ORGANIZATIONAL CHECKLIST FOR PROVIDING TBH SERVICES

Organizational Level Protocol Checklist	Notes
ORIENTATION & TRAINING OF STAFF	
❑ Protocol 1: Do you have behavioral health practitioners providing services via TBH trained on this protocol, agency specific protocols, and best practices in the delivery of services through TBH prior to providing services? Training should address:[1] ❑ Camera Equipment-Orientation, covering camera placement, focus, and movement in order to ensure that close-up or distance views are available as clinically appropriate, that distractions are minimal, that video images are as natural as possible, and that good eye contact is maintained. ❑ Sound/Volume Control-Orientation/training, ensuring that providers as well as staff at the client site understand how to mute the microphone(s) and adjust the volume so that the provider and client can hear each other clearly. ❑ Picture in Picture or Second Monitor-Orientation/training that ensures that providers as well as staff at the client site understand that clients should not see themselves on TV while receiving TBH services.	
❑ Protocol 2: Do you have originating site staff, including the attendant, technology staff, and front-desk staff, trained on appropriate TBH protocols related to their role (e.g. scheduling, referrals, troubleshooting, monitoring technology)?[2]	
❑ Protocol 3: Do you have at least one licensed provider who has received the training outlined in Protocol 1 on site at the originating site during any TBH session, referred to throughout the protocols as the attendant? The attendant does not have to be the client's referring provider or have clinical knowledge of a particular client, but must be available in the event of an emergency to provide appropriate assistance.[3]	
❑ Protocol 4: Do you have at least one technology staff person on site at the originating and far sites during any TBH session? Is this person trained to respond to technical problems that can occur during a TBH session?[4]	
❑ Protocol 5: Do you have an appointment protocol between originating and provider sites prior to conducting a TBH session?[5]	
REFERRALS & SCHEDULING	
❑ Protocol 6: Do you have a way to indicate in referrals whether the referral is for a one-time consult or an evaluation for ongoing treatment and management.[6]	
CONSENT	
❑ Protocol 7: Do you have a process to obtain client's Informed Consent to receive treatment via TBH prior to the client's initial TBH session? If informed consent is not documented on a form, referring providers should document voluntary verbal consent to utilize TBH. Clients may withdraw consent at any time. The risks, benefits, and limits of TBH will be explained including the confidentiality and privacy of the TBH system using non-	

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technical terms, e.g. TBH is as secure as a private phone call.[7]	
❑ Protocol 8: Are you using a common TBH Informed Consent form that meets the requirements of Protocol 6?	
CONFIDENTIALITY & PRIVACY	
❑ Protocol 9: Do you have billing and coding processes in place that share information across systems for the purposes of payment that do not risk exposure of mental health clients' personal health information?[8]	
CONDUCT OF THE TBH SESSION	
❑ Protocol 11: Do you have a process to ensure appropriate staff are available at the originating site to meet client and provider needs before, during, and after TBH sessions including technology staff with training on the TBH equipment?[9]	
❑ Protocol 13: Do you have a process in place to ensure the attendant will remain in the building and accessible for emergency support? If the attendant must be unavailable, an alternative attendant who can be contacted through the same means must be identified.	
❑ Protocol 14: Do you have a process in place to ensure the attendant is responsible for ensuring the client is led safely out of the building in the event of a fire or other emergency?[10]	

❑ Protocol 16: Do you have an agreement in advance as to how a session delay will be handled, including whether the following options are permitted if there is delay in starting the session or if the session is interrupted for equipment failures? It might include such things as:[11]
  ❑ Continue the session after the allotted time, if equipment and attendant are available.
  ❑ Finish the session, via telephone, if appropriate.
  ❑ Schedule another TBH session.
  ❑ Schedule an evaluation in person.
  ❑ Refer the client for an evaluation in person with another provider.	

❑ Protocol 17: Do you have a process to ensure that in the event of an equipment failure, in no case will a client be discharged without the attendant first discussing the disposition with the provider at the far-site?[12]	
CLINICAL RECORD KEEPING	
❑ Protocol 19: Can you make information available to the far-site provider that meets legal and regulatory requirements for referral and that provides supportive data to the practitioner in preparation for evaluating the TBH client and for on-going client management?[13]	
❑ Protocol 20: Are procedures in place between Network Providers and practitioners for sharing client mental health information, including clinical history, results of testing, laboratory results, and other relevant clinical data?[14]	
❑ Protocol 21: Are you able to maintain the same standards of accuracy, completeness and safeguarding of clinical records, in accordance with	

Organizational Level Protocol Checklist	Notes
facility, corporate and/or HIPAA policies and procedures, as would be expected if the client had been seen "in person" at the originating site?[15]	
❑ Protocol 22: Is the following additional information included in clinical records when TBH is provided to clients?[16] ❑ That the service was provided by TBH. ❑ The bandwidth of the session. ❑ The location of the remote site. ❑ Documentation in accordance with the remote site's standard operating procedures and guidelines.	
❑ Protocol 23: Do you have a plan to maintain the client's medical record at the originating site? Therefore, all permanent clinical records *shall* be kept at the originating site. All requests for copies of medical records will be directed to the originating site.[17]	
❑ Protocol 24: Do you have a process to ensure initial evaluations, consultations, opinions, documentation of services ordered or provided, diagnoses, summary of findings, recommended management, and/or progress notes are sent to the originating site within 48 hours by entry into the originating site's electronic medical record, fax, or other electronic means, which meet HIPAA standards, for inclusion in the client's medical record? The far-site may keep a convenience file on each client for ongoing continuity of care.[18]	
❑ Protocol 25: Do you accept forms, such as questionnaires, limits of confidentiality statements, etc., used by originating sites, to prevent duplication of information to be supplied by the client?[19]	
❑ Protocol 26: Do you have internal TBH policies describing additional procedures regarding record-keeping requirements, including making clinical records available to off-site TBH behavioral health providers, keeping duplicate records off site, getting the off-site TBH providers' records into the primary clinical record, and the storage of off-site records?[20]	
❑ Protocol 27: Can you provide VPN access to the far site provider to view and add to the client's record?[21]	
APPROPRIATE TBH SERVICES	
❑ Protocol 28: Can you ensure the standard of care delivered via TBH is equivalent to any other type of care that can be delivered to the client, considering the specific context, location and timing, and relative availability of in-person care?[22]	
❑ Protocol 29: Do you have a process for ensuring any modifications to specialty specific clinical practice standards for the TBH setting ensure that clinical requirements specific to the discipline are maintained?[23]	
Psychological & Cognitive Testing	
❑ Protocol 30: Do your policies reflect that cognitive testing should not be provided by TBH, due to research findings that it does not result in accurate results? If a specialized provider is needed, transport to the originating site for the cognitive testing is recommended. [24]	

Organizational Level Protocol Checklist	Notes
Other Diagnostics & Assessments	
❑ Protocol 31: Do your policies reflect the fact that emergency evaluation and remote assessment for seclusion and restraint is appropriate through TBH.[25]	
Medication Management & Prescriptions	
❑ Protocol 32: Do your physician, nurse practitioner, or physician's assistants have the means and expectation to fax, phone, or mail prescriptions and laboratory studies to the pharmacy or originating site by no later than 9:00am the day following the appointment?[26]	
❑ Protocol 33: Do you obtain oral or written informed consent from the client, parent, or legal guardian, unless treatments and procedures are under court order, prior to the initiation of any psychotropic medication? Is documentation of consent included in medical records provided to the originating site?[27]	
❑ Protocol 34: Do you establish clear protocols for prescribing through telebehavioral health, including communicating with clients the method for obtaining initial prescriptions and refills and reporting adverse affects?[28]	
Individual Psychotherapies	
❑ Protocol 35: Do you use standard practice guidelines for therapy to direct psychotherapy services within the TBH setting?	
❑ Protocol 36: Do you use evidence-based practice and empirically supported treatments in TBH and do you adapt them as appropriate for TBH?[29]	
EMERGENCY SERVICES & CLIENT SAFETY	
Client safety is paramount. Due to the nature and distance between the client and far-site provider incurred in TBH practice, additional measures must be taken to ensure client safety. The following guidelines will be followed during all TBH sessions.[30]	
❑ Protocol 38: Do you have TBH emergency protocols for each facility utilizing TBH, with a clear explanation of the roles and responsibilities in emergency situations, determination of outside facility hours emergency coverage, and guidelines for determining at what point additional staff and resources should be brought in to help manage emergency situations?[31]	
❑ Protocol 39: Do you ensure a crisis safety plan is developed with each client participating in TBH services that clearly outlines for the client who they should contact in a crisis?[32]	
❑ Protocol 40: Do you have policies in place for addressing safety issues with clients displaying strong affective or behavioral states prior to or upon conclusion of a session?[33]	
❑ Protocol 41: Are you prepared to provide an attendant with the client during the TBH session, based on the current understanding of the client and the TBH session process?[34]	
❑ Protocol 42: For TBH sessions where the end-site TBH provider has not required the presence of an attendant to be with the client during the session, do you ensure the following conditions are met?[35]	

Organizational Level Protocol Checklist	Notes
❑ An attendant, who can respond immediately to assist the client, will be available at the remote site.	
❑ An alternative communication medium (phone, pager, etc) must be available and known to the TBH provider to notify the attendant at the remote site that emergency support is needed.	
Equipment Needs for Confidentiality & Privacy	
❑ Protocol 57: Do you ensure all TBH endpoint equipment is password protected?[36]	
❑ Protocol 58: Do you ensure all TBH endpoint equipment is set to "auto answer mute" and "auto answer multipoint: do not disturb" so that clinical TBH sessions cannot be accidentally interrupted, including by a second video connection?[37]	
MONITORING & QUALITY IMPROVEMENT	
❑ Protocol 65: Do you have in place policies and procedures that address all aspects of administrative, clinical, and technical components regarding the provision of TBH and are the policies and procedures updated on an annual basis or more often as needed?[38]	
❑ Protocol 66: Do you have a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management? Do the quality improvement indicators address the critical components of providing TBH services and are they used to make programmatic and clinical changes?[39]	
❑ Protocol 67: Do you have policies and procedures to ensure consistent, high quality implementation of TBH? Key policies that *shall* be addressed include:[40] ❑ Release of information and informed consent. ❑ Identifying all required client information for a referral/consultation. ❑ A reliable process for communicating findings after the TBH session. ❑ Ensuring privacy and confidentiality. ❑ Intake procedures and screening. ❑ Staff roles and responsibilities. ❑ Transmission of client data. ❑ Use of electronic medical records. ❑ Appointment scheduling; synchronizing schedules at all sites. ❑ Transmission of prescriptions, lab orders and progress notes. ❑ Evaluation and measurement of client outcomes. ❑ Quality improvement. ❑ Safety. ❑ Licensing, liability and malpractice insurance. ❑ Continuous training.	

Organizational Level Protocol Checklist	Notes
SPECIAL POPULATIONS	
❑ Protocol 68: Do you have a policy for ensuring as a far-site provider, your behavioral health practitioners have cultural competency in the population they are serving at a distance?[41]	
Deaf and Hard of Hearing	
❑ Protocol 69: Are your attendant and front-desk staff at the originating site trained by the Daylight Partnership to ensure basic communication and cultural competency with deaf and hard of hearing clients?	
❑ Protocol 70: Are your providers prepared to complete a communication preference profile with deaf and hard of hearing clients prior to the delivery of services via TBH to ensure appropriate communication is provided during the TBH session?	
❑ Protocol 71: Do you have a process in place to consider if deaf and hard of hearing clients who would be considered for routine outpatient mental health and substance abuse treatment as potential clients for services via TBH if specialized providers are not available? Additional clinical judgment and knowledge of TBH should be used to assess individual clients for appropriateness of the TBH session, e.g. clients with gross movement disorders, potential to act out during the interview, etc.[42]	
❑ Protocol 73: Do you have a process to ensure that deaf and hard of hearing clients assessed by the on-site provider and felt to be in need of an acute psychiatric evaluation, due to safety, medical or time constraint issues, will have a disposition plan that is in accordance with local standard operating procedures? Clients/clients will not be "tied over" or placed on "close observation", until they can see the far-site provider.[43]	
❑ Protocol 74: Do you have a process in place to ensure that the consent to participate in TBH form is completed in a manner that ensures informed consent is achieved with deaf and hard of hearing clients?[44]	
❑ Protocol 75: Can your medical record include following additional information shall be included in the clinical records when the TBH is provided to deaf and hard of hearing clients?[45] ❑ Hearing status – deaf, hard of hearing, late deafened, etc.; ❑ Use of personal hearing assistive technology (hearing aids, cochlear implants, etc.); ❑ Preferred method of communication, including language and hearing assistive technology needs; ❑ Preferred language for visual or spoken communication; ❑ Preferred language for written materials; ❑ All signed, spoken, and written languages used, including if the deaf or hard of hearing client does not use sign language; ❑ Presence of interpreters/communication service providers during any service delivery; ❑ Preferred interpreter/communication service provider; ❑ Any incidents where interpreters/communication service providers or	

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assistive technology were not available; ❑ Preferred method(s) of remote contact; and ❑ Communication method used to secure informed consent.	
❑ Protocol 76: Do your policies reflect that emergency evaluation and remote assessment for seclusion and restraint through TBH may be preferable for Deaf clients if culturally and linguistically competent providers are not available at the originating site?[46]	
❑ Protocol 79: Do you have a policy to access remote interpreters for deaf clients as a last resort? When remote interpreters are used, do you ensure communication access through interpreters follows all relevant standards from the Daylight Standards of Care?[47]	
Children	
TBH is appropriate for services to children and generally has very positive outcomes, particularly when the child has "good verbal skills and is not aggressive, severely oppositional, or otherwise dysregulated."[48]	
❑ Protocol 85: Do you have a policy to ensure families are informed during scheduling to prepare their children for the TBH appointment.[49]	

RESOURCES

Center for Systems Integration (2010). *Standards of care for serving deaf and hard of hearing clients.* Denver, CO: Daylight Partnership, Mental Health Center of Denver, and Colorado Commission for the Deaf and Hard of Hearing.

Yellowlees, Peter, Jay Shore, and Lisa Roberts (2009). *Practice Guidelines for Videoconferencing-Based Telemental Health.* American Telemedicine Association.

Belz, Norbert, Leslie Bennet, Lisa Carnahan, Veronica Decker, Brian Grady, et al. (2009). *Evidence-Based Practices for Telemental Health.* American Telemedicine Association.

(year unknown). *Maryland Telemental Health, Kent County Protocols.* Part of the telemental health site developed by Dr. Brian Grady, Co-Chair of the American Telemedicine Association's Telemental Health Standards and Guidelines Working Group. http://www.telementalhealth.info/

Northern Arizona Regional Behavioral Health Authority. (Revised 2010). Clinical Telemedicine Services, Provider Manual. Arizona Department of Health Services, Division of Behavioral Health Services.

ENDNOTES

[1] Adapted from the Northern Arizona Regional Behavioral Health Authority protocol.

[2] Loosely based off the Northern Arizona Regional Behavioral Health Authority protocol with some additional information added from the Maryland Telehealth Network Kent County protocols.

[3] From the Maryland Telehealth Network Kent County protocols.

[4] Developed in response to feedback from the Mental Health Center of Denver

[5] From the Maryland Telehealth Network Kent County protocols.

[6] Adapted from the Maryland Telehealth Network Kent County protocols.

[7] From the Northern Arizona Regional Behavioral Health Authority protocol, that comes with a specific form that is not referenced here. Also used language around verbal consent from the Maryland Telehealth Network Kent County protocols.

[8] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 7

[9] Adapted from ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 10

[10] Adapted from the Maryland Telehealth Network Kent County protocols.

[11] Adapted from Maryland Telehealth Network Kent County protocols – general lack of examples of requirements associated with equipment failure in the other protocols/best practice materials.

[12] Adapted from Maryland Telehealth Network Kent County protocols - general lack of examples of requirements associated with equipment failure in the other protocols/best practice materials.

[13] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9

[14] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9 and ATA's Evidence-Based Practices for Telemental Health, p. 11

[15] From the Maryland Telehealth Network Kent County protocols.

[16] Loosely adapted from the Maryland Telehealth Network Kent County protocols and Northern Arizona Regional Behavioral Health Authority protocol..

[17] From the Maryland Telehealth Network Kent County protocols.

[18] Adapted from Maryland Telehealth Network Kent County protocols and specific types of information listed in the ATA's Evidence-Based Practices for Telemental Health, p. 12

[19] Adapted from Maryland Telehealth Network Kent County protocols

[20] Drawn from the Northern Arizona Regional Behavioral Health Authority protocol, which has each organization participating develop their own policies and procedures that go beyond the shared ones.

[21] Developed in response to feedback from the Mental Health Center of Denver

[22] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 8

[23] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 8

[24] The ATA's Evidence-Based Practices for Telemental Health states, p. 12: "It appears that VTC neuropsychological assessment is possible and often valid. However, it is recommended that research begin to develop new norms so that the thresholds used for impairment are valid when compared with face-to-face administration. Until this is accomplished, remote neuropsychological assessment will be able to provide a broad indication of areas of impairment, but may lack the same degree of resolution that face-to-face assessment provides." For this reason, these Protocols are recommending that cognitive testing be done in person whenever possible. This does not follow the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 12, which suggest that cognitive testing can be done, though with caution, through TBH.

[25] Appropriateness from ATA's Evidence-Based Practices for Telemental Health, p.19.

[26] Loosely based on both the Northern Arizona Regional Behavioral Health Authority protocol and the Maryland Telehealth Network Kent County protocols.

[27] Adapted from the Northern Arizona Regional Behavioral Health Authority protocol.

[28] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 13

[29] Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 12.

[30] From the Maryland Telehealth Network Kent County protocols.

[31] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 14

[32] This protocol is not adapted from the literature. It is a recommendation from Mental Health Center of Denver quality assurance staff.

[33] Adapted from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 14

[34] Adapted from the Maryland Telehealth Network Kent County protocols.

[35] From the Maryland Telehealth Network Kent County protocols.

[36] From the Northern Arizona Regional Behavioral Health Authority protocol.

[37] From the Northern Arizona Regional Behavioral Health Authority protocol.

[38] From the ATA's Evidence-Based Practices for Telemental Health, p. 10.

[39] From the ATA's Evidence-Based Practices for Telemental Health, p. 10.

[40] Verbatim from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19-20

[41] From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9

[42] From the Maryland Telehealth Network Kent County protocols.

[43] From the Maryland Telehealth Network Kent County protocols, adapted to deaf and hard of hearing clients.

[44] From the Northern Arizona Regional Behavioral Health Authority protocol combined with Daylight Standards of Care drawn from multiple sources.

[45] From the Daylight Standards of Care.

[46] Appropriateness from ATA's Evidence-Based Practices for Telemental Health, p.19, desirability from Daylight Standards of Care requirements around testing/evaluation by competent providers.

[47] Reference to the Daylight Standards of Care, with remote interpreting as a last resort due to Daylight Evaluation findings regarding client preferences.

[48] Directly from ATA's Evidence-Based Practices for Telemental Health, p. 16

[49] Adapted from the ATA's Evidence-Based Practices for Telemental Health, p. 16 - 18 and the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15