August 30, 2019

Jane Pearson, PhD
National Institute of Mental Health (NIMH)
Notice Number: NOT-MH-19-030
Submitted electronically to ResearchRTF@mail.nih.gov

Re: Request for Information: Guidance on Current Clinical Experience in the Use of Telemental Health for Suicide Prevention in Emergency Department Settings

Dr. Pearson:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input on this Request for Information (RFI) for guidance on current clinical experience in the use of telemental health for suicide prevention in Emergency Department (ED) settings.

Informatics is the science of how to use data, information, and knowledge to improve human health and the delivery of health care services. AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers, public health experts, and educators who bring meaning to data, manage information, and generate new knowledge across the research and healthcare enterprise. AMIA members advance health and wellness by implementing and evaluating informatics interventions, innovations, and public policy across settings and patient populations, adding to our collective understanding of health in the 21st century through peer-reviewed journals and scientific meetings.

AMIA strongly supports additional research on whether telehealth can support initiatives related to important public health topics, such as suicide risk reduction and opioid overdose prevention. We believe that research on telehealth related to these topics must be rigorously designed to understand what aspects of the socio-technical system effect – positively or negatively – interventions delivered via telehealth.

We note that there are many challenges related to telehealth, including: usability/security of technology; safety protocols with appropriate backup for in-person health care; licensing of out-of-state providers; regulatory/liability issues; and payment considerations. These challenges are likely to be similar across settings. However, best practices for telehealth in ED settings may face unique challenges and should thus be specifically considered. The need to adhere to 42 CFR Part 2 for delivery of substance use treatment also presents challenges regardless of whether services are delivered in person or via telehealth.

Finally, we note that regardless of whether screening is done in person or via telehealth, the lack of availability and/or accessibility of mental health and substance use treatment services in the

community continues to be a major roadblock to providing patients with appropriate care and is essential to address.

Below are individual areas on which NIH requested information. We have included feedback from select AMIA members who are mental health professionals and have direct experience in this space.

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The nature of the telehealth service being used (telehealth company; hospital staff; contractors), and what contributed to the selection and implementation of those services; the characteristics of the ED with regard to urban/rural setting, health disparity populations reached, annual patient visits.	"In our region, both rural and urban EDs use telehealth tools for screening of ED psychiatry patients. These EDs use a robot which is rolled into the room and video services are used to follow up with the emergency doctor with recommendations." "Our academic center has a specialized psychiatric emergency service with 24/7 attending psychiatrists on site. We have discussed using telepsychiatry for ED consults at the outlying hospitals in our county that are more than a 60-minute drive away, but have not yet implemented it. We are starting to implement outpatient telepsychiatry, but it has been challenging with low volumes, significant technology challenges (e.g. patients have to be registered in our system and in our patient portal to use the telemedicine software), coordination with distant site (e.g. they have to be able to address any safety needs and medical needs of the patient) and reimbursement challenges/questions (e.g. it is still unclear if it will be cost-effective)."

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Information on the types of technologies used for ED telehealth consultation (e.g., close circuit video; telephone; app-based; asynchronous consultations, etc.)	"Synchronous video conferencing." "I have seen increasingly more text-based/app-based mental health services available (through startups), but I do not have personal experience with them. These do, however, raise issues of effectiveness (in cost and quality), as well as practical and ethical issues. For example, what happens if a patient is texting and indicates suicidal ideation/plans? Is it sufficient to text someone and say to go seek emergency care? There must be a balance between the 'something is better than nothing' approach to mental health services and doing what is clinically effective and safe for patient and population care." "We are using synchronous technology for our outpatient telehealth via [major EHR vendor] integrated solution."
Information on the approach used in the ED patients to identify suicide risk and associated risk factors across age groups (e.g., postpartum depression, multiple comorbidities including substance use and mental disorders). If multiple screening tools are used suicide, alcohol, and other drugs, describe the work flow and steps that follow a positive screen.	"Our personnel use multiple tools and workflow depends on clinical condition. A positive screen results in admission or transfer to a psych unit." "Screening varies by hospital. At our own facility, we have a standard question about thoughts of self-harm or harm to others that we ask all ED patients at triage, unless they are critical (e.g., cardiac arrest, bleeding out from trauma). We then ask about recent attempts. The nursing assessment also includes SBIRT screening questions for

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	alcohol, substance use, and depression. Steps following a positive screen depend on the question. For drug/alcohol screen positivity, we have a substance counselor who sees the patient, does a more detailed screen (DAST, AUDIT), and does brief intervention and/or referrals as appropriate. For suicide risk (by screening on PHQ9), the patient placed on 1:1 for current ideation. For risk overall, a psych consult is conducted, aided by our 24/7 in- house staff."
Within the work flow, what decision-making process guides when, and for which patients (e.g., age groups, race/ethnicity, minority or health disparity populations, socioeconomic status, geographic location, languages and interpreter services for those with low fluency in English) telehealth consultation is sought for suicide risk and overdose risk.	"We have telemedicine video and audio tools to deal with these barriers." "The American Psychiatric Association (APA) has info on their website including a telepsychiatry toolkit (https://www.psychiatry.org/psychiatrists/practice/telepsychiatry). We have several in-hospital Spanish-speaking interpreters and use language line interpreting otherwise. Our processes are otherwise equivalent across the population subgroups noted."

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Describe the nature of the consultation, such as provider-to-provider consultation; and/or direct contact between the consultant and the patient. Information on the types of practices delivered by telehealth consultation, such as screening, evaluation, triage, intervention, disposition. Describe information on the financing mechanisms for the telehealth consultation services, and location of the provider or health system that initiated the consultation (e.g., urban versus rural, medically underserved area)	"Consultations are usually a provider to a screener with a background in mental health screening. The screeners are sometimes licensed in social work and and/or counseling. Our hospital has a contract with these providers and the patient is billed for the screening. Case law requires "expert" screening, as the emergency physician is not protected as they were previously. This also increases costs." "I have heard of employee-based insurance including coverage for a limited number of mental health services (e.g. access to a clinical psychologist) that have a small copay, after which more sessions are paid by the individual. These can also be available through corporate health. Many tech companies, for example, have on-site services that are provided by contracted health systems or other health and wellness services (gym, personal trainer, wellness coaches, dieticians, etc). Employee Assistance Programs (EAPs) are also a common resource, but is more often a place to obtain more information about local services that an employee could go to, independent of insurance; EAPs are not insurance. Another consideration is telehealth licensing. A telehealth physician *must* have a license to practice in the state in which the patient resides. The Interstate Medical

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	Licensure Compact[1] has expanded the possibilities for physicians."
Include information on whether the telehealth consultation service been evaluated, and if so, what outcomes (e.g., repeat ED visits; hospitalization; other health care utilization; deaths) were examined, and over what period of time.	"While I am unaware of any evaluations of telehealth consultations with respect to clinical or process outcomes, I think there is considerable interest in this though because of the recognition that mental health services in general are in short supply for many reasons. Combined with recent data on rising U.S. suicide rates[2], there certainly appears to be a unique intersection of these various issues that has yet to be explored." "Most evaluation studies focus on patients' perspective. The evaluation aspects mainly include: experience, benefits on costs, care

[1] https://imlcc.org/
[2] https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm

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	processes and quality, accessibility, and technical sides.
Describe any pressing research questions about telehealth health services for suicide prevention and overdose risk reduction and prevention in the ED.	"I want to know if external mental health screening is truly more accurate than physician screening. I believe this is a costly, unnecessary delay. We also need outcome studies on whether ED intervention with the follow-up overdose provider (rather than just referral with a handout or phone number) leads to increased follow through by patients." "I think pressing contextual issues for the research questions are policy and liability issues. I suspect any individual clinician or institution would be concerned about doing what is safe for the patient and reduce liability as much as possible (i.e. what happens if the protocol has unintended consequences in the context of suicide prevention or overdose prevention? The outcome could be fatal.) I also think that the workflow and teamwork aspects of incorporating telehealth into these clinical areas are understudied, as well." Although there have been a few recent studies of ER based suicide screening and intervention, I do not think we have sufficient replication and real-world implementation/evaluation to say that these interventions actually reduce risk or that the reductions in risk are offset by the "opportunity costs." For example, if a

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	clinician is asking someone screening questions who is having an acute asthma attack, they should be focusing on their breathing. Safety planning is another example that sounds intuitively positive. We have implemented it in person in our psych ER, but to do it right can take 15+ minutes of staff time. Even then, when it is done in a rushed fashion, it is less likely to be helpful. It should be noted that suicide risk assessment is challenging to study because of the low base rate of suicide death, even in a high-risk population. Additionally, if someone is identified as being at high risk, we are obligated to intervene. While ethically essential, it may make it hard to draw conclusions about outcomes. In terms of outpatient referral/follow-up, almost all screening models presuppose that services are available if patients are identified as being in need. However, for mental health and substance use services, it is very difficult to get services for reasons that go well beyond the scope of this RFI. With a national shortage of mental health professionals and a particular shortage of those who accept insurance (Medicare Medicaid), identifying individuals in need of services is unlikely to be helpful if no services are available. Collaborative care/integrated care models with primary care are an important development, but those clinicians are also overwhelmed, in short supply, and not able to provide

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	specialized mental health/substance use services to those who need them." "There are wo research questions in this context: 1) how to identify the high-risk patients (either suicidal or SUD patients) more effectively not only in the ER, but in other care settings; 2) can telemedicine be used as additional ways to treat opioid use disorder? The reason for the first question is that the screening questions may miss some of the patients who "know" how to answer questions correctly. As for the second question, we need new ways to treat SUD more effectively."
Telehealth Services Perspective Questions	
Describe any pressing research questions about telehealth services for suicide prevention and overdose risk reduction and prevention in the ED.	"Assuming that interventions are effective in-person to reduce suicide and overdose risk, the main research question is whether the effect is comparable for in-person vs. telehealth delivered service. However, without knowing whether it is truly effective, we believe it is premature to conduct telehealth-only studies. For instance, if one compared telehealth to the current state and found no difference, there would be no way to know if it was a deficiency of telehealth or a deficiency in the original conceptualization that these interventions would be effective in reducing risk."

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We hope our comments are helpful as you gather more information in this important area. Should you have questions about these comments or require additional information, please contact Jeffery Smith, Vice President of Public Policy at jsmith@amia.org or (301) 657-1291. You may also reach out directly to our members who assisted in this response below. We look forward to continued partnership and dialogue.

Sincerely,

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President and CEO
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We wish to acknowledge the following AMIA Member Respondents:

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