REPORT TO THE COMMISSION ON MENTAL HEALTH LAW REFORM

From the Working Group on Transportation

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TRANSPORTATION WORK GROUP MEMBERS

Berg, Michael
Department of Health
Office of Emergency Medical Services

Breton, Randolph (Randy)
Chief Operating Officer
Medical Transportation Services LLC
Physicians Transport Service

Burch, Stephanie R.
Captain
Suffolk Police Department
Suffolk, VA

Carlini, David
Director of Behavioral Medicine
Prince William Health System

Curran, Derek
Emergency Services Director
Hampton-Newport News Community Services Board

Grimes, Terry, Ed. D
President
Empowerment for Healthy Minds

Farr, M. Jay
Deputy Chief
Arlington Co. Police Department

Hancock, Catherine
Mental Health Policy Analyst
Department of Medical Assistance Services

Hickey, Jane (Chairman)
Senior Assistant Attorney General/Chief
Health Services Section
Office of the Attorney General

Hickman, Richard (Dick)
Deputy Staff Director
Senate Finance Committee

Hines, Judith (Judy)
President
Friends of Loudoun Mental Health

Holt, Gerald S. (Honorable)
Sheriff
Roanoke County

Jones, John W.
Executive Director
Virginia Sheriffs' Association

Jones, Thomas D. (Honorable)
Sheriff
Charlotte County

Knox, III Robert (Bob)
Department of Medical Assistance Services

Koehler, Sharon
Department of Mental Health Mental Retardation and Substance Abuse Services

Morgan, Gabe (Honorable)
Sheriff
City of Newport News

Overton, Jerry
Chief Executive Officer
Richmond Ambulance Authority

Sanders, Sherry
Coordinator of Crisis Services
Cumberland Mountain Community Services Board

Shrad, Dana
Executive Director
Virginia Association of Chiefs of Police

Staff:

Levy, Douglas
Interim Commission Director
Supreme Court of Virginia

Diggs, Thomas M.
Commission Staff Director and
Assistant Director of Judicial Progress
Supreme Court of Virginia

Sager, Jill
Research Assistant
University of Virginia
School of Law

Walker, Ruth Anne
Legislation Manager
DMHMRSAS

PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, the Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs and protect the rights of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Information regarding the Commission, its Task Forces and its Reports is available at http://www.courts.state.va.us/cmh/home.html.

The Commission also conducted three major empirical studies during 2007. The first was an interview study of 210 stakeholders and participants in the commitment process in Virginia. The report of that study, entitled *Civil Commitment Practices in Virginia: Perceptions, Attitudes and Recommendations*, was issued in April 2007. The study is available at http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

The second major research project was a study of commitment hearings and dispositions (the "Commission's Hearings Study"). In response to a request by the Chief Justice, the special justice or district judge presiding in each case filled out a 2-page instrument on every commitment hearing held in May 2007. (There were 1,526 such hearings). Findings from the Commission's Hearing Study served an important role in shaping the Commission's understanding of current commitment practice. The study can be found at http://www.courts.state.va.us/cmh/2007_05_civil_commitment_hearings.pdf.

Finally, the Commission's third project was a study of every face-to-face emergency evaluation conducted by Community Service Board ("CSB") emergency services staff during June 2007 (the "Commission's CSB Emergency Evaluation Study"). (There were 3,808 such evaluations.) The final report of the CSB Emergency Evaluation Study can be found at http://www.courts.state.va.us/cmh/2007_06_emergency_eval_report.pdf.

Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* ("Preliminary Report") in December, 2007. The Preliminary Report, which is available on-line at http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf, outlined a blueprint for comprehensive reform ("Blueprint") and identified specific recommendations for legislative consideration during the 2008 session of Virginia's General Assembly that focused primarily on the commitment process.

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission's consideration.

The accompanying report was prepared by the Working Group on Transportation. It represents the views and recommendations of the members of the Working Group and should not be construed as reflecting the opinions or positions of the Commission on Mental Health Law Reform, the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

Richard J. Bonnie
Chair, Commission on Mental Health Law Reform
December 2008

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I. INTRODUCTION

Mission: The Working Group on Transportation ("Transportation Working Group") was established by the Commission on Mental Health Law Reform ("Commission") to provide recommendations for implementing a cost effective three-tiered statewide transportation system for persons involved with the civil commitment process. The Commission endorsed this concept in its Preliminary Report issued in December 2007[1] based on the proposals made by the Task Force on Civil Commitment.[2] The goal was to develop a transportation plan that could be implemented by 2012 that would be designed:

1) to decriminalize the process and reduce stigma through reduction of Virginia's reliance on law-enforcement agencies and the use of restraints in the transportation process, while ensuring the safety of the person, the transporter and the public, and
2) to promote the recovery of the individual by enabling the provision of voluntary services in the least restrictive manner and setting.

It was anticipated that the transportation plan would include interim implementation steps, including recommendations for pilot projects. As part of the process, the Transportation Working Group also reviewed SB 102 (Cuccinelli) that was referred by the Senate to the Commission for study.

Work Plan: The Transportation Working Group was composed of exceptionally dedicated and knowledgeable members that met seven times by telephone conference call on June 9, June 25, July 16, August 18, September 8, September 22, 2008, and October 20, 2008. In addition, a small group met to discuss development of a Department of Medical Assistance Services ("DMAS") guidance document on billing for psychiatric transports described in Part III.C below.

The statutes, policies and practices of other states were reviewed, including those of Vermont, which has developed an assessment process for determining when and under what circumstances "humane restraints" may be used. At least 27 other states permit persons or entities other than law enforcement officers to transport, including family, friends, mental health professionals, ambulances, and public and private transportation companies. Most states do, however, continue to rely to a great extent on law enforcement to transport. Even so, the Transportation Working Group unanimously determined that law enforcement should be utilized only when a public safety issue is presented and not as the primary source of transportation.

Initially, the work plan was designed to study in detail each of the components of a three-tiered transportation system:

[1] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf.
[2] http://www.courts.state.va.us/cmh/2007_0221_preliminary_report.pdf,

1. **First tier:** Transportation by family and friends, community services boards ("CSBs")[3], taxi service, and Medicaid vendor transportation.

2. **Second tier:** Ambulance service or step-down service similar to a wheelchair or stretcher transport and the impact of requirements related to the Emergency Medical Treatment and Active Labor Act (EMTALA).

3. **Third tier:** Use of law enforcement for transportation, including potential for creation of "mental health officers," and use of restraints in transportation.

It became clear about halfway through the study that the three tiers listed above blend into each other and can be subdivided into at least six tiers.

II. VIRGINIA LAW

Virginia Code § 37.2-808(C) requires the magistrate issuing an emergency custody order ("ECO")[4] to specify the primary law-enforcement agency and jurisdiction to execute the ECO and provide transportation. Subsection D also requires the magistrate to "order the primary law-enforcement agency from the jurisdiction serviced by the community services board …to execute the order and provide transportation." Similarly, § 37.2-810(A) also requires the magistrate issuing the temporary detention order ("TDO")[5] to specify the law-enforcement agency and jurisdiction that shall execute the temporary detention order and provide transportation."

At least 27 other states permit individuals and entities other than law enforcement to assume custody and provide transportation in these circumstances. These include family, friends, mental health providers, ambulances and public and private transportation providers.[6]

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[3] CSBs and behavioral health authorities are agencies of local government established pursuant to §§ 37.2-500 and 37.2-601 respectively to provide mental health, mental retardation and substance abuse services within the jurisdictions they serve. There are 39 CSBs and one behavioral health authority in the Commonwealth. The term "CSB" will be used throughout this Report to refer to both CSBs and the behavioral health authority.

[4] Under Virginia law, upon a determination that there is probable cause to believe a person meets the statutory civil commitment criteria, a magistrate may issue an ECO for a law enforcement officer to take the person into custody and transport the person to a convenient location to be evaluated to determine whether the person meets the criteria for temporary detention and to assess the person's need for hospitalization or treatment.

[5] After an in-person evaluation by the CSB, a magistrate may issue a TDO if "it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment." The TDO is effective for a maximum period of 48 hours, with additional time allowed if it expires on a weekend or holiday.

[6] Compilation of Excerpts of State Laws on Transportation of Persons with Mental Illness prepared for the Commonwealth of Virginia Commission on Mental Health Law Reform, Jill Sager, University of Virginia Law School (June 2008).

Section 37.2-808 was amended during the 2008 General Assembly Session by adding a new subsection E to permit the law-enforcement agency providing transportation to transfer custody of the person to the facility or location to which the person is transported for evaluation under certain specified circumstances. This provision may have the effect in the future of relieving law-enforcement of some of the time involved in waiting for evaluations to occur, but it does not relieve it of the primary responsibility for providing transportation for both ECOs and TDOs. Unless §§ 37.2-808 and -810 are amended, alternatives to law-enforcement transportation as outlined in this Report will not be permitted.

Section 37.2-830 does permit a judge or special justice following the commitment hearing to place a person in the custody of any responsible person, including the facility in which he was detained, for the sole purpose of transporting the person to the commitment facility. The preceding section, § 37.2-829, permits the judge or special justice to consult with the person's treating physicians and the CSB regarding the person's dangerousness and whether the sheriff should transport or whether other alternatives authorized in § 37.2-830 may be utilized. This provision could be strengthened to insert the provisions in § 37.2-829 at the beginning of § 37.2-830 to require consideration of other alternatives before requiring the sheriff to provide the transportation. Section 37.2-830 would then be repealed.

Attached as Appendix A is draft legislation that is designed to amend these code sections to permit the alternative transportation options outlined in this Report.

Recommendation 1. The General Assembly should amend §§ 37.2-808, -810, and -829 and repeal § 37.2-830 to permit and strengthen the use of alternative forms of transportation other than law-enforcement.

Family members have also pointed out that if they could be notified that their family member is in crisis, they may be able to provide the transportation themselves, or in some cases, defuse the situation or provide alternative care so that emergency custody, detention and involuntary hospitalization may not be needed. The HIPAA Privacy Rule, 45 C.F.R. § 164.510(b)(ii), and the Virginia Health Records Privacy Act, § 32.1-127.1:03, permit such a disclosure but it does not appear absolutely clear to mental health professionals that this disclosure can occur. As a result, they often opt not to notify family members. Attached as Appendix B is draft legislation to amend §§ 32.1-127.1:03 and 37.2-804.1 to make it clear that family members may be notified when their relative is involved in the commitment process. The language used is taken directly from the HIPAA Privacy Rule. A provision is included to prohibit disclosure if the health care provider is aware that a protective order has been entered preventing contact between the family member and the person in crisis.

Draft legislation to amend this provision is attached as Appendix B.

Recommendation 2. The General Assembly should amend §§ 37.2-127.1:03 to permit family members to be notified when their relative in involved in the commitment process.

III. FIRST TIER TRANSPORTATION

The Transportation Working Group first assessed what transportation options including transportation by family and friends, CSBs, taxi services and Medicaid vendor transportation are currently being used as well as their effectiveness. It then explored other options that may be developed. Broadly, the Transportation Working Group concluded that the relative absence of non-crisis, voluntary transportation options for persons often leads to initiation of the involuntary commitment process and the engagement of law enforcement to intervene in crises and transport individuals to mental health assessment or treatment facilities. The flip side to this is a consensus that the extent to which voluntary services become more widely available, supported by the provision of 1st tiered transportation services, the less will be the need for crisis intervention services and the corresponding need for law enforcement intervention and transportation. The following discussion identifies some options for non-law enforcement transport.

A. HPR V Transportation Program. The Tidewater Region in Virginia is using $36,000 in reinvestment funds from the closure of the acute admissions unit at Eastern State Hospital to fund taxi transportation services for persons without other resources, with the Hampton/Newport News CSB serving as fiscal agent. Taxis are used only for voluntary transports when a mental health professional has determined that the person is capable of being a passenger in a cab with just a driver. Very few problems using taxis have been reported, and those problems have only been minor. Taxi companies have not complained. The Tidewater program may be successful, in part, because of the population density in Tidewater and the availability of taxis.

In Hampton/Newport News, emergency services workers are also very mobile and therefore few ECOs are issued. The emergency service worker's personal observation of the person in crisis leads to appropriate diversion to a crisis stabilization center. In one two-week period in May 2008, 49 TDOs were issued (for 50% of which, the person was Medicaid eligible). Approximately 20% of requests for CSB assessments come from law enforcement. The remaining requests come primarily from emergency departments. It has been postulated that perhaps taxis could also be used to transport appropriate individuals who have agreed to voluntary admission at the commitment hearing.

Recommendation 3. CSBs should consider the cost effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services. Access to such a service may prevent an individual's condition from deteriorating to the point that crisis intervention and more restrictive and costly hospitalization is needed.

B. CSB Emergency Crisis Workers. Reports from around the state indicate that crisis workers, who are mobile and often use their own cars, are prohibited by CSB policy from transporting individuals in crisis. However, it is reported that crisis workers and case managers do on occasion transport individuals, often in their personal vehicles, to crisis stabilization centers and other facilities when they have a personal comfort level with the individual usually developed through the person's prior history with the CSB. Consideration should be given to changes in CSB policies to permit crisis workers to transport in certain circumstances in either government owned vehicles or their personal cars. Liability insurance would be required for use of the person's private vehicle. If such changes are made, there may be a need for crisis workers to visit in teams, rather than individually as is the current practice (when done at all), which may have a staffing impact. Fifteen to twenty CSBs are also Medicaid transportation providers. CSBs may thus be reimbursed by Medicaid for this service.

Recommendation 4. CSBs should consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

C. Medicaid. Medicaid can pay for routine, urgent and emergency transportation if a Medicaid-eligible person is being transported for a medically necessary service to a Medicaid-covered service (Note: Hampton/Newport News CSB reported that approximately 50% of persons receiving crisis services for a two week period in May 2008 were Medicaid eligible). DMAS has agreed to develop written guidance on when Medicaid will reimburse for psychiatric transports. Transportation for routine medically necessary mental health services can be made through Logisticare, the DMAS broker for transportation services. The person must be Medicaid eligible, the services must be medically necessary and the provider must be a Medicaid provider. Medicaid taxis generally require 24-hour notice for a non-emergency transport and Logisticare now requires a 5-day notice in most circumstances.

Medicaid will also pay for urgent trips that are not emergencies but are not routinely scheduled trips without going through Logisticare. Transfer of a patient from a temporary detention facility to another facility to which the person has been committed, for example, would be considered an urgent trip. Medicaid will pay for such a transfer when the person is Medicaid eligible and is being transported to a Medicaid-covered service. It must be noted that Medicaid does not cover services provided in a free standing psychiatric hospital, that is, an Institution for Mental Disease (IMD). For example, Medicaid will reimburse for transportation to the Commonwealth Center for Children and Adolescents in Staunton because services for children ages 0-21 are covered by Medicaid. Transportation of adults age 65 and over to a Medicaid covered facility such as Piedmont Geriatric Hospital is also covered. But transportation of adults age 22-64 to Western State Hospital, an IMD, is not.

Similarly, transportation of a person under an ECO or TDO will also be reimbursed by Medicaid as an emergency service as long as the provider is a Medicaid transportation provider and the person is being transported to a Medicaid covered service. Medicaid will, therefore, reimburse CSBs, ambulance companies, other public or private transportation providers, police departments and sheriffs if they are enrolled as Medicaid transportation providers and the facility to which the person is transported is a Medicaid covered service, and not an IMD. In order to bill Medicaid for transportation, law enforcement agencies will need to become Medicaid providers, and will most likely need to rely upon CSBs to provide them with individuals' Medicaid numbers, which CSBs obtain as part of the temporary detention process, in order to bill Medicaid. CSBs may provide such information to law enforcement without the individual's authorization under the HIPAA Privacy Rule, 45 C.F.R. 164.506, as part of the process of obtaining payment for services for the individual.

Recommendation 5. DMAS should develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is economically feasible for them to become Medicaid providers in these circumstances.

D. Other Modes of Transportation:

Some areas and some providers find options other than law enforcement to provide transportation in voluntary treatment situations. Note the following:

- One third to one half of individuals come to CSBs, emergency departments or other treatment facilities in their personal vehicles or with a family member providing the transportation.
- In Southwest Virginia, the local sheriff's office will on occasion provide transportation unrelated to an ECO. There are no taxis or buses available in that region. The CSB may provide gas money for a family member to provide transportation.
- In some areas, peer counselors provide transportation. Liability insurance protections also need to be available to peer counselors in such circumstances.
- Some providers use vouchers to pay a provider or family member either a set fee per trip or per mile or to pay a gas station for a specific number of gallons of gas. (University of Virginia does this.) Vouchers are also used to pay taxis.

Other options include the following:

- Development of pilot projects, especially in rural areas that would provide incentives for private providers to develop transportation options should be

considered, or for smaller community-based hospitals to bring consumers to their facilities.

- Development of pilot projects using state funds through DMAS' Involuntary Civil Commitment Fund to provide private transportation services, vouchers, etc.
- Consideration of CSBs hiring of off-duty police officers or deputy sheriffs and providing them with vehicles. Location of such officers in Crisis Stabilization Centers may be most cost-effective.
- Consideration of CSBs hiring peer counselors to provide transportation. Vehicles or appropriate liability insurance would need to be provided.
- Consideration of peer organizations becoming Medicaid service providers or becoming Medicaid transportation providers through a CSB.
- Consideration by CSBs of regional transportation options to purchase shared vehicles and share on-call staff. Vehicles could be located at regional crisis stabilization centers.

Recommendation 6. CSBs, private providers and other stakeholders in each locality or region should work together and explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

IV. SECOND TIER TRANSPORTATION

A. Transportation by Ambulance. Second tier transportation services would include transportation by ambulance or a form of transportation, similar to a wheelchair or stretcher van, not requiring a basic or advanced life support vehicle or the level of trained staff needed for life-threatening conditions. The Office of Emergency Medical Services in the Department of Health certifies all Emergency Medical Services agencies in the Commonwealth, permits all vehicles, and certifies four levels of professionals providing services: First responders, emergency medical technicians, intermediate level and paramedic level.

The majority of emergency services are provided by municipal-based entities by a mix of career and volunteer organizations. Virginia Code § 15.2-955 now requires local governments to ensure that emergency medical services are provided in their communities. As a result, most localities are hiring EMS providers and are not relying as much on volunteer services. Funding is provided through the "$4.25 for Life" program (which is a surcharge on DMV vehicle registration fees), $.25 of which is earmarked for training and a percentage of the remaining $4.00 goes to the locality for training or equipment, but not for personnel. Donations and support from localities must cover the cost of fuel, insurance, equipment and maintenance for volunteer agencies.

The cost for a basic ambulance begins at $ 120,000 and goes to approximately $ 140,000. There are no licensed unmarked vehicles in Virginia. If regulation were changed to permit unmarked ambulances, this expensive vehicle could not be used for any other

emergency transport. The bulk of the expense for providing EMS coverage is devoted to providing coverage, i.e. making sure that staff is able to respond in an appropriate time to meet the needs of the public. Demand is increasing for services especially by and for the growing elderly population. The reimbursement rate from Medicare and Medicaid does not truly cover the costs of this service.

There are no regulations that specifically cover response to mental health emergencies nor is there a specific mental health emergency curriculum. More training in this area would be welcome. However, transportation for persons with psychiatric illnesses is frequently provided. The Office of Emergency Medical Services collects data on the numbers of transports of patients with a psychiatric disorder. It is not clear from the data currently collected, however, whether the transport was for a psychiatric emergency, whether the psychiatric disorder was a disorder co-occurring with another disorder that required the transport, or whether the transport was for routine medical care. A more precise nationwide coding system is being developed that should provide better information shortly.

Transportation in a psychiatric emergency is always provided upon request of law enforcement. In such cases, a law enforcement officer either rides in the vehicle with the patient or follows behind the ambulance. Unless a more adequate funding source is developed, all Transportation Working Group members agree that the use of ambulance services on a routine basis for transportation in mental health crises would not be cost-effective. Moreover, unless the person is suffering from a physical illness or injury, transportation of a person in psychiatric crisis lying prone and strapped to a stretcher is not therapeutic and would not be preferred by consumers.

Wheelchair or stretcher van transport in Virginia is not regulated by the Department of Health. Reimbursement is provided by Medicaid in accordance with the transporter's provider agreement with DMAS. No treatment is provided in a wheelchair van. In addition, there is usually no other person in the van to monitor the person's condition. Many persons experiencing a mental health crisis may also have co-occurring physical disorders or may have suffered self-inflicted injuries that may need to be addressed during the course of transport. Use of a lesser type of medical transport than an ambulance may give a false sense of security.

Physicians Transport Services located in Northern Virginia has, however, identified and purchased a prototype vehicle that could be used in providing psychiatric transports and for other medical conditions. The cost of such a vehicle is approximately half that of an ambulance. It is unmarked and can carry two persons in wheelchairs and one person on a stretcher. It has a bench for an attendant, which would always be necessary in a psychiatric transport, to sit on and monitor the passengers. Plexiglas would need to be installed to separate the driver from passengers. DMAS representatives and members of the Work Group have inspected the vehicle and believe Medicaid reimbursement would be available for this type of transport and it would meet the requirements for a psychiatric transport. A pilot project, described below, and utilizing this vehicle is being developed in Northern Virginia.

Recommendation 7. DMAS should reimburse for transportation for psychiatric transports in appropriate circumstances when provided by the prototype vehicle used by Physicians Transport Services in Northern Virginia or other similar vehicles.

B. Concerns about EMTALA. A question has been raised concerning the applicability of the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") to the transportation of persons from a hospital emergency department to another facility for temporary detention as the result of a Vermont case. At issue is whether transportation by law enforcement of persons in restraints is a violation of EMTALA. Under EMTALA, a person's emergency medical condition must be stable before a patient may be transferred to another facility and the physician transferring the patient, in the case of persons detained under an ECO or TDO, the emergency room physician, must determine the appropriate mode of transportation and use of restraints. The Centers for Medicare and Medicaid Services ("CMS") Interpretative Guidelines provide that "psychiatric patients are considered stable when they are protected and prevented from injuring or harming themselves or others." The CMS Guidelines go on to provide that use of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a patient for a period of time but may exacerbate the underlying medical condition. Research has not revealed any case law or interpretive information related to the mode of transportation and use of restraints as part of the commitment process.[7]

Recommendation 8. The Office of the Attorney General and counsel for CSBs should monitor litigation relating to EMTALA insofar as it may affect transportation of persons with mental illness.

V. THIRD TIER TRANSPORTATION

A. Transport by Law Enforcement. Use of law enforcement is the method employed by most states to provide transportation of persons in mental health crisis situations. As already noted, however, at least 27 other state laws do permit other persons, including family, friends, mental health professionals, ambulances and public and private transportation providers to take custody of the person and provide transportation.[8]

Neither police departments nor sheriffs departments receive specific funding for executing ECOs, TDOs or providing transportation following a commitment hearing. Law enforcement officers spend up to four hours, and often much longer, in hospital emergency departments waiting for completion of medical assessments, CSB evaluations, and location of a temporary detention bed. Thereafter, due to a shortage of psychiatric beds, even longer hours may be spent transporting individuals outside the jurisdiction to

[7] Center for Medicare and Medicaid Services, *State Operations Manual, Appendix V – Interpretative Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases* (Rev.1, 05-21-04) Tag A 407.
[8] *See* footnote 6 above.

other parts of the state, necessitating taking two officers and a vehicle off of the street and away from other law enforcement duties needed in that locality. Overtime expenses are often incurred. In addition, the apparent "criminalization" of a person experiencing a mental health crisis and trauma experienced by the individuals involved as a result of the law-enforcement transport, almost always in metal restraints, is stigmatizing and greatly impairs their recovery.

B. Sheriffs' Association Staffing Standards: The Sheriffs' Association completed a staffing study early in 2008 (the "Sheriffs' Study") to determine the number of staff needed to perform all of the duties imposed upon Sheriffs' Departments in the Commonwealth, The Sheriffs' Study, which has been adopted by the Compensation Board, indicated that 26.3 *additional* full time equivalent (FTE) positions are needed for Sheriffs' Departments statewide to provide necessary services related to the involuntary civil commitment process. The Sheriffs' Study did not address any additional staffing that may be needed as a result of the 2008 General Assembly changes permitting extension of temporary detention orders to 6 hours or execution of the new mandatory examination order and *capias* requirements that became effective July 1, 2008. The Sheriffs' Study also only addressed staffing needs and not resources, such as vehicles and gasoline. Furthermore, the Sheriffs' Study also only applied to Sheriffs' Departments and not local police agencies that also provide a significant amount of transportation for ECOs and TDOs.

C. Police Chiefs' Survey: The Association of Chiefs of Police also conducted a survey to identify the frequency that local police agencies, sheriffs' departments, EMS agencies, or others provided transportation for ECOs and TDOs ("Police Survey"). The Police Survey indicates local police provide transportation for ECOs and TDOs approximately 75% of the time and sheriffs' departments provide transportation the remainder of the time. (Sheriffs always provide transportation *following* the commitment hearing.) Of police departments reporting another entity provides transportation, most often that entity is EMS because of a physical injury or medical complication of the person needing transportation. Even in those cases, law enforcement maintains custody and an officer will either ride in the ambulance with the patient or follow behind in a squad car. The Police Survey also indicated that use of restraints is mandatory for 61% of police personnel providing transportation and officer discretion to use or not use restraints is permitted in approximately 29% of police departments. In those jurisdictions where officer discretion concerning the use of restraints is permitted, there do not appear to be any policies in place to guide the officer's discretion, which could lead to individual police officer liability if a wrong decision is made.

D. CIT Programs. The Transportation Working Group also examined whether the expansion of Crisis Intervention Teams, where certain law enforcement officers receive extensive training on interventions with persons in a mental health crisis would reduce the impact of commitment-related transportation on law enforcement. It was the consensus of the Transportation Working Group that, although an important response tool for mental health crises, CIT training for law enforcement would not necessarily reduce law enforcement resources now used in transporting person in mental health crises, To be

effective in reducing such transport, crisis stabilization centers or no refusal drop off centers would need to be conveniently located in the same or a nearby locality. If conveniently located, many persons could be stabilized at a crisis drop-off center, and the number of individuals requiring further transportation for commitment purposes would be reduced.

E. Mental Health Officers. The Transportation Working Group also explored other options to reduce the reliance on law enforcement in civil commitment cases. One was the possibility of CSBs or private providers employing "mental health officers" who would be available at assessment sites and who could respond to emergency mental health calls in a CSB or private provider vehicle and provide the follow-on transportation needed. CSBs in rural areas could form regional response teams or mental health pools. The Transportation Working Group noted, however, that because of the rapid response often required, patrol officers are in a better position to respond to emergencies than mental health officers would be. Mental health officers could, however, be located at crisis stabilization centers, therapeutic drop-off centers, or hospital emergency departments and could provide custody and further transportation to a temporary detention or commitment facility. The legislative changes recommended above to permit non-law enforcement transport in certain cases, however, would permit a continuum of individuals or entities to take custody of an individual and transport him for mental health assessment and treatment. Therefore, the designation of a specific person as a "mental health officer" would be unnecessary. The CSB or private provider would need to ensure in any circumstance that appropriate policies are in place to determine the level of risk involved in the transport and the most appropriate type of transport, and that staff are appropriately trained to provide this service.

F. Use of Restraints. One consequence of the transport of persons involved in the commitment process by law enforcement is the routine use of restraints. Although this may be appropriate for persons arrested and in cases where a person in a mental health crisis is a danger to self or others, the routine use of restraints for persons being transported tends to "criminalize" the experience, resulting in trauma and added stigma.

The Transportation Working Group reviewed the laws of other states and the system in Vermont concerning the use of restraints. Vermont law requires that secure transport be done in a manner that prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. 18 V.S.A. § 7511. By law, the Mental Health Commissioner in Vermont is responsible for providing transportation of persons in the civil commitment process and contracts with law enforcement to provide transportation on a per transport basis. A qualified mental health professional or designated hospital professional conducts an assessment and determines what type of transport will be provided and whether "humane restraints," such as Velcro or polyurethane should be used. Vermont has developed an assessment check list for this purpose. The Transportation Working Group thoroughly discussed this topic and reviewed the available research and literature. Because the responsibility to provide secure transportation in Virginia rests with law enforcement rather than with the Department of Mental Health, Mental Retardation and Substance

Abuse Services as is the case in Vermont, the Transportation Working Group has determined that an entity other than the law enforcement agency responsible for the transport should not make decisions concerning the type of restraint used.

However, the Transportation Work Group suggested that the Department of Criminal Justice Services ("DCJS") be contacted to determine if DCJS would be willing to develop model guidelines and policy on the use of restraints, including the use of humane restraints, and develop training in the use of these restraints through the academies. DCJS was contacted on this issue but indicated that under current law the use of restraints in mental health transports is a matter of policy for the local sheriffs and police departments. Section 9.1-102(36), (37) and (45) of the Virginia Code does list among the powers and duties of DCJS the requirement that it establish training standards and model policy for domestic violence situations, persons with Alzheimer's disease, and sexual assault response teams, as examples. This Code section could be amended to include transportation and the use of restraints related to the civil commitment process. The Sheriffs' Association and Association of Chiefs of Police are open to further education and discussion on this topic at their various meetings. For liability purposes, it would be helpful to consider updating policies on this topic to provide more guidance to patrol officers on the use of restraints, as well as reviewing emerging case law on the use of restraints for persons with disabilities. Enactment of the proposed legislation permitting persons and entities to provide transportation will hopefully, however, reduce the need for law enforcement to provide transportation, and the need to use restraints, in other than dangerous public safety situations.

Recommendation 9. The Commission should continue to study the use of restraints for persons involved in the civil commitment process.

VI. PILOT PROJECTS

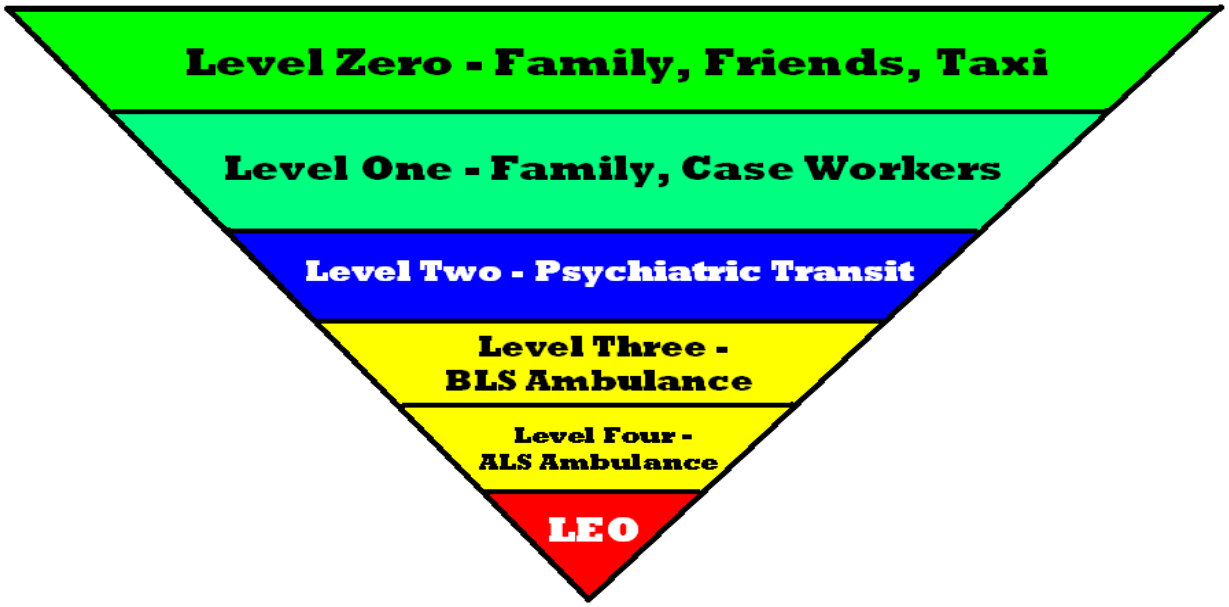
Randy Breton, Chief Operating Officer for Physicians Transport Service, and Jay Farr, Deputy Chief of Police in Arlington, in conjunction with other law enforcement agencies, mental health professionals, consumers and family members are developing a pilot project to be implemented in Arlington, Alexandria, Fairfax and Falls Church to be implemented as soon as legislation is enacted permitting entities other than law enforcement to provide transportation ("Northern Virginia Pilot Group")..

The Northern Virginia Pilot Group has developed draft Psychiatric Transfer Guidelines with two goals:

1) To provide a clear decision pathway for case workers, law enforcement officers and magistrates to help determine with reasonable certainty the safest and most appropriate means of transferring a person with psychiatric needs while protecting the rights and dignity of the person; and
2) To effectively utilize law-enforcement officers (LEO) and emergency services workers (EMS) when appropriately serving citizens in need while reducing the care costs to the person and the Commonwealth

The Psychiatric Transfer Guidelines contain a description of six levels of consumer behavior that would guide the type of transport that would be appropriate for that individual consumer. Below is an inverted pyramid that depicts the different levels of transport.

Physicians Transport Service has also purchased two prototype vehicles that can be utilized to provide the Level Two transport described below. This specialty vehicle costs approximately half that of an ambulance and would be unmarked. Plexiglas or other barrier will need to be installed between the driver and passenger area. A second provider will ride with the passenger at all times. It will not be an EMS vehicle. The vehicle is capable of providing wheel chair and stretcher services. A parent, relative or guardian can accompany the person if that person is not a cause of escalation. The vehicle cannot provide medical care, oxygen, suction, medications, etc. Each provider will be required to have CPR, First Aid, AED and psychiatric training. Medicaid will reimburse for this transport for emergency and urgent care situations.



Law-enforcement agencies, EMS agencies, and mental health professionals will be encouraged to inspect the prototype vehicle and review the policies, procedures and results of this project and to utilize whatever portions may be of assistance in developing alternative transportation in their localities.

Recommendation 10. The Commission should take formal steps to assure that the proposed Northern Virginia pilot project is evaluated and that a report is submitted to the Commission.

APPENDIX A

D R A F T

Alternative Transportation Legislation

§ 37.2-808. Emergency custody; issuance and execution of order.

A. Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. Any emergency custody order entered pursuant to this section shall provide for the disclosure of medical records pursuant to § 37.2-804.2. This subsection shall not preclude any other disclosures as required or permitted by law.

When considering whether there is probable cause to issue an emergency custody order, the magistrate may, in addition to the petition, consider (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any relevant hearsay evidence, (5) any medical records available, (6) any affidavits submitted, if the witness is unavailable and it so states in the affidavit, and (7) any other information available that the magistrate considers relevant to the determination of whether probable cause exists to issue an emergency custody order.

B. Any person for whom an emergency custody order is issued shall be taken into custody and transported to a convenient location to be evaluated to determine whether the person meets the criteria for temporary detention pursuant to § 37.2-809 and to assess the need for hospitalization or treatment. The evaluation shall be made by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the Department.

C. Prior to issuing the emergency custody order , the magistrate shall determine, after consideration of any available information provided by the community services board or its designee, the local law enforcement agency, if involved, the petitioner, the treating physician and others whether transportation can be provided by a family member or friend, a representative of the community services board, a health care provider, a representative of the facility at which the person will be evaluated, or another transportation provider with personnel trained to provide transportation in a safe manner. If the magistrate finds that such a person or provider is available, and is willing and

capable of safely providing the transportation, the magistrate shall order that the person be placed in the custody of that person or provider for the sole purpose of providing transportation pursuant to this section. If no other person or entity is available that is willing and capable of safely providing transportation, the magistrate shall specify the primary law-enforcement agency and jurisdiction to execute the emergency custody order and provide transportation. Transportation under this section shall include transportation to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law. Transportation under this section shall include transportation to a medical facility for a medical evaluation if a physician at the hospital in which the person subject to the emergency custody order may be detained requires a medical evaluation prior to admission.

D. Where transportation is required to be provided by a law-enforcement officer, tThe magistrate shall order the primary law-enforcement agency from the jurisdiction served by the community services board that designated the person to perform the evaluation required in subsection B to execute the order and provide transportation. If the community services board serves more than one jurisdiction, the magistrate shall designate the primary law-enforcement agency from the particular jurisdiction within the community services board's service area where the person who is the subject of the emergency custody order was taken into custody or, if the person has not yet been taken into custody, the primary law-enforcement agency from the jurisdiction where the person is presently located to execute the order and provide transportation.

E. The law-enforcement agency providing transportation pursuant to this section may transfer custody of the person to the facility or location to which the person is transported for the evaluation required in subsection B or G if the facility or location (i) is licensed to provide the level of security necessary to protect both the person and others from harm, (ii) is actually capable of providing the level of security necessary to protect the person and others from harm, and (iii) has entered into an agreement or memorandum of understanding with the law-enforcement agency setting forth the terms and conditions under which it will accept a transfer of custody, provided, however, that the facility or location may not require the law-enforcement agency to pay any fees or costs for the transfer of custody.

F. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing an emergency custody order pursuant to this section.

G. A law-enforcement officer who, based upon his observation or the reliable reports of others, has probable cause to believe that a person meets the criteria for emergency custody as stated in this section may take that person into custody and transport that person to an appropriate location to assess the need for hospitalization or treatment without prior authorization. Such evaluation shall be conducted immediately.

H. Nothing herein shall preclude a law-enforcement officer or other person or entity transporting a person who has been taken into custody pursuant to this section from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section.

I. The person shall remain in custody until a temporary detention order is issued, until the person is released, or until the emergency custody order expires. An emergency custody order shall be valid for a period not to exceed four hours from the time of execution. However, upon a finding by a magistrate that good cause exists to grant an extension, an emergency custody order may be renewed one time for a second period not to exceed two hours. Good cause for an extension includes the need for additional time to allow (i) the community services board to identify a suitable facility in which the person can be temporarily detained pursuant to § 37.2-809 or (ii) a medical evaluation of the person to be completed if necessary. Any family member, as defined in § 37.2-100, employee or designee of the local community services board as defined in § 37.2-809, treating physician, or law-enforcement officer may request the two-hour extension.

J. If an emergency custody order is not executed within four hours of its issuance, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if such office is not open, to any magistrate serving the jurisdiction of the issuing court.

K. Payments shall be made pursuant to § 37.2-804 to licensed health care providers for medical screening and assessment services provided to persons with mental illnesses while in emergency custody.

§ 37.2-810. Transportation of person in the temporary detention process.

A. Prior to issuing the temporary detention order pursuant to § 37.2-809, the magistrate shall determine, after consideration of any available information provided by the community services board or its designee and the local law enforcement agency, if involved, the petitioner, the treating physician, and others whether transportation can be provided by a family member or friend, a representative of the community services board, a health care provider, a representative of the facility in which the person will be detained, or another transportation provider with personnel trained to safely provide the transportation. If the magistrate finds that such a person or provider is available, and is willing and capable of safely providing the transportation, the magistrate shall order that the person be placed in the custody of that person or provider for the sole purpose of providing transportation pursuant to this section

~~A.~~B. Where transportation is required to be provided by a law-enforcement officer, t~~T~~he magistrate issuing the temporary detention order shall specify the law-enforcement agency and jurisdiction that shall execute the temporary detention order and provide transportation. The magistrate shall specify in the temporary detention order the law-enforcement agency of the jurisdiction in which the person resides to execute the order and provide transportation. However, if the nearest boundary of the jurisdiction in which

the person resides is more than 50 miles from the nearest boundary of the jurisdiction in which the person is located, the law-enforcement agency of the jurisdiction in which the person is located shall execute the order and provide transportation. The order may include transportation of the person to such other medical facility as may be necessary to obtain further medical evaluation or treatment prior to placement as required by a physician at the admitting temporary detention facility.

C. Nothing herein shall preclude a law-enforcement officer or other person or entity transporting a person who is in custody pursuant to this section from obtaining emergency medical treatment or further medical evaluation at any time for a person in his custody as provided in this section. Such medical evaluation or treatment shall be conducted immediately in accordance with state and federal law.

~~B~~D. A law-enforcement officer may lawfully go to or be sent beyond the territorial limits of the county, city, or town in which he serves to any point in the Commonwealth for the purpose of executing any temporary detention order pursuant to this section. Law-enforcement agencies may enter into agreements to facilitate the execution of temporary detention orders and provide transportation.

§ 37.2-829. Transportation of person in civil admission process.

When a person has volunteered for admission pursuant to § 37.2-814 or has been ordered to be admitted to a facility under §§ ~~37.2-814~~ 37.2-817 through 37.2-821, ~~a determination shall be made by~~ the judge or special justice shall determine, after consultation ~~regarding the transportation of that person to the proper facility. The judge or special justice may consult~~ with the person's treating mental health professional ~~and~~ or any involved community services board staff regarding the risk of harm to the person or others, whether transportation can be provided by a family member or friend, a representative of the community services board, a health care provider, a representative of the facility to which the person will be admitted, or another transportation provider with personnel trained to safely provide the transportation. If such a person or provider is available, and is willing and capable of providing the transportation, the judge or special justice shall order that the person be placed in the custody of that person or provider for the sole purpose of providing transportation pursuant to this section ~~and whether the sheriff should transport or whether transportation alternatives as provided in § 37.2-830 may be utilized~~. If the judge or special justice determines that the person requires transportation by the sheriff, the person may be delivered to the care of the sheriff, as specified in this section, who shall transport the person to the proper facility. In no event shall transport commence later than six hours after notification to the sheriff or other person or entity transporting a person pursuant to this section of the judge's or special justice's order.

The sheriff of the jurisdiction where the person is a resident shall be responsible for transporting the person unless the sheriff's office of that jurisdiction is located more than 100 road miles from the nearest boundary of the jurisdiction in which the proceedings took place. In cases where the sheriff of the jurisdiction of which the person is a resident is more than 100 road miles from the nearest boundary of the jurisdiction in which the

proceedings took place, it shall be the responsibility of the sheriff of the latter jurisdiction to transport the person. ~~The cost of transportation of any person ordered to be admitted pursuant to §§ 37.2-814 through 37.2-821 shall be paid by the Commonwealth from the same funds as for care in jail.~~

If any state hospital has become too crowded to admit any such person, the Commissioner shall give notice of the fact to all sheriffs and shall designate the facility to which they shall transport such persons.

~~§ 37.2-830. Custody of person ordered to be admitted for purpose of transportation.~~

~~Any judge or special justice may order that a person admitted pursuant to this chapter be placed in the custody of any responsible person, including a representative of the facility in which the person is temporarily placed during the temporary detention period, for the sole purpose of transporting the person to the proper facility.~~

APPENDIX B

Privacy Notice to Family Members

11-07-2008 Draft (Final Draft)

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors; or

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413.

Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.2-710, 37.2-839, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 10 (§ 37.2-1000 et seq.) of Title 37.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding

under § 19.2-169.6, 19.2-176, or 19.2-177.1, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under § 16.1-338, 16.1-339, 16.1-342, or 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, 19.2-176, or 19.2-177.1, or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Article 3 (§ 37.2-423 et seq.) of Chapter 4 of Title 37.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision 1 of this subsection;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-

901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title; and

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment.

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Chapter 8 of Title 37.2 of the individual's location and general condition when the individual has agreed to such notification; has been provided an opportunity to object to such notification and does not express an objection; or it can be reasonably inferred from the circumstances, based on the professional judgment of the health care provider, that the individual does not object. If the individual is incapable of making a decision regarding notification or an opportunity to object to notification cannot practicably be provided because of an emergency circumstance, notification may be made if the health care provider, in the exercise of professional judgment, determines that such notification is in the best interests of the individual. Notification shall not be made if the provider knows that the family member or personal representative has been prohibited by court order from contacting the individual.

Notwithstanding the provisions of subdivisions 1 through ~~33~~ 34 of this subsection, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation

of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health

care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name .....

Health Care Entity's Name .....

Person, Agency, or Health Care Entity to whom disclosure is to be made .....

Information or Health Records to be disclosed .....

Purpose of Disclosure or at the Request of the Individual .....

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was

protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) .....

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign .....

Relationship or Authority of Legal Representative .....

Date of Signature .....

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9 of this subsection, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena

or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND

THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8 of this subsection.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the

individual who is the subject of the health record in making decisions related to his health care.

§ 37.2-804.2. Disclosure of records.

Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently providing services to a person who is the subject of proceedings pursuant to this chapter shall, upon request, disclose to a magistrate, the court, the person's attorney, the person's guardian ad litem, the examiner identified to perform an examination pursuant to § 37.2-815, the community services board or its designee performing any evaluation, preadmission screening, or monitoring duties pursuant to this chapter, or a law-enforcement officer any information that is necessary and appropriate for the performance of his duties pursuant to this chapter. Any health care provider, as defined in § 32.1-127.1:03, or other provider who has provided or is currently evaluating or providing services to a person who is the subject of proceedings pursuant to this chapter shall disclose information that may be necessary for the treatment of such person to any other health care provider or other provider evaluating or providing services to or monitoring the treatment of the person. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained.

Any health care provider providing services to a person who is the subject of proceedings pursuant to this chapter may notify a family member or personal representative of the person’s location and general condition in accordance with § 32.1-127.1:03(D)(34), unless the provider knows that the family member or personal representative is prohibited by court order from contacting the person.

Any health care provider disclosing records pursuant to this section shall be immune from civil liability for any harm resulting from the disclosure, including any liability under the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.), as amended, unless the person or provider disclosing such records intended the harm or acted in bad faith.

APPENDIX C

SUMMARY OF RECOMMENDATIONS

Recommendation 1. The General Assembly should amend §§ 37.2-808, -810, and -829 and repeal § 37.2-830 to permit and strengthen the use of alternative forms of transportation other than law-enforcement.

Draft legislation to amend this provision is attached as Appendix A.

Recommendation 2. The General Assembly should amend §§ 37.2-127.1:03 to permit family members to be notified when their relative in involved in the commitment process.

Draft legislation to amend this provision is attached as Appendix B.

Recommendation 3. CSBs should consider the cost effectiveness of developing contracts with taxi services or other regional transportation providers to provide transportation and/or vouchers for transportation to medical appointments and other needed mental health services. Access to such a service may prevent an individual's condition from deteriorating to the point that crisis intervention and more restrictive and costly hospitalization is needed.

Recommendation 4. CSBs should consider changing their policies to specify when and under what circumstances CSB crisis workers, case managers and other employees may transport persons in government owned and personal vehicles as part of the delivery of mental health services. CSBs that have not done so should consider becoming Medicaid transportation providers.

Recommendation 5. DMAS should develop written guidance as soon as possible on the requirements and conditions under which Medicaid will reimburse for routine, urgent and emergency mental health assessment and treatment. CSBs that have not already done so should assess whether it would be fiscally advantageous to become a Medicaid provider of transportation services for their consumers and encourage, where possible, private transportation providers to develop such services. Police and sheriffs' departments should also assess whether it is economically feasible for them to become Medicaid providers in these circumstances.

Recommendation 6. CSBs, private providers and other stakeholders in each locality or region should work together and explore the feasibility of alternative methods of financing and providing transportation services for consumers, including use of peer counselors, off-duty law enforcement officers, and private mental health service providers, to determine whether they would be available and feasible in their area for providing needed transportation services for consumers.

Recommendation 7. DMAS should reimburse for transportation for psychiatric transports in appropriate circumstances when provided by the prototype vehicle used by Physicians Transport Services in Northern Virginia or other similar vehicles.

Recommendation 8. The Office of the Attorney General and counsel for CSBs should monitor litigation relating to EMTALA insofar as it may affect transportation of persons with mental illness.

Recommendation 9. The Commission should continue to study the use of restraints for persons involved in the civil commitment process.

Recommendation 10. The Commission should take formal steps to assure that the proposed Northern Virginia pilot project is evaluated and that a report is submitted to the Commission.