

COLORADO DAYLIGHT PARTNERSHIP TELEBEHAVIORAL HEALTH PROTOCOLS FOR COLORADO

(INCLUDING PROTOCOLS FOR SERVING DEAF AND HARD OF HEARING CLIENTS)

Prepared as part of Colorado’s Daylight Partnership
by Spark Policy Institute
(Revised June 26, 2011)

TABLE OF CONTENTS

| | |
|---|----|
| Introduction..... | 2 |
| Definitions | 2 |
| TBH Protocols for Network Providers | 3 |
| Orientation & Training of Staff | 3 |
| Referrals & Scheduling..... | 3 |
| Consent | 3 |
| Confidentiality & Privacy | 4 |
| Conduct of the TBH Session | 4 |
| Clinical Record Keeping..... | 5 |
| Appropriate TBH Services | 6 |
| Emergency Services & Client Safety | 7 |
| Technical Quality of TBH..... | 8 |
| Prioritization of Clinical TBH | 9 |
| Monitoring & Quality Improvement..... | 9 |
| Special Populations <i>including Deaf and Hard of Hearing</i> | 10 |
| Resources..... | 14 |
| Endnotes | 14 |

INTRODUCTION

The Telebehavioral Health (TBH) Protocols were developed to support the Daylight Project's telebehavioral health network of providers. The protocols were carefully researched to ensure alignment with best practices nationally. They are based on the work of the American Telemedicine Association and telehealth protocols in use in Arizona and Maryland. Each protocol has an endnote indicating the original source and extent of adaptation. The American Telemedicine Association's recommended protocols cover many additional topics not addressed in this condensed set of protocols. For additional information, please see the resources section.

The Special Populations section of the protocol thoroughly covers TBH services to deaf and hard of hearing clients. These protocols are tied to the Daylight Standards of Care, a research-based document that outlines critical issues for organizations to address in order to provide culturally and linguistically accessible and component care to deaf and hard of hearing clients.

The Protocols are currently in draft form, with the expectation that they will *be narrowed down to the most critical protocols*. As of June 16th, the Protocols have been reviewed by Daylight Partnership staff and partners as well as the Mental Health Center of Denver's Policies and Procedures Committee. They have been revised in response to this feedback.

Currently, most protocols are **shall** protocols, indicating they are required. Some protocols are included as **will** protocols, indicating they are desired. Largely, the designation matches the level of requirement from the source document.

DEFINITIONS

- **TBH:** Telebehavioral health, the delivery of mental health and/or substance abuse services through electronic equipment providing both a visual and auditory experience.
- **Attendant:** Staff person responsible for ensuring TBH equipment functions properly and client is supported in using it at the originating site.
- **Originating Site:** Provider site where the client is located and a staff person may or may not be present.
- **Network Provider:** A provider organization participating in telebehavioral health, regardless of whether they are the originating site or far-site.
- **Far-site:** The far-site is defined as the telebehavioral health site where the provider is seeing the client at a distance or consulting with a client's provider.
- **Shall:** Protocols that include the word **shall** are intended as practices that will be followed with all delivery of TBH by Network Providers.
- **Will:** Protocols that include the word **will** are intended as best practice recommendations for Network Providers to consider in their delivery of TBH services.

TBH PROTOCOLS FOR NETWORK PROVIDERS

ORIENTATION & TRAINING OF STAFF

1. Network Providers **shall** ensure that all behavioral health practitioners providing services via TBH receive training on this protocol, agency specific protocols, and best practices in the delivery of services through TBH prior to providing services. Training should address:¹
 - Camera Equipment-Orientation, covering camera placement, focus, and movement in order to ensure that close-up or distance views are available as clinically appropriate, that distractions are minimal, that video images are as natural as possible, and that good eye contact is maintained.
 - Sound/Volume Control-Orientation/training, ensuring that providers as well as staff at the client site understand how to mute the microphone(s) and adjust the volume so that the provider and client can hear each other clearly.
 - Picture in Picture or Second Monitor-Orientation/training that ensures that providers as well as staff at the client site understand that clients should not see themselves on TV while receiving TBH services.
2. Network Providers **shall** ensure originating site staff including the attendant, technology staff, and front-desk staff are trained on appropriate TBH protocols related to their role (e.g. scheduling, referrals, troubleshooting, monitoring technology).²
3. Network Providers **shall** have at least one licensed provider who has received the training outlined in Protocol 1 on site at the originating site during any TBH session, referred to throughout the protocols as the attendant. The attendant does not have to be the client's referring provider or have clinical knowledge of a particular client, but must be available in the event of an emergency to provide appropriate assistance.³
4. Network providers **shall** have at least one technology staff person on site at the originating and far sites during any TBH session. This person must be trained to respond to technical problems that can occur during a TBH session.⁴

REFERRALS & SCHEDULING

5. Network Providers **shall** establish an appointment protocol between originating and provider sites prior to conducting a TBH session.⁵
6. Network Providers **shall** indicate in referrals whether the referral is for a one-time consult or an evaluation for ongoing treatment and management.⁶

CONSENT

7. Network Providers **shall** obtain client's Informed Consent to receive treatment via TBH prior to the client's initial TBH session. If informed consent is not documented on a form, referring

providers should document voluntary ^{hearing clients)} verbal consent to utilize TBH. Clients may withdraw consent at any time. The risks, benefits, and limits of TBH will be explained including the confidentiality and privacy of the TBH system using non-technical terms, e.g. TBH is as secure as a private phone call.⁷

8. Network Providers at the originating and far site **will** adopt a common TBH Informed Consent form that meets the requirements of Protocol 6.

CONFIDENTIALITY & PRIVACY

9. Network Providers **shall** have billing and coding processes in place that share information across systems for the purposes of payment that do not risk exposure of mental health clients' personal health information.⁸
10. Network Providers **shall** ensure all TBH equipment in rooms where clients may be present for TBH or face-to-face sessions or meetings are either turned off or covered with a lens cover when not in use to ensure privacy of non-TBH sessions.⁹

CONDUCT OF THE TBH SESSION

11. Network Providers **shall** ensure that appropriate staff are available at the originating site to meet client and provider needs before, during, and after TBH sessions including technology staff with training on the TBH equipment.¹⁰
12. Network Providers **shall** ensure all persons in the TBH rooms at both sites are identified to all participants prior to the TBH session. Disclosing persons who are attending the consultation **shall** be done by panning each end of the TBH room with the video camera or at a minimum, announcing the presence of individuals present and asking the client's permission for additional persons to be in the room. Permission from the client is not required if safety concerns mandate the presence of another individual or if the client is being legally detained, but should be encouraged by the practitioner.¹¹
13. During the TBH session, the attendant **shall** remain in the building and accessible for emergency support. If the attendant must be unavailable, an alternative attendant who can be contacted through the same means must be identified.
14. In the event of fire or other facility emergency, the attendant **shall** be responsible for ensuring the client is led safely out of the building.¹²
15. When the TBH session ends, the provider **shall** tell the client whether and when to follow-up, including whether to make a follow-up appointment through the originating site front desk.¹³
16. Network Providers **shall** have an agreement in advance as to how a session delay will be handled, including whether the following options are permitted if there is delay in starting the session or if the session is interrupted for equipment failures:¹⁴
 - Continue the session after the allotted time, if equipment and attendant are available.
 - Finish the session, via telephone, if appropriate.

- Schedule another TBH session.
 - Schedule an evaluation in person.
 - Refer the client for an evaluation in person with another provider.
17. Network Providers **shall** ensure that in the event of an equipment failure, in no case will a client be discharged without the attendant first discussing the disposition with the provider at the far-site.¹⁵
18. Network Providers **shall** ensure that the picture-in-picture feature at the client's site is turned off unless the TBH provider specifically requests that it be turned on for a particular client. If a second monitor is present at the client site, it is turned off during clinical sessions so that only the TBH provider is seen onscreen.¹⁶

CLINICAL RECORD KEEPING

19. Information **shall** be available to the far-site provider that meets legal and regulatory requirements for referral and that provides supportive data to the practitioner in preparation for evaluating the TBH client and for on-going client management.¹⁷
20. Procedures **shall** be in place between Network Providers and practitioners for sharing client mental health information, including clinical history, results of testing, laboratory results, and other relevant clinical data.¹⁸
21. The same standards of accuracy, completeness and safeguarding of clinical records **shall** be maintained, in accordance with facility, corporate and/or HIPPA policies and procedures, as would be expected if the client had been seen "in person" at the originating site.¹⁹
22. The following additional information **shall** be included in clinical records when TBH is provided to clients:²⁰
- That the service was provided by TBH.
 - The bandwidth of the session.
 - The location of the remote site.
 - Documentation in accordance with the remote site's standard operating procedures and guidelines.
23. The client's medical record is maintained at the originating site. Therefore, all permanent clinical records **shall** be kept at the originating site. All requests for copies of medical records will be directed to the originating site.²¹
24. Network Providers **shall** send initial evaluations, consultations, opinions, documentation of services ordered or provided, diagnoses, summary of findings, recommended management, and/or progress notes to the originating site within 48 hours by entry into the originating site's electronic medical record, fax, or other electronic means, which meet HIPAA standards, for inclusion in the client's medical record. The far-site may keep a convenience file on each client for ongoing continuity of care.²²

25. Network Providers **shall** accept forms, such as questionnaires, limits of confidentiality statements, etc., used by originating sites, to prevent duplication of information to be supplied by the client.²³
26. Network Providers **shall** develop TBH policies describing additional procedures regarding record-keeping requirements, including making clinical records available to off-site TBH behavioral health providers, keeping duplicate records off site, getting the off-site TBH providers' records into the primary clinical record, and the storage of off-site records.²⁴
27. If the originating site has an electronic medical record, the network provider **will** provide VPN access to the far site provider to view and add to the client's record.²⁵

APPROPRIATE TBH SERVICES

28. The TBH operation and its health professionals **shall** ensure that the standard of care delivered via TBH is equivalent to any other type of care that can be delivered to the client, considering the specific context, location and timing, and relative availability of in-person care.²⁶
29. Any modifications to specialty specific clinical practice standards for the TBH setting **shall** ensure that clinical requirements specific to the discipline are maintained.²⁷

Specific services are addressed below. Services not mentioned below may or may not be appropriate for TBH and should be considered on an individual service basis.

Psychological & Cognitive Testing

30. Network Providers **will not** provide cognitive testing by TBH, due to research findings that it does not result in accurate results. If a specialized provider is needed, transport to the originating site for the cognitive testing is recommended.²⁸

Other Diagnostics & Assessments

31. Network Providers **will** consider that emergency evaluation and remote assessment for seclusion and restraint is appropriate through TBH.²⁹

Medication Management & Prescriptions

32. Physician, nurse practitioner, or physician's assistants **shall** fax, phone, or mail prescriptions and laboratory studies to the pharmacy or originating site by no later than 9:00am the day following the appointment.³⁰
33. Network Providers **shall** obtain oral or written informed consent from the client, parent, or legal guardian, unless treatments and procedures are under court order, prior to the initiation of any psychotropic medication. Documentation of consent must be included in medical records provided to the originating site.³¹

34. Network Providers **shall** establish clear protocols for prescribing through telebehavioral health, including communicating with clients the method for obtaining initial prescriptions and refills and reporting adverse affects.³²

Individual Psychotherapies

35. Standard practice guidelines for therapy **shall** direct psychotherapy services within the TBH setting.
36. Evidence-based practice and empirically supported treatments **shall** be followed and adapted by the Network Providers to be appropriate for TBH.³³
37. Persons engaged in providing psychotherapy services **shall** be aware of their professional organizations positions on TBH and incorporate the professional association standards whenever possible.

EMERGENCY SERVICES & CLIENT SAFETY

*Client safety is paramount. Due to the nature and distance between the client and far-site provider incurred in TBH practice, additional measures must be taken to ensure client safety. The following guidelines will be followed during all TBH sessions.*³⁴

38. Network Providers **shall** develop TBH emergency protocols for each facility utilizing TBH, with a clear explanation of the roles and responsibilities in emergency situations, determination of outside facility hours emergency coverage, and guidelines for determining at what point additional staff and resources should be brought in to help manage emergency situations.³⁵
39. Network Providers **shall** develop a crisis safety plan with each client participating in TBH services that clearly outlines for the client who they should contact in a crisis.³⁶
40. Network Providers **shall** be aware and have policies in place for addressing safety issues with clients displaying strong affective or behavioral states prior to or upon conclusion of a session.³⁷
41. Network Providers **shall** be prepared to provide an attendant with the client during the TBH session, based on the current understanding of the client and the TBH session process.³⁸
42. For TBH sessions where the end-site TBH provider has not required the presence of an attendant to be with the client during the session, Network Providers **shall** ensure the following conditions are met:³⁹
- An attendant, who can respond immediately to assist the client, will be available at the remote site.
 - An alternative communication medium (phone, pager, etc) must be available and known to the TBH provider to notify the attendant at the remote site that emergency support is needed.

TECHNICAL QUALITY OF TBH

43. Network Providers **shall** assess all TBH connections and equipment for quality of video and audio signal prior to being used to provide services.⁴⁰
44. Network Providers **shall** regularly monitor connections to ensure quality, appropriate bandwidth, and appropriate security.⁴¹
45. Network Providers **shall** have policies and procedures in place to ensure the physical security of TBH equipment and the electronic security of data.⁴²
46. Network Providers **shall** have appropriate redundant systems and appropriate recovery procedures in place to ensure availability of the network for critical connectivity.⁴³
47. Organizations **shall** ensure compliance with all relevant safety laws, regulations, and codes for technology and technical safety.⁴⁴
48. Organizations **shall** have infection control policies and procedures in place for the use of TBH equipment and client peripherals.⁴⁵

Equipment Needs

49. Network Providers **shall** provide all services at a minimum bandwidth of 1500 kbps.⁴⁶
50. Network Providers **shall** use equipment that has features allowing for changing video clarity (e.g. brightness and contrast) and audio quality (microphone and speaker volumes).⁴⁷
51. Network Providers **shall** use cameras on the client-end that are high quality.⁴⁸
52. Network Providers **will** ensure the resolution of the display monitor matches, as closely as possible, the resolution of the acquired image being displayed.⁴⁹
53. Network Providers **will** use equipment that can be controlled by the provider on the far-site to pan, tilt, and zoom the camera.⁵⁰
54. Network Providers **will** use equipment that allows for videos to be played so that people at other locations can see and hear them, record meetings when clinically appropriate and, with client permission, and share information on common white board or via computer files.
55. Network Providers **will** use equipment that allows for on screen message to notify user of such conditions as loss of far-site video, incomplete or dropped connections, mute/unmute, etc.
56. Network Providers **will** minimize the gaze angle (the angle between the participant's local camera and where the participant looks at the distant onscreen participant) to increase perception of having direct eye contact.⁵¹

Equipment Needs for Confidentiality & Privacy

57. Network Providers **shall** ensure all TBH endpoint equipment is password protected.⁵²

58. Network Providers **shall** ensure all TBH endpoint equipment is set to “auto answer mute” and “auto answer multipoint: do not disturb” so that clinical TBH sessions cannot be accidentally interrupted, including by a second video connection.⁵³
59. Network Providers **shall** ensure all client services via TBH using the commodity internet use AES encryption or Virtual Private Networks to ensure the transmission is secure.⁵⁴

Physical Environment

60. Network Providers **shall** provide TBH services in rooms that are safe, have adequate acoustics, provide comfortable seating, and mitigate interruptions from electronic devices.⁵⁵
61. Network Providers **shall** ensure the TBH room is well lit, minimizes visual distractions (e.g. clutter, bookshelves, decorations), and avoids shadows falling across the client’s face (150 candles at the client site is recommended), preferably using light sources as close to daylight as possible.⁵⁶
62. Network Providers **shall** treat both locations as client TBH rooms regardless of the room’s intended use, with appropriately designed audio and visual privacy, including no unauthorized access during the TBH session, sound proofing (doors/walls) or use of white-noise equipment, window coverings or opaque glass, and signage indicating the room is in use.⁵⁷

Provider Issues

63. Network Providers **will** consider solid colors. Patterned and striped clothing requires more bandwidth to update a more dynamic picture and is visually distracting.⁵⁸

PRIORITIZATION OF CLINICAL TBH

64. Clinical TBH sessions **shall** take priority over all other types of videoconferences (administrative, training, etc). Network Providers **shall** bump non-clinical videoconferences when necessary to accommodate clinical videoconferences.⁵⁹

MONITORING & QUALITY IMPROVEMENT

65. Network Providers and practitioners **shall** have in place policies and procedures that address all aspects of administrative, clinical, and technical components regarding the provision of TBH and **shall** keep the policies and procedures updated on an annual basis or more often as needed.⁶⁰
66. Network Providers and practitioners **shall** have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management. The quality improvement indicators **shall** address the critical components of providing TBH services and **shall** be used to make programmatic and clinical changes.⁶¹

67. Network Providers **shall** develop policies and procedures to ensure consistent, high quality implementation of TBH. Key policies that **shall** be addressed include:⁶²

- Release of information and informed consent.
- Identifying all required client information for a referral/consultation.
- A reliable process for communicating findings after the TBH session.
- Ensuring privacy and confidentiality.
- Intake procedures and screening.
- Staff roles and responsibilities.
- Transmission of client data.
- Use of electronic medical records.
- Appointment scheduling; synchronizing schedules at all sites.
- Transmission of prescriptions, lab orders and progress notes.
- Evaluation and measurement of client outcomes.
- Quality improvement.
- Safety.
- Licensing, liability and malpractice insurance.
- Continuous training.

SPECIAL POPULATIONS

68. The far-site providers TBH **will** have cultural competency in the population he or she is serving at a distance.⁶³

Deaf and Hard of Hearing

69. Attendant and front-desk staff at the originating site **shall** attend training from the Daylight Project to ensure basic communication and cultural competency with deaf and hard of hearing clients.

70. Network Providers **shall** complete a communication preference profile with deaf and hard of hearing clients prior to the delivery of services via TBH to ensure appropriate communication is provided during the TBH session.

71. Network Providers **will** consider deaf and hard of hearing clients who would be considered for routine outpatient mental health and substance abuse treatment as potential clients for services via TBH if specialized providers are not available. Additional clinical judgment and knowledge of TBH should be used to assess individual clients for appropriateness of the TBH session, e.g. clients with gross movement disorders, potential to act out during the interview, etc.⁶⁴

72. Network Providers **shall** ensure that consent is received in a manner that ensures informed consent is achieved with deaf and hard of hearing clients.⁶⁵
73. Network Providers **shall** ensure that deaf and hard of hearing clients assessed by the on-site provider and felt to be in need of an acute psychiatric evaluation, due to safety, medical or time constraint issues, will have a disposition plan that is in accordance with local standard operating procedures. Clients/clients will not be “tied over” or placed on “close observation”, until they can see the far-site provider.⁶⁶
74. Network Providers **shall** ensure the clinical record includes a signed form for informed consent to participate in TBH services and shall ensure that the form is completed in a manner that ensures informed consent is achieved with deaf and hard of hearing clients.⁶⁷
75. The following additional information shall be included in the clinical records when the TBH is provided to deaf and hard of hearing clients:⁶⁸
- Hearing status – deaf, hard of hearing, late deafened, etc.;
 - Use of personal hearing assistive technology (hearing aids, cochlear implants, etc.);
 - Preferred method of communication, including language and hearing assistive technology needs;
 - Preferred language for visual or spoken communication;
 - Preferred language for written materials;
 - All signed, spoken, and written languages used, including if the deaf or hard of hearing client does not use sign language;
 - Presence of interpreters/communication service providers during any service delivery;
 - Preferred interpreter/communication service provider;
 - Any incidents where interpreters/communication service providers or assistive technology were not available;
 - Preferred method(s) of remote contact; and
 - Communication method used to secure informed consent.
76. Network Providers **will** consider that emergency evaluation and remote assessment for seclusion and restraint through TBH may be preferable for Deaf clients if culturally and linguistically competent providers are not available at the originating site.⁶⁹
77. Network Providers **shall** provide TBH services with deaf clients in rooms with a visual signaling system for doors.⁷⁰
78. Network Providers **shall** be prepared to use additional technology to improve visual quality of the TBH session when clients use sign language as their primary language, including high bandwidth, high resolution, larger screen size, and cameras and camera angles that show both the provider and client from the chest up.⁷¹

79. Network Providers **shall** access remote interpreters for deaf clients as a last resort. When remote interpreters are used, Network Providers **shall** ensure communication access through interpreters follows all relevant standards from the Daylight Standards of Care.⁷²
80. Network Providers **shall** be prepared to use additional technology when either the client or provider is hard of hearing, including high bandwidth, hearing assistive technology, and equipment that has audio at 7 kHz full duplex with echo cancellation and easy to use volume adjustment.⁷³
81. Network Providers **shall** use high quality microphones and assess microphone placement and room acoustics prior to use in sessions. Recommendations to improve room acoustics include carpeting, soft furniture, acoustical treatments, or other sound absorbing characteristics.⁷⁴

Geriatric

82. Network Providers **shall** be prepared to use additional technology to help with visual and auditory impairment including large monitors, high bandwidth, and high resolution.⁷⁵
83. Network Providers **will** consider including family members as clinically appropriate and with permission of the client.⁷⁶
84. Network Providers **will** adapt interviewing techniques for clients who may be cognitively impaired or find it difficult to adapt to the technology.⁷⁷

Children

TBH is appropriate for services to children and generally has very positive outcomes, particularly when the child has “good verbal skills and is not aggressive, severely oppositional, or otherwise dysregulated.”⁷⁸

85. Network Providers **shall** inform families during scheduling to prepare their children for the TBH appointment.⁷⁹
86. Network Providers **shall** ensure remote camera control is available to allow the provider to view and observe children as they move about the room.⁸⁰
87. Network Providers **shall** ensure the room is of sufficient size to include a child or youth, a parent, and one or two other individuals, with space for the child to move about the room, play, and separate from the parent(s).⁸¹
88. Network Providers **shall** provide a table in the TBH room for the child to draw or play, but the table should not interfere with communication.⁸²
89. Network Providers **will** only provide play therapy through TBH when carefully planned adaptations are agreed upon by the originating and far sites, including a staff member on site with the child, to improve understanding of the child’s level of attunement, pleasure in interactions, and spontaneity in play.⁸³

Rural Populations

90. Clinicians working with clients from rural or frontier issues **shall** be aware of issues unique to working with rural populations via TBH:⁸⁴
- Clinicians **shall** discuss firearm ownership, safety, sanctioned use of firearms and meaning of firearms to clients in rural areas. Clinicians **shall** be prepared to negotiate with clients over firearm disposition, and consider involvement of clients' families as appropriate.
 - Clinicians **shall** be sensitive of impact of disclosures made during emergency management on client confidentiality and relationships in small communities.
 - Clinicians **shall** consider including families in emergency treatment situations where possible and clinically appropriate, while also assessing and be attentive to exacerbation of family tensions in small communities.
 - Clinicians **shall** assess substance issues, be familiar with local resources for substance use assessment and treatment, and be prepared to play a more active role in substance use treatment.

RESOURCES

- Spark Policy Institute (2010). *Standards of care for serving deaf and hard of hearing clients*. Denver, CO: Daylight Partnership, Mental Health Center of Denver, and Colorado Commission for the Deaf and Hard of Hearing.
- Yellowlees, Peter, Jay Shore, and Lisa Roberts (2009). *Practice Guidelines for Videoconferencing-Based Telemental Health*. American Telemedicine Association.
- Belz, Norbert, Leslie Bennet, Lisa Carnahan, Veronica Decker, Brian Grady, et al. (2009). *Evidence-Based Practices for Telemental Health*. American Telemedicine Association.
- (year unknown). *Maryland Telemental Health, Kent County Protocols*. Part of the telemental health site developed by Dr. Brian Grady, Co-Chair of the American Telemedicine Association's Telemental Health Standards and Guidelines Working Group.
<http://www.telementalhealth.info/>
- Northern Arizona Regional Behavioral Health Authority. (Revised 2010). *Clinical Telemedicine Services, Provider Manual*. Arizona Department of Health Services, Division of Behavioral Health Services.

ENDNOTES

-
- ¹ Adapted from the Northern Arizona Regional Behavioral Health Authority protocol.
 - ² Loosely based off the Northern Arizona Regional Behavioral Health Authority protocol with some additional information added from the Maryland Telehealth Network Kent County protocols.
 - ³ From the Maryland Telehealth Network Kent County protocols.
 - ⁴ Developed in response to feedback from the Mental Health Center of Denver
 - ⁵ From the Maryland Telehealth Network Kent County protocols.
 - ⁶ Adapted from the Maryland Telehealth Network Kent County protocols.
 - ⁷ From the Northern Arizona Regional Behavioral Health Authority protocol, that comes with a specific form that is not referenced here. Also used language around verbal consent from the Maryland Telehealth Network Kent County protocols.
 - ⁸ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 7
 - ⁹ From the Northern Arizona Regional Behavioral Health Authority protocol.
 - ¹⁰ Adapted from ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 10
 - ¹¹ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 11, and Northern Arizona Regional Behavioral Health Authority protocol.
 - ¹² Adapted from the Maryland Telehealth Network Kent County protocols.
 - ¹³ Adapted from the Maryland Telehealth Network Kent County protocols.
 - ¹⁴ Adapted from Maryland Telehealth Network Kent County protocols – general lack of examples of requirements associated with equipment failure in the other protocols/best practice materials.
 - ¹⁵ Adapted from Maryland Telehealth Network Kent County protocols - general lack of examples of requirements associated with equipment failure in the other protocols/best practice materials.

*Daylight Partnership Telebehavioral Health Protocols for Colorado
(including protocols for serving deaf and hard of hearing clients)*

- ¹⁶ Adapted from the Northern Arizona Regional Behavioral Health Authority protocol.
- ¹⁷ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9
- ¹⁸ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9 and ATA's Evidence-Based Practices for Telemental Health, p. 11
- ¹⁹ From the Maryland Telehealth Network Kent County protocols.
- ²⁰ Loosely adapted from the Maryland Telehealth Network Kent County protocols and Northern Arizona Regional Behavioral Health Authority protocol..
- ²¹ From the Maryland Telehealth Network Kent County protocols.
- ²² Adapted from Maryland Telehealth Network Kent County protocols and specific types of information listed in the ATA's Evidence-Based Practices for Telemental Health, p. 12
- ²³ Adapted from Maryland Telehealth Network Kent County protocols
- ²⁴ Drawn from the Northern Arizona Regional Behavioral Health Authority protocol, which has each organization participating develop their own policies and procedures that go beyond the shared ones.
- ²⁵ Developed in response to feedback from the Mental Health Center of Denver
- ²⁶ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 8
- ²⁷ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 8
- ²⁸ The ATA's Evidence-Based Practices for Telemental Health states, p. 12: "It appears that VTC neuropsychological assessment is possible and often valid. However, it is recommended that research begin to develop new norms so that the thresholds used for impairment are valid when compared with face-to-face administration. Until this is accomplished, remote neuropsychological assessment will be able to provide a broad indication of areas of impairment, but may lack the same degree of resolution that face-to-face assessment provides." For this reason, these Protocols are recommending that cognitive testing be done in person whenever possible. This does not follow the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 12, which suggest that cognitive testing can be done, though with caution, through TBH.
- ²⁹ Appropriateness from ATA's Evidence-Based Practices for Telemental Health, p.19.
- ³⁰ Loosely based on both the Northern Arizona Regional Behavioral Health Authority protocol and the Maryland Telehealth Network Kent County protocols.
- ³¹ Adapted from the Northern Arizona Regional Behavioral Health Authority protocol.
- ³² From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 13
- ³³ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 12.
- ³⁴ From the Maryland Telehealth Network Kent County protocols.
- ³⁵ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 14
- ³⁶ This protocol is not adapted from the literature. It is a recommendation from Mental Health Center of Denver quality assurance staff.
- ³⁷ Adapted from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 14
- ³⁸ Adapted from the Maryland Telehealth Network Kent County protocols.
- ³⁹ From the Maryland Telehealth Network Kent County protocols.
- ⁴⁰ Loosely adapted from the Northern Arizona Regional Behavioral Health Authority protocol. Arizona has a formal process in place for assessing quality of connection and equipment. Updated to match ATA's Practice Guidelines for Videoconferencing-Based Telemental Health's language.
- ⁴¹ Loosely adapted from the Northern Arizona Regional Behavioral Health Authority protocol. Again, their system is more formally designed and so their guidelines are more specific. Updated to match ATA's Practice Guidelines for Videoconferencing-Based Telemental Health's language.
- ⁴² Adapted from ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19
- ⁴³ Adapted from Guidelines, p. 19
- ⁴⁴ Verbatim from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19

*Daylight Partnership Telebehavioral Health Protocols for Colorado
(including protocols for serving deaf and hard of hearing clients)*

- ⁴⁵ Verbatim from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19
- ⁴⁶ Adapted from the Northern Arizona Regional Behavioral Health Authority protocol minimum, which exceed recommendations of the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, but adapted for deaf and hard of hearing clients.
- ⁴⁷ Adapted from ATA's Evidence-Based Practices for Telemental Health, page 9
- ⁴⁸ Adapted from Northern Arizona Regional Behavioral Health Authority protocol.
- ⁴⁹ Adapted from ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 18
- ⁵⁰ Adapted from Northern Arizona Regional Behavioral Health Authority protocol, "Hardware may have pan/tilt/zoom capability and can be controlled by the far-site camera so that behavioral health providers can zoom in on clients as necessary."
- ⁵¹ From the ATA's Evidence-Based Practices for Telemental Health, page 9
- ⁵² From the Northern Arizona Regional Behavioral Health Authority protocol.
- ⁵³ From the Northern Arizona Regional Behavioral Health Authority protocol.
- ⁵⁴ From the Northern Arizona Regional Behavioral Health Authority protocol.
- ⁵⁵ From the ATA's Evidence-Based Practices for Telemental Health, page 9, but added the visual/auditory privacy, based on the Maryland Telehealth Network Kent County protocol, and added language from the Daylight Standards of Care.
- ⁵⁶ Shortened version of the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19, enhanced with language from the Daylight Standards of Care.
- ⁵⁷ Adapted from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 18 and ATA's Evidence-Based Practices for Telemental Health, page 9, Maryland Telehealth Network Kent County protocols, and on Northern Arizona Regional Behavioral Health Authority protocol.
- ⁵⁸ Directly from the ATA's Evidence-Based Practices for Telemental Health, p. 9.
- ⁵⁹ From Northern Arizona Regional Behavioral Health Authority protocol.
- ⁶⁰ From the ATA's Evidence-Based Practices for Telemental Health, p. 10.
- ⁶¹ From the ATA's Evidence-Based Practices for Telemental Health, p. 10.
- ⁶² Verbatim from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 19-20
- ⁶³ From the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 9
- ⁶⁴ From the Maryland Telehealth Network Kent County protocols.
- ⁶⁵ From the Northern Arizona Regional Behavioral Health Authority protocol, combined with Daylight Standards of Care.
- ⁶⁶ From the Maryland Telehealth Network Kent County protocols, adapted to deaf and hard of hearing clients.
- ⁶⁷ From the Northern Arizona Regional Behavioral Health Authority protocol combined with Daylight Standards of Care drawn from multiple sources.
- ⁶⁸ From the Daylight Standards of Care.
- ⁶⁹ Appropriateness from ATA's Evidence-Based Practices for Telemental Health, p.19, desirability from Daylight Standards of Care requirements around testing/evaluation by competent providers.
- ⁷⁰ From the Daylight Standards of Care.
- ⁷¹ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 9 and ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15 reference to geriatric with discussion on auditory impairment.
- ⁷² Reference to the Daylight Standards of Care, with remote interpreting as a last resort due to Daylight Evaluation findings regarding client preferences.
- ⁷³ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 9 and ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15-16 reference to geriatric with discussion on auditory impairment.

- ⁷⁴ Adapted from the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 17, related to the quality of equipment.
- ⁷⁵ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 9 and ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁷⁶ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 9 and ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁷⁷ Adapted from ATA's Evidence-Based Practices for Telemental Health, p. 9 and ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁷⁸ Directly from ATA's Evidence-Based Practices for Telemental Health, p. 16
- ⁷⁹ Adapted from the ATA's Evidence-Based Practices for Telemental Health, p. 16 - 18 and the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁸⁰ Adapted from the ATA's Evidence-Based Practices for Telemental Health, p. 16 - 18 and the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁸¹ Adapted from the ATA's Evidence-Based Practices for Telemental Health, p. 16 - 18 and the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁸² Adapted from the ATA's Evidence-Based Practices for Telemental Health, p. 16 - 18 and the ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, p. 15
- ⁸³ From the ATA's Evidence-Based Practices for Telemental Health, p. 16.
- ⁸⁴ Entire section taken verbatim from p. 12 Practice ATA's Practice Guidelines for Videoconferencing-Based Telemental Health.