes) clinics focused on mental/behavioral health

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| <p>issues such as pain management, behavioral health disorders, substance use disorders (including the use and abuse of opioids) and other addictions. Project ECHO is a collaborative model of medical education and care management. 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 front-line clinicians with 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.</p> |
| <p>3 Establish clinical fellowships in telemental health at academic medical and other mental health/behavioral health professions training programs for the purpose of meeting the identified needs of the public mental health system in the Commonwealth.</p> |
| <p>4 Establish less restrictive policies that would facilitate telemental health practice across state lines. Examples include the adoption of interstate compacts, establishment of special telemental health licenses, and establishment of expedited licensing processes for telemental health providers.</p> |
| <p>5 Establish and manage a directory of Virginia-licensed telemental health providers that can serve as a referral network for those seeking services either for themselves or for their patients/clients. This could be in the form of an online searchable database of providers who have been trained to deliver telemental health services.</p> |
| <p>6 Establish a sub-field in emergency telepsychiatry and provide incentives for participation.</p> |

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| <p>Problem 3: Financial Barriers: Concerns remain about the sustainability of telemental health services. These include barriers related to reimbursement by both public and private payers (e.g., limitations on the scope of reimbursable services, fee schedules that may not adequately cover costs) and the lack of a mechanism for delivering care to those who are uninsured or underinsured.</p> |
| <p>Policy Initiatives/Options</p> |
| <p>1 Provide enhanced reimbursement for providers who provide telemental health services to rural and other underserved populations.</p> |
| <p>2 Work with payers to identify funds to provide mental health/behavioral health providers with reduced rates or fee waivers for telemental health certification training and/or reduced rates or fee waivers for license renewals in exchange for banking hours of “free” services to the uninsured/underinsured.</p> |
| <p>3 Conduct a cost-benefit analysis to examine whether hiring clinicians to provide telemental health services would ultimately reduce the financial burden on emergency services, corrections, hospitals and state psychiatric facilities.</p> |
| <p>4 Identify and leverage existing resources through public-private partnerships that could be used to train and compensate a pool of clinicians who would be available to serve uninsured/underinsured populations (e.g., job sharing across municipalities, partnerships with hospitals/health systems, payers and foundations, pay as you go contracts) and identify an interoperable portal/platform and process that would enable providers to join the pool.</p> |

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| 5 | Explore coverage and market reforms to increase available insurance coverage/benefits for telemental health services. |
| 6 | Expand the list of originating sites eligible to receive Medicaid coverage for telemental health services to include both schools and homes. |
| 7 | Provide incentives for case management services to mitigate the financial burden of “no-shows” on clinicians and leverage mobile health applications to assist with case management (e.g., secure text messaging, mobile apps, remote monitoring/hovering) |

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| Problem 4: Patient/Client Barriers: Patients/clients may have difficulties accessing telemental health services for a variety of reasons. These include: 1) lack of access to high speed Internet services; 2) lack of access to technology or discomfort with using technology and 3) concerns about stigma associated with seeking treatment for a mental illness. | |
| Policy Initiatives/Options | |
| 1 | Provide incentives/leverage existing incentives (e.g., financial models) for integrating telemental health with primary care services. |
| 2 | Leverage existing Commonwealth broadband efforts and FCC/USAC Program efforts (Rural Health Care, High Cost, Lifeline, and Schools and Libraries Programs) to increase access to broadband and cellular infrastructure in rural and underserved areas. |
| 3 | Develop training programs and establish implementation processes that take into consideration cultural perceptions, stigmas and fear/discomfort with technology. |
| 4 | Develop cost-effective case management models (e.g., peer support, lay health workers/promoters, community paramedics, remote patient monitoring/hovering) to support patients/clients with technology, accessing telemental health, and help people to remain stable. |

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| Problem 5: Policy Barriers: In order to facilitate the expansion of telemental health, laws and regulations must be updated to ensure that they adequately accommodate new technology-enabled models of care. | |
| Policy Initiatives/Options | |
| 1 | Ensure that a solution is developed to address challenges with prescribing all schedules of psychotropic medications via telemental health as it relates to the establishment of a doctor-patient relationship, the Drug Control Act, and the Ryan Haight Act. |
| 2 | Develop a plan to address continued challenges with access to/sharing of electronic medical records. |
| 3 | Study the current mental/behavioral health workforce and make recommendations for how to better engage and leverage the full continuum of the mental/behavioral health workforce in Virginia (e.g., LCSWs, LPCs, Psych NPs, Psychologists, Psychiatrists), |

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| ensuring that they are practicing to the full extent of their education, training and license. |
| 4 Establish standards of care for out of state providers offering telemental health services in Virginia. |
| 5 Develop mechanisms (processes and procedures) to ensure that patients have access to recommended formulary and to ensure that medication reconciliation and continuity is facilitated during care transitions. |

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| Problem 6: Preventive Care Barriers: Prevention of mental disorders and promotion of mental health will reduce the burden associated with mental disorders. However, there is a lack of resources, and lack of awareness of programs and initiatives focused on preventing mental health issues and crises. |
| Policy Initiatives/Options |
| 1 Establish reimbursement and payment models that enable the use of a broad range of mental/behavioral health professionals (psychiatrists, psychologists, LCSWs, and other therapists) to deliver preventive care to a variety of settings (schools, primary care, home, workplace/EAPs, nursing homes, assisted living facilities). |
| 2 The Offices of the Secretary of Health and Human Resources and Public Safety develop a plan to raise awareness, educate, identify barriers and facilitate the better use of telemental health services throughout the criminal justice system, particularly with access to telemental health prevention, assessment, and treatment services in regional jails. |
| 3 Raise awareness about telemental health and prevention services through direct outreach into the community (e.g., clubhouses, peer run groups). |

RECOMMENDATIONS

Of the twenty-nine policy initiatives/options identified in the Policy Framework, the Telemental Health Work Group on Policy Development would like to put forward the following twelve for immediate consideration. The following policy initiatives/options have potential for high impact and could be reasonably achieved in a 12 month period.

To address **Provider Barriers**, it is recommended that:

1. The Office of the Secretary of Health and Human Resources provide policy clarification and guidance regarding liability/malpractice; privacy and security requirements, standards of care, and standards for technology and interoperability. The Georgia Public Policy Foundation has developed "The Guide to the Issues" (<http://www.georgiapolicy.org/additional-links/guidetotheissues/>) on a variety of topic areas and these guides could potentially serve as a model.
2. 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. 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.

To address **Workforce Barriers**, it is recommended that:

3. 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. Project ECHO is a collaborative model of medical education and care management. 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 front-line clinicians with 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.
4. Clinical fellowships in telemental health at academic medical and other mental health/behavioral health professions training programs be established for the purpose of meeting the identified needs of the public mental health system in the Commonwealth. The University of Virginia Center for Telehealth has an existing model for training the next generation of clinicians in telehealth that could serve as a model for other health professions training programs.

5. 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.

To address **Financial Barriers**, it is recommended that:

6. The Joint Commission on Healthcare study the costs/benefits of different models for providing telemental health services and their impact on reducing the financial burden on emergency services, corrections, hospitals and state psychiatric facilities. Models could include providing outpatient telemental health services in the community to patients with sub-acute needs, providing consulting/collaborating services in the ED to reduce psychiatric boarding, and assessing whether having the Virginia Department of Behavioral Health and Developmental Services hire providers who can dedicate themselves to providing telemental health services statewide would be more cost-effective than contracting with providers to deliver these services.
7. The Office of the Secretary of Health and Human Resources identify and leverage existing resources through public-private partnerships (payers, foundations, etc.) that could be used to train and compensate a pool of clinicians who would be available to serve uninsured/underinsured populations (e.g., job sharing across municipalities, partnerships with hospitals/health systems, payers and foundations, pay as you go contracts) and identify an interoperable portal/platform and process that would enable providers to join the pool.
8. The Virginia Department of Medical Assistance Services expand its list of eligible originating sites for telemental health services to include both schools and homes.

To address **Patient/Client Barriers**, it is recommended that:

9. The Offices of the Secretary of Health and Human Resources and the Secretary of Technology identify ways to leverage existing Commonwealth broadband efforts and FCC/Universal Services Administrative Company (USAC) Program efforts (Rural Health Care, High Cost, Lifeline, and Schools and Libraries Programs) to increase access to broadband and cellular infrastructure in rural and underserved areas.

To address **Policy Barriers**, it is recommended that:

10. The Commonwealth makes every effort to ensure that a solution is developed to address challenges with prescribing all schedules of psychotropic medications via telemental health as it relates to the establishment of a doctor-patient relationship, the Drug Control Act, and the Ryan Haight Act. Efforts to address this are currently being led by Virginia State Senator Dunnivant.
11. The Joint Commission on Healthcare study the current mental/behavioral health workforce and make recommendations for how to better engage and leverage the full continuum of the mental/behavioral health workforce in Virginia (e.g., LCSWs, LPCs,

Psych NPs, Psychologists, Psychiatrists), ensuring that they are practicing to the full extent of their education, training and license.

To address **Preventive Care Barriers**, it is recommended that:

- 12.** The Offices of the Secretary of Health and Human Resources and Public Safety develop a plan to raise awareness, educate, identify barriers and facilitate the better use of telemental health services throughout the criminal justice system, particularly with access to telemental health prevention, assessment, and treatment services in regional jails.