



Behavioral Emergency Management Guidelines for Telemental Health

*With Special Considerations for Home Based and
Alternative Unsupervised Clinical Settings*

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Main Resources

- **American Telemedicine Association**
 - Practice Guidelines for Videoconferencing-Based Telemental Health
 - Evidence-Based Practice for Telemental Health
- **Department of Defense (National Center for Telehealth & Technology T2)**
 - Telemental Health Guidebook
- **Department of Veterans Affairs, Office of Telehealth Services**
 - Telemental Health Emergency and Contingency Guidelines
 - Telemental Health Operations Manual (May 2011)
- **Department of Veterans Affairs, VISN 20 Home Based Telemental Health Pilot**
 - Standard Operating Procedure Manual

What is *Telemental Health (TMH)*?

- **Language of technology**
 - “Telemental Health”
 - “Tele Behavioral Health”
 - “Telepsychiatry”
 - “Telepsychology”
- **Hub & Spoke Model**
- **Home Based TMH**
- **Alternative Unsupervised Clinical Settings**

Telemental Health (TMH) in the VA

FY 2011 Clinic –Based Telemental Health:

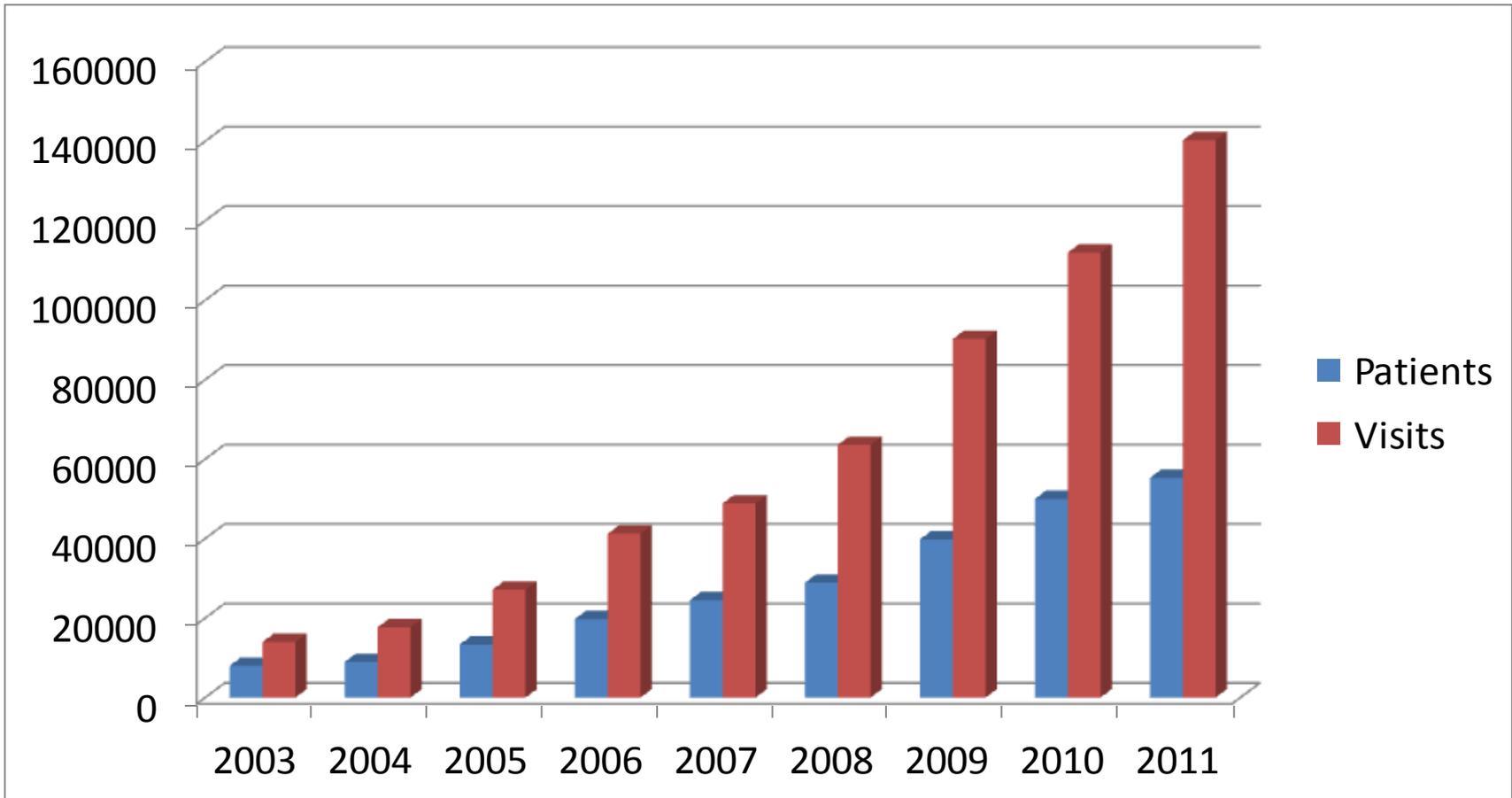
- 55,000 TMH video patients
- 140,000 TMH visits
- 146 hospitals
- 531 Community Based Clinics

Telehealth Service agreement

Each facility shall have a policy in place regarding emergency management. Please refer to the Office of Telehealth Service, Clinical Video training center for further information.

TMH Growth in the VA

- From 2003-2011, Telemental Health *annual* encounters have increased approx 10 fold from 14,000 to over 140,000.
- From 2003-2011, Telemental Health *annual* unique patients have increased > 6 fold from 8,000 to over 55,000.
- Total Telemental Health encounters from 2003-2011 = over 500,000



Current use

- Is used to treat virtually **every DSM** (Diagnostic and Statistical Manual) diagnosis, including affective disorders, anxiety disorders/ PTSD, psychotic disorders, and substance use disorders.
- Is employed to deliver virtually every treatment modality including individual therapies, group therapies, medication management, family therapy, couples therapy, cognitive behavior therapies, psychological testing, etc
- Takes place at multiple sites of care including VA medical centers, VA Community Based Outpatient Clinics, non-VA healthcare facilities, student health centers, homeless shelters, supervised housing sites, and residence.
- Is delivered by clinicians from multiple mental health professions and specialties including psychiatrists, psychologists, advanced practice clinical nurse specialists, physician assistants, social workers, RNs, addiction specialists, vocational rehabilitation specialists, and trainees.

Emergency Management in TMH: *The Basics*

Essentials

- **Licensing:** VA as Federal Agency requires single license; VA still must abide by states' licensing law that govern involuntary detention/commitment.
- **Involuntary detention / commitment:** abandonment and negligence. Technical failure during session.
- **Liability:** bound by same duty of care provision as face-to-face. Provide same comprehensive care as in-person.
- **Best Practices:** practice within local legal regs, clinical judgment in pt. selection, utilize accepted suicide assessment tools, have contingency plan.
 - Informed Consent – limits of TMH – emergency protocols mutually agreed to.

Pre-Session Procedures

- Have all direct phone numbers for the patient site (phone in the room where CVT session is occurring/telehealth support staff/on-call clinician/front desk/ security).
- Safety plans should be developed in advance and follow the appropriate site's protocol.
- Walk through the back-up plan with the patient in the event that the connection is dropped or failed (e.g. if after 3 attempts to reconnect VTel, the therapist will call the veteran and complete the session over telephone).
- Does your patient have your Emergency Contact Information?

Technology breakdown

- **Issues of abandonment** may occur in the event of the breakdown of technology, causing a disruption of the session.
 - The clinician shall have a backup plan in place and the plan shall be communicated to patient prior to commencement of treatment. The clinician may review the technology backup plan on a routine basis.
- The plan may include calling the patient first via telephone and attempting to troubleshoot the issue together. If further assistance is needed, the distant side clerk may be contacted for additional technical support. A TCT is a technician who is responsible at the patient site to assist all telehealth encounters.
- If the technical issue cannot be resolved, the clinician may elect to complete the complete the session via plain old telephone system (POTS). The plan may also include providing patient with access to other mental health care, either in the clinic or in the community.

Contingency Plans

- **Know your clinical back-up plan.**
- **Same-day communication plan:**
 - Patient crisis, appointment changes, therapist or patient running late, etc.
- **Technology back-up plan**
 - TCT, PSA, phone, combo
- **Consult with your local facility's policy on responding to emergencies.**
In most cases, each facility has their own policies and procedures.
 - If you work from medical center and access numerous clinics this is especially important.

Contingency Plans

Emergency plans should address:

- **Medical Emergencies**
- **Voluntary and involuntary psychiatric hospitalization**
 - Contacting Veteran-end staff about need to hospitalize
 - Who decides where the Veteran is sent
 - What are the state and local laws about this at the Veteran-end
- How is the **Veteran transported** in these situations?
 - Who will transport and who arranges transport?
 - Who will wait with the Veteran?
- **What happens if** there is a fire alarm, weather alert, bomb threats, or other emergency alert?

Patient Evaluation

The Psychology of Suicide

Prominent Aspects: Crisis, Ambivalence, Communication

The Worker

❖ Effect of Communication: excess anxiety within worker may cause loss of confidence in being helped. Feelings about Death.

Basic Principles

1. Establish relationship, contact, info gathering.
2. Identification / clarification of focal problems.
3. Evaluation of suicidal potential
4. Assessment of strength and resources
5. Mobilization of resources (patients' / others')
6. Formulation of therapy plan / initiation of appropriate action.

Risk Factors: age/sex, symptoms, stress from patient POV, suicide plan, resources, prior suicide hx, medical status, communication, reactions of others, Older Males, Depression, Psychosis, Agitation, (Agitated Depression), Isolated and alone

Shneidman, E.S., Farberow, N.L. & Litman, R.E. (1970)

Risk Assessment

- * Use clinical judgment in selecting patients for TMH visits.
- 1. Assess socio-demographic risk factors
- 2. Ask about stressors
- 3. How are things going in: *your marriage/relationship, your family, at home, at work (cover health, financial, marital, family, legal, occupational factors)*
- 4. Screen for dep., anx, agitation
- 5. Screen for alcohol abuse
- 6. Assess for risk of suicide. Ask.
 - a) Further evaluate for plan and lethality

Firearms/Weapons

Know how to negotiate disposition over firearms and weapons with Veterans

All VA federal facilities prohibit firearms and/or weapons on the property. Prior to beginning treatment, the clinician shall discuss with the patient whether they have access to firearms and/or weapons. If so, the clinician shall negotiate a mutually agreeable disposition of the firearms and/or weapons during the period of the telemental health appointment. If the patient does not agree with the plan, treatment must not commence.

Exclusion Criteria*

- **Rejects telehealth** in the informed consent process.
- With **immediate need** for hospitalization.
 - Acutely violent or unstable Veterans with poor impulse control
 - Active suicidal or homicidal ideation
 - Severely decompensated
- **Dementia**
 - confusion or mild cognitive decline.
- Essential medical monitoring that is unavailable on site
- Psychotic disorders that may be exacerbated by telemental health (e.g. ideas of reference regarding television)
- Untreated Substance abuse/dependence (current and/or extensive history with elongated sobriety and relapse)
- Significant sensory deficits

* ATA, VA/OTS

Exclusion Criteria **

- Without access to DSL, cable, 3g or 4g internet connection/computer.
- More complicated medical cases
- More complicated psychiatric cases
- Unable to identify a PSP

**** VISN 20 HBTMH Pilot**

Guidelines



American Telemedicine Association

- Additional personnel in room in addition to family members.
- Services preferred to be provided on-site and in-person.
- Make a determination whether immediate intervention is deemed necessary for patient safety.
- Obtain info on local regulations and emergency resources
- Identification of potential local collaborators

American Telemedicine Association

- Emergency protocols: roles and responsibilities in emergency situations,
 - Outside clinic hours emergency coverage
 - Guidelines for determining at what point others should be brought in to assist
- Be familiar with local civil commitment regulations
- Local staff to initiate/assist with civil commitments
- Perception of control
- Safety issues

DoD Telemental Health Guidebook

Site/command specific protocols.

from Guidebook:

4.4.4. (page 18), *Emergencies and Patient Safety*

- Clear and established protocols via SOPs to handle technical, medical and clinical emergencies
- Provider at distant site have secondary method of contact for immediately contacting patient/staff at originating site
- Someone at originating site as point of contact
- Both sites have immediate access to emergency contact numbers
- SOP should assign responsibility for contacting emergency personnel

www.t2health.org/programs-telehealth

VA-Office of Telehealth Services

Table 7 Emergency Procedures Checklist

Assessing Dangerousness	Do you know the existing emergency procedures for patients verbally or physically acting out at each patient site?
	What if the patient becomes imminently dangerous to on-site staff and/or their caregiver while in session?
	How will you notify the patient end staff that there is a dangerous patient? Who would they call on-site, how would they respond? What if the person designated does not respond?
	Do they have Security/Police on site? If not, how quick can they respond/be on campus? Who will call them? What are the local emergency numbers for each site? What is the address/floor/room number so you can direct dispatch?
	What if the patient leaves the Telehealth room visibly/verbally upset and you cannot locate him physically or by phone? What is your plan?
Voluntary Psychiatric Hospitalization	What if the patient is making statements regarding suicidal and/or homicidal ideation?
	Do you know the existing policy for voluntary psychiatric hospitalization at the patient site?
	How would you alert the patient end staff that the patient needs voluntary hospitalization? Do they have a MH urgent care team? If not, who will come and assess/make arrangements? What if they do not respond?
	Would the patient go to the VA or a local facility? What are the local emergency mental health resources? Who decides?
Involuntary Psychiatric Hospitalization	Do you know your state's laws/VA policy on governing involuntary hospitalization? Do they allow remote clinicians to get detention orders? If not, who will get the order? Can another on-site clinician obtain detention orders?

Medical and Environmental Emergencies	How would you notify the patient end sight there is a medical emergency in the Telehealth room? Who would they contact?
	Would the patient go to a VA or other (closer) hospital? Who decides that?
	Who would call for the ambulance, how would family members be addressed or notified?
	How would you manage your session if a fire alarm, weather alert, bomb threat, or any other emergency alert system is conducted at your or patients site?
Transportation	Are there any transportation policies in place for patients with medical or mental health emergencies?
	How will the patient be transported? Who would arrange the transportation? Who would wait with the patient until transportation arrives?
Pharmacy	How are prescriptions disseminated from the remote clinic?
	Will on-site staff need to be involved?
	Will a local pharmacy need to be involved if medication is needed imminently?
	Will the prescription be called in and by whom? Or will a prescriber on-site write an urgent prescription?
Laboratory	Can laboratory specimens be obtained at the patient site? What is the procedure?
	If there are no laboratory capabilities at the patient site, can labs be obtained locally? At the parent VA? What are the procedures?
	Do you know the hours of operation for the patient site lab?
Referral Resources	Co-morbid conditions may need to be addressed by another clinician or the patient may be ready to move to a different treatment plan. What are the procedures?
	How would you make referrals for additional therapeutic modalities (CBT group) or to additional clinicians (primary care follow-up)?
	What is your plan if your patient is asking for local community resources? Do you know the resources for that community (have contacts available) or could you contact on-site staff for referrals?

VISN 20 Home Based Telemental Health Pilot Program

Program Features

- What is HBTMH?
- Pilot Launch: February 2010
- To date: 525+ appointments w/100+ Veterans
- 40 Providers trained throughout VISN 20 (Alaska, Washington, Idaho, Oregon)
- Phase I,II,III
- PSP and PSP-T
- Standard Operating Procedure Manual (Shore, 2011)
- ASH-25 (Shore, 2011)

Inclusion Criteria

1. Referral for MH – access to care issues.
2. Must have a computer / broadband access.
3. Must have PCP/MH POC.
4. Must be an enrolled Veteran.
5. Must be able to enlist a PSP.
6. Provider completed an ASH.
7. Exclusionary criteria ruled out.

ASH-25

A Structured Guide for the Assessment of Suitability for Home Based Telemental Health
(Shore, 2011)

- Not psychometrically constructed, no norms. Simply a guideline to assist with case conceptualization.
 - Scores currently being evaluated to develop cut-offs for PSP inclusion.
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- Factor I: Mental Health
 - Factor II: Medical
 - Factor III: Access to Care
 - Factor IV: Systems
 - Factor V: Patient Support System

But, is it safer?

A standardized measure of patient's perceptions of safety was collected throughout treatment. (Score range 5-35). Pre-Mean: 30; Post-Mean: 30.6

“I would feel more comfortable and safe doing this at home because my anxiety is so severe I would not feel safe, secure or comfortable. I would be unable to participate (if weren't available at home).”

Patient Support Person (PSP)

- **A Patient Support Person (PSP) has been identified and is accessible**
 - This can be a family member, caregiver or any adult within the home This may also include neighbor
 - This is an individual who can be contacted to assist, where safe and indicated, in the event of an emergency
 - PSP does not have to be in home during session, nor do they need to “live with” Veteran.

Home / Unsupervised Settings

- The PSP must be briefed regarding their role and expectations prior to initiation of treatment
- It is strongly recommended that the Patient Support Person (PSP) receive brief behavioral emergency education to avoid potential risk
- Provider will need a Release of Information (ROI) signed by patient to allow Patient Support Person contact in case of emergency

Home / Unsupervised Settings

- Once onsite responders or Emergency Personnel have arrived and have patient under care and have vacated the home, the Home Based Telemental Health Provider will contact the Local VA/CBOC Provider and be notified of the emergency. Provider to remain as point of contact until the Veteran's PCP confirms coverage.
- Only under extreme circumstances should PSP transport patient to the hospital.
 - Seek guidance from emergency personnel (while on phone). If circumstances (distance, medical emergency), most likely transport.
 - Always use good clinical judgment.

Imminent risk

Ensure safety of patient, means and likelihood of self harm/others, level of urgency necessary to prompt immediate transport.

Do not leave the patient alone.

If Patient becomes unconscious and disappears from site of the provider:
Provider to contact Distant side Clerk (PSA) or Patient Support Person to provide visual assistance and evaluation of circumstances. “Patient is on the ground, they are unconscious, Veteran is having a seizure.”

Provider instructs PSA to Contact Onsite MD and PSP to contact 9-1-1 from their home.

Referral Resources

- How would you make referrals or consults for additional and/or specialty care in the community?
- Do you know community resources for the distant end? Examples are medical and mental health care for family members, food and clothing banks, housing, shelters, and childcare.

Key Points

- #1: Patient Safety
- #2: Have local Emergency contact information (CBOC PSA, PSP, CBOC Security local ER, local ambulance, local, police and fire)
 - Have easy access to ALL of this information before session begins.
- Create contingency plans
- Informed consent include unique emergency management protocol mutually agreed to
- Consult with State laws regarding Police holds, involuntary commitment
- Be familiar with local resources
- *Home Based – Unsupervised Clinical Settings*
 - Thorough Patient evaluation
 - Before beginning each session, verify that the Patient Support Person is accessible during the session (PSP does not have to be in same physical location as patient during the session).
 - Have PSP info readily available as well as local emergency personnel

Additional resources

1. Godleski, L., Nieves, J.E., Darkins, A., Lehmann, L. (2008). VA Telemental Health: Suicide Assessment. *Behav. Sci. Law* **26**: 271-286.
2. Gros, D.F., Veronee, K, Strachan, M., Ruggiero, K.J., Acierno, R. (2011). Managing suicidality in home-based telehealth. *Journal of Telemedicine and Telecare*. **17**: 332-335
3. Shore, J.H, Hilty, D.M., Yellowlees, P. (2007). Emergency management guidelines for telepsychiatry. *Gen. Hosp Psychiatry*. **29**: 199-206
4. Yellowlees P., Burke, M.M, Marks, S.L., Hilty, D.M., Shore, J.H. (2008) Emergency Telepsychiatry. *Journal of Telemedicine and Telecare*, **14**: 277-281
5. Veteran's Crisis Line/National Suicide Prevention Lifeline (800-273-8255)

Thank you

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