REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Options for Increasing the use of Telemental Health Services in the Commonwealth – Final Report

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 415

COMMONWEALTH OF VIRGINIA
RICHMOND
2018

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

Joint Commission on Health Care Membership

Chair
The Honorable Rosalyn R. Dance

Vice-Chair
The Honorable T. Scott Garrett

Senate of Virginia
Senator George L. Barker
Senator Charles W. Carrico, Sr.
Senator Siobhan S. Dunnavant
Senator John S. Edwards
Senator L. Louise Lucas
Senator Glen H. Sturtevant, Jr.
Senator David R. Suetterlein

Virginia House of Delegates
Delegate David L. Bulova
Delegate Benjamin L. Cline
Delegate C.E. Hayes, Jr.
Delegate Patrick A. Hope
Delegate Riley E. Ingram
Delegate Kaye Kory
Delegate Christopher K. Peace
Delegate Christopher P. Stolle
Delegate Roslyn C. Tyler

Commission Staff

Michele L. Chesser, Ph.D.
Executive Director

Paula R. Margolis, Ph.D., MPH
Senior Health Policy Analyst

Andrew D. Mitchell, Sc.D.
Senior Health Policy Analyst

Stephen G. Weiss, M.P.A.
Senior Health Policy Analyst

Agnes Dymora
Executive Assistant/Office Manager

JOINT COMMISSION ON HEALTH CARE

Senator Rosalyn R. Dance, Chair

November 1, 2018

The Honorable R. Creigh Deeds
Pocahontas Building, Room No: E503
Senate of Virginia
P. O. Box 396
Richmond, VA 23218

Dear Senator Deeds:

Attached please find the final report on expanding telemental health services in the Commonwealth, as mandated by 2017 budget amendment HB1500 Item 312 #1c. The Interim Report may be found on the Joint Commission for Health Care website.[1]

If you have any comments or questions regarding this report, please do not hesitate to contact me.

Sincerely,

Michele Chesser, Ph.D.
Executive Director,
Joint Commission on Health Care

CC: Senator Rosalyn R. Dance

[1] http://jchc.virginia.gov/3.%20Options%20for%20Increasing%20the%20use%20of%20telemental%20health.pdf

Preface

This final report of a two-year study was mandated by 2017 budget amendment HB1500 Item 312 #1c which directed the Joint Commission on Health Care (JCHC) to study options related to the recommendations set forth in the October, 2016 report of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century (Subcommittee,) Telemental Health Workgroup (Workgroup) for increasing the use of telemental health services in the Commonwealth.

An Interim Report was submitted to the JCHC during their August 22, 2017 meeting. The Interim Report focused on four of 12 recommendations made by the Workgroup in their October 2016 report. The four recommendations included appropriating funds for the following activities: 1) creating the Virginia Appalachia Telehealth Network Initiative - Virginia Pilot; 2) continuation and expansion of Project ECHO (Extension for Community Health Outcomes); 3) the creation, maintenance, and marketing of a telemental health provider directory; and, 4) updates to the telehealth educational resources at the Southside Training and Telehealth Academy (STAR). The JCHC approved the policy option to take no action, deferring to the Subcommittee. Actions of the Subcommittee resulted in the passage of Budget Amendment Item #312.OO allocating $1.1M in each year of the 2019-2020 biennium (total $2.2M) for these activities.

Prior to this Final Report, the Workgroup reviewed their October 2016 report and revised several of the recommendations, based on developments that had occurred over the proceeding time period. This Final Report includes updates on actions taken over the past year and provides information on possible pathways and considerations for action on the updated Workgroup recommendations.

Possible pathways for increasing the use of telemental health include: 1) increasing Medicaid fees for psychiatric services; 2) increasing Medicaid fees paid to originating sites that facilitate telehealth services; 3) creating a committee to evaluate models for consolidating contracts for psychiatric services provided to clients of Community Services Boards (CSBs); 4) allocate funding for telehealth fellowships at Virginia academic health centers; and, 5) request that the Virginia Department of Corrections (VADOC) and Virginia Commonwealth University Health System (VCU-HS) develop policies to improve the exchange of offender medical information, including electronic exchange of information and access to electronic medical chart information by providers at both institutions.

Joint Commission members and staff would like to acknowledge and thank those who assisted in this study including: Richard Bonnie, M.D. and John E. Oliver, Institute of Law, Psychiatry and Public Policy, University of Virginia School of Law; Holly Mortlock, Policy Director Department of Behavioral Health and Developmental Services; Carol Pratt, Policy Advisor to the Commissioner, Virginia Department of Health; William Lessard, Director, Provider Reimbursement, Department of Medical Assistance Services (DMAS); Brian McCormick, Director, Policy and Research Division, DMAS; Karen Rheuban, M.D., University of Virginia

(UVA); Kathrine Wibberly, Director Mid-Atlantic Telehealth Resource Center at UVA; and, David Catell-Gordon, Mid-Atlantic Telehealth Resource Center at UVA.

The study and this report was assigned to and completed by Paula R. Margolis, Ph.D., MPH, Senior Health Policy Analyst at the Joint Commission on Health Care. She may be contacted at pmargolis@jchc.virginia.gov.

Table of Contents

Executive Summary

OPTIONS FOR INCREASING THE USE OF TELEMENTAL HEALTH SERVICES IN THE COMMONWEALTH

Study mandate – Title 30, Chapter 18, *Code of Virginia*

B. *The Joint Commission on Health Care shall study options for increasing the use of telemental health services in the Commonwealth. The Joint Commission on Health Care shall specifically study the issues and recommendations related to telemental health services set forth in the report of the Service System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century. All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request. The Joint Commission on Health Care shall submit an interim report to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century by November 1, 2017 and a final report of its findings to the Joint Subcommittee by November 1, 2018.*

Background

At the 2014 Regular Session of the General Assembly, the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (the Subcommittee) was established pursuant to Senate Joint Resolution 47. The 12-member Joint Subcommittee was directed to review the laws of the Commonwealth governing the provision of mental health services, including involuntary commitment of persons in need of mental health care, and recommend statutory or regulatory changes to improve access to services, the quality of services, and outcomes for individuals in need of services. The Subcommittee formed workgroups in order to address various aspects of the mental health system in the Commonwealth, including the Telemental Health Workgroup (the Workgroup) and make recommendations on expanding the use of telemental health, especially in mental health provider shortage areas.

The Workgroup Concluded that "*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, telemental health has not been widely adopted within the Commonwealth*."[1]

The Policy Framework that was developed by the Workgroup centered around barriers across six problem areas or domains. These include:

1. Provider Barriers: This includes provider hesitance in using telemental health technologies to facilitate care delivery due to a lack of training and competence, skepticism about the impact of technology on establishing rapport and building relationships with patients/clients, concerns about clinical workflows and lack of clarity regarding policies.

2. Workforce Barriers: This includes limited access to mental health services in rural and underserved communities due to difficulties with recruitment and retention and provider shortages and misdistribution.

3. Financial Barriers: This includes barriers related to reimbursement by both private and public payers and the lack of a mechanisms for delivering care to those who are uninsured/underinsured.

4. Patient/Client Barriers: This includes barriers to accessing telemental health due to inadequate access to high speed internet services, lack of access to technology and/or discomfort with technology, and stigma associated with seeking mental health services.

5. Policy Barriers: This includes challenges with laws, regulations and other policies that do not adequately address new technology enabled models of care.

6. Preventive Care Barriers: This includes a lack of resources and programs that focus on preventing mental health issues and crises.

The Workgroup proposed 12 recommendations based on their potential for high impact and an ability to be achieved within a 12-month period. The JCHC Interim Report focused on a sub-set of the twelve recommendations that were most amenable to action during the 2018 General Assembly session, including: The Appalachian Telehealth Imitative - Virginia Pilot; Project ECHO; updating the Southside Training and Telehealth Academy (STAR) resources; and, a directory of telemental health providers that can be accessed by individuals and used by non-behavioral health services providers for referrals.

The Workgroup stated that three years of funding was required to implement the four recommendations. During the 2018 General Assembly session, a budget amendment (HB5002 Item 312.OO) was passed allocating $1.1M per State Fiscal Year (total of $2.2M over the biennium) to establish the Appalachian Telemental Health Initiative - Virginia Pilot Program, and related activities. The Subcommittee may consider allocating funds for the third year in the upcoming General Assembly session.

The Appalachian Telehealth Initiative - Virginia Pilot

The telemental health pilot in Appalachia involves several organizations including: The Virginia Department of Behavioral Health and Developmental Services (DBHDS) as a pass-through and

fiscal agent, the University of Virginia (UVA), the Healthy Appalachia Institute at UVA Wise, and the Virginia Telehealth Network.

The objectives of the Pilot include: Establish a referral network of Virginia-licensed telemental health providers who could serve clients in Southwest Virginia; develop an online telemental health training portal through *Telehealth Village* (a newly created umbrella organization for telehealth training in the Commonwealth); developing a system of incentives for licensed mental health providers to become trained in telemental health; providing services to uninsured and underinsured clients prioritizing those in the Appalachian region; increasing the capacity of community-based clinicians in the Appalachian region to better manage patients with behavioral health/substance use issues through Project Echo; and, assess progress and evaluate the outcomes and impact of the Initiative (See Appendix A for the work plan).

Implementation of the work plan requires that a Memorandum of Understanding (MOU) be signed between UVA and DBHDS. Finalizing the MOU has taken longer than anticipated, due to the need to refine the performance metrics. The parties have agreed to execute the MOU in the near future, in order to begin recruiting staff while metrics are finalized. Because of the delay, State general funds allocated for the project have not yet been expended and may result in funds reverting back to the General Fund at the end of the State Fiscal Year. Bringing money forward from a prior year is done at the discretion of the Governor. Budget language would be needed to bring unspent funds forward for the Pilot. The Subcommittee may consider introducing Budget language in the upcoming General Assembly session for this purpose.

Project Echo

Project ECHO employs a collaborative practice model using the "spoke and hub" system that links expert specialist teams at an academic "hub" with primary care clinicians in local communities – the "spokes" of the model. Project ECHO sessions allow for a team of specialists to consult on individual, de-identified patient cases via video conferencing with primary care and other providers across the state. Sessions also can include a didactic section on pre-determined topics (including medication assisted treatment for substance use), and continuing medical education credits are available. Providers can participate over computers and smart phones.

The Virginia Department of Health received a one-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a pilot Project ECHO program in Virginia which is co-administered by the Virginia Department of Medical Assistance Services (DMAS). The Project ECHO pilot launched in 2018. Virginia Commonwealth University, University of Virginia, and Virginia Tech Carilion have partnered with the Virginia Department of Health, the Department of Medical Assistance Services, and the Department of Behavioral Health and Developmental Services to address the opioid crisis using Project ECHO.

Using the ECHO model, they have developed *Virginia Opioid Addiction ECHO*, an innovative mentoring-based learning network that connects subject matter experts to practicing providers, clinicians and social health professionals in the field. The Virginia Opioid Addiction ECHO Clinical Team Leader is Dr. Mishka Terplan, MD, MPH, professor in VCU's Department of

Obstetrics and Gynecology and a nationally known addiction specialist. Dr. Terplan and his team work in partnership with a multidisciplinary team ranging from addiction psychology to rehabilitation counseling, as well as VCU Health's Continuing Medical Education department. Providers fill out a de-identified case presentation form prior to the session that is used to guide the on-line consult with addiction specialists.[2] Virginia Opioid Addiction ECHO has several ongoing didactic learning opportunities, a schedule which can be found on their website.[3] Topics include: Fentanyl derivatives, Chronic Pain and OUDs, Office Based Opioid Treatment using the DMAS Model, Trauma Informed Care, and Treating Those Experiencing Opioid Addiction. The Workgroup supports expanding on this model to include telemental health (in addition to substance use disorders), which could build upon the opioid addiction platform and maximize its utility.

Southside Training and Telehealth Academy (STAR)

STAR, which is part of the Virginia Health Workforce Development Authority, is a training program in Martinsville, VA that offers classes for health care providers seeking to use advanced telemedicine and telehealth systems for rural and medically-underserved populations. Programs include: Board Certified Telemental Health Provider training for mental health professionals, Certified Telemedicine Clinical Presenter training, Certified Telehealth Coordinator/Technical Professional, and HIPAA training. The Workgroup recommended that funds be allocated to update the STAR website and materials. During the 2018 General Assembly session funds were allocated for this purpose. In 2018, STAR moved under the broader Telehealth Village, the hub platform for telehealth training managed by UVA.

Telemental Health Provider Directory

The Pilot will establish an on-line referral network that will allow providers to post information about specialty and state licenses, allow patients to identify providers with open appointments, display patient ratings of providers, provide information on insurance networks in which providers participate, and include information on patient satisfaction. Work can commence after the execution of the MOU between UVA and DBHDS.

Outstanding Workgroup Recommendations

Clinical Fellowships - The Workgroup recommended that clinical fellowships in telemental health be established at academic medical centers, noting that the UVA Center for Telehealth has an existing model currently used for training residents that could serve as a model for other health professional training programs. The Workgroup posited that a clinical fellowship could attract psychiatrists who may remain in Virginia after completion. UVA is interested in establishing a new fellowship program. Standing up a Graduate Medical Education (GME) Strategic Analysis Team would be the first step, prior to going before the GME Committee for approval. Informal, internal discussions at UVA have occurred but are in the very initial stage.

The Subcommittee may wish to indicate support for the establishment of a telemental health fellowship program at UVA, which would require funding at a future point for operational and administrative expenses, faculty and fellowship salaries.

Expand Originating Sites Allowed to Bill Medicaid – Currently the Virginia Department of Medical Assistance Services (DMAS) allows a variety of locations to serve as originating sites ("spokes" where a patient is located) that are eligible for Medicaid reimbursement, including physician offices, Rural Health Centers, Federally Qualified Health Centers, Community Services Boards, hospitals, renal units, some residential treatment centers, nursing homes and health department clinics. Covered telemental health services include evaluation and management for behavioral and substance use disorders; psychiatric diagnostic interview examinations; individual, group and family psychotherapy; and, substance abuse crisis intervention. To date, schools have not been designated as approved originating sites. The Workgroup recommended allowing schools to become eligible as originating sites with the ability to provide all DMAS-covered telehealth services. Communications with DMAS staff indicate that this is under consideration but has not been acted upon. The Subcommittee may wish to consider introducing legislation to allow schools to act as originating sites under DMAS.

Increase Telepsychiatry Use at Community Services Boards (CSBs) – One Workgroup recommendation focused on financial barriers that limit access to psychiatrists who treat clients at CSBs across the Commonwealth. The Workgroup reported that each CSB is responsible for contracting psychiatrists and posited developing a centralized contracting model with one fiscal agent managing the contract across all CSBs using DBHDS as the fiscal agent. Central contracting could reduce redundant administrative burdens and costs associated with the current individual CSB contracting structure. Other alternative models mentioned included: 1) providing funds to State Mental Health Facilities to hire and situate psychiatrists who could serve the region using telepsychiatry; 2) have DBHDS disperse funds to regions for regionalization of telemental health services.

Correspondence with the DBHDS Policy Director clarified that DBHDS does not hire service providers directly and is not considered the appropriate entity to hire and provide direct care in the community. the Workgroup recommended creating a committee to explore other models of contracting for telepsychiatry services by CSBs, in order to streamline operations. The committee would include representatives from DHBDS, the VACSB, State Mental Health Facilities, and other appropriate individuals. The committee would be tasked with identifying a workable model, determining methods of implementation, determining costs, identifying sources of funding (including Budget requests), and assessing if and how the model could become self-sustaining. The Subcommittee may consider establishing this committee.

Increase Medicaid Reimbursement for Psychiatric Services - A variety of CSB leaders have conveyed that, while they fully support telemental health and think they it is an important tool for expanding access to care, psychiatric services in general. But, the cost to deliver psychiatric service, (including in-person and telepsychiatric services), is greater than reimbursement. Costs

for telepsychiatry include equipment costs, connectivity fees, and originating site staff which are required by the Centers for Medicare and Medicaid Services (CMS) to facilitate telehealth visits; therefore, delivering services via telehealth is more costly than in-person services and not pursued because it is considered to be unaffordable.[4]

Most CSB clients are either indigent or receive Medicaid reimbursement, and with Medicaid expansion effective January 1, 2019, the CSBs' share of clients who receive Medicaid is expected to increase. An increase in DMAS reimbursement rates for psychiatric and originating site facility fees may help ease the financial barrier preventing CSBs to provide services via telehealth.

The Centers for Medicare and Medicaid Services require that state Medicaid agencies pay for telehealth services in the same way that they pay for in-person services, unless the state submits a separate State plan amendment that is approved by CMS. Medicaid does not reimburse for the purchase of telemedicine equipment or connectivity fees.

Currently DMAS reimburses providers one fee for a billable service, regardless of the method of service delivery (e.g., in-office or telehealth); therefore, the fees paid to psychiatrists delivering care via telehealth is the same as the fee paid for in-person visits. In order to increase rates paid for telepsychiatric services, DMAS would need to either increase the rates paid for all psychiatric services or submit a separate State plan amendment to raise psychiatrist fees for telemental health only. In addition to the professional fee, DMAS pays a $20 facility fee to originating sites per telehealth visit. The fee was established in 2002 and has never been updated.

During the 2018 General Assembly session, DMAS recommended that psychiatry rates increase from 82.5% to 100% of Medicare rates. Budget amendment HB30 Item 303 #29 was introduced in the 2018 General Assembly session to allocate $671,000 in the first year, and $704,550 in the second year of the FY 2019-2020 State budget, in order to increase these rates. The amendment failed to pass, but DMAS representatives expressed an interest in reintroducing budget language in the upcoming session.[5]

The 2018 Medicare payment rate for the originating site facility fee is $25.76. The fee is adjusted each year by the Medicare Economic Index (MEI).[6] The Subcommittee may request that DMAS estimate the amount of State General Fund dollars that would be required to increase the Virginia Medicaid originating site facility fee to 100% of the 2018 Medicare rate, with annual changes, based on the Medicare methodology.[7]

Telemental Health in the Criminal Justice System - The Workgroup recommended that a plan be developed to facilitate the better use of telemental health services throughout the criminal justice system addressing prevention, assessment, and treatment services. In a September 19, 2018 report to the JCHC on the quality of health care services in Virginia jails and prisons, JCHC Senior Health Policy Analyst, Stephen Weiss, reported that the Virginia Sheriff's Association and the Virginia Association of Regional Jails fielded in electronic survey to 66 local and regional jails, in order to get baseline information on their health services systems.

Forty of the 66 jails responded (60%) to the survey. Nineteen respondents reported using telehealth services, of which, 8 reported having vendor contracts for the provision of both telehealth and telepsychiatry services, and 11 reported that they used the services for psychiatric care only.[8]

In the report, it was noted that offenders frequently move between different prisons due to the ability of a prison to provide appropriate care for offenders with various health issues. This movement requires medical charts to be moved. The study noted that none of the health care record systems operated by jails or prisons are integrated, that paper charts continued to be used, and offender charts may include multiple files. Also noted was the fact that offender records often have to be faxed to off-site providers, which is particularly staff-intensive. One of the report conclusions was that medical records need to be converted from paper to electronic records and information transfer for telemedicine needs to be streamlined and improved. As a result of this conclusion, one policy option presented to the JCHC was that the Virginia Department of Corrections develop policies to improve the exchange of offender medical information, including electronic exchange of information for telemedicine, telepsychiatry and electronic medical chart access by health care providers and report on the policies and an implementation plan by October 2019 (as of the writing of this report, the JCHC had not yet voted on policy options).

Work Force Development - Telemental Health Fellowships - Training in telepsychiatry is critical to building mental health care capacity in rural and underserved communities. Even brief learning experiences may increase the likelihood that psychiatrists will incorporate telepsychiatry into their practices. Telepsychiatry training should address technical components in the use of videoconferencing, interpersonal and collaborative skills to work with providers in rural communities, and administrative abilities to work across organizations.[9]

The Workgroup recommended that one avenue for addressing the shortage of psychiatrists in the Commonwealth is to create telepsychiatry fellowship opportunities. Fellowships are undertaken after the completion of medical school and residency programs. The American Medical Association expressed support for telemedicine graduate medical education (GME) in Resolution 330-A-15, Telemedicine in Medical Education, noting that "telemedicine has demonstrated significant value in patient access to care, physician and patient satisfaction, health outcomes and the reduction of health care costs".[10]

The UVA Department of Psychiatry and Neurobehavioral Sciences, in conjunction with the UVATelemedicine Department have expressed a strong interest in creating a telepsychiatry fellowship program. Fellows could be stationed at both spoke and hub locations and provide psychiatry and behavioral assessments and care throughout the Commonwealth. In addition, the program could 'dovetail' with Project Echo to expand professionals who can educate primary care providers in successfully treating behavioral health and substance use disorders.

Medical school resident and fellowship programs are largely funded through Medicare and are limited by federal funding caps. Virginia academic medical centers have reached theses caps, but, new programs (at sites without a program) are not limited by these funding caps.[11] Steps for

developing a program include: establish an institutional affiliation or sponsorship and locate a primary training site; develop a budget and secure funding; determine a timeline for application, accreditation, recruitment and program initiation; develop an educational vision, ensure alignment of faculty; and, marketing and recruitment.[12]

Policy Options

1. Introduce a Budget Amendment allocating $1.1M General Funds to support the third year of activities related to the Appalachian Telemental Health Initiative – Virginia Pilot.

2. In order to offset unspent funds allocated for the Appalachian Telehealth Initiative – Virginia Pilot that will revert to the State General fund at the end of SFY 2019, introduce Budget language during the 2019 General Assembly session to bring the unspent funds forward from the previous State Fiscal Year(s).

3. Express support for UVA to convene a Strategic Development Team to establish a clinical fellowship in telepsychiatry, with the understanding that State General Funds may be required at a future date, and request that the Team provide a, workplan, budget and timeline for implementation by October 1, 2019.

4. Introduce legislation mandating that DMAS designate schools as allowable telehealth originating sites.

5. Reintroduce a Budget amendment in the 2019 General Assembly session to allocate $671,000 General Funds in the first year, and $704,550 General Funds in the second year, of the FY 2019-2020 State budget, in order to increase DMAS psychiatrist rates (legislators may wish to consult with DMAS staff, in order to confirm or update these amounts).

6. Introduce a Budget amendment in the 2019 General Assembly session to allocate State General Funds to increase the DMAS telehealth originating site facility fee to 100% of the Medicare rate, including annual Medicare fee increases. DMAS could estimate the amount of a proposed budget increase by analyzing past usage plus an adjustment to account for an expected increase in volume that may result from an increase in the facility and psychiatrist fees.

7. Create a workgroup to explore models of contracting for telepsychiatry services for CSB clients, in order to increase access and streamline administrative costs. A workgroup could include representatives from DBHDS, VACSB, State Mental Health Facilities, and other appropriate participants.

8. Request that the Virginia Department of Corrections develop policies to improve the exchange of offender medical information, including electronic exchange of information

for telemedicine, telepsychiatry and electronic medical chart access by health care providers and report on the policies an implementation plan and related costs by October 2019.

Legislative Action

During the 2018 General Assembly session, a budget amendment (HB5002 Item 312.OO) was passed allocating $1.1M per year (total of $2.2M over the biennium) to establish the Appalachian Telemental Health Initiative - Virginia Pilot, and related activities.

JCHC Staff for this Report

Paula R. Margolis, Ph.D., MPH
Senior Health Policy Analyst

ENDNOTES

[1] Report of the Telemental Health Work Group on Policy Development, October 6, 2016.
[2] https://www.vcuhealth.org/telehealth/for-providers/education/va-opioid-addiction-echo.
[3] https://www.vcuhealth.org/telehealth/for-providers/education/virginia-opioid-addiction-echo-curriculum-calendar.
[4] Correspondence with John Oliver, Esq. July 10, 2018.
[5] Correspondence with William Lessard, DMAS Provider Reimbursement Director, September 26, 2018.
[6] Section 1834(m)(2)(B) of the Social Security Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for CY 2018, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.76. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10393.pdf
[7] Data received from DMAS indicate that utilization of the facility fee billing code is low; 7,143 instances were found in the DMAS claims and encounter data for SFY 2018 (based on run-out to October 24, 2018). Due to the truncated run-out period, which is generally six months, the actual number of instances may be somewhat under-represented.
[8] Quality of Health Care Services in Virginia Jails and Prisons, and Impact of Requiring Community Services Boards to Provide Mental Health Services in Jails – Final Report of 2-year Study; Http://jchc.virginia.gov/3.%20Staff%20Report.%20Quality%20of%20Health%20Care%20Services%20in%20VA%20jails%20and%20prisons.pdf
[9]https://www.researchgate.net/publication/265054588_Telepsychiatry_in_Graduate_Medical_Education_A_Narrative_Review.
[10] American Medical Association, 2016. Telemedicine in Medical Education Resolution 330-A-15.
[11] Barajaz and Turner, 2016. Medical Education Online, 21:32271 – http://dx.doi.org/103402/meo.v21.32271.
[12] Ibid.

SCOPE OF WORK

APPALACHIAN TELEMENTAL HEALTH INITIATIVE – VIRGINIA PILOT

Mission: To advance the innovative use of telehealth as a solution for improved mental health, behavioral health and substance abuse outcomes; and reducing barriers of time, distance, and provider scarcities for those living and working in the Appalachian Region of Virginia.

Goal 1: To improve access to mental health care for the rural and/or underserved populations in the Appalachian Region of Virginia.

Objectives	Specific Project Tasks/Activities/Steps	Timeline (Start/End)	Major Milestones	Person(s) Responsible
1. To establish a referral network of Virginia licensed telemental health providers (to include licensed social workers, counselors, psychiatrists, psychiatric nurse practitioners and psychologists) who could provide services to patients/clients in southwest Virginia.	**Establish, maintain, update and manage an online directory of Virginia-licensed telemental health providers.**			
	• Identify all the types of licensed mental health providers who may be able to provide telemental health services in Virginia and potential end-users of the telemental health provider directory	• Year 1, Q1– Year 1, Q2	• Lists made available and discussed with Advisory Board	Virginia Telehealth Network – Mara Servaites
	• Conduct key informant interviews with licensed mental health providers, including representatives of associations, professional organizations, training programs, and other relevant individuals and groups to help inform the development of the directory.	• Year 1, Q3- Year 1, Q4	• Report summarizing findings and draft template made available and discussed with Advisory Board	Virginia Telehealth Network – Mara Servaites
	• Conduct key informant interviews with potential end-users, including representatives from associations,	• Year 1, Q3- Year 1, Q4	• Report summarizing findings and draft template made	Virginia Telehealth Network – Mara Servaites

	professional and consumer advocacy organizations, and other relevant individuals and groups to inform development of the directory.		available and discussed with Advisory Board	
	• Design and development of web-based database/directory with policies, procedures and protocols for maintenance, updates and quality improvement	• Year 2, Q1– Year 2, Q2	• Availability of Telemental Health Provider Directory	Virginia Telehealth Network – Mara Servaites and Jennifer O'Dell
	• Development of marketing and outreach materials and plans for Telemental Health Provider Directory	• Year 2, Q2	• Availability of marketing and outreach materials and plans	Virginia Telehealth Network – Mara Servaites and Jennifer O'Dell
	• Ongoing maintenance and regular updates to the Telemental Health Provider Directory	• Year 2, Q2 & ongoing	• Availability of up-to-date online directory of Virginia licensed telemental health providers	Virginia Telehealth Network – Mara Servaites and Jennifer O'Dell
	Recruit a broad spectrum of licensed mental health providers to provide telehealth services as part of a regional referral network for residents in the Appalachian Region of Virginia.			
	• Develop position description and recruit for Project Director and Outreach Coordinator	• Year 1, Q1– Year 1, Q2	• Positions established and filled	Healthy App. Institute – Margie Tomann
	• Develop strategic plan with timelines for engaging trainees, license-eligible providers and licensed providers.	• Year 1, Q2- Year 1 Q3	• Draft strategic plan made available,	Healthy App. Institute – Project Director

			discussed with Advisory Board and finalized.	
	• Implementation of strategic plan	• Year 1, Q4 & ongoing	• Increase in numbers of licensed mental health providers added to the directory of telemental health providers and increase in providers available to provide services to rural and/or underserved populations in the Appalachian Region of Virginia	Healthy App. Institute – Outreach Coordinator
	• Bi-annual progress report to Advisory Board	• Year 2, Q2 & ongoing	• Availability of bi-annual progress report	Healthy App. Institute – Project Director
2. To develop and make available world class online telemental health training.	Establish Telemental Health Training Portal through Telehealth Village • Develop position description and recruit for part time Project Coordinator	• Year 1, Q1-Year 1 Q2	• Positions established and filled	UVA Center for Telehealth – Lauren Purnell
	• Make available existing telemental health content online through Telehealth Village	• Year 1, Q1-Year 1, Q2	• Access to telemental health introductory and certification training modules online	UVA Center for Telehealth – Lauren Purnell

	• Development of marketing materials and begin marketing of telemental health training content (including establishing of online and social media presence)	• Year 1, Q3 & ongoing	• Availability of marketing materials, online/social media presence and physical presence at events and conferences	Healthy App. Institute – Outreach Coordinator, New College Institute and UVA Center for Telehealth – Project Coordinator
	• In collaboration with the National Board for Certified Counselors, obtain input from a broad spectrum of mental health providers (to include, but not limited to LCSWs, counselors, psychiatrists, psychiatric nurse practitioners and psychologists) in order to develop training packages specific to the needs of each type of professional and identify gaps or revisions needed in existing training modules.	• Year 1, Q2- Year 1, Q4	• Report summarizing findings.	UVA Center for Telehealth – Project Coordinator
	• Development of a plan for packaging existing modules tailored for specific mental health professionals, marketing, development of new modules (up to 2 per year) and making needed revisions, updates, edits or additions to existing training modules.	• Year 1, Q4 Year 2, Q1	• Draft implementation plan and timeline for training module packaging, marketing, development and updates made available, discussed with Advisory Board and finalized	UVA Center for Telehealth – Lauren Purnell

	• Development and production of new online training related to Appalachian Cultural Competency for mental health providers.	• Year 1, Q2-Year 1, Q4	• Availability of training module related to Appalachian Cultural Competency for mental health providers in Telehealth Village.	Healthy App. Institute – Margie Tomann and Project Director with input from local Appalachian Studies consultants and UVA Psychiatry/ ETSU
	• Implementation of strategic plan	• Year 2, Q1 & ongoing	• Availability of "one-stop shop" for online telemental health training through Telehealth Village	UVA Center for Telehealth – Project Coordinator
	• Bi-annual progress report to Advisory Board	• Year 2, Q2 & ongoing	• Availability of bi-annual progress report	UVA Center for Telehealth – Lauren Purnell
3. To develop a system of incentives for licensed mental health providers to become trained in telemental health and to provide services to uninsured/underinsured patients/clients in rural and underserved areas in Virginia, with a focus on those from Appalachian Region first.	• Obtain input from a broad spectrum of mental health providers (to include, but not limited to LCSWs, counselors, psychiatrists, psychiatric nurse practitioners and psychologists) in order to develop a package of incentives for training service delivery to patients in rural and underserved areas in Virginia.	• Year 1, Q2-Year 1, Q4	• Report summarizing findings.	Healthy App. Institute – Outreach Coordinator
	• Development of a plan for packaging and marketing the incentive program tailored for specific mental health professionals	• Year 2, Q1	• Draft implementation and marketing plan and timeline made	Healthy App. Institute – Project Director and

			available, discussed with Advisory Board and finalized	Healthy App. Institute Business Development Analyst/Consultant
	• Implementation of plan	• Year 2, Q2 & ongoing	• Increase in numbers of licensed mental health providers trained in telemental health and available to provide services to rural and/or underserved populations in the Appalachian Region of Virginia	Healthy App. Institute – Outreach Coordinator
	• Bi-annual progress report to Advisory Board	Year 2, Q2 & ongoing	• Availability of bi-annual progress report	Healthy App. Institute – Project Director
4. To establish a statewide interoperable HIPAA compliant technology infrastructure for telemental health providers participating in the referral network.	• Develop position description and recruit for a Unified Communications Network Engineer	• Year 1, Q1– Year 1, Q2	• Positions established and filled	UVA Center for Telehealth - David Cattell Gordon and Healthy App. Institute – Margie Tomann
	• Research, test (including end-user testing from a variety of telemental health professionals) make recommendations for a scalable, financially sustainable platform with pricing/business model.	• Year 1, Q3– Year 1, Q4	• Report summarizing findings and recommendations.	UVA Center for Telehealth - Unified Communications Network Engineer and Healthy App. Institute Business

				Development Analyst/Consultant
	• Platform selected, procured and deployed	Year 1, Q4 – Year 2, Q2	• Recommendations made available, discussed with Advisory Board and adopted.	Healthy App. Institute – Project Director
	• Development of marketing plan and materials regarding technology infrastructure	• Year 1, Q4 – Year 2, Q2	• Availability of marketing plan and materials	Healthy App. Institute – Outreach Coordinator
	• Provide ongoing technical support and training for mental health providers in using telehealth technology/platform	• Year 2, Q2 & ongoing	• Increase in numbers of licensed mental health providers using the platform	UVA Center for Telehealth - Unified Communications Network Engineer
5. To increase the capacity of community-based clinicians in the Appalachian Region of Virginia to better manage patients with mental/ behavioral health issues in their own practices through the use of Project ECHO.	• Establish team of Hub Mental Health Providers including Pediatric Psychiatry	• Year 1, Q1-2	• Establish landing page for information about Project ECHO topics	UVA Psychiatry: Kimberly Albero, Program Administrator Larry Merkle, Psychiatrist Jordan Rosen, Psychiatrist Michelle Storer, Director of Finance
	• Establish a schedule of topics and speakers	• Year 1, Q1 & ongoing	• Post Schedule of topics and speakers to landing page	
	• Advertise to Community Providers and solicit input through needs assessment. Build on existing network of providers from VDH Substance Abuse Project ECHO	• Year 1, Q1 & ongoing	• Establish CME for TeleECHO clinics	

	• Provide quarterly report of participation			
Goal 2:: To ensure long term sustainability of the Appalachian Telemental Health Initiative				
Objectives	**Specific Project Tasks/Activities/Steps**	**Timeline (Start/End)**	**Major Milestones**	**Organization and Individual Responsible**
1. To engage key stakeholders in the development of the initiative.	• Establish an Advisory Board for the Initiative	• Year 1, Q1– Year 1, Q2	• Inaugural Advisory Board roster finalized and first meeting scheduled	UVA Center for Telehealth - David Cattell Gordon and Healthy App. Institute – Margie Tomann
	• Establish meeting schedule and hold regular meetings to obtain input from Advisory Board	• Year 1, Q1– Year 1, Q2	• Regular meeting schedule published	Healthy App. Institute – Project Director
2. To assess progress and evaluate outcomes and impact of the initiative	• Identify key program metrics (process, short term and medium term outcomes and impacts) and develop data collection plan	• Year 1, Q3– Year 1, Q4	• Draft program evaluation plan and timeline made available, discussed with Advisory Board and finalized	Healthy App. Institute – Project Director
	• Implement data collection plan	• Year 1, Q4 & ongoing	• Availability of data	Healthy App. Institute – Project Director

	• Annual progress report to DBDHS and General Assembly (or as requested)	• Year 1, Q4 & ongoing	• Availability of annual progress report	Healthy App. Institute – Project Director
3. To create a business plan for the Appalachian Telemental Health Initiative.	• Develop request for proposals for business development analyst/consultant and solicit bidders.	• Year 1, Q3– Year 1, Q4	• Contract established	Healthy App. Institute – Margie Tomann and Project Director
	• Conduct market/industry/customer and competitive analyses.	• Year 1, Q4– Year 2, Q1	• Draft analyses report available, discussed with Advisory Board and finalized	Healthy App. Institute Business Development Analyst/Consultant
	• Develop description of initiative and define scope of services/products, develop management/operations plan, and financial plan to include break-even analysis, budget projections and investments needed.	• Year 2, Q2– Year 2, Q4	• Draft plan available, discussed with Advisory Board and finalized	Healthy App. Institute Business Development Analyst/Consultant
	• Implement business plan	• Year 3, Q1 & ongoing	• Initiative is able to be sustaining by July 1, 2022	Healthy App. Institute – Project Director