COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

Wednesday, December 29, 2021

The Honorable Ralph S. Northam, Governor
Patrick Henry Building
1111 E Broad St
Richmond, VA 23219

Governor Northam:

Item 320.II of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to continue the workgroup from 2020 on who should conduct evaluations for temporary detention orders (TDOs) in Virginia. The language states:

> *The Department of Behavioral Health and Developmental Services shall continue the Temporary Detention Order Evaluator Workgroup established pursuant to Chapters 918 and 919 of the 2020 Acts of Assembly. The workgroup shall report its implementation plan to the Governor, and Chairs of the House Health, Welfare, and Institutions Committee, the Senate Education and Health Committee, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2021.*

This report details the findings and recommendations of the TDO Evaluator Workgroup. Staff is available to answer any questions.

Sincerely,

Alison G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

Wednesday, December 29, 2021

The Honorable R. Creigh Deeds, Chair, Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century
The Honorable L. Louise Lucas, Chair, Senate Committee on Education and Health
The Honorable Mark D. Sickles, Chair, House Committee on Health, Welfare, and Institutions
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senators Deeds and Lucas and Delegate Sickles:

Item 320.II of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to continue the workgroup from 2020 on who should conduct evaluations for temporary detention orders (TDOs) in Virginia. The language states:

> *The Department of Behavioral Health and Developmental Services shall continue the Temporary Detention Order Evaluator Workgroup established pursuant to Chapters 918 and 919 of the 2020 Acts of Assembly. The workgroup shall report its implementation plan to the Governor, and Chairs of the House Health, Welfare, and Institutions Committee, the Senate Education and Health Committee, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2021.*

This report details the findings and recommendations of the TDO Evaluator Workgroup. Staff is available to answer any questions.

Sincerely,

Alison G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Report on Item 320.II of the 2021 Appropriations Act

Report on Who Should Conduct TDO Evaluations in Virginia

To the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Wednesday, December 29, 2021

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Table of Contents

Table of Contents

Executive Summary 6
Preface 8
Introduction 9
Background 9
Guiding Principles in the Involuntary Commitment Process 9
Virginia's Current Process for Conducting Preadmission screenings for Individuals under an Emergency Custody Order 10
Responsibilities of CPSCs 12
Current Requirements to Become a CPSC in Virginia 13
Past Studies of the Preadmission Screening Process in Virginia 14
Potential Benefits of Expanding Evaluators 16
Considerations for Expanding Evaluators 16
Pathway 1: New Categories of Professionals within the CSB System 16
Pathway 2: Expand Categories of Evaluators to Include Clinicians in Emergency Rooms . 17
General Recommendations for Improving the TDO evaluation process 17
Workgroup Findings 18
Quality Improvement 18
Administrative Process Improvement 20
Pathway 1 21
Pathway 2 22
Workgroup Recommendations 22
Invest in peer support services. 22
Establish a quality review committee for TDO evaluations. 23
Develop crisis services that meet the needs of populations that require specialized care. 23
Collaborate across stakeholders to enhance psychiatric treatment in the emergency room. 24
Continue investments in the acute psychiatric bed registry. 24
Maintain the current eligible CPSC while investing in process enhancements. 24
Conclusion 25
Appendices 26

Executive Summary

The workgroup to study who should conduct TDO evaluations met three times during the summer of 2020 with representatives from Virginia's community services boards (CSBs), community hospitals, law enforcement, mental health advocates, and other stakeholders. The final report laid out two possible pathways to expansion of TDO evaluators in Virginia, including:

1. Adding new categories of eligible professionals within the CSB system; and
2. Expanding the categories of evaluators to include clinicians in emergency rooms.

In 2021, the workgroup focused on developing additional detail around both Pathway 1 and Pathway 2, addressing key areas such as eligibility for new CPSCs, required orientation and training, and the specific responsibilities of CPSCs. In order to address these topics, the workgroup first considered how to improve the administrative processes involved in TDO evaluations as well as quality management of these evaluations. These considerations served as a foundation to the subsequent discussions around the two pathways to expansion.

Discussions held by the workgroup over two years resulted in several actionable recommendations to improve and enhance the TDO evaluation process. These recommendations are independent of whether or not the General Assembly expands the pool of individuals eligible to conduct TDO evaluations.

Invest in peer support services.

The workgroup recommends that the General Assembly invest in a rate study, conducted by the Department of Medical Assistance Services, to enhance rates for peer supporters. The workgroup also recommends that specialized rates for their role as supporters in the TDO evaluation process be considered.

Establish a quality review committee for TDO evaluations.

The workgroup recommends that a multi-disciplinary, inter-agency committee with stakeholder participation be established to develop a statewide process for the standardization, monitoring, a quality assurance of TDO processes and outcomes.

Develop crisis services that meet the needs of populations that require specialized care.

For many individuals with a primary diagnosis of dementia, intellectual or developmental disability, or intoxication who are subjects of a TDO evaluation, civil commitment or inpatient hospitalization is not the best course of treatment/action. Alternative services should be developed to divert individuals from inpatient hospitalization and decrease the incidence of civil commitment.

Collaborate across stakeholders to enhance psychiatric treatment in the emergency room.

The prompt initiation of psychiatric treatment for individuals in crisis results in better outcomes for the individual and reduces the rate of TDO dispositions. While all emergency departments provide basic stabilizing services, there is significant variation in psychiatric resources. Inter-agency collaboration as well as collaboration with academic medical centers is needed to optimize emergency psychiatric care in the Commonwealth.

Continue investments in the acute psychiatric bed registry.

While the new bed registry platform is expected to come online in the fall of 2021, ongoing support for the maintenance of this platform as well as training for proper use of the platform is critical to maximizing its effectiveness.

Maintain the current eligible CPSC while investing in process enhancements.

To facilitate expanding TDO evaluators in the Commonwealth, the current processes should first undergo system enhancements to improve quality, oversight, and improve efficiencies. The TDO evaluation is a critical entry step into the behavioral health system which is being enhanced through the work of STEP-VA and Project BRAVO.

Preface

Item 320.II of the 2021 Appropriations Act directs the Department of Behavioral Health and Developmental Services (DBHDS) to continue the workgroup from 2020 on who should conduct evaluations for temporary detention orders (TDOs) in Virginia. The language states:

> *The Department of Behavioral Health and Developmental Services shall continue the Temporary Detention Order Evaluator Workgroup established pursuant to Chapters 918 and 919 of the 2020 Acts of Assembly. The workgroup shall report its implementation plan to the Governor, and Chairs of the House Health, Welfare, and Institutions Committee, the Senate Education and Health Committee, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2021.*

Introduction

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directed the Department of Behavioral Health and Developmental Services (DBHDS) to conduct a workgroup, charged with:

1. Reviewing the current process for conducting evaluations for temporary detention orders (TDO), including barriers to timely completion of evaluations; and
2. Developing a comprehensive plan to expand the individuals who can conduct these evaluations.[1]

The workgroup met three times during the summer of 2020 with representatives from Virginia's community services boards (CSBs), community hospitals, law enforcement, mental health advocates, and other stakeholders. The final report laid out two possible pathways to expansion of TDO evaluators in Virginia, including:

1. Adding new categories of eligible professionals within the CSB system; and
2. Expanding the categories of evaluators to include clinicians in emergency rooms.

The first option, or Pathway 1, was presented as a minimally disruptive and simple way (no Code changes required) to expand the workforce of certified preadmission screening clinicians (CPSCs) within CSBs. The second option, or Pathway 2, was presented as a way to potentially expedite evaluations when an individual is awaiting treatment in an emergency room by allowing emergency room clinicians to conduct evaluations. The workgroup did not come to a consensus on which pathway to pursue.

In 2021, the workgroup focused on developing additional detail around both Pathway 1 and Pathway 2, addressing key areas such as eligibility for new CPSCs, required orientation and training, and the specific responsibilities of CPSCs. In order to address these topics, the workgroup first considered how to improve the administrative processes involved in TDO evaluations as well as quality management of these evaluations. These considerations served as a foundation to the subsequent discussions around the two pathways to expansion. This report summarizes those conversations and presents the recommendations from the 2021 TDO Evaluator Workgroup.

Background

Guiding Principles in the Involuntary Commitment Process

In 2020, the TDO Evaluator Workgroup adopted core guiding principles in the involuntary civil commitment process to center conversations on the individual receiving care. Those principles continued to be foundational to the workgroup in 2021.

The behavioral health landscape has evolved over the past several decades, shaped by the discovery of effective treatments for psychiatric conditions, the movement of deinstitutionalization and the building of community mental health services, and the advocacy for awareness of the civil rights of individuals with disabilities, therefore ensuring that

---

[1] Report on Chapter 918 of the 2020 Acts of Assembly: https://rga.lis.virginia.gov/Published/2021/RD17/PDF

involuntary commitment is only utilized as a last resort. In recognition of this, the following guiding principles were adapted from the federal Substance Abuse Mental Health Services Administration (SAMHSA) to ground the discussions and inform policies that may affect Virginia's civil commitment process: [2]

Guiding Principles in the Involuntary Commitment Process

(Adapted from SAMHSA)

- Honor individuals' treatment preferences
- Never issue a temporary detention order when a person is otherwise willing to participate voluntarily in services
- Respect and protect the dignity of the person in every step of the process
- Help the person access care in the least restrictive setting
- Clearly communicate all relevant information with the person
- Balance beneficence and personal autonomy
- Employ due process protections at every level
- Consider a person's history of trauma as part of the assessment
- Ensure all persons involved in the process are free of material conflict of interest
- Carefully consider the purpose of commitment in identifying appropriate services
- Use information from family and friends to help inform care
- Individualize care and practice shared decision-making with the person

Virginia's Current Process for Conducting Preadmission screenings for Individuals under an Emergency Custody Order

All individuals under an emergency custody order (ECO) in Virginia must undergo a preadmission screening, and this process is a complex, multi-stage set of tasks; individuals who are not under an ECO may also undergo a preadmission screening. It is a pivotal point within the larger civil commitment process because if involuntary treatment is recommended and a TDO is issued, the individual in crisis is deprived of his or her liberty. The significance of the individual's liberty interest prescribes constraints on the health care and legal decisions involved; emergency evaluations must be comprehensive to assure appropriate disposition, but they also must be completed in a timely manner. As a result, a multitude of aims and tasks are concentrated in the brief 8-hour emergency custody period authorized under an ECO.

The preadmission screening process can be divided into six phases which may occur simultaneously. [3] Key requirements of the six phases are summarized below including approximate amount of time spent on each phase or task.

---

[2] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.

[3] The process for civil commitment of adults is cited in Virginia Code §§ 37.2-808, 37.2-809, 37.2-809.1, 37.2-810, 37.2-813, 37.2-814, 37.2-815, 37.2-816, and 37.2-1104. For minors, the process is set forth in Virginia Code §§ 16.1-338, 16.1-339.1, 16.1-340, 16.1-340.1, 16.2-341-16.2-345. 5

Phase	Action	Description	Approximate Time Spent within the 8-hr ECO period[4]
1	**Referral – Initiation of the ECO**	There are many different entry points into emergency behavioral health services including routine outpatient services, in a local emergency room, by phone, through law enforcement, or from an inpatient medical unit. Evaluations could be conducted in any of those or other locations.	30 minutes (from issuance of the ECO to initiation of the assessment by the CPSC)
2	**Notification of the CPSC**	When an individual is taken into custody by law enforcement, CSB Certified Preadmission Screening Clinicians (CPSCs) are notified of the execution of an ECO. Each region has protocols for this process to ensure activities are completed within the timeframes required. If the individual is not under an ECO, a CSB may still conduct a preadmission screening upon request.	
3	**Conducting the TDO Evaluation** (in-person or through a two-way electronic audio and video communication system)	An evaluation is completed as soon as possible after receiving notification of the need. Under the current performance contract between DBHDS and the CSBs, the assessment is required to begin within one hour of being contacted in an urban area and within two hours in a rural area.	55 minutes
4	**Evaluation Results & Development of a Plan**	The CPSC will determine the least restrictive treatment needed and will refer the individual for community-based services if the criteria for inpatient commitment are not met. If the evaluation was completed outside of a medical environment, the individual may be taken to a local emergency department for medical assessment prior to transport to an inpatient psychiatric facility. The CPSC must then complete a nine-page preadmission screening report[5] form before beginning the process of locating a bed when involuntary inpatient treatment is deemed necessary. Community treatment or voluntary inpatient treatment may also be possible dispositions.	20 minutes
5	**Execution of the Plan**	If the individual meets the criteria for involuntary inpatient hospitalization, the evaluator will	Up to 370 minutes

[4] A follow-up review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission. DBHDS. (2016).
[5] Preadmission Form, accessible at: http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures

		complete a number of notifications and then begin a bed search, beginning with community hospitals or crisis stabilization units. Each of these facilities must be contacted by phone and followed with a fax of the preadmission screening form (PAS form) and any other supporting documentation for the potential willing facility to review and consider. If no other placement can be found, the state hospital will be notified and it will serve as the facility of last resort. Individuals who do not meet the criteria for temporary detention will be referred to appropriate community services by the CPSC.	(average 240 minutes)
6	**Disposition Completed**	When a facility has been identified, the CPSC then contacts the magistrate to request the issuance of a TDO. If no facility is identified prior to the expiration of the ECO, the state hospital is designated as the facility of last resort.	
Post-TDO issuance		A commitment hearing is then held after a sufficient time for evaluation and treatment but no later than 72 hours after the TDO is issued.	Up to 72 hours for adults and 96 hours for minors

Responsibilities of CPSCs

Certified Preadmission Screening Clinician (CPSCs) are responsible for a range of duties, beginning upon an initial request for evaluation, and continuing through inpatient placement or referral to appropriate community services:

1. The CPSC (employed by the CSB) is first contacted by law enforcement when someone is taken into emergency custody (§ 37.2-808.J). If the individual is not under an ECO, a CSB may still conduct a preadmission screening upon request.
2. After being notified by law enforcement that an individual has been taken into emergency custody, the CPSC must call the state facility for the area so that they are aware that, should a TDO be issued and no alternative facility identified, the individual would be transported to said facility (§ 37.2-809.1).
3. The nine-page preadmission screening form developed in 2017 by Institute of Law, Psychiatry and Public Policy and DBHDS to assess risk following evidence-based practices must be completed through interviews with the individual, treating providers, and family members when appropriate as well as review of medical records and other related information. Additionally, the CPSC must ensure the least restrictive action is taken to meet the individual's needs (§ 37.2-816).[6]
4. The CPSC must determine, prior to the issuance of the temporary detention order, the individual's insurance status (§ 37.2-809.G).

[6] Preadmission Form, accessible at: http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures

5. The CPSC must also determine the facility of temporary detention and note it on the preadmission screening form. If necessary, he or she may change the facility of temporary detention. In that case, the CPSC must provide written notice to the clerk of the issuing court of the name and address of the alternative facility (§ 37.2-809.E).
6. After completing the evaluation, the CPSC must call the state facility back with information necessary to determine the services an individual will need (§ 37.2-809.1).
7. If the individual is ordered to mandatory outpatient treatment, the CPSC must participate in the commitment hearing (§ 37.2-817).
8. If the CPSC recommends that the person should not be subject to a temporary detention order, he or she must take the following steps (§ 37.2-809.L).
    a. Inform the petitioner, the person who initiated emergency custody, if such person is present, and an onsite treating physician of his or her recommendation.
    b. Promptly inform such person who initiated emergency custody that the CSB will facilitate communication between the person and the magistrate if the person disagrees with recommendations of the employee or designee of the CSB who conducted the evaluation and the person who initiated emergency custody so requests
    c. Upon prompt request made by the person who initiated emergency custody, arrange for such person who initiated emergency custody to communicate with the magistrate as soon as is practicable and prior to the expiration of the period of emergency custody.

Current Requirements to Become a CPSC in Virginia

The current certification requirements for CSB Preadmission Screening Clinicians were most recently updated in July of 2016.[7] CPSCs must be employed or designated by a CSB. Certification for CPSCs is based on three elements:

I. Licensure Status or Equivalent

All new hire CPSCs must have an acceptable professional license to participate as a CPSC, or have appropriate educational level attainment with other required standards if they are unlicensed.

- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Psychologist (LCP)
- Psychiatric Nurse Practitioner, Psychiatric Clinical Nurse Specialist, or Physician
- Bachelors Prepared Registered Nurse (BSN) with five years of experience
- Ph.D. OR Psy. D in clinical or counseling psychology
- The following Master's degrees are deemed to meet these requirements:
    - Master of Social Work (MSW)
    - A clinical degree in counseling from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs [CACREP]

[7] Certification of Preadmission Screening Clinicians. DBHDS. (July 1, 2016)

- Master of Science in Rehabilitation from a CACREP accredited program
- If a Board Executive Director has evaluated the transcript and experience of a potential CPSC with a master's degree other than one listed above that includes appropriate clinical training, a request may be submitted to DBHDS for review and a decision whether this requirement is met.

Any CPSC who does not meet the above educational standards but was hired on or before July 1, 2009 without an interruption in their employment conducting preadmission screening evaluations or if he or she was hired between July 1, 2008 and July 1, 2016 provided they met the educational and other requirements as of July 1, 2008.

II. Completion of an online training modules and experiential components of training

To be certified to conduct emergency evaluations, the candidate must complete requisite online, DBHDS-established training modules, which include topics ranging from the role and responsibility of the CPSC, the legal requirements related to Virginia's civil commitment process, resources for alternatives to hospitalization, interfacing with magistrates and special justices, the process for securing state facility beds, and other relevant parallel processes such as medical assessment. Then, the individual must complete 40 hours of observation of direct emergency services client or collateral contact conducted by a certified CPSC, conduct at least 3 prescreening evaluations under direct observation by a certified CPSC, and receive attestation by their supervisor that, based upon direct observation, the applicant has reached a minimal acceptable level of clinical competence and procedural knowledge to be certified. Due to the potential safety risks, for a minimum of three months after certification, the newly certified person must consult with a supervisor on any case where he/she intends to recommend a release from an ECO without hospitalization. [8]

III. Approval by the CSB clinical supervisor

The final requirement to become a certified CPSC is approval by the CSB clinical supervisor, who is a licensed mental health professional.

Variance to the Process to Meet Requirements to Become a CPSC

CSBs can request a variance to the requirements detailed above due to hardship. Each variance must be signed by the executive director and approved by DBHDS.

Past Studies of the Preadmission Screening Process in Virginia

The process for conducting preadmission screenings in Virginia has been studied multiple times in recent years. In 2014, DBHDS conducted an assessment of CPSC qualifications, training, and oversight. The report concluded that the qualifications, training, and oversight of CPSCs should be strengthened via an enhanced certification program, standards of supervision, a standardized

---

[8] In Virginia, preadmission screening clinicians must complete a certification program approved by DBHDS per § 37.2-809.

orientation, and enhancing ongoing training requirements, all of which were implemented following the report.[9]

The following year, in 2015, DBHDS conducted a review of Virginia's practice of conducting emergency evaluations, which analyzed CPSC response times through a CSB survey. The results, most recently updated in 2016, found that 94 percent of preadmission screenings began within two hours. Delays in initiating evaluations were determined to be primarily due to multiple simultaneous requests being received by the CSB. The 2015 workgroup made the following five recommendations to improve the performance of the emergency evaluation system:

1. Further examine response times through an additional survey, obtaining explanatory information for longer response times, and a review of CSB service models.
2. Review and update the preadmission screening form to determine if it could be reduced in length without sacrificing quality, explore the possible use of an electronic form, and consider allowing ER physicians to agree or disagree with the disposition on the form. The current prescreening form was developed out of this recommendation.
3. Create a viable alternative to shared responsibility between CSBs and emergency departments where there are persistent delays in evaluation times.
4. Examine training options for additional clinicians related to the evaluation process and community alternatives to inpatient hospitalization.
5. Review requiring magistrates to accept telephone testimony of emergency room physicians.[10]

In 2019, the SB1488 workgroup reported on recommendations to address the high census at Virginia's state mental health hospitals. One of the recommendations included permitting licensed mental health professionals and other qualified clinicians outside of CSBs to conduct preadmission screening evaluations. Several workgroup members noted that such a change would be complex, impacting multiple other process and could possibly lead to an inadvertent increase in hospital admissions.[11]

As a result of the SB1488 workgroup's recommendation, the 2020 TDO Evaluator Workgroup was formed. The workgroup was charged with:

1. Reviewing the current process for conducting evaluations for temporary detention orders (TDO), including barriers to timely completion of evaluations; and
3. Developing a comprehensive plan to expand the individuals who can conduct these evaluations.[12]

The workgroup was comprised of representatives from Virginia's CSBs, community hospitals, law enforcement, mental health advocates, and other stakeholders. The final report reflected the

---

[9] https://rga.lis.virginia.gov/Published/2014/SD9/PDF
[10] Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission. DBHDS. (2015). Available at: https://rga.lis.virginia.gov/Published/2015/RD387/PDF
[11] Report on the Implementation of Senate Bill 1488 (2019) and Item 310 CC.I of the 2019 Appropriations Act. DBHDS. (2019). Available at: https://rga.lis.virginia.gov/Published/2019/RD587/PDF
[12] Report on Chapter 918 of the 2020 Acts of Assembly: https://rga.lis.virginia.gov/Published/2021/RD17/PDF

workgroup's input regarding potential benefits and drawbacks of expanding who can conduct evaluations in Virginia and possible Pathways to expansion.

Potential Benefits of Expanding Evaluators

Expediting the preadmission screening process. This was a top motivator for many workgroup participants in 2020. However, it was also noted that this effect may be a minimal effect, as data from 2015 suggests 94 percent of evaluations begin within two hours.[13]

Building workforce capacity. Expanding the pool of eligible CPSCs could allow CSB staff to spend more time in diversion strategies such as crisis intervention, warm handoffs to community providers, and emergency room avoidance, especially taking into consideration the proposed expansion for mobile crisis services.

Improving continuity of care. Individuals presenting to the emergency department who have already been evaluated by an emergency room physician would benefit by not having to provide their mental health history again and experience another evaluation by a different evaluator.

Expanding access to evaluators for reassessment prior to hospitalization. Reassessments are often needed because the clinical picture of an individual can change over an eight hour period, such as for individuals who are intoxicated or convert to a voluntary status. Expanding evaluators could allow for additional resources to conduct timely reassessments.

Considerations for Expanding Evaluators

Time with evaluator. Some workgroup participants thought that CPSCs at CSBs may have more time to spend with the individual in crisis to complete the evaluation than clinicians in the emergency room.

Conflict of interest. It was noted that consideration should be given to clinicians in hospitals with psychiatric units as well as to any potential for real or perceived bias among emergency room clinicians.

Connection to community resources. Participants in 2020 noted the critical role of the CSB in connecting individuals to alternatives to inpatient hospitalization.

Potential increase in TDO admissions. Evaluators who work in private hospital settings may not be fully aware of all community alternatives to the state psychiatric hospitals, and the workgroup expressed that this could inadvertently lead to an increase in TDO dispositions. This would put additional strain on the state mental health hospital system, which is already suffering from significant census pressures and staffing shortages.

Pathway 1: New Categories of Professionals within the CSB System

Proposed Changes. The first pathway proposes to expand the type of professionals who can conduct evaluations at the CSB. This plan does not propose any changes to the current TDO evaluation process; it simply expands the number of professionals who are employed or

---

[13] Review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission. DBHDS. (2015). Available at: https://rga.lis.virginia.gov/Published/2015/RD387/PDF

contracted with a CSB who are eligible to become CPSCs. CSBs would continue to have discretion in hiring from the pool of eligible individuals.

Workgroup Discussion. Workgroup members representing the CSBs and advocacy organizations generally expressed support for this option because it would expand the number of individuals who can conduct evaluations.

The expanded group of evaluators would be employees or contractors of the CSB. The CSB charged with evaluating an individual would retain responsibility for the clinical quality of the evaluation as well as the entire prescreening process, which includes bed finding and interaction with the magistrate. A key focus on the current process that would remain intact is on identifying the least restrictive alternative for treatment and diversion from DBHDS state hospitals whenever feasible.

Workgroup members who feel the current process is not rapid enough and want to expand the number of individuals who can conduct evaluations did not believe this option would expand the pool of evaluators sufficiently to address these concerns. Some workgroup members also stated concerns with the quality of the current evaluations and felt this option would not provide a platform to make improvements.

Pathway 2: Expand Categories of Evaluators to Include Clinicians in Emergency Rooms

Proposed Changes. Under this pathway, when an eligible provider (physician, psychiatrist, or licensed mental health professional, or LMHP) encounters an individual that has been brought to an emergency department under an ECO, they could conduct the evaluation or contact a CSB to do so.

This proposed change would require significant updates to the Code of Virginia. In addition, it would require an update to current prescreening training and certification. The new category of CPSCs would be required to complete the necessary training and certification process with modifications for the physicians and psychiatrists in the emergency department who are trained in the evaluation process. The modifications would address Virginia's TDO statute including a review of individual's rights as well as a discussion about least restrictive alternatives.

Workgroup Discussion. There was not consensus within the workgroup regarding whether this expansion in evaluators would produce faster or higher quality evaluations. In addition, there were concerns from some members that any recommended placements would not consider the least restrictive alternative and may increase admissions to DBHDS state hospitals. There were also a number of questions about completion of the prescreening process outside of the evaluation, including the necessary paperwork, bed search, and attendance at legal hearings. The CSBs noted that they could not speak to an individual's status at the commitment hearing unless they conducted the evaluation. Finally, members noted that Local Inpatient Purchase of Service (LIPOS) funding may present a conflict for non-CSB evaluators. Workgroup members noted that a policy excluding payment for hospitals admitting individuals evaluated by their physician or LMHP could be implemented.

General Recommendations for Improving the TDO evaluation process

Several important topics arose in the 2020 TDO Evaluator Workgroup that were general to the TDO process and not specific to either of the two pathways laid out above. As such, the workgroup made six key recommendations for the improvement of the TDO evaluation process.

Recommendation #1: Prioritize and continue the development of a comprehensive system of care in Virginia through STEP-VA and new or enhanced Medicaid rates through Project BRAVO. This is critical to preventing the incidence of inpatient psychiatric hospitalization.

Recommendation #2: Integrate principles of continuous quality improvement to ensure that any implemented system changes are standardized, monitored, and periodically revised as needed.

Recommendation #3: Streamline current processes, such as completion of TDO-related paperwork and bed searches, which are time-consuming and take away from time spent with an individual in crisis in need of support.

Recommendation #4: Invest in an enhanced bed registry tool to facilitate greater efficiency in the process of bed placement.[14]

Recommendation #5: Consider and monitor the impact of changes to current processes on inpatient psychiatric bed capacity, especially the impact to the state mental health hospitals given the critically high state hospital census.

Recommendation #6: Avoid conflict of interest on the part of the evaluator at all times.

Workgroup Findings

The 2021 TDO Evaluator Workgroup met three times between June and August of 2021 as a full group. In addition, there were four subgroups formed within the workgroup focused on quality improvement, administrative process improvement, and developing greater detail around Pathways 1 and 2. Each of the four subgroups met twice during the summer. Representatives from CSBs, community hospitals, emergency room physicians, psychiatrists, mental health advocates, and others participated in the workgroup, and a full list of participants is available in Appendix A.

Quality Improvement

The Workgroup universally acknowledged the need for establishing foundational quality standards to the process. Because of the limited state level oversight related to the standardization, monitoring of data, outcomes and quality, changes to the current system are a challenge to implement. Regardless of which pathway may be pursued, any further changes to the TDO process and roles of CPSCs would necessitate a quality oversight process. These recommendations related to quality are needed as a critical step that accompanies any change to the current process. In 2011, SAMHSA released the National Behavioral Health Quality Framework, which laid out three aims for quality improvement in behavioral health:

[14] RD513 - Acute Psychiatric Bed Registry Workgroup Report – November 6, 2020. Available at: https://rga.lis.virginia.gov/Published/2020/RD513

- **Better Care**: Improve the overall quality, by making health care more patient centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of positive health in addition to delivering higher-quality health care.
- **Affordable Care:** Increase the value (cost-effectiveness) of health care for individuals, families, employers, and government.[15]

The workgroup used this framework to guide its conversation around quality improvement, focused on how to ensure consistency of TDO evaluations and achievement of better quality outcomes throughout the ECO/TDO process. This is critical to ensuring no dips in quality occur if the categories of professionals eligible to conduct TDO evaluations were to expand. Key takeaways from the quality improvement subgroup included:

- *Considerations related to **improving the patient experience**, including greater use of peer support specialists during the TDO evaluation and improved communication and care coordination between parties involved in the TDO process.*
    - Peer support specialists provide valuable advocacy to individuals with mental health or substance use conditions. They can help to communicate individual preferences throughout the TDO evaluation process, help to share resources and connect individuals to community-based care.
    - The subgroup also discussed the importance of enhancing psychiatric clinical management during the TDO evaluation process, noting that initiating any treatment that can begin in the emergency department is critical to potentially preventing the need for a TDO, minimizing time spent in inpatient hospitalization, and improving health outcomes for individuals.
    - In general, the workgroup noted that the emergency department is not the ideal location for individuals experiencing a behavioral health crisis. In addition to initiating emergency psychiatric treatment while individuals are in the emergency department, rapidly connecting them to alternative services and settings is critical to their recovery. Any data that could be provided from hospital emergency departments around treatment provided and length of stay could help to target interventions designed to provide rapid treatment for individuals experiencing a crisis.
- *Considerations related to **improving health outcomes** through greater use of community-based services and diversion from inpatient hospitalization when appropriate.*
    - The subgroup discussed the importance of reassessments of individuals under an ECO to prevent TDO dispositions in cases where an individual may be stabilized before the expiration of the ECO.
    - There was also discussion around the need to improve communication between involved parties and supporters, guardians, and other individuals who may be able to advocate on behalf of the individual or consent to treatment on behalf of the individual. The subgroup also recommended to put in place means to ensure communication between key parties involved during the TDO process, such as

[15] https://www.nasmhpd.org/sites/default/files/SAMHSA%20Quality%20Improvement%20Initiative.pdf

    - doctor-to-doctor communication during referral to inpatient settings, or communication with an individual's guardian or authorized representative.
    - Finally, the subgroup highlighted the importance of person-centered treatment, including building out specialized care for individuals such as those with a primary diagnosis with dementia or substance use disorder and those with intellectual or developmental disabilities and diversion from emergency room settings through the use of community-based crisis services as intended through Project BRAVO.
- *Considerations related to* ***improving cost-efficiency*** *to maximize the utilization of limited resources and ensure TDO dispositions occur only when clinically appropriate.*
    - The subgroup noted that there is significant variability at the local level on the implementation of quality review and oversight of the TDO evaluation process. A focus on improving standardization of documentation, training of workforce related to more uniform implementation of TDO criteria, shifting away from a risk avoidance framework to a "no force first" framework, and supporting CPSCs around the issuance/non-issuance of TDO recommendations is critical.
    - The subgroup also suggested the development of Regional and a Statewide Quality Review Committee to standardize processes, evaluate case summaries, outcomes, and review and analyze data to identify trends and make recommendations for system quality improvements and enhancements to the TDO process. This Committee must be multi-disciplinary, interagency, and include stakeholder participation.

Finally, the subgroup discussed key outcomes of improved quality of the TDO evaluation process, including:

- A reduction in TDOs issued over time as access to community-based, high-quality services increase and more individuals are diverted to community-based care or avoid the need for an ECO or TDO in the first place due to high-quality services.
- A reduction in the trauma experience, measured through baseline survey data on patient experience.
- Standardization of documentation, oversight, and application of the TDO criteria.

Administrative Process Improvement

As noted previously in this report, a key motivator for many workgroup participants to expand who can conduct TDO evaluations in Virginia was to expedite the TDO evaluation process. This subgroup was charged with identifying ways to increase administrative efficiencies in the process. Two key areas were identified as the most time-consuming: the completion of the nine-page preadmission screening form (usually taking an hour to an hour-and-a-half) as well as the identification of an available bed (around 4-6 hours) for individuals for whom the issuance of a TDO is recommended.

To begin, the subgroup reviewed the preadmission screening form and discussed the history of the development of the form as well as its primary use as a legal document. The subgroup did not identify any portions of the form that should be shortened or removed.

Then, the subgroup received an update on the acute psychiatric bed registry. The bed registry was studied in 2020 in the Acute Psychiatric Bed Registry Workgroup, and the report outlined

key functionalities that the registry should have to improve the bed search process.[16] Currently DBHDS is pursuing an updated data system which will include a new bed registry platform – implementation of the updated call center is planned by the end of calendar year 2021, with the updated bed registry coming online in 2022. The new platform will help to alleviate many of the inefficiencies in the bed search process, including calling multiple hospitals and faxing those hospitals patient information to request a bed, as secure upload and sharing of patient information will be incorporated into the new platform. Aside from implementation of the bed registry, and working toward interoperability of the registry with electronic health records of participating hospitals, there were no additional recommendations for improving the bed search process.

Pathway 1

Once conversations around quality and administrative process improvement concluded, the workgroup spilt into subgroups to develop additional detail and answer open questions around Pathway 1 and Pathway 2, developed in the 2020 workgroup. The Pathway 1 subgroup focused on which categories of professionals (including education, licensure, and experience level) at CSBs should be eligible to conduct evaluations, how those new evaluators should be trained, and what the oversight process for the expanded workforce should be.

<u>Newly eligible professionals</u>

The subgroup discussed the critical education and experience levels necessary to take on the responsibility of conducting TDO evaluations. Participants agreed that categories of eligible professionals could be expanded to Master’s level individuals beyond the current list of eligible Master’s degrees so long as the field of study was related to behavioral health services. Additionally, these Master’s level professionals should have at least three years of relevant experience, which the subgroup defined as experience in crisis services and/or behavioral health evaluation and risk assessment. The subgroup also thought that Bachelor’s level individuals with medical degrees should be eligible to conduct evaluations if they also have the requisite three years of relevant experience. Currently, Bachelor’s level nurses are eligible with five years total experience.

One key consideration of any expansion of CPSCs is alignment with system changes underway in Virginia to the comprehensive crisis system. Alignment with requirements laid out in Project BRAVO with regard to new and enhanced Medicaid rates should be considered in future changes to CPSC eligibility requirements.

<u>Training</u>

The subgroup discussed whether training requirements, including the orientation checklist and experiential requirements for CPCSs, should be adapted for newly eligible professionals. The subgroup felt these requirements were important for all CPSCs and should not be modified.

<u>Oversight</u>

[16] RD513 - Acute Psychiatric Bed Registry Workgroup Report – November 6, 2020. Available at: https://rga.lis.virginia.gov/Published/2020/RD513

Finally, the subgroup discussed any necessary additional oversight for newly eligible CPSCs. The subgroup discussed concerns that expanding the workforce of CPSCs could lead to increased risk-averse behaviors, potentially leading to an inadvertent increase in TDO dispositions. Adopting the recommendations from the quality improvement subgroup was identified as a critical piece to any expansion of eligible CPSCs in Virginia. In addition, the subgroup discussed the current requirement for new CPSCs to consult with a supervisor for all evaluations of individuals under an ECO that do not lead to a TDO disposition. The subgroup felt that the system would benefit from broadening this requirement to include consultation with a supervisor for all TDO evaluations within the first three months of CPSC work.

Pathway 2

The Pathway 2 subgroup was charged with determining – should eligible CPSCs be expanded to include physicians, psychiatrists, and LMHPs in emergency room settings – what the training requirements and division of responsibilities should look like between emergency room evaluators and CSBs. Representatives from the Virginia College of Emergency Physicians (VACEP) as well as the Psychiatric Society of Virginia (PSV) noted that emergency physicians and psychiatrists did not support pursuing Pathway 2. They, and others on the workgroup, did not believe that a division of responsibilities was practicable given the complexity of those responsibilities and of the TDO evaluation process in general and that the CSBs should remain responsible for the entire process. The Virginia Hospital & Healthcare Association (VHHA) continued to express its support for Pathway 2 and expansion of evaluators into the emergency room. It noted that hospitals would agree to take on all of the responsibilities (see Responsibilities of CPSCs) should clinicians in emergency rooms be eligible to conduct the TDO evaluation. However, given the impact of the COVID-19 pandemic on Virginia's community hospitals, VHHA did not want to pursue Pathway 2 statewide at the time of this report.

Workgroup stakeholders agreed that the TDO evaluation process is complex, and that simplifying some of the procedures would enable easier pathways to expansion of eligible CPSCs. This would require further study with a wider range of stakeholders to determine legal avenues to simplifying this process. Not all workgroup participants, however, thought that further study of the process was necessary. Some participants noted that the tradeoff of simplification is fewer protections for individual freedoms. Many noted that the multiple levels of legal oversight helps to prevent individuals from being denied certain freedoms when they are involuntarily committed, and removing layers of oversight could inadvertently lead to increased hospitalizations when the Commonwealth is attempting to divert more individuals to community-based services.

Workgroup Recommendations

The discussions held in the four subgroups – quality improvement, administrative process improvement, Pathway 1, and Pathway 2 – as well as the debrief conversations held with the full workgroup, led to several actionable recommendations to improve and enhance the TDO evaluation process regardless of which pathway might be chosen.

Invest in peer support services.

The workgroup recommends that the General Assembly invest in a rate study, to be conducted by the Department of Medical Assistance Services, which would enhance rates for peer

supporters and consider specialized rates for their role as supporters specifically in the TDO evaluation process.

As Medicaid rates are studied and developed, direct funding to place peer supporters in hospital emergency rooms for the purpose of supporting individuals undergoing TDO evaluations would help improve the experience in the short-term. Peer support during psychiatric crises is a well-documented, evidence-based practice that improves individual outcomes. Additional investment in supervisors of peer support specialists is also needed.

Finally, investment in training for peer support specialists in supporting individuals undergoing an evaluation for a TDO would benefit the peer workforce.

Establish a quality review committee for TDO evaluations.

This committee would work to establish a statewide process for quality assurance including increased standardization and monitoring of outcomes of TDO evaluations; standardization the application of TDO criteria and documentation; qualifications of CPSCs necessary for alignment with new or proposed Medicaid rates through project BRAVO; evaluation of case summaries; and review and analysis of data to identify trends and make recommendations for quality improvements. It would be a multi-disciplinary, inter-agency group with stakeholder participation, [17] comprised of a state-level advisory board and regional quality committees based on the 5 DBHDS regions, which are responsible for the data acquisition, analysis, reporting, and evaluation of civil commitments and its outcomes. Funding would be required to establish the committee and dedicate resources to regular review of TDO evaluation outcomes. In addition, legislation would be required to grant the committee access to preadmission screening forms as well as to minimize liability for the participants to the process. Establishing a quality management process related to the preadmission screening assessment will help identify opportunities to maximize the use of least restrictive alternatives as prescribed in the Code of Virginia for all. The quality management process can also help identify gaps in accessible services for communities and recommend the development of needed resources.

Develop crisis services that meet the needs of populations that require specialized care.

For many individuals subject to a TDO evaluation, civil commitment and often inpatient hospitalization is not the best course of treatment/action. Many of these individuals have a primary diagnosis of dementia, an intellectual or developmental disability, or be intoxicated. In many of these cases, alternative services should be developed to divert individuals from inpatient hospitalization and avoid the incidence of civil commitment. Funding should ensure that all Virginians have access to the services regardless of location or insurance status. The General Assembly has recently invested in these efforts in particular for the dementia population, and at the time of this report, work is being concluded through the Dementia Services Workgroup to develop recommendations for alternative services to better meet the needs of individuals with

[17] Mortality Review Committee FY20 Annual Report, available here: https://dbhds.virginia.gov/assets/doc/QMD/sfy20-mrc-annual-report.pdf

dementia.[18] Additional, similar investments should be made to identify alternative services and pilot those services in the Commonwealth.

Collaborate across stakeholders to enhance psychiatric treatment in the emergency room.

The workgroup discussed the importance of initiating psychiatric treatment for individuals in crisis as soon as possible to deliver higher quality care – resulting in better outcomes for the individual – and reduce the rate of TDO dispositions. However, while all emergency departments are required to provide basic emergency, stabilizing services under EMTALA, it was noted that community hospitals vary greatly in their psychiatric resources, and it would be difficult to develop further statewide standards in this area. Further discussion and collaboration among DBHDS, PSV, VHHA, and VACEP as well as with academic residency training programs could aid in exploring how to optimize emergency psychiatric care in Virginia.

Continue investments in the acute psychiatric bed registry.

While the new bed registry platform is expected to come online in the fall of 2021, ongoing support for the maintenance of this platform as well as training for proper use of the platform is critical to maximizing its effectiveness. In addition, it will take additional time and resources to make the platform interoperable with electronic health records, which will help to automate much of the updating of available beds throughout Virginia. Additional work to achieve interoperability will help to further reduce administrative inefficiencies in the TDO process.

Maintain the current eligible CPSC while investing in process enhancements.

To facilitate expanding TDO evaluators in the Commonwealth, the current processes should first undergo system enhancements to improve quality, oversight, and improve efficiencies. The TDO evaluation is a critical entry step into the behavioral health system which is being enhanced through the work of STEP-VA and Project BRAVO.

The workgroup did not express any objections to expanding the pool of eligible CPSCs through Pathway 1, or allowing for individuals with a Bachelor’s degree in a medical field and three years of relevant experience or with a Master’s degree in a behavioral health-related field and three years of relevant experience to become CPSCs. This Pathway would require DBHDS to update its eligibility standards, including with a provision for supervisory oversight of all TDO evaluations for the first three months of a new CSPC’s employment. No legislative changes are required. However, the workgroup did not feel that this would significantly expand the workforce or significantly increase the pool of CPSCs. Additionally, any changes to eligibility for CPSCs should be evaluated for alignment with the model of care of the Commonwealth’s crisis system transformation, including specific requirements for new crisis Medicaid rates coming online in December of 2021 through Project BRAVO.[19]

---

[18] Item 321.N of the 2021 Appropriations Act allotted $3.5 million to support the diversion and discharge of individuals with dementia, $2.8 million to establish contracts for the diversion and discharge of individuals with dementia into private settings, and $727,000 for a pilot mobile crisis program for individuals with dementia. It also directed the Secretary of Health and Human Resources to convene a workgroup to make recommendations for this population, which is due to the General Assembly on November 1, 20201.

[19] The workgroup concluded its review of this report on September 21, 2021. DBHDS and DMAS, in collaboration with system stakeholders, are still identifying the specific CPSC requirements with regard to licensure and supervision that would align with federal requirements for Medicaid billing of new comprehensive crisis services.

No participants were supportive of expanding CPSCs through Pathway 2 at the time of this report, though VHHA was supportive of implementing this Pathway at a later date once the impact of the COVID-19 pandemic lessens. Furthermore, most of the participants expressed no interest in pursuing Pathway 2 until such time as an in-depth review of the legal processes associated with the TDO evaluation were evaluated by the appropriate parties and, should it be recommended, simplifications to the evaluation process were made. Again, stakeholders acknowledged the need to have foundational aspects of quality, oversight, and address inefficiencies in the system to be able to expand to other professionals in emergency department settings.

Conclusion

The TDO Evaluator Workgroup has made several important recommendations for the evaluation process that center around the guiding principles for involuntary commitment addressed earlier in this report, putting the individual's experience and his or her health as a top priority for any changes the Commonwealth undertakes. These recommendations include support for peer supporters to advocate on behalf of individuals undergoing an evaluation, quality oversight to improve outcomes for individuals, and the ongoing development of person-centered, specialized services as well as emergency psychiatric treatment. Administrative efficiencies are being gained through the implementation of an enhanced acute psychiatric bed registry platform and should continue to be supported. Regarding a pathway for expansion for TDO evaluators, a first step would be broadening the pool of eligible CPSCs within the CSB system. In order to continue conversation around Pathway 2, several workgroup participants urged further study to examine and review the legal process of the TDO evaluation, though other participants had concerns about opening up this process to simplification. Furthermore, continued recovery of the healthcare system from the impacts of the COVID-19 pandemic is necessary before further consideration of Pathway 2 occurs.

Appendices

Appendix A: Workgroup Representatives

Workgroup Chair: Heidi Dix, Deputy Commissioner for Quality Assurance and Government Relations

Workgroup Members		Round 1: Subgroup	Round 2: Subgroup
Department of Medical Assistance Services	Alyssa Ward	Quality Improvement	
Mental Health America - Virginia	Bruce Cruser	Quality Improvement	Pathway 1
National Alliance on Mental Illness - Virginia	Kathy Harkey	Quality Improvement	
Office of the Executive Secretary (advisory capacity only)	Jonathan Green	Administrative Process Improvement	
	Kristi Wright	Quality Improvement	Pathway 1
Self-Advocate	Jennifer Spangler	Quality Improvement	Pathway 1
The Psychiatric Society of Virginia	Dr. Tony Graham	Quality Improvement	Pathway 1; Pathway 2
	Mark Hickman	Quality Improvement	
Virginia Association of Community Services Boards	Curt Gleeson	Quality Improvement	Pathway 2
	Jennifer Faison		
	Sarah Gray	Administrative Process Improvement	
	Sandy O'Dell	Quality Improvement	Pathway 2
Virginia Association of Counties	Katie Boyle	Quality Improvement; Administrative Process Improvement	Pathway 1; Pathway 2
Virginia Association of Police Chiefs	Dana Schrad		
	Major Judson Flagg		Pathway 1
Virginia College of Emergency Physicians	Aimee Perron-Seibert	Quality Improvement; Administrative Process Improvement	Pathway 2
	Dr. Bruce Lo		Pathway 1; Pathway 2
	Dr. Joran Sequiera	Quality Improvement; Administrative Process Improvement	

Virginia Hospital and Healthcare Association	Cindy Estes	Quality Improvement; Administrative Process Improvement	
	Jennifer Wicker		
	Kurt Hooks	Quality Improvement; Administrative Process Improvement	Pathway 1
VOCAL	Elizabeth Bouldin-Clopton	Administrative Process Improvement	
	Heather Orrock		Pathway 1

Other Stakeholders

Senate Finance and Appropriations Committee	Mike Tweedy
House Appropriations Committee	Susan Massart
Division of Legislative Services	Sarah Stanton
Senator George Barker	
Office of the Attorney General	Allyson Tysinger
Office of Senator Deeds	Tracy Eppard

DBHDS Staff:

Alex Harris, Policy and Legislative Affairs Director
Dr. Alexis Aplasca, Chief Clinical Officer
Mary Begor, Crisis Services Coordinator