



Institute of Law, Psychiatry,
and Public Policy

**Telemental Health in Emergency Settings:
“Smart Practices” for Community Services Boards
Learned
from the Field**

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The Institute of Law, Psychiatry and Public Policy (ILPPP) at the University of Virginia is an interdisciplinary program in mental health law, forensic psychiatry, forensic psychology, forensic neuropsychology and forensic social work. Institute activities include academic programs, forensic clinical evaluations, professional training, empirical and theoretical research, and public policy consultation and review.

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Preface

The following report was created to support “SJ-47” – the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, specifically, the work of the Emergency Services Expert Advisory Panel. Telemental health has been frequently discussed by the panel as a way to enhance emergency services. In order to inform the panel and Community Services Boards (CSBs) statewide on how telemental health can be used specifically to enhance emergency services, researchers from the Institute of Law, Psychiatry, and Public Policy (ILPPP) have been looking closely at existing emergency telemental health practices and their current and potential use in emergency departments and other emergency settings. Researchers interviewed five CSBs who were identified as using emergency telemental health services through ILPPP surveys of CSBs in 2016. Two hospitals that have partnered with Fairfax-Falls Church CSB were also identified during the interview process and contacted for interviews on their experiences and perspectives on their internal use of telemental health and their telemental health partnerships with Fairfax-Falls Church CSB.

This report, using the experiences and examples provided by these existing programs, provides “smart practice” recommendations for CSBs when implementing and structuring an emergency telemental health program. The recommendations were formed after speaking with the five CSBs that either currently have an operating emergency telemental health program or are in the process of implementing a program. The recommendations themselves come from researchers’ synthesis of information gained from the interviews and from recommendations offered by CSBs and CSB partners.

We would like to thank the CSBs, hospitals, and VACSB who contributed their time and expertise to this report. Your contributions are greatly appreciated.

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1. Executive Summary

- Policymakers are interested in leveraging teleconferencing technologies to improve the efficiency of the mental health emergency services system.
- Some Community Services Boards (CSBs) are already making use of this technology to support the pre-admission screening (“prescreen”) process (i.e., to determine whether a person in mental health crisis meets the criteria for issuance of Temporary Detention Order [TDO]) and have reported satisfaction with their programs.
- We identified four general teleprescreening models for CSBs that can be used to meet different needs.
- Smart practices* for implementing a teleprescreening program were identified and are presented in this report.
- Some CSBs are using telemental health for ancillary services such as commitment hearings and Crisis Stabilization Unit (CSU) screenings.
- Teleconferencing technologies may have additional applications including use in state hospitals and use as part of a multi-CSB pool of prescreeners for use when high volumes of prescreen requests occur.

2. Background

The Emergency Services Expert Advisory Panel, established to support the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century (abbreviated in this report as SJ47 in reference to the senate joint resolution establishing the subcommittee), is interested in how teleconferencing can be used to enhance emergency mental health services in Virginia. Consequently, this report was created to summarize how CSBs are currently using telemental health[†] in emergency contexts, specifically when conducting prescreening evaluation services. It also presents information about how these programs might be expanded to further enhance the provision of emergency services in Virginia. Note that this report does not recommend statewide adoption of any telemental health program for prescreening, and we make no claims that telemental health evaluations are superior to face-to-face evaluations. This is meant as a guide for CSBs seeking to implement a telemental health program, improve a current program, or investigate options for improving evaluation efficiency. To give context for the Emergency Services Panel’s interest in telemental health, the following provides an overview of relevant information about the mental health system in Virginia.

“Psychiatric boarding” is a problem nationwide and significantly contributes to emergency department crowding. Psychiatric boarding can be described as “the time spent waiting in a hospital emergency department (ED) for an inpatient hospital bed or transfer to another inpatient facility by patients with primary psychiatric conditions.”¹ Psychiatric patients are over four times more likely to be subject to boarding and on average must wait more than

* Smart practices are derived from specific practices analyzed for an understanding of “why”, “when”, and “where” they work to apply their fundamental principles in other contexts or settings. Smart practices recognize that there is no one size fits all solution but provide strong guidance for establishing programs.

[†] Note: There are many terms used to describe teleconferencing for mental health services such as telemental health or telepsychiatry. In this report, the term “telemental health” will be used to describe all types of telemental health activities and does not necessarily include psychiatric (i.e., provided by a psychiatrist) services. The scope of this report includes emergency evaluations performed by CSBs.

two times as long as non-psychiatric patients to receive services for their condition.⁷ Psychiatric patients may face delays in treatment or risk of elopement when they are subject to emergency department crowding and subsequent boarding.^{3,8} In addition, it is estimated that emergency departments lose \$2,264 per psychiatric patient due to direct patient costs and opportunity costs.⁶ Reducing the time each psychiatric patient spends in the emergency department is therefore a high priority in order to decrease excess costs, increase ED bed turnover, reduce patient time to treatment, and decrease emergency department crowding.

In Virginia, the emergency services system is experiencing volume-related pressures that result in increased crowding and psychiatric boarding. In recent years, volumes of Emergency Custody Orders (ECOs), TDOs, and civil commitments have increased, adding strain to Virginia emergency services. ECO counts in Fiscal Year (FY) 2016 were 23.8% higher than counts in FY 2014 and TDO counts were 12.8% higher. Involuntary civil commitment orders decreased slightly from FY 2014 to FY 2015, and then increased by approximately 4.2% from FY 2015 to FY 2016.² Rising commitments have also led to state hospitals operating at high capacity due to the high demand for psychiatric beds. In 2016, state hospitals reached 88% capacity[‡] and received 16.9% of TDOs, a 7-point increase from 2015 (DBHDS, personal communication, February 13, 2017; Central State Hospital, personal communication, March 1, 2017).^{10, 11} These volume-related pressures also make it difficult for CSBs to respond to requests for emergency evaluations in a timely manner. In order to absorb the increased volume of requests for emergency evaluations while meeting timeliness standards, CSBs may need to consider new strategies for increasing the efficiency of the prescreen process. In the past, some hospitals have responded to increased patient numbers by utilizing teleconferencing to spread their resources internally. One such hospital, Inova, began working with Fairfax-Falls Church CSB to extend these teleconferencing services into the prescreening process. The partnership has allowed them to significantly improve timeliness of prescreening evaluations by reducing prescreener response times. This is discussed further in the Partner Perspectives section on page 15.

It is important to note that psychiatric boarding is a complex issue with many proximal and distal causes such as lack of appropriate outpatient community or inpatient resources. There are many factors that contribute to psychiatric boarding, but the prescreen is the main one that is at least partially under CSB control and thus will be the focus of this report. Decreases in CSB response times to evaluation requests in mental health emergency settings are not a source of immediate relief for psychiatric boarding. Instead, these incremental improvements in efficiency may produce downstream effects that reduce psychiatric boarding time. This may be especially impactful for non-mandated evaluations (such as CSU evaluations) for which CSB involvement would be appropriate. For these evaluations, there may be longer waiting times for patients, especially during peak times when there are many requests for mandated evaluations for patients under an ECO. If prescreeners are able to spend less time traveling to mandated evaluations, they may be able to address non-mandated evaluations sooner.

In 2015, HB 2368 created a legislative directive to review CSB emergency evaluation practices¹² – looking at the possibility of authorizing psychiatrists and emergency physicians to

[‡] This figure should not be interpreted to mean that state hospitals are underutilizing beds by 12%. The Virginia Department of Health has determined that once bed occupancy reaches 90%, new psychiatric beds are needed. As such, a bed occupancy rate of 88% may be considered quite high.⁴

evaluate individuals for involuntary civil admission where appropriate to expedite emergency evaluations and generally looking for anything that could reduce the length of the emergency evaluation process and reduce psychiatric boarding. The idea to review emergency evaluation timeliness in general grew out of this initial charge. To gain further understanding of bottlenecks within the emergency evaluation process, DBHDS worked with the CSBs and the Institute of Law, Psychiatry and Public Policy to conduct a series of surveys on CSB timeliness. The 2016 version of the survey found that most prescreenings took place in hospital emergency departments. Fewer than 14% of prescreens took place in CSBs meaning that in most cases prescreeners needed to travel to other sites. Some CSBs conducted “teleprescreens” but this reflected only a small proportion of all prescreens. During the two-week period that surveys were collected, prescreeners drove approximately 9,520 miles to get to the evaluation sites. Almost 1 in 5 evaluations were more than 10 miles away. For CSBs that had significant delays in response time (defined as 2 hours between initial contact and the start of the evaluation), 53% reported this was due to receiving multiple evaluation requests simultaneously.⁹ In these cases, telemental health would have been useful in reducing prescreener travel and patient wait times for CSBs that provide evaluations to multiple locations.

Some CSBs have chosen to address increasing numbers of prescreen requests by leveraging teleconferencing equipment to conduct remote evaluations. During our work on HB 2368, as well as interviews with CSB Executive Directors for another study, it became apparent that some CSBs were already implementing innovative uses of telemental health technology to support the prescreen process or to conduct comprehensive teleprescreens. The most recent iteration of the timeliness survey (conducted in October 2016) showed that the length of time between initial CSB contact and arriving for an emergency evaluation was shorter for CSBs that perform teleprescreens. However, time taken to complete an evaluation was not significantly different. During interviews with CSBs using telemental health in emergency evaluations, they reported that they began using it out of necessity. It is possible that they would have longer than average times if they were not using telemental health. Note also that this is not a controlled experiment so the effect of the “tele”- intervention on evaluation time is not certain. One certainty is that none of the CSBs implementing teleprescreening were among the CSBs that were selected for intervention due to evaluation delays.

Law enforcement officers are the default transportation providers for individuals under an ECO, and as such, spend many hours transporting and waiting with evaluatees undergoing an emergency evaluation. Law enforcement agencies are therefore looking for ways to make the prescreening process more efficient, with an end goal of reducing the number of officer hours spent driving evaluatees to prescreen sites. According to the Virginia Sheriff’s Association, in 2016, sheriffs were short by 110 positions that were needed in order to meet State Compensation Board Staffing Standards for Mental Health Transportation. The number of mental health transports, including those for ECO and TDO evaluations, has increased 8.3% between calendar year (CY) 2013 and CY 2015. Some rural jurisdictions send two deputies for 12 or more hours in order to facilitate these mental health transports. The excessive time spent transporting mental health patients requires funds for overtime and reduces the number of available personnel for other law enforcement activities.⁵

3. Methods

ILPPP researchers identified CSBs that were conducting teleprescreens or had indicated they were working towards implementing a teleprescreen program of some kind by reviewing Executive Director Survey transcripts, results from a brief follow-up survey on CSB telepsychiatry activities, and HB 2368 timeliness data that captured whether evaluations were performed via televideo. ILPPP researchers coordinated interviews with the five identified CSBs through the Virginia Association of Community Services Boards (VACSB). ILPPP researchers interviewed CSB staff members who were knowledgeable about the teleprescreen programs, including Emergency Services Directors, IT leadership, Executive Directors, and other staff with day-to-day knowledge of prescreening activities. Researchers interviewed each of the CSBs identified through the abovementioned screening methods, resulting in a 100% response rate[§]. ILPPP researchers also interviewed available key partner organizations, specifically local hospitals, about their participation in emergency telemental health partnerships with the CSBs.

4. Main Findings

Through the interviews with CSBs, ILPPP researchers identified four main models of emergency telemental health programs: *Triage*, *Routine Teleprescreening*, *Contingency Teleprescreening*, and *TDO and Commitment Hearing Management*.

Triage emergency telemental health targets timeliness related to significant travel barriers (e.g., distance or difficult geography) between the prescreener site and an outlying locality with low demand for evaluations. The prescreener initially interviews the patient at the locality partner site (e.g., law enforcement office) and recommends travel to the prescreener site to complete the evaluation only if it is possible that a TDO would be requested. See page 20 for more information.

Routine Teleprescreening is designed to reduce travel time (due to traffic, distance, or high volume of evaluations across multiple sites) between the prescreener site and local partner sites. Evaluations are regularly completed via teleconferencing and the CSB has teleconferencing connections with multiple partner sites in the area. See page 21 for more information.

Contingency Teleprescreening is used occasionally to address timeliness concerns during after-hours evaluations, late at night, during poor weather conditions, or when providing evaluation services to locations with lengthy security processes. Local partners are those sites that request evaluations under the aforementioned circumstances. Prescreeners may perform teleprescreens from home in some circumstances. See page 22 for more information.

TDO and Commitment Hearing Management is designed to be used regularly to reduce time spent travelling to the magistrate's office when requesting or processing TDOs and/or to testify at commitment hearings. Magistrate Polycom and fax machines are used to facilitate TDO requests from the patient site. See page 23 for more information.

[§] Note that CSBs that have started working towards implementation of teleprescreen programs since Fall 2016 may not have been captured by this report.

Researchers also identified universal challenges and their solutions as well as benefits of emergency telemental health programs. These were distilled from all interviews to the most salient points that are likely to occur in all settings. Not all programs reported the identified challenges specifically but they are all relevant to emergency telemental health programs in that they are possibilities that should be discussed and planned for. The identified benefits may increase the efficiency of the prescreening and commitment processes and are also relevant to all programs. They also played an important role for CSBs in gaining partner and staff buy-in to the program, a concept discussed later in First Steps.

4.1. Universal challenges and solutions

- *Ongoing IT concerns:* Due to security and internet changes at CSB and partner locations, IT departments will need to regularly update lists of approved IP addresses and other security measures that may impact the ability to maintain a telemental health link. In order to address these ongoing concerns, the IT departments of the CSB and the partner locations will need to maintain a good, working relationship.
- *Patient contraindications:* Occasionally there will be patients who are not willing to use teleconferencing for evaluations or whose conditions make teleconferencing less effective or harmful (e.g., acute psychosis). In these cases, it may be best to perform a face-to-face evaluation or make adjustments to the teleprescreening process such as those made by Inova (see Partner Perspectives, page 15) to direct the patient to focus on a telephone instead of the screen.
- *Reliance on collateral contacts:* Prescreeners already spend significant time gathering patient information from collateral contacts in order to inform the disposition recommendation. Due to the nature of telemental health **, it is especially important to gather sufficient information from collateral contacts such as the patient's family, hospital staff, and law enforcement officers before making recommendations. This may require special training for local partners to educate them on how to look for and report patient behaviors not observable to the prescriber over video. These collateral contacts do not receive the same training as prescreeners and as such, they may miss more subtle patient behaviors, movements, odors, etc. When establishing relationships with local partners, it is important to make this expectation clear prior to beginning telemental health emergency evaluations.
- *Coordination and timeliness of information transfers:* This challenge is not exclusive to telemental health in emergency settings but affects all areas where telemental health is utilized. Prescreeners must work with the patient site on the transfer of necessary information (e.g., lab results and doctor's notes) to other facilities and their own offices for consideration during an evaluation. This can be challenging when the prescriber is not physically located at the patient site. As such, issues related to timeliness and accuracy of information can add time and hindrances to the teleprescreening process. This can impact the bed search process for patients under an ECO who meet criteria for a TDO. These patients face additional time restraints

** CSBs report that when using telemental health, prescreeners must rely on collateral sources for information that cannot be observed via a video connection, e.g., if the client smells of alcohol, or if they are engaging in off-screen behaviors that are relevant to the evaluation.

beyond that of other patients, increasing the importance of timeliness and accuracy in the transfer of information. Prior to implementing a telemental health prescreening program, CSBs must establish clear procedures and standards for the transfer of patient information with partner organizations.

- *Infrastructure and network connections:* When arranging partnerships for teleconferencing, the local partner sites may not have adequate network capacity or bandwidth. This is especially a concern with smaller hospitals or agencies. CSBs will need to thoroughly test the networks at partner sites to determine if these types of issues will arise. If they do, CSBs will need to work with the partner to upgrade their network. This may involve installing a new line that is exclusively for CSB use or simply upgrading the network that is already in place. This can be a costly endeavor but in some cases, the partner site may be willing to pay part or all of the cost if they see it as a benefit to their ongoing services.
- *Telemental health training:* Some CSBs may want to consider training options in telemental health (see STAR Telehealth information on page 12). Most CSBs with emergency telemental health programs reported that they train prescreeners internally via mock interviews or that their staff previously gained familiarity with telemental health technology in other contexts (e.g., to provide or obtain psychiatric services).
- *Software updates and security patches:* Teleconferencing software will occasionally need security patches that can be quite expensive. These updates are highly recommended as they are often used to “patch” weak areas in the software that are vulnerable to cyber threats. It is also recommended that CSBs negotiate security contracts with teleconferencing companies (available for a periodic fee) to avoid unexpected costs.

4.2. Universal benefits

- *Time saved:* Telemental health emergency evaluations decrease travel time to and from facilities for prescreeners which also decreases response time. This benefits prescreeners, local partner staff (hospital emergency department staff and/or law enforcement officers), and patients.
- *Safety:* Telemental health also addresses concerns about safety which arise when prescreeners must travel in poor weather conditions or late at night.
- *Patient benefits:* The patients benefit from fewer disruptions and less time spent in the hospital or in police custody.
- *Staff availability:* Shorter wait times for patients also frees up hospital emergency departments and law enforcement officers more quickly. Staff at CSBs will also be more available at CSB locations if they are not spending time travelling between partner locations.

In addition, researchers identified various smart practices for implementing a successful program, discussed in detail in First Steps when Implementing an Emergency Telemental Health Program (see page 10). Specifically, there are considerations for identifying local partners, securing infrastructure to support telemental health, IT coordination, and staff preparation or training. These smart practices are designated “First Steps” because they are the most important

elements of an emergency telemental health program and must be considered early on in the planning process. CSBs looking to start their own program should carefully consider these recommendations before implementation. Like the challenges and benefits discussed above, not all of the smart practices in First Steps were part of the planning process for all CSBs who participated in the interviews. Instead, these come from CSB recommendations based on their experiences for others who are starting an emergency telemental health program. These also reflect generalizable smart practices distilled from current CSB practices identified by researchers as useful for program implementation.

Another important aspect of a telemental health program is technology such as hardware and software used for teleconferencing, security updates, and compatibility with local partners (see Technology, page 14). Interviewed CSBs varied in the technology they use as well as in the technology-related challenges they faced. Researchers decided to present this information as a separate section given the variation and specificity of technology experiences for CSBs. While it is separate from the section on First Steps, the smart practices and CSB experiences in the technology section are also important for planning a telemental health program.

Two key partner organizations participated in interviews: Inova Fairfax Hospital and Dominion Hospital. Both organizations provided information on the process of beginning the telemental health partnership with Fairfax-Falls Church CSB, challenges they encountered, benefits of the partnership, and information on their internal teleconferencing programs. Information gained from these interviews is presented in Partner Perspectives, page 15.

5. First Steps when Implementing an Emergency Telemental Health Program

Prior to full implementation of an emergency telemental health program, there are several steps that should be completed. These may include:

- Selecting a model (see page 24)
- Identifying local partners
- Securing infrastructure to support telemental health (e.g., bandwidth)
- IT coordination between the CSB and partner sites, including protocols for secure file transfer
- Staff preparation or training at CSB and partner sites

5.1 Identifying Local Partners

When identifying local partners, CSBs should focus on locations where there are significant barriers to timeliness of emergency evaluations that are related to distance, geography, traffic, or volume of evaluations. Local partners will be those local entities that are involved with individuals when evaluations are requested. Local partners may include hospitals, law enforcement, and detention centers, among others. It is also important that these local partners directly benefit from the use of telemental health in emergency evaluations. Receiving direct benefits (e.g., less staff time spent with the individual or fewer resources used by the individuals) is essential to engaging these partners in forming a telemental health link.

In some cases, local partners may be willing to pay a portion of costs for purchasing equipment or upgrading networks. Partners may be more willing to cover part or all of the cost if they view it as beneficial to their current services or as beneficial in potentially reclaiming resources otherwise spent on emergency evaluations. This should be discussed with partners in advance to properly budget for costs in establishing a telemental health link.

Examples of Local Partners:

- Valley CSB partners with law enforcement in Highland County to perform prescreening triage via teleconferencing (see Triage Model for more information) in order to avoid significant time spent by law enforcement officers transporting the patient over difficult terrain that is often subject to hazardous driving conditions.
- Fairfax-Falls Church CSB partners with Inova and Dominion hospitals to provide teleconferencing evaluations due to high volume of requested evaluations and significant traffic delays.

Establishing Relationships with Local Partners

It is important for essential personnel at the partner site to “buy-in” to telemental health for emergency evaluations. Essential personnel may include: executive and clinical leadership, staff directly affected or involved in evaluations, and the site IT department. Considerations about IT department coordination are discussed below. It is important to discuss how the partner site and personnel will benefit from use of telemental health in emergency evaluations. Possible benefits may include less time spent on transporting patients, reduced waiting times for CSB prescreeners, and freeing up facility space and staff more quickly. Expectations for partner staff should also be discussed prior to program implementation. These expectations may involve active involvement in setting up teleconferencing equipment, patient observation, and communicating relevant patient information to prescreeners and other partners who may receive the patient. Establishing a good relationship with these essential personnel may require regular meetings prior to establishment of the telemental health link.

Selling points for local partners

- Reduced CSB response time and patient wait times
- Reduced patient length of stay
- Hospital staff and resources can be made available for other purposes more quickly

See Partner Perspectives, page 15, for example outcomes and Universal Benefits, page 9

5.2 Internet Infrastructure

Using telemental health through a secure link involves sending a large amount of data over the CSB and partner site networks. It is not uncommon for these networks to require upgrades to properly facilitate telemental health evaluations, especially for partner sites that do not already have teleconferencing services. The main issue is increasing bandwidth, which requires a system upgrade or installation of a dedicated network exclusively for teleconferencing. This seems to be an issue that arises more often in small hospitals or other small local partners. Some local partners may also insist on using a separate network for telemental health evaluations due to privacy or concerns that usage may adversely affect network connections for other hospital functions.

CSBs should first test network connections at partner sites to ensure that they will be able to sustain the transmission of high-quality, secure video data over the network. If possible, CSBs should attempt to test networks by making encrypted, video calls on teleconferencing equipment. Tests with standard, non-secure video calls may appear to have sufficient connectivity and bandwidth but there are significant differences in the amount of data transmitted through these and higher-quality, secure teleconferencing calls. In addition, CSBs should test the connection at different times and in the locations where evaluations are likely to occur. There may be variation in usage of the hospital or local partner network that can overburden the internet connection and interfere with teleconferencing. It is also important to note that portable WiFi devices may not function in these locations due to interference from the partner's network. Overall, extensive testing of networks at CSB and local partner locations is a vital part of assessing implementation barriers and costs.^{††}

If the network is inadequate, the upgrades can range from simple, inexpensive upgrades to more extensive, costly full network installations. Some CSBs may find that hospitals or other local partners are willing to pay for a portion or the full cost of upgrades. This may be the case if they view the upgrade as beneficial to currently offered services or they view teleconferencing evaluations as highly beneficial to their organization. Upgrading a network can also be a lengthy process and CSBs should be prepared for this possible delay in implementation.

5.3 IT Coordination

CSBs and local partners will each have their own IT department^{‡‡} with network security requirements that apply to telemental health. During initial planning, IT departments should meet frequently to establish an understanding of organizational requirements and a good, working relationship. When these two departments form a good relationship, the establishment of a telemental health link can be more easily achieved. It is important to maintain this relationship as there will be ongoing barriers to connecting the systems due to system and security updates or changing internet providers. IT groups

^{††} Note that even after extensive testing and upgrades to internet infrastructure, there may be occasions when internet outages or other technical difficulties occur that preclude conducting a teleprescreen. CSBs should develop contingency plans with partner organizations for such outages, which may include briefly switching to telephonic evaluation, or having the prescreener drive to the evaluation site and conduct an in-person interview.

^{‡‡} Note that for Administrative-Policy CSBs and other CSBs that are integrated into the local government, there may be additional county or city IT requirements that must be met.

will be able to respond quickly to such events if they already have an established line of communication. It is also important that IT departments discuss and plan for secure file transfer between the patient site and prescriber location and/or treatment facilities for use during the evaluation and the bed search process.

5.4 Staff Preparation and Training

When preparing a telemental health program for emergency evaluations, it is important to engage CSB staff, especially prescreeners, throughout the entire process. Staff “buy-in” is critical for the success of telemental health for emergency evaluations. One recommendation is to train staff on the equipment with several mock evaluations to increase comfort and familiarity with the technology. In addition to technical training, it is important to prepare staff for the culture change that accompanies a transition to telemental health. Staff should be counseled on the importance of framing telemental health evaluations as the norm for the evaluatee, as framing can impact patients’ experience with the technology. CSBs with an existing telemental health program for emergency evaluations have remarked that most staff members realize the benefits of telemental health once the program is underway. Telemental health can save prescriber time, reduce exhaustion or burnout caused by travel between sites, reduce the need to travel in poor weather or late at night, and reduce patient time in hospitals or police custody. CSB prescreeners also report that they appreciate that telemental health allows them to spend more time engaged in client care than in driving.

It can be beneficial to introduce staff to telemental health programs gradually. One possible start point is the Contingency Teleprescreening Model described on page 22. CSBs with these programs reported training staff using methods such as mock evaluations and cross-training by using teleconferencing for other services. If staff would like further experience, there is a telemental health training program jointly sponsored by the University of Virginia Center for Telehealth and the New College Institute. It has training options for Board Certified Telemental Health Providers as well as HIPAA training for telehealth settings. Contact information for this program is:

STAR Center <http://www.startelehealth.org/>

Melissa Shively, STAR Program Assistant
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30 Franklin Street
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Office: 276-403-5610
Fax: 276-403-5604
Email: mshively@newcollegeinstitute.org

6. Technology

6.1 System Hardware and Software

Most CSBs have already purchased teleconferencing equipment. Some CSBs have also leveraged partner organizations' existing teleconferencing resources, such as the Magistrate Polycom, for emergency telemental health programs. In some cases, CSBs have been able to leverage grant funds for purchasing equipment. Three commonly used brands of teleconferencing equipment are Polycom, Cisco, and Tandberg systems. When planning for longevity of a telemental health program, CSBs should budget for ongoing costs and possible system upgrades and/or equipment purchase to facilitate technology compatibility with local partners. Ongoing costs may include a security contract with a teleconferencing company (discussed below), upgrading older system software, purchasing new equipment, and upgrading networks to sustain a teleconferencing link. Some CSBs may also need to purchase or utilize portable WiFi-enabled devices for telemental health evaluations completed in alternative locations, such as prescreener homes in the case of after-hours prescreens. Some CSB staff note that using portable, mobile technology (e.g., tablets, smartphones, and laptops) for evaluations may result in poor image or audio quality, particularly if the device has a small screen. This may compromise the effectiveness of a teleprescreen by reducing prescreener capacity to discern subtle aspects of body language and eye movement. Laptops or desktop computers with large screens may be more appropriate mediums for telemental health evaluations. These are important considerations for CSBs looking to implement a telemental health program that includes evaluations conducted over portable technology.

6.2 Security service

When purchasing teleconferencing equipment, it is important to research the company's policy on security updates. Oftentimes, there will be necessary system updates that patch a weakness in the system that is a security threat. Security updates are not always included in the equipment purchase price and can be costly if purchased on a piecemeal basis. One way to mitigate unexpected security upgrade costs is to purchase a security contract with the teleconferencing company when equipment is purchased. These types of purchases should be considered when constructing the initial budget as they are necessary, ongoing costs.

6.3 Concerns about compatibility with local partners

It is important to be sure that the CSB's teleconferencing equipment and software is compatible with local partners who may have different systems. Often, these systems will not communicate and other equipment or software may need to be purchased. If possible, CSBs should also aim to select equipment that is compatible with potential future collaborators, such as neighboring CSBs.

6.4 Magistrate Polycom

The Magistrate Polycom system is a secure teleconferencing system that connects with the local Magistrate's office. It is possible to link with this system to provide emergency evaluations with the proper equipment. Using the local Magistrate Polycom system may be an option when there is not high demand for telemental health emergency evaluations and the Magistrate's office is not using the system frequently. The Magistrate

system works by allowing CSBs to connect to the secure “bridge,” which functions as a chatroom for teleconferencing. It supports high-quality, encrypted video calls and does not involve purchase of additional equipment in locations where it has already been installed. Prior to planning a teleconferencing program around this, CSBs should contact the local Magistrate’s office to discuss the possibility. They will also need permission from the Supreme Court of Virginia. CSBs that have used this system in the past did not face significant difficulty in making these arrangements, though there may be differences between localities. One CSB that uses the Magistrate Polycom system, Valley CSB, noted that it faced numerous difficulties with the Polycom connection to the Magistrate system. These connection issues were due to periodic network changes such as security updates that inadvertently altered the pathway for the Polycom system connection to the Magistrate “bridge.” Valley CSB was able to solve these issues by installing a dedicated connection through its internet service provider which bypasses its internal servers.

7. Partner Perspectives

7.1 Inova Fairfax Hospital, Local Partner with Fairfax-Falls Church CSB

Overview and Outcomes

Inova implemented telemental health for its own use before partnering with Fairfax-Falls Church and therefore was able to provide insights as a primary user and as a partner with a CSB. Inova is the largest health care system serving Northern Virginia, including Fairfax County, Loudoun County, and the cities of Alexandria, Fairfax, and Falls Church. Inova began using telemental health internally prior to beginning their partnership with Fairfax-Falls Church CSB. Their internal program was implemented several years ago to address internal response times of their psychiatric liaisons (mental health clinicians who perform psychiatric evaluations in the emergency rooms at Inova). Prior to the implementation of this program, response times for the psychiatric liaisons could be as much as 6 hours from the time the request for evaluation was made until the liaison was able to start the assessment. The reason for this was that one liaison was responsible for covering up to 3 separate emergency departments across Northern Virginia, thus requiring the liaison to travel between the facilities to perform the evaluations. Thus, Inova reported that it chose to implement a telemental health program, which ultimately resulted in a significant reduction in the wait times to approximately 50 minutes.

Inova staff noted that Fairfax-Falls Church CSB had similar issues with response time for prescreen evaluations, especially during off-hours, as the CSB had only one mobile crisis team to cover the county. The CSB was convinced of the usefulness of the program after observing the success that Inova had with using the program. Inova reported that the CSB was able to “sell” the idea to stakeholders by emphasizing the benefits including reduced length of stay in the emergency departments, reduced wait times, and a reduction in the need for the CSB staff to commute to the various hospitals within the Inova System. When the telemental health partnership was first introduced, a cultural shift away from in-person prescreens to prescreens conducted utilizing the

telemental health program was needed by both the Inova staff and the CSB staff. However this shift was eventually facilitated as staff soon realized the value of conducting prescreen evaluations remotely via the telemental health program.

The program was piloted at one of Inova's smaller community hospitals, Fair Oaks, that was very supportive of using the telemental health program for evaluations. This hospital was especially interested in piloting the program because they did not have a dedicated psychiatric liaison and as a result, they experienced many timeliness issues. The pilot telemental health program reduced patient length of stay and psychiatric liaison response times, the latter by 86%. This pilot data helped show other Inova hospitals the benefits of the program, which prompted them to make the decision to participate in the telemental health program as well.

Inova reported that their telemental health program has been very successful. In 2016, over 3,500 evaluations were conducted by the psychiatric liaisons via the telemental health program and timeliness for all evaluations significantly improved, especially during overnight hours. Inova has also partnered with Fairfax-Falls Church CSB to utilize the telemental health program to evaluate individuals who may be appropriate for step-down to crisis stabilization and for purposes of assessing patients who want to leave the hospital against medical advice once they are admitted to the unit. Inova is also exploring the possibility of using the telemental health program for the commitment hearings that occur in their units when the petitioner is unable to be present for the hearing. Currently, petitioners who are staff members must wait for unspecified lengths of time for the hearings to start. This impacts the staff members' ability to provide evaluations to other patients and requires additional staff to cover in their absence. Inova is also interested in expanding the telemental health program to their "nocturnist" (a hospital-based physician who works during the overnight hours). The nocturnist will be able to use the telemental health program to complete histories and physicals for patients admitted to the inpatient psychiatric units. This would facilitate a more timely start of care for nighttime psychiatric admissions.

Challenges and Solutions

Like the CSBs, Inova reported some internet connectivity-related challenges to implementing their program. Inova's telemedicine department has been responsible for installing and supporting the telemental health program, and Inova is currently addressing infrastructure issues to bring the servers in-house to provide greater stability to the program. The telemedicine department has also installed a 24-hour monitoring service to the telemental health carts so that they can remotely assist with any technical issues that may occur at any time.

Another challenge has been human error when using the equipment. For example, telemental health carts utilize batteries, which must be charged, and if staff fail to plug the cart in when it is not in use, the decreased charge can affect the ability to use the equipment when needed. Frequent changes in the emergency department staff have also affected the efficient use of the telemental health program. Some staff may not have been trained well in how to use the equipment. One way the Inova telemedicine

department has addressed this issue has been to provide multiple educational activities and to post directions on the cart with easy to follow instructions. Implementation of the telemental health program has also been affected by the cultural dependence of the ED staff on the “in-person” psychiatric liaisons. Inova reported that the emergency department staff often feel ill-equipped to adequately treat patients with mental health or substance abuse issues and historically they have allowed the psychiatric liaison to “manage” the case when they were present in the ED. With the implementation of the telemental health program, the emergency room staff must now manage the patient because the psychiatric liaison is no longer physically present in the emergency room.

Cultural shifts from in-person evaluations to evaluations delivered via telemental health were initially difficult for some of the Inova mental health clinicians as well as some of the emergency room physicians and nursing staff. When the ED staff would set up the telemental health equipment for patients, they would often frame the program in a negative manner. They would indicate their own dissatisfaction with the program and tell the patient that they felt evaluations should not be done via tele-video. This led to patient dissatisfaction with the process. After counseling, education, and experience with program effectiveness (e.g., improved response times), emergency room staff better appreciated how their attitude impacted the patient experience. As a result, they began to re-frame the way the program was presented to the patient to normalize it as a standard procedure at Inova. As a result of staff referring to telemental health as the norm for Inova, patients were receptive to tele-video evaluations.

Inova noted that telemental health evaluations may not be appropriate for all of their patients and some patients may require workarounds to facilitate the evaluation. This applies to patients presenting with delusions or paranoia related to surveillance or technology in particular. However, Inova has not had as many difficulties in this area, as was initially anticipated when planning the program. Inova addressed any difficulties that arose with workarounds, such as directing the individual to utilize a phone rather than the screen or conducting an in-person evaluation in more challenging cases.

Inova’s final concern with telemental health program is an ongoing challenge regarding billing for telemental health services. Currently Medicare does not reimburse for telemedicine services except in rural designated health provider shortage areas.^{§§} Northern Virginia is far from rural but still experiences issues related to access due to high volumes of patients and long commute times to reach medical facilities. Some commercial carriers reimburse for telemedicine services while others do not. Inova is currently working to understand the technical issues that result in claim denials such as, “place of service” codes, contracting/registration, etc. Inova is optimistic that they will be able to overcome billing barriers in the long-term, especially given the shortage of psychiatrists that exists, even in urban areas.

Overall, they report that the Inova Behavioral Health telemental health program has produced some very positive results. Inova has successfully partnered with the

^{§§}For more information see: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf>

Fairfax-Falls Church Community Service Board and hopes to expand those services by partnering with Loudon County to offer telemental health capability to patients in need of services through the Loudoun County CSB.

7.2 Dominion Hospital, Local Partner with Fairfax-Falls Church CSB

Overview and Outcomes

Dominion Hospital is a freestanding mental health care facility in Northern Virginia serving children, adolescents, and adults. They have a special focus on crisis intervention and stabilization in their inpatient and partial hospitalization programs. Fairfax-Falls Church CSB approached Dominion to begin a telemental health program and they are currently Dominion's only CSB partner. Dominion began their telemental health partnership with Fairfax-Falls Church CSB 1.5 years ago to address CSU evaluations for patients ready to discharge to a less intensive care setting. Prior to the implementation of this program, the patients in need of a CSU evaluation would have to go out into the community to the CSB. This involved a lot of coordination of patient transportation and transition points. Oftentimes, Dominion needed to send staff to accompany the patients. The process demanded many resources and time from Dominion and added concerns about patient functioning because patients being transferred to a CSU had acute symptoms. Establishing their telemental health program in their Assessment and Referral Department has reduced the need to send patients into the community in order to conduct CSU evaluations, thereby reducing transition points and patient stress. It has also helped to get patients into CSB services and the CSUs sooner than in the past (same or next day rather than 2-3 days). Because of the time saved through telemental health, clinicians are able to work in other areas of the hospital where they are needed and can prioritize people coming in from the community.

Dominion noted that they piloted the program for 8 weeks in the hospital before implementation. During the pilot, each unit of the hospital was assigned a therapist to assess connectivity and identify problems and solutions for barriers to consent. One challenge they faced was minimal usage of the technology, but the benefits were apparent for patients who had difficulty attending face to face appointments. The pilot results were used to expand access for therapists in the Assessment and Referral Department as well as inpatient, intensive outpatient, and partial hospitalization programs.

Dominion expanded teleconferencing services to CSB intake evaluations for patients. This helps keep up continuity of care when the person is discharged. Dominion noted that Medicaid prescreening is one potential area where they can expand teleconferencing in the future. Currently, it takes up to 72 hours to do a Medicaid prescreen because these types of screenings tend to be a lower priority for CSBs. Some Medicaid prescreens for children have been facilitated via teleconferencing in appropriate circumstances.

Challenges and Solutions

Staff at Dominion were very responsive to using the teleconferencing technology but had many questions about potential problems that might arise with this new

technology. However, arranging the training for staff was fairly easy as the previous director of their Assessment and Referral Department was largely responsible for setting up the technology and training staff quickly. Because Dominion is part of a larger network of hospitals, they were able to use policies and procedures from their parent company, HCA's Capital Division, to develop their own. Dominion also set up designated inpatient staff to manage teleconferencing in their facility, including a discharge planner, administrative coordinator, therapist, and leader from social work. However, Dominion noted that coordinating tele-evaluations with the CSB can be challenging because the CSB does not have dedicated technical staff to facilitate and coordinate the use of telemental health equipment when evaluations are conducted. This is mostly an issue for step-down CSU evaluations; this could be related to the non-mandated nature of these evaluations (i.e., unlike emergency evaluations of individuals who are being held under an ECO, they do not have an 8 hour timeline.) Patients at Dominion have also been receptive and cooperative because they are informed about the process in advance and must consent to using teleconferencing.

Dominion experienced difficulties with firewall barriers in the early stages of the partnership that have largely been resolved. Occasionally, Dominion will still have to adapt to new firewall updates that interfere with teleconferencing functionality but these are manageable adjustments. They suggested that these types of firewall problems may not occur as often in CSBs connecting with smaller hospitals that do not change firewalls frequently. They also expressed concerns with the lack of transportability of the teleconferencing equipment as it needs to be connected to certain ports. Dominion noted that teleconferencing often cannot be used for recommitments as this technology is inappropriate for patients on the thought disorder spectrum who are responding to internal stimuli that focuses on media and television. However, they suggested that this might be a feasible option for recommitments for patients who are experiencing depression.

Overall, Dominion believes that the benefits of telemental health in emergency or preventive settings outweighs the risk in 95% of cases. They emphasized that technology issues that may cause the call to fail do not occur in most cases. Some suggestions of furthering the use of telemental health are for proactive, preventive efforts. One way they are addressing this is with their virtual therapy program. This program will use the HIPAA compliant online video conferencing program, Virtual Therapy Connect, which can be used on a standard computer with webcam or a smartphone. This virtual therapy program will be available to download on patient and clinician computers or on smartphones and tablets. They also gave an example of using telemental health for Virginia's efforts to do depression screenings in schools. They suggested that CSBs can establish telemental health services in schools to reach patients prior to a crisis.

8. Models of Emergency Telemental Health Programs

In interviews with CSBs around the state that currently use telemental health in emergency evaluations, four program models were clear. These models are outlined below and may serve as a guide for structuring an emergency telemental health program. Each CSB should structure the program to best fit their needs and treat these models as flexible references for smart practices.

Triage Model

Item	Description
Who this works for	Rural CSBs with significant travel times/geographic barriers to one or a few outlying regions. This model works when the demand for these “triage” screenings is low. The main concern addressed in this model is travel to and from the patient’s originating location and subsequent loss of time and/or personnel in the local police department as well as unnecessary patient time in custody.
Partner	Sheriff’s Office or Police Department (or other first point of contact for individuals such as Federally Qualified Health Centers [FQHCs])
Purpose	Used to determine likelihood of requesting a TDO for an individual when there is ambiguity about whether the patient will meet TDO criteria and if alternative community resources will provide sufficient treatment. If the prescriber believes a TDO and/or hospitalization is definitely not necessary, the law enforcement officer (or other location staff) will not need to transport the individual to the prescriber location or other health care provider (e.g., hospital ED) to complete the evaluation. The prescriber may be able to resolve non-TDO level crises over the telemental health link by arranging a safety plan or community treatment plan for the patient. If the prescriber believes the patient may be in need of a TDO and/or hospitalization, an ECO is initiated at this time. The patient is then transported to a medical facility near the prescriber to complete the evaluation and receive medical clearance. It should be noted that prescribers may be more conservative in their recommendations in these situations given the limitations of a pre-evaluation.
Frequency of Use	Occasional use
Infrastructure Requirements	Network connections at the outlying location and the prescriber location need to be sufficient to maintain a teleconferencing link.
Equipment	This model is particularly well suited for using the Magistrate Polycom system due to the low level of use the model requires. It is less likely to interfere with Magistrate business than other models, particularly in locations with lower volumes of Magistrate activity. Prescribers may need portable WiFi-enabled devices for evaluations completed in alternative locations, such as their homes in the case of after-hours prescreens. As noted in the Technology section (page 14) these devices may have significant limitations.
Associated Costs	Magistrate Polycom may not incur additional costs because it is already installed at some locations. If the network is insufficient, networks may need to be upgraded prior to implementation, which can incur installation costs if there is not already a network available. Portable WiFi-enabled devices need to be purchased and may incur ongoing, monthly costs.
Pros	<ul style="list-style-type: none"> • Leverage existing, unused Magistrate Polycom technology for this “triage” screening. • If the CSB prescriber can determine TDO is not appropriate via Polycom, then the officers do not have to take the lengthy trip over potentially challenging geography to the CSB location (e.g., a 4-5 hour round trip for Valley CSB). • Law enforcement or other responsible agency is strongly incentivized to participate in order to reduce the amount of time their officers or responsible personnel spend on transportation. This is particularly helpful in rural locations with a limited number of officers and staff available. They also do not have to incur possible overtime costs. • In cases where a TDO seems likely and the person must then be transported, prescribers can use the time while the patient is being transported to gather information from collateral contacts or begin the bed search process.
Cons	<ul style="list-style-type: none"> • If a TDO is indicated, the patient must be transported to the CSB location or hospital for medical clearance and continuation of the evaluation.
Associated CSBs	<ul style="list-style-type: none"> • Valley CSB <p>Please note: The models of emergency telemental health programs were created from interviews with multiple CSBs. Not all contributing CSBs are implementing all parts of the model.</p>

Routine Teleprescreening

Item	Description
Who this works for	CSBs in either rural or urban locations may benefit from this model. It is best for those experiencing significant difficulties in response time due to travel (traffic or distance) or high volume of evaluation requests.
Partner	Hospitals, emergency departments, CIT programs, police departments, and/or jails where patients are located. This model requires partnerships with multiple locations in the region to be effective.
Purpose	Prescreeners at a central site will connect to partner locations to reduce travel time that may add unnecessary time to the evaluation process. In some cases, prescreeners will travel to the patient site for face-to-face evaluations but this should be decided on a case-by-case basis.
Frequency of Use	Regular, frequent use; ~30% of evaluations or more
Infrastructure Requirements	Network connections at all partner locations and the prescriber location need to be sufficient to maintain a teleconferencing link.
Equipment	Teleconferencing equipment will need to be installed at each partner location as well as the prescriber location. It is important to ensure that the systems at partner sites will be compatible with prescriber site systems.
Associated Costs	If the network is insufficient, networks may need to be upgraded prior to implementation which can incur installation costs if there is not already a network available.
Pros	<ul style="list-style-type: none"> • Prescreeners no longer travel to partner sites to perform evaluations. • Law enforcement officers/other staff save time usually spent transporting the patient between sites. • The locality does not need to reduce the number of officers available when there is an ECO. • Patients spend less time in the police car being transported and have fewer disruptions which means that they can stay close to home particularly for patients who do not require hospitalization. • Prescreeners may work part-time and have day jobs, which means that staying home or at a central location and avoiding excess travel, particularly during nighttime hours, for teleconferencing would be a favorable option; these part-time prescreeners may also be able to work more frequently if they can avoid commuting.
Cons	<ul style="list-style-type: none"> • Connecting to multiple locations can be challenging due to the need to work within the regulations of various IT departments. • Partners should be trained in mental health emergencies. This is especially the case for maintaining high percentages of CIT-trained law enforcement officers.
Associated CSBs	<ul style="list-style-type: none"> • Fairfax-Falls Church CSB and Western Tidewater CSB <p>Please note: The models of emergency telemental health programs were created from interviews with multiple CSBs. Not all contributing CSBs are implementing all parts of the model.</p>

Contingency Teleprescreening

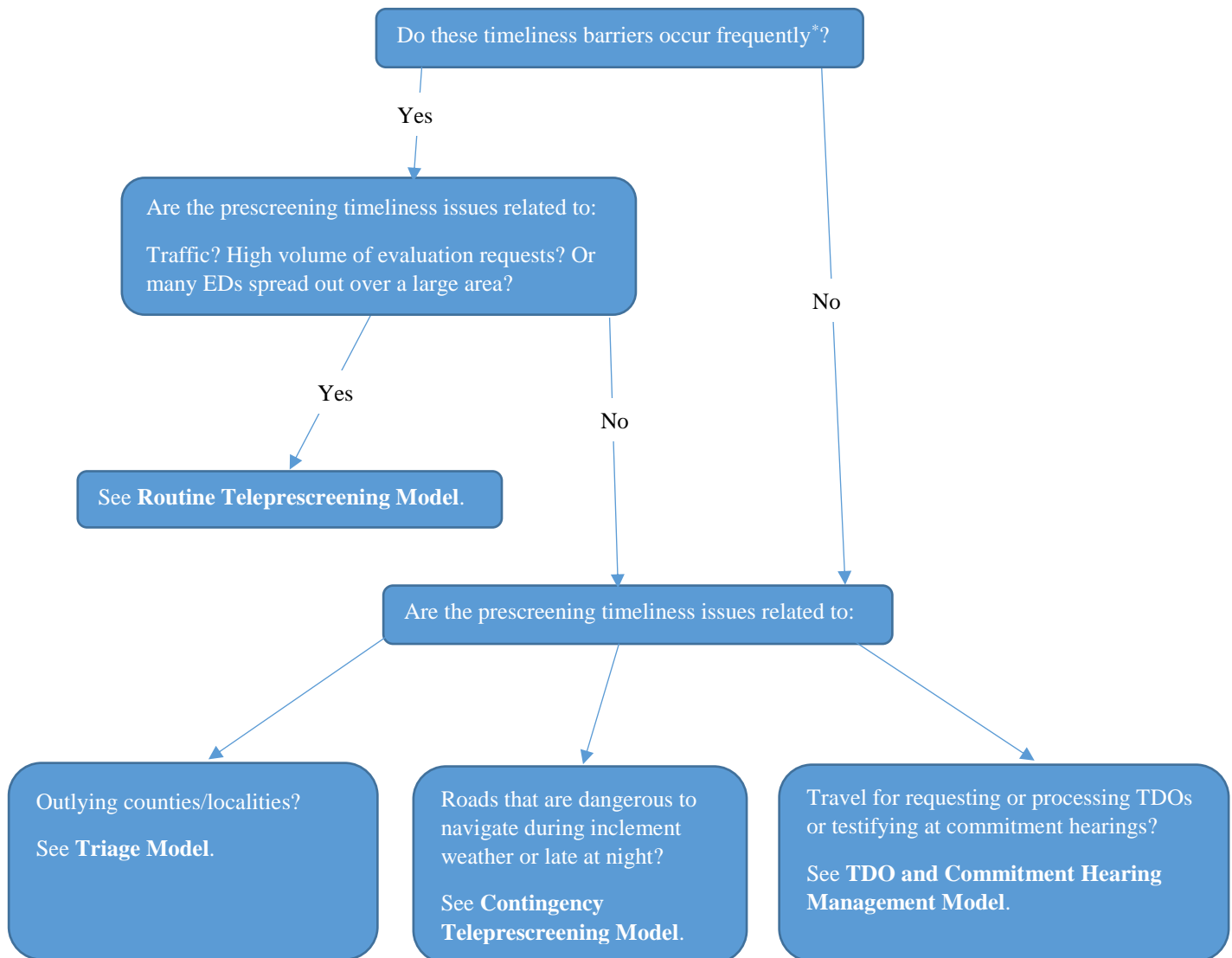
Item	Description
Who this works for	This model is best for CSBs who have concerns about prescreeners travelling to the evaluation site after-hours, late at night, during poor weather conditions, or when providing evaluation services to locations with lengthy security processes (e.g., jails or military bases).
Partner	This model works with a variety of different partners and may include a single partner or many depending on the needs of the CSB.
Purpose	Telemental health may be used when patients are in certain locations, such as jails, to cut down on time that would be spent going through security. It may also be used after-hours when prescreeners would need to drive significant distances in order to reach patients or when there are poor weather conditions which would make such travelling hazardous. In this model, telemental health is used in “special circumstances” and face-to-face prescreening is used for almost all evaluations.
Frequency of Use	Occasional use in certain circumstances
Infrastructure Requirements	Network connections at partner locations and the prescreener location need to be sufficient to maintain a teleconferencing link.
Equipment	Teleconferencing equipment will need to be installed at each partner location as well as the prescreener location. Most teleconferencing systems will be sufficient but it is important to ensure that the systems at partner sites will be compatible with prescreener site systems. Prescreeners may need portable WiFi-enabled devices for evaluations completed from alternative locations, such as their homes for after-hours prescreens.
Associated Costs	If the network is insufficient, networks may need to be upgraded prior to implementation which can incur installation costs if there is not already a network available. Portable WiFi-enabled devices need to be purchased and may incur ongoing, monthly costs.
Pros	<ul style="list-style-type: none"> • Prescreening staff would save time driving to the patient site for after-hours evaluations. • Prescreening staff would avoid driving in potentially hazardous weather conditions. • Staff may be less likely to become fatigued if there are several prescreens in a row, though this will not be the case if these prescreens are in the same location. • Prescreeners may work part-time and have day jobs, which means that staying home or at a central location and avoiding excess travel, particularly during nighttime hours, for teleconferencing would be a favorable option; these part-time prescreeners may also be able to work more frequently if they can avoid commuting. • This may be a good model to introduce teleconferencing prescreens to staff who are particularly wary or uncomfortable with using it for a large portion of evaluations. • During peak hours, it is possible to have part-time or off-duty prescreeners (who may otherwise be unavailable) perform evaluations from their homes via teleconferencing to increase available staff.
Cons	<ul style="list-style-type: none"> • If prescreeners are connecting to the secure teleconferencing system from offsite (e.g., their homes), then the CSB may need to purchase equipment to allow them to connect securely which can be an ongoing cost, often in the form of monthly fees.
Associated CSBs	<ul style="list-style-type: none"> • Colonial Behavioral Health and Harrisonburg-Rockingham CSB <p>Please note: The models of emergency telemental health programs were created from interviews with multiple CSBs. Not all contributing CSBs are implementing all parts of the model.</p>

TDO and Commitment Hearing Management

Item	Description
Who this works for	This model is best for CSBs who have concerns about time spent travelling between partner or prescreener locations and the magistrate office when requesting TDOs or hearing location when participating in commitment hearings. This is particularly useful when patients are at facilities outside of the immediate CSB area when a hearing occurs.
Partner	CSBs will need to partner with the local magistrate and Supreme Court of Virginia as well as hospitals, emergency departments, CIT centers, police departments, and/or jails where patients are located.
Purpose	In this model, CSBs use teleconferencing to request TDOs and attend commitment hearings to provide petitioner testimony. When requesting TDOs after an evaluation, the Magistrate Polycom system is used. For commitment hearings, prescreeners may use the Magistrate system or another secure teleconferencing system that connects to the hearing location. The systems may be linked with the CSB locations as well as local partners in the area. This enables prescreeners to request TDOs while at any screening site in the locality and attend hearings from a central location. This model also may be a more preferable arrangement for magistrates who are more comfortable processing TDO requests when they have a face-to-face interaction with the prescreener, as opposed to requests made by telephone. The Magistrate may also use secure printers to send the TDO to the prescreener, thus eliminating any travel time spent by law enforcement officers or prescreeners who would otherwise need to travel to the Magistrate's location for a physical copy. Travel time to commitment hearing locations is also eliminated in this model.
Frequency of Use	Regular use
Infrastructure Requirements	Network connections at partner locations need to be sufficient to maintain a teleconferencing link.
Equipment	This model requires the use of the Magistrate Polycom system for TDO requests. For commitment hearings, other teleconferencing equipment may be used depending on the hearing location and connections with local partners. Teleconferencing equipment may need to be installed at each partner location as well as the prescreener location. It is important to ensure that the systems at partner sites will be compatible with prescreener site systems.
Associated Costs	Magistrate PolyCom may not incur additional costs because it is already installed at some locations. If the network is insufficient, networks may need to be upgraded prior to implementation.
Pros	<ul style="list-style-type: none"> • Law enforcement officers or prescreeners no longer need to travel to the Magistrate's office to request and obtain TDOs. • It may shorten the length of stay for the patient. • Prescreener travel time is eliminated for commitment hearings. • Prescreener can sign and fax/send the petition for TDO. Magistrates are more comfortable with the prescreener completing the civil commitment petition if the TDO is requested via the Magistrate Polycom equipment or other real-time videoconference rather than over the phone.
Cons	<ul style="list-style-type: none"> • Working with technical and IT concerns from the Magistrate's office, local partners, and the CSB may provide some difficulties when installing and setting up the Magistrate Polycom in partner locations.
Associated CSBs	<ul style="list-style-type: none"> • Fairfax-Falls Church CSB and Valley CSB <p>Please note: The models of emergency telemental health programs were created from interviews with multiple CSBs. Not all contributing CSBs are implementing all parts of the model.</p>

9. Selecting a Model

Not all CSBs will need to implement a telemental health program. CSBs should carefully consider the impacts of adopting each model including pros, cons, and additional complications to the prescreening process specific to their CSB and locality. If the benefits to implementing a program (such as increased evaluation efficiency) outweigh the costs, then a telemental health program may be appropriate. When selecting a model for a telemental health program, you must first identify where timeliness barriers occur. First, review areas where timeliness issues occur in the prescreening process and follow-up civil commitment processes such as hearings and recommitment evaluations and hearings. Then walk through the following questions that serve as a guide for identifying these barriers and determining which model may be best suited for your CSB.



*Note that frequency can be determined on an individual basis. The main point to consider when determining if timeliness barriers are frequent is whether they occur enough to add significant burden to time or resources (e.g. personnel, transportation, local partner resources) during the prescreen evaluation. For some CSBs, this is 2-5 times/week and others it is 5-10 times/week.

Note: Some CSBs have no need for teleprescreens. These may include CSBs that have a relatively low volume of prescreens with short distances to travel. However, it is worth considering other uses of teleconferencing (see Possible Extensions below):

- To communicate with magistrate
- For civil commitment hearings
- Linkages with state hospitals (e.g., for recommitment hearings or discharge planning)

10. Possible Extensions

10.1 Pool of prescreeners

Some CSBs suggested that having a shared “pool of prescreeners” available between CSBs could reduce timeliness concerns during peak hours. This would mean that prescreeners from a nearby CSB can be contacted when the prescreeners at another cannot conduct an evaluation in a timely manner. The substitute prescriber would then perform the evaluation via teleconferencing. This might be helpful during volume surges when the number of available prescreening staff is not sufficient to respond to multiple requested evaluations in a timely manner. High volume periods may also include persons who are in crisis and may meet commitment criteria but are not under an ECO and who often face delays in being screened because ECO cases require priority. A pool of prescreeners may be more cost effective and feasible than overstaffing as a precaution for these peak hours. Note that multiple evaluations received simultaneously was the main reason listed for timeliness delays during the recent CSB Prescreening Timeline survey conducted pursuant to HB 2368.⁹

Several considerations would need to go into such an endeavor including knowledge of local resources, which would require additional localized training. Due to lack of knowledge about specialized local resources, the substitute prescriber may tend towards recommending a TDO in cases where community resources could have been appropriate. This concern would be lessened by using prescreeners from neighboring CSBs who may already be familiar with local resources. In general, making a TDO decision for an unfamiliar patient is challenging and may result in a more conservative TDO decision. This is more likely to occur with a substitute prescriber rather than a regular employee of the CSB, who may have previously encountered the evaluatee at the CSB. Overall, when considering the possibility of using a pool of prescreeners, one must consider that these evaluations take place within the context of the local community—CSB staff caution against adopting a program that would use prescreeners from relatively far-flung communities in Virginia. Other considerations include contractual structure, coordinating technology, and coordinating prescriber testimony at commitment hearings which could potentially be facilitated by teleconferencing.

10.2 Other Extensions

Use with state hospitals (ancillary): CSBs also suggested the idea of a teleconferencing link (or secure web application) between CSBs and state hospitals. This would primarily be for re-certifications, recommitment

preadmission screenings, discharge assistance planning, and other meetings or screenings that may require travel from the CSB to state hospitals.

Use for bed searches and medical clearance: Another idea a CSB suggested was to use teleconferencing to enhance the bed search process and for communications between physicians for medical clearance.

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