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VETERANS HEALTH ADMINISTRATION

Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of emergency preparedness, as of November 1, 2019, for Veterans Health Administration (VHA) outpatient telemental health care in a VA patient-clinic location as a response to steadily expanding telehealth care over the last decade in an increasingly virtual and technology-driven environment.[1] Telehealth is a technology-based, virtual mode of health care used "to provide clinical care in circumstances where distance separates those receiving services and those providing services."[2] Telehealth delivery of mental health care is referred to as telemental health. This review included telemental health care in VA clinics, excluding home and non-VA locations.

While telehealth has many benefits, it brings unique patient safety challenges related to the management of emergencies, such as distance preventing direct intervention by the remote provider. In spite of distance, remote providers must be prepared to respond to emergencies at the patient-clinic location by quickly accessing information and initiating an appropriate response. Telemental health care planning and communication has complexities beyond that of face-to-face mental health care.

After the World Health Organization's declaration of the COVID-19 pandemic in March 2020, VHA planned to leverage telehealth services in lieu of certain face to-face care to ensure safety of veterans and staff. Patient visits shifted away from in-person clinic care as often as possible to telehealth including "in-home virtual care visits."[3] This report discusses emergency procedures specific to the provision of telemental health care to patients located within a VA setting. As patients return to VA clinic locations for telemental health care, deficiencies identified in this report related to emergency procedures and contact information need to be addressed. During the review, the OIG collected telehealth staff perceptions regarding pandemic processes for consideration of future reviews of the telemental health program.

OIG staff interviewed VHA leaders from the Office of Connected Care and the Office of Mental Health and Suicide Prevention to gain an understanding of national expectations and telehealth emergency practices within telemental health care. While the Office of Connected Care has oversight of administrative and clinical operations of telehealth services, there is collaboration with the Office of Mental Health and Suicide Prevention as subject matter experts for telemental

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[1] For the purpose of this review, OIG uses the term *patient-clinic location* to refer to the VA clinic location where the patient is receiving telemental health care.

[2] VHA Telehealth Services, *About Us,* accessed April 24, 2019, https://vaww.telehealth.va.gov/about/index.asp. (This is an internal VA website not publicly accessible.)

[3] VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home*, March 11, 2020. https://vaww.infoshare.va.gov/sites/telehealth/docs/covid19-memo.pdf. (This website was accessed April 15, 2020. This is an internal website that is not available to the public.)

health care. The OIG interviewed staff who represented 58 randomly selected patient-clinic locations to clarify emergency preparedness processes and gain insight on how telemental health care is implemented at each location, specific to clinical video telehealth offered to patients at VA clinic locations.

The OIG requested documentation from the 58 patient-clinic locations regarding telemental health's emergency preparedness from October 1, 2016, through November 1, 2019. For the purpose of this review, OIG defined the telehealth emergency plan as the collection of required clinic-specific, telehealth emergency procedures and processes that address mental health emergencies, medical emergencies, and technological disruptions. The OIG reviewed documentation provided regardless of title to identify telehealth emergency plans for any content of telehealth emergency procedures. The OIG determined VHA lacked telehealth emergency preparedness to ensure the safe delivery of telemental health care at patient-clinic locations, with missing or incomplete telehealth procedures and processes, to manage mental health and medical emergencies, and technological disruptions.

The OIG found a majority of patient-clinic locations were missing some or all emergency procedures required in telehealth emergency plans. The Office of Connected Care requires telehealth emergency plans contain emergency procedures specific to telehealth, including mental health emergencies, medical emergencies, and technological disruptions. Emergency procedures within telehealth emergency plans provide staff with instructions on steps to take, specific to practices and resources of the patient-clinic location. The OIG found telehealth emergency procedures provided were most often not specific to the patient-clinic location, difficult to locate, and scattered through various policies or documents. The OIG concluded that the lack of emergency plans or specificity to both telehealth and the patient-clinic location may result in delays in intervention due to a lack of clear procedural steps and extensive time searching for documents. This may be particularly complicated for remote providers serving multiple patient-clinic locations who may lack familiarity with locating various facilities' emergency plan documents.

The majority of patient-clinic locations did not provide the three procedures required of a telehealth emergency plan. Fifty-five of 58 (95 percent) patient-clinic locations did not provide documentation of a process for annual updates to telehealth emergency procedures. Despite not finding evidence of emergency plan updates, staff at 26 of 58 (48 percent) facilities stated during interviews that emergency plans were being updated at least annually at the facility. Without a consistent process for routine review and updates to the telehealth emergency plan, telehealth staff may rely on incorrect emergency procedures, resulting in delayed or inadequate response to patient emergencies.

Telehealth emergency plans and emergency contact information provided by patient-clinic locations did not include defined telehealth staff roles and responsibilities during telehealth emergencies. According to Connected Care guidance, telehealth staff roles and responsibilities

should be defined to ensure knowledge of staff's actions to take during specific emergency procedures within the telehealth emergency plan. The OIG concluded that without clearly defined telehealth staff roles and responsibilities during emergencies, patient care may be delayed or inadequate due to a poorly coordinated emergency response.

The OIG found contact lists failed to include a minimum of two emergency contact staff, each with two contact methods, and specificity to the patient-clinic location. The Office of Connected Care guidance states the contact list must "have several people listed with several ways to connect to those people" during telehealth emergencies.[4] The OIG concluded without a telehealth emergency contact list that identifies the relevant and alternate staff specific to the patient-clinic location, a telepresenter or remote provider may not be able to establish immediate communication to initiate emergency procedures and fail to connect to resources at the patient-clinic location, increasing risk for delay of patient care in an emergency.[5] The OIG also found Connected Care lacked guidance for a consistent process for telehealth staff's communication of emergency information for each telehealth session. The OIG concluded that without communicating or verifying the telehealth emergency contact lists, telehealth staff may not have the correct emergency contact information prior to the start of a telemental health session to facilitate emergency intervention.

The OIG concluded VHA facilities lacked a process for differentiating the telemental health setting in patient safety event reporting methods. Without a reporting process that consistently requires identification of the telehealth or telemental health setting for patient safety events, National Center for Patient Safety, Veterans Integrated Service Network, and VHA facilities may lack awareness of vulnerabilities in processes for telehealth care, including telehealth patient emergencies. This can lead to missed opportunities to understand event trends and make safety improvements within the telehealth setting.

The OIG distributed a questionnaire on June 18, 2020, to 333 patient-clinic location telepresenters and remote providers, to evaluate specific issues encountered by staff prior to the pandemic. Questionnaires were completed by 187 of the 333 recipients. The most frequent concern of questionnaire respondents was that emergency contact staff at patient-clinic locations

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[4] VHA Office of Telehealth Services, *Clinical Video Telehealth: Telemental Health Suicide Prevention Emergency* Care, October 2012, accessed January 1, 2019, https://vaww.infoshare.va.gov/sites/telehealth/docs/tmh-spec.pdf. (This is an internal VA website not publicly accessible.)

[5] VHA, *Connected Care/Telehealth Manual*, November 2018, accessed October 7, 2019, https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx?FilterField1=Category&FilterValue1=Operations%20Manuals&FilterType1=Choice&id=%2Fsites%2FVHA%2DTelehealth%2Fdocs%2Fth%2Dmnl%2Epdf&parent=%2Fsites%2FVHA%2DTelehealth%2Fdocs. (This is an internal VA website not publicly accessible.) The *telepresenter* is a staff member at the patient-clinic location who assists the remote provider and patient by escorting the patient to the telehealth room and assisting with use of technology. The telepresenter also observes and assists for any further clinical or technological needs that arise. "The telepresenter is responsible for acting as the hands, eyes, ears, and nose for the provider."

did not remain available to be reached during telemental health care. Respondents also reported there was no emergency contact information exchanged between telepresenter and remote providers prior to telemental health sessions or they were unsure if there was a process. Respondents noted the importance of communicating with each other prior to telemental health sessions.

The OIG concluded that delays in intervention may occur during telehealth emergencies as a result of

- Missing telehealth emergency plans and procedures,
- Emergency procedures not specific to telehealth care or the patient-clinic location,
- Lack of a process for annual updates to telehealth emergency procedures,
- Undefined telehealth staff roles and responsibilities for telehealth emergency plans,
- Missing or insufficient emergency contact information for relevant telehealth staff, and
- Lack of a process to verify and communicate emergency contact information among telehealth staff.

The OIG also concluded that missed opportunities for patient safety and a general lack of awareness for vulnerabilities may occur without a consistent process for patient safety event reporting that identifies the telehealth setting.

The OIG made five recommendations to the Under Secretary for Health. Two involved telehealth national processes for the development, update, and monitoring of emergency plans that are telehealth and patient-clinic location specific. Other recommendations addressed national processes for communication of telehealth staff responsibilities during emergencies, communication and maintenance of emergency contact information, and the development of streamlined reporting of patient safety events specific to the telehealth setting.

Comments

The Under Secretary for Health concurred with the recommendations and provided an acceptable plan (see appendix A). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

IT	information technology
OIG	Office of Inspector General
VHA	Veterans Health Administration
TSA	telehealth service agreement
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a national review of emergency preparedness, as of November 1, 2019, for Veterans Health Administration (VHA) outpatient telemental health care in a VA patient-clinic location, excluding home and non-VA locations.[1]

Office of Connected Care

The Office of Connected Care (Connected Care), aligned under the Assistant Deputy Under Secretary for Health for Health Informatics, is the VHA national program office focused on "delivering health IT [information technology] solutions that increase Veterans' access to care and support Veterans' participation in their own health care."[2] Telehealth Services is one of Connected Care's programs. Connected Care leads telehealth implementation and expansion nationwide by addressing business, technical, quality, and clinical issues to ensure the needs and safety of patients are being met.

VHA Telehealth

Telehealth is a technology-based, virtual mode of health care used "to provide clinical care in circumstances where distance separates those receiving services and those providing services."[3] Telehealth improves access to care by reaching patients in remote areas as well as those in locations with provider shortages. A recent OIG report identified psychiatry as first on the severe

[1] VHA, *Telemental Health Factsheet*, February 2018, accessed July 21, 2020, https://www.va.gov/anywheretoanywhere/docs/TeleMental_Health_factsheet.PDF. *Telemental health care* is "the use of information and telecommunication technologies to deliver mental health services when the provider and the Veteran are separated by geographical distance." For the purpose of this review, the OIG defines or refers to terms specific to this review. Unless otherwise noted, the OIG is unaware of any conflict with current VHA definitions. The OIG refers to *telemental health care* more narrowly than the VHA definition, as mental health services delivered through clinical video telehealth only, when the provider and the veteran are separated by physical distance. The OIG defined *emergency preparedness* as VHA's development, implementation and monitoring of telehealth procedures and processes specific to mental health and medical emergencies, and technological disruptions, to ensure the safe delivery of telemental health care in outpatient clinic locations. A technological disruption can include, but is not limited to, issues such as equipment or software failure. The OIG defines *mental health emergency* as imminent danger to self, others, or property during a telemental health visit. Emergencies in this report, in general, may refer to mental health, medical, or technological crises or incidents that occur during a telemental health visit.

[2] VHA, *Functional Organizational Manual*, Version 5, 2019, accessed December 9, 2019, https://www.va.gov/FOM-5-Final-July-2019.pdf. (This is an internal VA website not publicly accessible.) "Health Informatics is the bridge between clinicians and IT to realize value from information systems that advance the delivery and management of healthcare."

[3] VHA Telehealth Services, *About Us,* accessed April 24, 2019, https://vaww.telehealth.va.gov/about/index.asp. (This is an internal VA website not publicly accessible.)

occupational shortage list, with psychology as seventh.[4] Telehealth extends provider reach and expands access to provider expertise and specialty. Other benefits include reduction of travel time and cost for patients.

While telehealth has many benefits, it also brings unique patient safety challenges related to the management of emergencies. As the Assistant Deputy Under Secretary for Health for Clinical Operations noted in February 2020, "telehealth is different from in-person care because the remote provider is not onsite, at the patient site, to participate in an emergency or activate a local/patient response."[5]

History of VHA Telehealth

Telehealth has a long-standing presence in VHA. In 1994, increased collaboration between clinical and information technology (IT) staff led to implementation of telehealth at local VHA levels. As VHA changed focus from being a centralized, hospital-focused organization to being more primary care oriented, the use of telehealth was recognized as a needed resource. From 1994 until 2003, telehealth pilots were conducted in 30 VA medical centers, with local, facility level innovation driving telehealth forward.[6]

In 2003, Connected Care was established to support the development of new models of care in VHA using technologies to address the health needs of veterans. From 2004–2010, VHA began organizing telehealth efforts at the national level. Telehealth platforms were developed across most VA medical centers and many community-based outpatient clinics.[7]

In 2009, transformation initiatives, known as T21 initiatives, were established by the Under Secretary for Health and funded by the Secretary of VA.[8] One of the major T21 initiatives focused on telehealth implementation and expansion. According to the VHA's telehealth

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[4] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages,* Report No. 20-01249-259, September 23, 2020, https://www.va.gov/oig/pubs/VAOIG-20-01249-259.pdf.

[5] VHA, Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Telehealth Clinical Emergency Plans,* February 10, 2020, accessed July 28, 2020, https://vaots.blackboard.com/bbcswebdav/library/LibraryContent/tem/Telehealth%20Clinical%20Emergency%20Plans%20Memo-02363868.pdf. (This is an internal VA website not publicly accessible.)

[6] National Institutes of Health National Center for Complementary and Integrative Health, *Pilot Studies: Common Uses and Misuses.* accessed September 20, 2020, https://www.nccih.nih.gov/grants/pilot-studies-common-uses-and-misuses. A pilot, also known as a pilot study, is a "small-scale test of the methods and procedures to be used on a larger scale."

[7] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013. A community-based outpatient clinic is a "VA-operated, VA-funded, or VA-reimbursed site of care, which is located separate from a VA medical facility. A community-based outpatient clinic can provide primary, specialty, subspecialty, mental health, or any combination of health care delivery services that can be appropriately provided in an outpatient setting."

[8] VHA, *T21 Implementation and Sustainment Guide*, Version 1.5, November 2014, accessed September 15, 2020, https://www.vendorportal.ecms.va.gov/FBODocumentServer/DocumentServer.aspx?DocumentId=3093674&FileName=VA249-17-R-0071-016.pdf.

strategic plan, "VHA invested more than $460 Million over a 4-year period ([fiscal year] FY10–FY13) in clinical technology, staffing assets, and associated resources to support VISNs [Veterans Integrated Service Networks] in rapidly implementing and growing Telehealth."[9]

Telehealth expansion included strategic approaches and infrastructure to provide telehealth throughout VA locations and to patients anywhere, including homes. Challenges with implementation included "clinical buy-in, credentialing and privileging, staff training, technology standardization and interoperability, securing revenue streams, clinical risk management, relationships with IT/biomedical engineering, and ensuring the quality of care."[10]

Some barriers existed for providers delivering care across state lines. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 expanded use of remote providers to deliver telehealth care to non-VA locations and across state lines despite licensure.[11] Specifically, remote providers were allowed to provide telehealth care to patients located in different states from the remote provider, even when a provider was not licensed by that state, regardless of state laws, regulations, and licensure restrictions.

VHA initiated the expansion of telehealth services into the home and non-VA locations, with a goal for 100 percent of "all care providers who deliver ambulatory care, including Specialty Care providers, to be capable of providing services into the home, to a Veteran's mobile device, or other locations through telehealth by the end of FY 2021."[12] In 2018, VHA also initiated a strategic plan, *Anywhere to Anywhere VA Telehealth, Strategic Plan: 2018-2020 Update* to further implement virtual care across the organization.[13] The strategic plan outlined metrics, milestones, and barriers to implementation of telehealth care.

VHA Telemental Health

In VHA, telehealth may be synchronous (real-time and interactive) or asynchronous (information stored and accessed later). Clinical video telehealth, a synchronous modality of telehealth care

[9] VHA, *Strategic Plan for National Telehealth Services within the Department of Veterans Affairs*, FY 14-15, June 2013.

[10] Adam Darkins, "Perspective: The Growth of Telehealth Services in the Veterans Health Administration Between 1994 and 2014: A Study in the Diffusion of Innovation," *Telemedicine and e-Health* 20, no. 9 (September 2014): 761-8.

[11] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, 2018. Pub. L. No. 115-182 §151 (2018).

[12] VHA Notice 2018-25, *Expansion of Telehealth into the Home and Other Non-VA Settings*, June 8, 2018, accessed October 7, 2019, https://vaww.infoshare.va.gov/sites/telehealth/docs/Forms/AllItems.aspx. (This is an internal VA website not publicly accessible.) FY is the abbreviation for fiscal year that starts October 1 and ends September 30.

[13] VHA, *Anywhere to Anywhere VA Telehealth, Strategic Plan: FY 2018-2020 Update,* accessed July 16, 2020, https://vaww.telehealth.va.gov/about/index.asp. (This is an internal VA website not publicly accessible.)

allows real-time, interactive video conferencing when the provider and patient are in distant VHA locations.[14] This review focuses on clinical video telehealth.[15]

Mental health care delivered via clinical video telehealth is referred to as telemental health.[16] The Office of Mental Health and Suicide Prevention works collaboratively with Connected Care regarding mental health clinical issues as subject matter expert.[17] One function of the Office of Mental Health and Suicide Prevention is

> To eliminate barriers that impede prevention, treatment, recovery, and rehabilitation services for Veterans with substance use disorders and mental illnesses, including the use of multiple virtual care modalities (e.g., tele-mental health, mobile apps, secure messaging, etc.) to provide services to Veterans in their preferred location (clinic, home, school, work, etc.).[18]

Telemental health also extends reach to conduct suicide evaluations in remote areas while minimizing the cost and need to travel.

Over the last decade, telemental health has steadily increased (see figure 1).[19]

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[14] VHA, *VHA Telehealth Services Factsheet,* Not Dated, accessed November 4, 2020, https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/ts-factsheet.pdf. (This is an internal VA website not publicly accessible.)

[15] VHA, *VHA Telehealth Services Factsheet.* Asynchronous is defined as "technologies to acquire and store clinical information (for example, data, image and sound) which is then forwarded to, or retrieved by a provider at another location for clinical evaluation" without real-time interaction between the provider and patient.

[16] VHA Handbook 1006.02. The term *mental health care* describes "health services provided in conjunction with psychiatric and psychological health."

[17] VHA, *Functional Organizational Manual*, Version 5, 2019. The Office of Mental Health and Suicide Prevention "improves the quality and availability of a full continuum of behavioral and mental health services, including prevention strategies, outpatient, residential, and inpatient treatments, and recovery and rehabilitation services to promote optimal mental health and quality of life, and reduce illness, death, disability and cost resulting from mental disorders including and substance use disorders (SUD) among Veterans."

[18] VHA, *Functional Organizational Manual*, Version 5, 2019.

[19] Telemental health encounters increased steadily from 123,811 in fiscal year 2010 compared to 1,578,949 for a portion of fiscal year 2020, October 1 through July 31. In figure 1, encounters across fiscal years included all mental health clinic types and all clinical video telehealth treatment, to include care to non-VA locations.

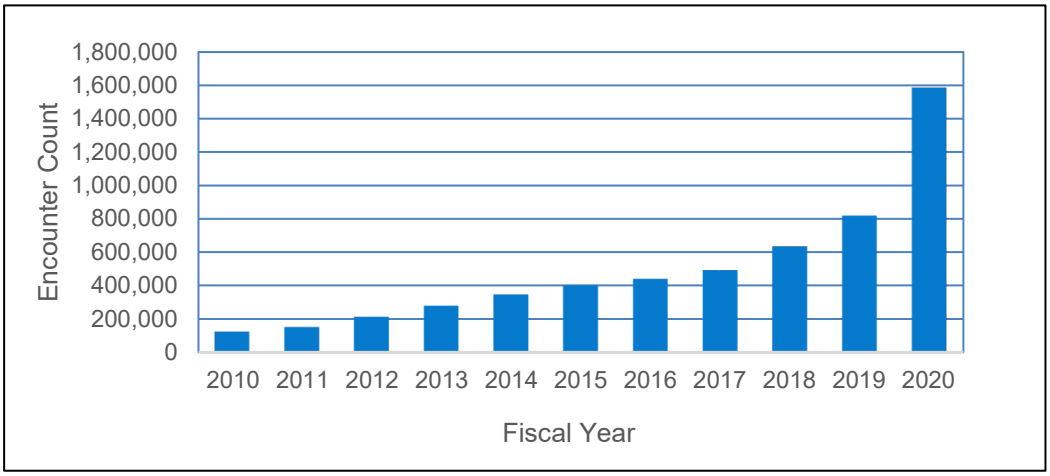

Figure 1: VHA telemental health clinical video encounters by fiscal year (October 1 through September 30); fiscal year 2020 data provided through July 31[20]
Source: VHA Corporate Data Warehouse encounter data

In a 2017 memorandum, the Acting Under Secretary for Health supported the expansion of VHA's telehealth capability so that patients received telemental health care by licensed mental health providers when licensed mental health providers were not accessible for face-to-face care.[21] The expansion supported delivering telemental health irrespective of whether the patient or provider were in the same state and regardless of whether the patient had been previously assessed by the provider in person.

Telehealth Funding

VA annual budgets from fiscal years 2010 through 2020 reflect continued increases to support telehealth's services. While the telehealth budget did not have funds specific to telemental health services, the costs of actual patient encounters for telemental health have steadily increased over the last decade (see figure 2).

[20] VHA Handbook 1006.02. An encounter is a professional contact between a patient and a provider with responsibility for diagnosing, evaluating, and treating the patient's condition.

[21] VA Acting Deputy Under Secretary for Health Memorandum, *Expansion of Telehealth Services by Physicians and Licensed Mental Health Providers in the Department of Veterans Affairs (VA)*, June 5, 2017, accessed July 16, 2020, https://dvagov.sharepoint.com/sites/vha-telehealth/docs/forms/allitems.aspx?FilterField1=Category&FilterValue1=Policies&FilterType1=Choice&id=%2Fsites%2FVHA%2DTelehealth%2Fdocs%2Fexp%2Dth%2Dsrv%2Epdf&parent=%2Fsites%2FVHA%2DTelehealth%2Fdocs. (This is an internal VA website not publicly accessible.)

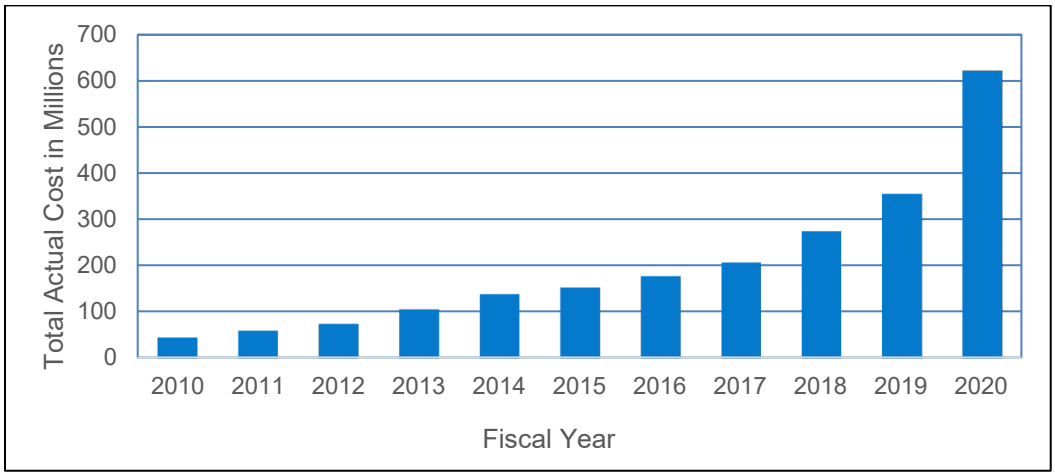

Figure 2: VHA total cost for telemental health clinical video encounters by fiscal year (October 1 through September 30); fiscal year 2020 data provided through July 31
Source: VHA Corporate Data Warehouse encounter data

VA's fiscal year 2021 budget request included an increase of $271 million dollars for access to telehealth care.[22]

Emergencies During Telemental Health Care

In the event of mental health emergencies, medical emergencies, and technological disruptions, the remote provider is reliant on the information available from a distance and unable to intervene in the same manner as when conducting a face-to-face visit in a VA clinic. If the emergency information or contact numbers at the patient-clinic location lack detail or are outdated, not accessible, or difficult to locate, the remote provider may not be able to respond as needed to the situation.[23]

During telemental health sessions, a remote provider who attempts to connect with local emergency services by phone may be of little to no assistance when the patient could be several states or hundreds of miles from the remote provider. In spite of distance, remote providers must be prepared to respond to emergencies at the patient-clinic location and quickly access information and initiate an appropriate response. Remote providers need access to and knowledge of clinic-specific, telehealth emergency procedures, also referred to as the telehealth

[22] VA Office of Budget, *VA 2021 Budget Request: Fast Facts,* accessed August 3, 2020, https://www.va.gov/budget/docs/summary/fy2021VAsBudgetFastFacts.pdf. (This is an internal VA website not publicly accessible.)

[23] For the purpose of this review, OIG uses the term *patient-clinic location* to refer to the location in which the patient is receiving telemental health care.

emergency plan, in order to have awareness of the unique process and resources for the clinic and to support the patient and patient-clinic location staff depending on the type of emergency.[24]

A telepresenter must be reachable and respond immediately to a medical or mental health emergency or technological disruption.[25] The telepresenter initiates emergency procedures and remains with the patient during the emergency, depending on environmental safety.

VHA's Telehealth Response to the Pandemic

Although the time frame for the COVID-19 pandemic is outside the range of this review, the impact regarding the delivery of healthcare, especially telehealth, has been significant and warrants recognition and discussion.

COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2.[26] COVID-19 spreads mainly from respiratory droplets from an infected person in close contact with others. The Centers for Disease Control and Prevention recommend social distancing as a public health strategy to prevent transmission.[27] VHA planned to leverage telehealth services, when possible, to ensure safety of veterans and staff after the World Health Organization's declaration of the COVID-19 pandemic in March 2020, in lieu of certain face-to-face care.[28]

On March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief and Economic Security Act, also known as the CARES ACT, which provided $2.2 trillion in economic relief. One component of the CARES Act included funding for VA telehealth.[29] The CARES Act

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[24] For the purpose of this review, OIG defined *telehealth emergency plan* to include the collection of required clinic-specific, telehealth emergency procedures and processes.

[25] VHA, *Connected Care/Telehealth Manual*, November 2018, accessed October 7, 2019, https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx?FilterField1=Category&FilterValue1=Operations%20Manuals&FilterType1=Choice&id=%2Fsites%2FVHA%2DTelehealth%2Fdocs%2Fth%2Dmnl%2Epdf&parent=%2Fsites%2FVHA%2DTelehealth%2Fdocs. (This is an internal VA website not publicly accessible.) The *telepresenter* is a staff member at the patient-clinic location who assists the remote provider and patient by escorting the patient to the telehealth room and assisting with use of technology. The telepresenter also observes and assists for any further clinical or technological needs that arise. "The telepresenter is responsible for acting as the hands, eyes, ears, and nose for the provider."

[26] World Health Organization, *Naming the Coronavirus Disease,* accessed June 22, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it.

[27] Centers for Disease Control, *Coronavirus Disease 2019 (COVID-19): Keep Your Distance to Slow the Spread*, accessed June 21, 2020, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html. The strategy of placing at least six feet between individuals, referred to as *social distancing*.

[28] VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home,* March 11, 2020.

[29] The Coronavirus Aid, Relief and Economic Security Act (CARES ACT), Pub. L. No. 116-136 (2020).

enabled "VA to enter into short-term agreements with telecommunication companies to deliver free or subsidized support for mental health services through a telehealth connection."[30]

This report discusses emergency procedures specific to the provision of telemental health care to patients located within a VA setting. During the COVID-19 pandemic, VHA transitioned to delivering care in the home rather than in a VA setting. As patients return to VA settings for telemental health care, deficiencies identified in this report related to emergency procedures and contact information need to be addressed. A Connected Care executive leader, during an interview, predicted a continued increase in utilization beyond the pandemic for all modalities of telehealth. Additionally, the OIG collected telehealth staff perceptions regarding pandemic processes for consideration of future reviews of the telemental health program.

Prior OIG Reports

OIG published three reports related to topics covered in this review within the past three years.

In July 2019, the OIG published a healthcare inspection that determined patients had limited access to outpatient mental health and the telemental health program.[31] The OIG found patients were telephoned for telemental health care consults but not assessed for immediate needs or urgency of care, such as completing a suicide risk assessment that would have been done if the patient was in-person. The 12 recommendations made to the Facility Director have been completed and closed.

In July 2020, the OIG published a report that outlined VHA's continued response to the pandemic.[32] The report highlighted a multitude of actions taken by VHA, Veterans Integrated Service Network (VISN), and facility leaders to maintain operations, including adjustments to healthcare practices and the use of telehealth. It also provided VHA leaders with descriptions of the evolving challenges for delivery of care. While the OIG made no recommendations, the report presented strategies that various facilities put into place over several months to promote discussion and consideration of lessons learned and best practices among facility and community healthcare leaders.

In March 2021, the OIG published a report that outlined VHA's virtual primary care response to the COVID-19 pandemic between February 7, 2020, and June 16, 2020, to include the expansion of virtual care.[33] Options for virtual care included video conferencing through the VA Video

[30] VHA, *CARES Act Helping VA Boost Protections for Veterans,* April 8, 2020, accessed September 11, 2020, https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=5415.

[31] VA OIG, *Concerns with Access and Delays in Outpatient Mental Health Care, New Mexico HCS, Albuquerque, New Mexico,* Report No. 17-05572-170, July 23, 2019.

[32] VA OIG, *Review of Veteran Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020.

[33] VA OIG, *Review of Veterans Health Administration's Virtual Primary Care Response to the COVID-19 Pandemic*, Report No. 20-02717-85, March 11, 2021.

Connect and third-party applications such as Skype, as well as telephone appointments. OIG found while virtual encounters increased, telephone contacts represented 81 percent of all primary care encounters during the review period. In questionnaire responses, primary care providers reported (1) virtual care scheduling was challenging, (2) a lack of training and support for veterans with VA Video Connect, and (3) problems for veterans with equipment and internet connectivity. Two recommendations addressed access, equipment, and VA Video Connect training and support; both remain open.

Scope and Methodology

On October 25, 2019, the OIG initiated a national healthcare review of emergency plans and emergency procedures for VHA outpatient telemental health care in a VA clinic location. The review evaluated preparedness for mental health emergencies, medical emergencies, and technological disruptions as a response to steadily expanding telehealth care in an increasingly virtual and technology-driven environment.[34]

The OIG determined that of the 140 healthcare systems with telemental health encounters from October 1, 2018, through September 30, 2019, there were 3,027 paired clinics.[35] The review included 58 paired clinics that were randomly selected with a focus on the assessment of patient-clinic location's emergency preparedness. The review included telemental health care in VA clinics, and excluded home and other non-VA locations.[36]

OIG staff requested Connected Care policies to evaluate VHA national requirements and expectations related to emergency safety plans and procedures for patient-clinic locations participating in telemental health care as of November 1, 2019. The following document topic areas were reviewed: (1) list of VISN and facility telehealth coordinators; (2) training requirements by role; (3) telehealth budget; (4) organizational charts; (5) emergency preparedness for medical, mental health, and technological emergencies; (6) telehealth service agreement policies and relevant templates; (7) quality assurance processes; and (8) telehealth incident reporting. The OIG found multiple terms were used when describing telehealth emergency plans throughout Connected Care guidance; therefore, the OIG reviewed facility

[34] VHA Handbook 1006.02. The term *outpatient care* is defined as services patients receive from providers while not in an inpatient setting.

[35] VHA Handbook 1006.02. The term *healthcare system* is defined as "an integrated health care delivery system under the direction of one administrative parent facility and comprised of multiple health care facilities, offering an array of health care services to Veterans in a defined geographic area." The term *paired clinics* describes telehealth care delivered from a remote provider location to a different VA clinic location for the patient.

[36] To better understand services delivered by the Telemental Health Program, the OIG analyzed data from VHA Corporate Data Warehouse for trends in annual telemental health encounters and total actual cost from fiscal years 2010 through 2020 (see figures 1 and 2).

documentation regardless of document location or title for required content such as procedures and responsibilities of staff.[37]

OIG staff interviewed combined representatives from Connected Care and the Office of Mental Health and Suicide Prevention on December 16, 2019, to gain understanding of their expectations and review emergency practices of telemental health care.[38] The OIG conducted a second interview that included the Executive Director of Telehealth Services on August 20, 2020.

Other interviewees included facility-level staff to clarify and gain insight on how telemental health care was being implemented at patient-clinic locations. The OIG did not evaluate staff statements against patient-clinic locations' practices. From January 21–30, 2020, OIG staff conducted group interviews with staff from the randomly selected patient-clinic locations. The OIG requested participation from each patient-clinic location's facility telehealth coordinator(s) and mental health service chief or their representatives. Additional group interview participants invited by each facility included telehealth program coordinators, telehealth support staff, mental health clinic coordinators, patient safety managers, outpatient clinic managers, suicide prevention coordinators, and VISN telehealth coordinators.

OIG staff requested patient-clinic location's documentation for the review period, October 1, 2016—November 1, 2019, to gain understanding of facility expectations and review emergency practices of telemental health care at patient-clinic locations. Facility documents requested included policies or guidance for (1) telehealth service agreement between the paired clinics, (2) telehealth emergency plans or procedures, (3) telehealth quality management, (4) telehealth incident reporting, and (5) telemental health staff training, as well as staff lists of facility telehealth coordinators, suicide prevention coordinators, remote providers, and telepresenters.[39]

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[37] VHA Office of Telehealth Services, *Clinical Video Telehealth: Telemental Health Suicide Prevention Emergency* Care, October 2012, accessed January 1, 2019, https://vaww.infoshare.va.gov/sites/telehealth/docs/tmh-spec.pdf. (This is an internal VA website not publicly accessible.) Various terms were used throughout this guidance without clear distinction or definition: individualized emergency telemental health plan, individualized procedures and protocols, a plan, and contingency plans for technology disruptions. VA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Telehealth Emergency Plans,* February 10, 2020, accessed July 28, 2020, https://vaots.blackboard.com/bbcswebdav/library/LibraryContent/tem/Telehealth%20Clinical%20Emergency%20Plans%20Memo-02363868.pdf. (This is an internal VA website not publicly accessible.) Various terms were used in this memorandum without clear distinction: telehealth clinical emergency plan, telehealth emergency plan, plan to manage emergencies, emergency plan, and the synchronous video telehealth emergency plan. Without a definition from VHA, the OIG will refer to the collective requirements for telehealth emergency procedures as the *telehealth emergency plan* for the purpose of this review.

[38] For the purpose of this review, the OIG will refer to the joint interview with representatives of VHA Office of Connected Care, VHA Office of Mental Health and Suicide Prevention, and other program representatives, as *Connected Care staff interview(s)*.

[39] VHA, *Telehealth Manual*, November 2018. The telehealth service agreement is a document that specifies the clinical, business, and technical details of telehealth operations.

The results were analyzed across all patient-clinic locations followed by external validation of conclusions. The OIG did not verify the reason for missing facility documents, in part, related to VHA's need to prioritize care during the pandemic.

On June 18, 2020, the OIG distributed, via email, an online questionnaire with multiple choice and open-ended text-response questions to be completed by July 2, 2020, to evaluate specific issues that remote providers and telepresenters encountered pre-pandemic. The OIG used staff lists of telepresenters and remote providers that were reported by patient-clinic locations as having delivered telemental health care at that location from October 1, 2016, through November 1, 2019. Questionnaires were distributed to each staff listed, unless the list indicated the employment status as no longer employed or no longer in the indicated position. Of the 333 questionnaires distributed, 187 were completed, analyzed, and included in the review.[40] Of 187 respondents, 89 (48 percent) were telepresenters and 98 (52 percent) were remote providers. Results of data analysis were peer reviewed for accuracy.

OIG staff reviewed professional practice guidelines from the American Psychiatric Association, American Telehealth Association, Substance Abuse and Mental Health Services Administration, and The Joint Commission.[41] OIG staff also reviewed professional literature on the topics of telehealth, telemental health, emergency planning, and benefits and clinical considerations for telemental health care.

The OIG considered VHA guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology

[40] An additional 39 questionnaires were completed and excluded from the review due to the respondent indicating no further role in telemental health care.

[41] American Psychiatric Association and the American Telehealth Association, *Best Practices in Videoconferencing-Based Telemental Health*, April 2018, accessed May 22, 2019, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf. The American Psychiatric Association "is the main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world." The American Telehealth Association "is the principal organization bringing together telemedicine practitioners, healthcare institutions, government agencies, vendors and others involved in providing remote healthcare using telecommunications." Substance Abuse and Mental Health Administration, *A Treatment Improvement Protocol 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services*, November 2015, accessed September 21, 2020, https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4924.pdf. The Substance Abuse and Mental Health Services Administration is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. "Facts about The Joint Commission," accessed August 17, 2020, https://www.jointcommission.org/about-us/facts-about-the-joint-commission. The Joint Commission, an independent organization that sets safety standards and accredits over 22,000 healthcare systems, has issued standards regarding telehealth that specifically relate to provider credentialing and privileging and not emergency planning.

and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

As the use of telehealth care, and specifically telemental health care, increased over the last 10 years, multiple policies and guidance documents were issued that were not consistently aligned in content. In the documents received in response to the request for the 58 patient-clinic locations' telehealth emergency plans, the OIG noted that facilities used inconsistent terminology for telehealth emergency plans and provided inconsistent telehealth emergency plan documents and processes.

Due to inconsistent terms and processes at national and facility levels, the OIG reviewed all documentation provided for the presence of any of the required emergency procedures for mental health emergencies, medical emergencies, and technological disruptions. The OIG focused its review on patient-clinic locations; processes specific to the remote-providers' locations were not reviewed. During the inspection, the OIG identified deficiencies in patient safety reporting related to telemental health care that are discussed in section 4.

1. Telehealth Emergency Plans

The *Connected Care/Telehealth Manual* (Telehealth Manual), November 2018, *Telemental Health Supplement* (Supplement), August 2017, and *Telemental Health Suicide Prevention and Emergency Care* (Telemental Health Suicide Prevention), October 2012, guidance state each telehealth clinic should have procedures for managing mental health and medical emergencies and technological disruptions that may occur during telehealth care.[42] The OIG defined the collection of required clinic-specific, telehealth emergency procedures and processes, as telehealth emergency plans.

Each of the three types of telehealth emergency procedures were requested from the 58 selected patient-clinic locations as part of the OIG's document request. Twenty-five of 58 (43 percent) patient-clinic locations provided documentation of one or more telehealth emergency procedures to manage mental health or medical emergencies, or technological disruptions. Nine of 58 (16 percent) patient-clinic locations provided all three types of telehealth emergency procedures. The mental health emergency documents provided by patient-clinic locations did not include

[42] VHA, *Telehealth Manual*, November 2018, accessed October 7, 2019, https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx?FilterField1=Category&FilterValue1=Operations%20Manuals&FilterType1=Choice&id=%2Fsites%2FVHA%2DTelehealth%2Fdocs%2Fth%2Dmnl%2Epdf&parent=%2Fsites%2FVHA%2DTelehealth%2Fdocs. (This is an internal VA website not publicly accessible.) VHA, *TeleMental Health: Supplement*, August 2017, accessed October 7, 2019, https://dvagov.sharepoint.com/sites/VHA-Telehealth/docs/Forms/AllItems.aspx?FilterField1=Category&FilterValue1=Operations%20Manuals&FilterType1=Choice&id=%2Fsites%2FVHA%2DTelehealth%2Fdocs%2Ftmh%2Dspp%2Epdf&parent=%2Fsites%2FVHA%2DTelehealth%2Fdocs. (This is an internal VA website not publicly accessible.) VHA, *Telemental Health Suicide Prevention*, October 2012. This document is used as clinical guidance for provider training.

telehealth procedures for initiating and accomplishing involuntary detainments and commitments, which is discussed in a subsequent section.[43]

The Supplement states telehealth staff should collaborate with relevant mental health staff and remote providers to develop the clinic-specific telehealth emergency plan.[44] Connected Care guidance does not further identify persons responsible to ensure the process is followed for development and review of the telehealth emergency plan.[45] Telemental Health Suicide Prevention guidance states, "For all telemental health programs it is critical to establish site protocols and emergency contingencies with each facility and clinic."[46] The guidance further outlines important safety protocols and a list of questions to consider when developing a telemental health emergency plan and preparing providers to address mental health and medical emergencies, and technological disruptions.[47]

The Telehealth Manual requires procedures for managing telehealth emergencies be included in telehealth service agreements (TSAs) and in facility-level policies.[48] A TSA is an agreement between the receiving patient-clinic location and the remote-provider location for each telehealth service.[49] The function of a TSA is to specify the clinical, business, and technical details of telehealth operations and includes responsibilities for safety.[50] In guidance issued in May 2017, TSAs should be approved and reviewed by facility telehealth coordinators, service chiefs, and chiefs of staff from both the remote-provider location and patient location.[51] TSAs should be communicated to telehealth staff prior to initiating telehealth services and should include emergency procedures and emergency contact information.

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[43] Merriam-Webster, *Definition of detain,* accessed November 5, 2020, https://www.merriam-webster.com/dictionary/detainment#other-words. Detainment is defined as "to hold or keep in or as if in custody." Merriam-Webster, *Definition of involuntary admission,* accessed November 5, 2020, https://www.merriam-webster.com/dictionary/involuntary%20admission. Involuntary admission is defined as "court-ordered institutionalization of a person suffering from mental illness usually upon a finding that the person is dangerous to himself or herself or to others: civil commitment." For the purpose of this review, the OIG will refer to the process of detainment followed by involuntary admission, as *involuntary detainment and commitment*.

[44] VHA, *Supplement*, August 2017.

[45] VHA, *Executive Summary, Telehealth Service Agreement Guidance,* May 24, 2017; VHA, *Supplement*, August 2017.

[46] VHA, *Telemental Health Suicide Prevention,* October 2012.

[47] VHA, *Telemental Health Suicide Prevention*, October 2012.

[48] VHA, *Telehealth Manual*, November 2018; VHA, *Supplement*, August 2017. For the purpose of this review, the OIG uses the term *facility-level* to define all facilities or clinics that consist of a designated healthcare system. In a 2020 directive issued after the review period, VHA Directive 1914, *TH Clinical Resource Sharing Between VA Facilities*, April 27, 2020, VHA indicated that the TSA "defines contingency and clinical and behavioral emergency plans for the service or provides references to those plans," whereas having a service-level plan and the option to provide only a reference to an external plan conflicts with active guidance documents from Connected Care.

[49] VHA, *Telehealth Manual*, November 2018.

[50] VHA, *Telehealth Manual*, November 2018.

[51] VHA, *Executive Summary, Telehealth Service Agreement Guidance*, May 24, 2017.

In November 2015, the Substance Abuse Mental Health Services Administration, recommended identifying steps to take in the event of a patient safety issue during telemental health care.[52] Additional guidance in 2018, from the American Psychiatric Association and American Telehealth Association recommended establishing a set of "Standard Operating Procedures or Protocols that should include (but are not limited to) the following administrative, clinical, and technical specifications: roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues."[53]

Telehealth Emergency Procedures of Patient-Clinic Locations

After searching TSAs or other documents provided by facilities that referenced telehealth, the OIG found a majority of patient-clinic locations were missing some or all emergency procedures required in telehealth emergency plans. (see table 1). The OIG received 44 of the 58 (76 percent) TSAs from patient-clinic locations as part of the facility document request; however, not all patient-clinic locations included or referenced emergency procedures within the TSA. Forty-nine of the 58 (84 percent) patient-clinic locations were missing at least one type of the telehealth emergency procedures as required by the telehealth emergency plan.

Table 1: Number of Missing Telehealth-Specific Emergency Procedures by Type

Procedure Type	Count of Locations Missing Telehealth Emergency Procedures
Mental Health Emergency	44
Medical Emergency	44
Technological Disruption	38

Source: OIG document review data of 58 patient-clinic locations

Although the Telehealth Manual states that emergency procedures be included in the TSA, Connected Care staff informed the OIG that emergency procedures were not defined within the TSA but could be found in facility policies by type of emergency. The OIG therefore reviewed all patient-clinic location documents for the three emergency procedures, which were often difficult to locate and scattered through various types of policies or documents. Forty-three of 58 (74 percent) patient-clinic locations did not have patient-clinic location specific telehealth procedures.

[52] Substance Abuse and Mental Health Services Administration, *A Treatment Improvement Protocol 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services*, November 2015.

[53] American Psychiatric Association and American Telehealth Association, *Best Practices in Videoconferencing-Based Telemental Health*, April 2018.

The provision of telemental health care adds an extra layer of complexity for planning and communication that extends beyond face-to-face mental health care. Thus, an up-to-date clinic and telehealth specific emergency plan with procedures to address the various emergencies that can occur may fill knowledge gaps and outline steps to take in an emergency situation.

The OIG concludes when emergency procedures are missing or lack specificity to the location or telehealth, staff may lack clear steps to take delaying intervention and extending time searching for procedures. This may be particularly complicated for remote providers serving multiple patient-clinic locations who lack familiarity with locating various facilities' emergency plan documents.

Mental Health Emergencies, Including Involuntary Detainment and Commitment

As noted above, telehealth-specific procedures for mental health emergencies were missing (see table 1). For the purpose of this review, mental health emergency is defined as imminent danger to self, others, or property during a telemental health visit. Mental health emergencies can be life-threatening.

The Telemental Health Suicide Prevention guidance contains a list of questions that can be used to orient providers and patient-clinic locations to the unique considerations related to preparing for telemental health care.[54] Mental health emergency questions may include

> How will you notify the patient end staff that there is a dangerous patient? Who would they call on-site, how would they respond? What if the person designated does not respond?
>
> Do they have Security/Police on site? If not, how quick can they respond/be on campus? Who will call them? What are the local emergency numbers for each site? What is the address/floor/room number so you can direct dispatch?
>
> What if the patient leaves the Telehealth room visibly/verbally upset and you cannot locate [the patient] physically or by phone? What is your plan? [55]

This list of questions is not exhaustive and demonstrates the unique considerations for mental health emergencies during telemental health care that extend beyond typical facility policies and procedures.

[54] VHA, *Telemental Health Suicide Prevention*, October 2012.

[55] VHA, *Telemental Health Suicide Prevention*, October 2012.

Involuntary Detainment and Commitment

The OIG noted a conflict between Connected Care's written guidance and Connected Care staff's guidance verbalized to the OIG during interviews regarding remote-provider knowledge of involuntary detainment and commitment procedures.[56] The Supplement and VHA Handbook, *Uniform Mental Health Services in VA Medical Centers and Clinics* state providers should have knowledge of VA patient facility policy as well as laws of the state where the patient is receiving care for involuntary detainment and commitment.[57] In contrast to the Supplement, a Connected Care staff member stated in the event of circumstances that require involuntary detainment and commitment, remote providers are not expected to know the patient-clinic location procedures or state laws but should connect the patient to the emergency contacts at the patient clinic. According to the Supplement, the processes for involuntary detainment and commitment require coordination of patient-clinic location resources that may include a combination of a VA licensed independent practitioner or community emergency services.[58]

The OIG found 50 of 58 (86 percent) patient-clinic locations were missing procedures for involuntary detainment and commitment. Patients considered a danger to self or others can be detained and committed involuntarily to a psychiatric hospital to ensure safety. While an assessment for dangerousness and subsequent petition for detainment is traditionally conducted in-person, it may be completed through telemental health. However, state laws regarding involuntary detainment have great variability and not all states allow for evaluation or initiation of the detainment process via telemental health. The unique nature of remote care and the variability of state laws regarding involuntary detainment and commitment presents a potential information gap for remote providers when patient-clinic locations lack telehealth-specific emergency procedures.

The Telemental Health Suicide Prevention guidance includes questions to prepare remote providers for telemental health care when involuntary detention may be warranted such as

> Do they allow remote clinicians to get detention orders? If not, who will get the order? Can another on-site clinician obtain detention orders?[59]

The Telemental Health Suicide Prevention guidance does not address all issues related to involuntary detainment and commitment during telemental health care; however, these questions reveal information needed by remote providers to conduct telemental health care with clarity.

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[56] VHA, *Supplement*, August 2017; VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[57] VHA, *Supplement*, August 2017; VHA Handbook 1160.01, 2008, amended November 16, 2015.

[58] VHA, *Supplement*, August 2017.

[59] VHA, *Telemental Health Suicide Prevention*, October 2012.

Medical Emergencies

As noted above, telehealth emergency procedures specific to emergency preparedness regarding medical emergencies were missing (see table 1). Medical emergencies include a host of potential warning signs, such as bleeding that will not stop, difficulty breathing, change in mental status, chest pain, or loss of consciousness. Like all staff, telehealth staff must be prepared for medical emergencies. The Telemental Health Suicide Prevention guidance provides several questions for consideration regarding the role of telehealth staff during a medical emergency. Medical emergency questions may include

> Would the patient go to a VA or other (closer) hospital? Who decides that?
>
> Who would call for the ambulance, how would family members be addressed or notified?[60]

The questions, although not exhaustive, illustrate unique aspects of telemental health emergency plans that extend beyond typical facility policy and warrant detailed instruction.

Technological Disruptions

As noted above, telehealth emergency procedures specific to technological disruptions were missing (see table 1). Reliable technology is vital to avoid disconnection from the patient during a telemental health session, especially important during emergency situations.[61] If technology fails, remote providers should coordinate clinically indicated patient care by contacting staff at the patient-clinic location, community services, or by arranging follow-up care. Telehealth emergency procedures for technological disruptions include processes for a backup delivery of care method to restore connection virtually, communication by telephone, transition of patient care to a clinical provider at the patient-clinic location, and community services.[62]

Connected Care staff interviewed by the OIG specified that technological disruption procedures are included in Connected Care instruction guides for restoring technology independently or with assistance of the national help desk. Connected Care staff stated each facility is recommended to have daily huddles to discuss flow of work, contact information, and test the telehealth equipment.

The Telemental Health Suicide Prevention guidance identified a list of questions for patient-clinic location staff and remote providers to consider for telehealth emergency preparedness during technology disruptions, such as[63]

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[60] VHA, *Telemental Health Suicide Prevention,* October 2012.

[61] VHA, *Telemental Health Suicide Prevention,* October 2012.

[62] VHA, *Supplement,* August 2017; VHA, *Telemental Health Suicide Prevention*, October 2012.

[63] VHA, *Telemental Health Suicide Prevention*, October 2012.

> Will the patient have the clinician phone number also? Would the patient try to call the clinician or alert the on-site staff of the equipment failure?
>
> If clinician-patient connectivity is not restored, what are the instructions?
>
> Do you know where there is back-up telemental health equipment in the provider and/or patient site?

Technological disruption procedures that reflect the unique resources and protocols related to each patient-clinic location are critical elements of a telehealth emergency plan.

Telehealth Emergency Plan Updates

The Supplement states "emergency plans must be updated annually at a minimum, as well as whenever necessary (e.g., staff turnover)."[64] The Supplement does not specify who is responsible for oversight of telehealth emergency plan updates, but states facilities should determine a responsible party.[65] As noted above, the telehealth emergency plan is a compilation of three required emergency procedures. The majority (49 of 58) of patient-clinic locations did not provide the three procedures required of a telehealth emergency plan. Fifty-five of 58 (95 percent) patient-clinic locations did not provide documentation of a process for annual updates to telehealth emergency procedures. Despite not finding evidence of emergency plan updates, staff at 26 of 58 (48 percent) facilities stated during interviews that emergency plans were being updated at least annually at the facility. The remainder of facilities reported processes for frequency of updates were greater than annually and others had no specified frequency.

An open-ended question in the OIG questionnaire to remote providers and telepresenters included the option of listing concerns regarding patient safety during telemental health visits. One questionnaire respondent wrote the telehealth emergency plan was not updated after a significant resource, onsite security personnel, was discontinued.

Without a consistent process for routine review and updates to the telehealth emergency plan, telehealth staff may rely on incorrect emergency procedures, resulting in delayed or inadequate response to patient emergencies.

2. Telehealth Staff Responsibilities During Emergencies

The OIG found 48 of 58 (83 percent) patient-clinic locations did not include defined telehealth staff roles and responsibilities during telehealth emergencies within their telehealth emergency procedures or emergency contact information. According to the Supplement, emergency procedures should define actions expected to be taken and roles and responsibilities of staff at

[64] VHA, *Supplement*, August 2017.
[65] VHA, *Supplement*, August 2017.

both the patient-clinic locations and remote-provider locations.[66] In the context of this section, roles and responsibilities refer to the coordinated procedural steps for each member of staff to take and role clarity in the event of an emergency, and is not referring to the clinical judgment of providers. Without clearly defined telehealth staff roles and responsibilities, patient care may be delayed or inadequate due to a poorly coordinated emergency response.

3. Emergency Contact Information

According to the Supplement, a remote provider's immediate access to up-to-date emergency contacts for the patient-clinic location is critical to respond to an emergency.[67] Industry practice guidance also emphasizes the importance to confirm the contact information of patients, emergency contacts, and community emergency resource information for telehealth services. Guidance from the Substance Abuse Mental Health Services Administration includes the development of contact information for crisis or backup remote providers and local emergency services.[68] In close alignment, in 2018, the American Psychiatric Association/American Telemedicine Association recommended remote providers at the start of each clinical visit communicate and document identification and accuracy of key contacts information during the session.[69]

Emergency Contact Lists

Of the 58 patient-clinic locations reviewed, 37 (64 percent) provided emergency contact lists and 21 (36 percent) did not. The telehealth emergency contact list is a document that identifies relevant staff, details primary and alternate methods of communication, and includes patient-clinic location community emergency resources.[70] The Telehealth Manual states that in the event of a patient emergency, the remote provider or the patient-clinic location staff use the emergency contact list to establish immediate communication and initiate emergency procedures. The *Telehealth Service Agreement Executive Summary* indicates, and Connected Care staff confirmed during interviews, that the telehealth emergency contact list should contain all contact information for telehealth staff. Without a telehealth emergency contact list that identifies the relevant and alternate staff, the telepresenter or the remote provider may not be able to establish immediate communication to initiate emergency procedures.

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[66] VHA, *Supplement*, August 2017.

[67] VHA, *Supplement*, August 2017.

[68] Substance Abuse and Mental Health Administration, *A Treatment Improvement Protocol 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services*, November 2015.

[69] American Psychiatric Association and American Telemedicine Association, *Best Practices in Videoconferencing-Based TeleMental Health*, April 2018.

[70] VHA, *Telemental Health Suicide Prevention*, October 2012; VHA, *Telehealth Manual*, November 2018.

Emergency Contact List Elements

The Telehealth Manual and Telemental Health Suicide Prevention guidance state the contact list must include several emergency contact persons and methods for connecting during telehealth emergencies.[71] Of the 37 patient-clinic locations that provided emergency contact lists, the OIG found 23 (62 percent) patient-clinic locations lacked a minimum of two emergency contact persons and 28 (76 percent) patient-clinic locations lacked two methods of contact for each contact person. Five of the 37 (14 percent) patient-clinic locations with telehealth emergency contact lists had all required elements.

The most frequently stated concern from remote providers and telepresenters who responded to open-ended questions in the OIG questionnaire was emergency contact persons did not remain available during telemental health sessions. When an emergency occurs during a telemental health session, the remote provider relies on immediate communication and assistance from the patient-clinic location emergency contacts to avoid delays in emergency intervention. Remote providers cited delays in immediately reaching emergency contacts at patient-clinic locations demonstrated the need for more than one emergency contact. Statements from respondents included[72]

> Depending on the clinic, it has not always been easy to contact someone during the visit. Listed phone numbers often go to a message or phone tree and never reach a real person.
>
> If there was an emergency in the room, I am not confident in getting access to staff at the [community-based outpatient clinic], I would have contacted local emergency services first, as it was very difficult to reach a front staff or other members on the phone.
>
> At times Telehealth staff at the VA location of the veteran are not available and it can be difficult to get in touch with someone should an emergency happen.

Without a patient-clinic location specific emergency contact list that contains sufficient information for relevant and alternate contact persons, a remote provider may fail to reach resources at the patient-clinic location, increasing risk for delay of patient care in an emergency.

[71] VHA, *Telemental Health Suicide Prevention*, October 2012; VHA, *Telehealth Manual*, November 2018.

[72] The OIG did not validate responses nor make a judgment with respect to the accuracy or strength of each respondent comment. While responses provided additional context, respondent comments should not be generalized across all VHA remote providers or telepresenters. The statements listed are not the full listing of statements by respondents. The OIG made edits to statements to correct spelling and write out abbreviations.

Communication of Emergency Information

Connected Care lacks guidance for a consistent process for telehealth staff's communication of emergency information for each telehealth session. The Supplement states it is the responsibility of the telepresenter to communicate with the remote provider before a telehealth session regarding who is present with the patient in the room and any other relevant information, but does not specifically require communication of emergency contacts before a telehealth session.[73] The telepresenter is responsible to listen for and report any symptoms or observations of suicidality, homicidality, intoxication, anxiety, or behavioral observations that are concerning before or during a telehealth session. Connected Care guidance does not specify how this information is communicated between telehealth staff, though it states a phone must be available in the telehealth room, where feasible, for communication between the telepresenter and remote provider. Communication methods between the telepresenter and remote provider can vary between telephone, text, instant message, or video chat.[74] Connected Care staff stated that a remote provider should know which staff at the patient-clinic location will take over the patient's emergency care.

One question on the OIG questionnaire asked whether emergency contact information is exchanged between telepresenter and remote provider prior to telemental health sessions. Twenty-two percent of respondents, comprised of nine telepresenters and 32 remote providers, replied "no" or that they were "unsure."[75]

An open-ended question on the OIG questionnaire included listing facility or individual practices found to be innovative or helpful to ensure patient safety before and/or during telemental health sessions. Remote providers and telepresenters cited the importance of communicating with each other prior to telemental health sessions:

> The telepresenter will [instant message] me if they notice anything unusual or if anything was mentioned in conversation before the session starts that stands out to the telepresenter…For example, if the Veteran is known by the telepresenter and is especially quiet or does not seem to have bathed recently this can be helpful information.
>
> From my perspective as a [telehealth clinical technician] that has been involved in Telehealth for six years, pre-appointment coordination with the provider is the most essential practice to making sure that all aspects of the clinical video telehealth session, including safety, is conducted in a professional manner and

[73] VHA, *Supplement*, August 2017.

[74] VHA, *Supplement*, August 2017.

[75] Questionnaire instructions were provided to staff to respond "Yes," "No," or "Unsure" to the following statement: Prior to the start of telemental health sessions, the telepresenter and teleprovider [remote provider] exchange emergency contact information.

> makes both the patient and provider more at ease in the use of the technology in getting their mental health treatment.
>
> We have the emergency information for the telemental health provider. If the room changes or the information changes the presenter will inform staff at the beginning of the session.

The OIG concluded the process of communication between the telepresenter and remote provider before a telehealth session would provide the opportunity for the sharing of accurate emergency contact information. Prior to a telehealth session, the telepresenter can also share patient observations with the remote provider that may help improve patient care. Without having or verifying the telehealth emergency contact lists prior to sessions, telehealth staff may not have the correct emergency contact information to facilitate intervention in an emergency.

4. Process for Patient Safety Event Reporting and Tracking in Telemental Health

Per the OIG's review of facility documents provided, 53 of 58 (91 percent) patient-clinic locations did not have a process for differentiating the telemental health setting in patient safety event reporting methods.[76] When asked in an interview, Connected Care staff stated telehealth incidents cannot be distinguished from those of in-person visits.

VHA guidance requires facility staff to report adverse events and close calls to the facility patient safety manager.[77] Since 2018, VHA has offered reporting software known as the Joint Patient Safety Reporting System to healthcare systems. The Joint Patient Safety Reporting System has templated data fields, including a drop-down list to indicate the department where the event occurred, such as primary care or mental health. Some healthcare systems have a department dropdown for general telehealth, not specific to telemental health. The drop down list is mutually exclusive, which results in only one department setting selected. For example, if a patient adverse event or close call occurs during a telemental health visit, the event would likely be recorded as occurring during a mental health visit and not in the context of telehealth.

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[76] VHA Handbook 1050.01, *VHA National Patient Safety Improvement*, March 04, 2011. VHA requires reporting of adverse events and close calls to patient safety during patient care. For the purpose of this report, the OIG further defines the reporting of adverse events and close calls during patient care as patient safety event reporting.

[77] VHA Handbook 1050.01. Adverse events are untoward incidents, injuries, or other harmful events associated with care or services provided by a medical facility; more common examples include procedural errors, drug complications, missing patient events, or patient falls. "A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention." VHA, *VA National Center for Patient Safety*, updated December 3, 2018, accessed July 19, 2020, https://www.patientsafety.va.gov/index.asp. All VA hospitals have a patient safety manager who participates in a multi-disciplinary team and is responsible for assessing the facility's reported safety concerns and reporting to the National Center for Patient Safety.

Some facility staff interviewed reported that when an event occurred during a telemental health session, the information is reported as a mental health event and the telehealth aspect is added in an optional text field in the Joint Patient Safety Reporting System. Additionally, some facility staff interviewed identified other types of patient safety event reporting systems or processes, such as notification to the Disruptive Behavior Committee or the Suicide Prevention Coordinator.

In interviews, staff from 30 facilities stated they were either unsure or did not have a method to identify the telehealth or telemental health setting in their reporting systems (see table 2). Staff at seven facilities stated their reporting system had a drop down list identifying telehealth or telemental health setting.

Table 2: Patient Safety Event Reporting Method to Identify the Telehealth Setting

Facility Method to Identify Telehealth	Count of Facilities by Method
Narrative text field	17
Listed as a setting to select	7
No method	14
Unsure of method	16
Reported directly to the Suicide Prevention Coordinator, Disruptive Behavior Committee, or Mental Health Services	2
Combination of reporting methods	2

Source: OIG analysis of 58 facility interviews

Without a process for patient safety event reporting that consistently requires identification of the telehealth or telemental health setting, the National Center for Patient Safety and facilities may lack awareness of vulnerabilities in telehealth care, including telehealth patient emergencies. This can lead to missed opportunities to understand safety trends and make safety improvements within the telehealth setting.

Conclusion

VHA has steadily expanded telemental health care over the last decade. Telemental health improves access to care by reaching patients in underserved areas and in locations with provider shortages. Though the COVID-19 pandemic occurred after the OIG review period, the pandemic highlighted the need for telehealth care in lieu of certain face-to-face care during times of unforeseen circumstances. Patient visits shifted away from in-person clinic care as often as possible to telehealth at home. As patients return to VA clinic locations for telemental health

care, deficiencies identified in this report related to emergency procedures and contact information need to be addressed.

Given the increased use of telemental health within VHA, it is important to recognize the unique patient safety challenges as the remote provider is not at the same location as the patient and unable to participate in person in an emergency. The remote provider must have knowledge of available resources and emergency services at patient-clinic locations and the specific steps to take in an emergency during a telehealth session, which cannot be fully addressed in general facility policy.

The OIG determined VHA lacked telehealth emergency preparedness for patient-clinic locations. Telehealth procedures and processes to manage mental health and medical emergencies and technological disruptions that would ensure the safe delivery of telemental health care in patient-clinic locations were missing or incomplete. Up-to-date, clinic and telehealth-specific emergency procedures are needed for telehealth staff to immediately respond to mental health and medical emergencies, and technological disruptions.

A majority of the patient-clinic locations reviewed were missing telehealth emergency procedures for mental health, including involuntary detainment, and medical emergencies, as well as technological disruptions. Emergency plans provided by facilities lacked specificity to telehealth and patient-clinic locations, were difficult to locate, scattered in various documents, and lacked a process for annual updates. When telehealth staff are not immediately able to locate an accurate emergency plan relevant to the patient-clinic location resources there may be delays or gaps in patient safety intervention. Based on difficulties locating information related to telemental health emergency preparedness, the OIG concluded that remote providers and their telemental health patients would benefit from a user-friendly process that allows easy access to patient-clinic location telehealth emergency plans.

A majority of the patient-clinic locations reviewed did not have defined telehealth staff roles and responsibilities during telehealth emergencies included in their emergency procedures or emergency contact information. VHA facilities were missing telehealth emergency contact lists or required elements of the emergency contact list and lacked guidance for a consistent process for telehealth staff's communication of emergency information. Communication of emergency information and understanding of the roles and responsibilities of all telehealth staff during an emergency in a telehealth session is critical to prevent delays in patient intervention.

The OIG concluded VHA facilities lacked a process for differentiating the telemental health setting in patient safety event reporting methods. Without a consistent reporting process that identifies the telehealth setting for patient safety events, VHA may lack awareness of vulnerabilities and miss opportunities for safety improvements in telehealth.

Recommendations 1–5

1. The Under Secretary for Health ensures the Office of Connected Care Telehealth Services and the Office of Mental Health and Suicide Prevention collaborate to develop a consistent process for facility implementation of telehealth emergency plans tailored for telehealth care and the patient-clinic locations that are inclusive of procedures addressing mental health and medical emergencies and technological disruptions during telemental health care.
2. The Under Secretary for Health verifies the Office of Connected Care Telehealth Services reviews and implements oversight of telehealth emergency plan processes to include expectations for updating and monitoring.
3. The Under Secretary for Health confirms the Office of Connected Care Telehealth Services develops consistent processes for healthcare systems to define and communicate individual telehealth staff responsibilities during telehealth emergencies, specific to the patient-clinic locations.
4. The Under Secretary for Health ensures the Office of Connected Care Telehealth Services has a consistent process for healthcare systems to develop, maintain and communicate accurate, patient-clinic location specific telehealth emergency contact information to all telehealth staff, to include remote providers.
5. The Under Secretary for Health collaborates with the Office of Connected Care Telehealth Services to develop a streamlined process to report patient safety events specific to telehealth that clearly identifies the setting and specific service line to allow tracking, trending, and monitoring.

Appendix A: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 14, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic (VIEWS 05034687)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report, Deficiencies in Emergency Preparedness for Veterans Health Administration Telemental Health Care at VA Clinic Locations Prior to the Pandemic.
2. The Veterans Health Administration concurs with OIG's report and provides an action plan and general and technical comments.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

Attachments

OIG Response to the Under Secretary for Health Memo

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments that may disclose information that could change OIG findings in the final report.[78] For this report, VHA provided the OIG comments referenced in the Under Secretary for Health's memo during the draft review phase. The OIG considered the comments and determined they did not change any findings in the report.

[78] VA OIG GM Directive 306, *Comments to Draft Reports*, April 10, 2014, amended April 24, 2019.

Under Secretary for Health Response

Recommendation 1

The Acting Under Secretary for Health ensures the Office of Connected Care Telehealth Services and the Office of Mental Health and Suicide Prevention collaborate to develop a consistent process for facility implementation of telehealth emergency plans tailored for telehealth care and the patient-clinic locations that are inclusive of procedures addressing mental health and medical emergencies, and technological disruptions during telemental health care.

Concur.

Target date for completion: May 31, 2022

Under Secretary for Health Comments

The Office of Connected Care Telehealth Services and the Office of Mental Health and Suicide Prevention will establish an online platform to manage location-specific, clinic-based telehealth emergency procedures and contact information. The platform will be accessible to health care professionals and provide procedures for handling technology, medical and mental health emergencies that may arise during clinic-based video telehealth sessions.

The Office of Connected Care Telehealth Services and the Office of Mental Health and Suicide Prevention will also collaborate on national guidance documents and training revisions for emergency handoffs and implementation of the online platform.

Recommendation 2

The Acting Under Secretary for Health verifies the Office of Connected Care Telehealth Services reviews and implements oversight of telehealth emergency plan processes to include expectations for updating and monitoring.

Concur.

Target date for completion: May 31, 2022

Under Secretary for Health Comments

The Office of Connected Care Telehealth Services will develop national standards for updating and monitoring telehealth emergency plan processes and contact information.

The Office of Connected Care Telehealth Services will include tools in its online platform to monitor updates to clinic-based telehealth emergency plan information.

Recommendation 3

The Acting Under Secretary for Health confirms the Office of Connected Care Telehealth Services develops consistent processes for healthcare systems to define and communicate individual telehealth staff responsibilities during telehealth emergencies, specific to the patient-clinic locations.

Concur.

Target date for completion: May 31, 2022

Under Secretary for Health Comments

The Office of Connected Care Telehealth Services will develop national standards for individual staff responsibilities during telehealth emergencies that address requirements at patient specific locations.

Recommendation 4

The Acting Under Secretary for Health ensures the Office of Connected Care Telehealth Services has a consistent process for healthcare systems to develop, maintain and communicate accurate, patient-clinic location specific telehealth emergency contact information to all telehealth staff, to include remote providers.

Concur.

Target date for completion: May 31, 2022

Under Secretary for Health Comments

The Office of Connected Care Telehealth Services will establish an online platform to serve as a standard location for clinic-based telehealth emergency procedures and contact information.

The Office of Connected Care Telehealth Services will develop national guidance documents and training to implement the online platform as the national standard for managing clinic-based telehealth emergency procedures and contact information.

Recommendation 5

The Acting Under Secretary for Health collaborates with the Office of Connected Care Telehealth Services to develop a streamlined process to report patient safety events specific to telehealth that clearly identifies the setting and specific service line to allow tracking, trending, and monitoring.

Concur.

Target date for completion: May 31, 2022

Under Secretary for Health Comments

VHA National Center for Patient Safety will collaborate with the Office of Connected Care Telehealth Services to enhance capture of patient safety events specific to telehealth in the Joint Patient Safety Reporting (JPSR) system, a commercial software solution shared by VA and the Department of Defense. To meet expectation, JPSR software enhancements will be required to standardize capture of telehealth related patient safety reports, including service line and location. It should be noted that JPSR is an incident reporting system that allows for tracking, trending, and monitoring of those events and close calls that are self-reported.

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