Telejustice: Reaching Incarcerated Veterans via Telehealth

Peter Shore, PsyD

Telehealth offers a method to improve the efficiency of specialists in the Veterans Justice Outreach program and expands its delivery of associated services.

The mission of the veterans justice programs (VJPs), which began in 2007 with the initiation of Health Care for Reentry Veterans (HCRV) and expanded in 2009 to include Veterans Justice Outreach (VJO), is to prevent homelessness and provide justice-involved veterans with timely access to mental health and substance abuse services or other VA benefits.[1] About 50% of homeless veterans have a history with the criminal justice system, and about 10% of all individuals incarcerated in the U.S. are veterans.[2]

As the VA's use of telehealth services increases at non-VA settings, new opportunities emerge to reach veterans. One such population is incarcerated veterans, who can receive VJO and HCRV services. This article focuses primarily on the implementation of jail/prison outreach via clinical video telehealth (CVT) by VJO, which has already expanded to court liaison work (also provided by VJO) and may further expand to jail/prison outreach by HCRV. The article also describes the development and implementation of the VA's first telejustice program (TJP) at the VA Portland Health Care System (HCS) and briefly presents a second TJP at the VA New Jersey HCS Lyons Campus. Currently, there are about 15 known telejustice programs across the VA (Table 1).

Dr. Shore is the director of Telehealth at the VA Northwest Health Network (VISN 20) and an assistant professor of psychiatry at the Department of Psychiatry, Oregon Health and Science University, both in Portland, Oregon.

BACKGROUND

Overall, there were about 57,000 veterans seen in VJPs in fiscal year (FY) 2014, an estimated 11% increase over the previous year and an estimated 45% increase from FY12.[3] Until November 2012, incarcerated veterans were able to access VJO services only by a face-to-face visit with traveling VA providers. Clinical video telehealth, conducted between a patient and a provider through real-time two-way communication, is a viable option to help improve access to care. In FY14, there were about 248,000 unique veterans who used CVT technologies to access about 660,000 appointments.[4]

Telemental health (TMH) via clinic-based CVT was first implemented in the VA in 2003. To date, more than 500,000 TMH encounters have occurred. Clinical video telehealth into the home (CVT-IH), which is focused on nonclinic settings was implemented nationally by VHA telehealth services in February 2013. Utilization of CVT-IH has increased from about 1,300 veterans seen (about 6,900 visits) in FY12 to about 4,200 veterans seen (about 20,000 visits) in FY14.[4] Nationally, from June 2011 to April 2014, about 150 veterans received some form of VJO services via telehealth through a total of about 500 visits.

Each VAMC has a VJO specialist who serves as a liaison between the VA and law enforcement, court (particularly Veterans Treatment Courts and other collaborative treatment courts), and jails. About 225 VJO specialists provide a variety of services, including outreach, treatment matching/linkage assessment, court liaison and court team participation, and education/training to law enforcement on veteran-centric issues such as posttraumatic stress disorder (PTSD) and traumatic brain injury. Specialists spend significant time traveling to provide these jail/prison outreach services.

The VA Portland HCS specialist, a licensed clinical social worker, had been in contact with representatives at the Deschutes County Adult Jail in Oregon and had determined there were veterans who could benefit from VA services, but she was unable to make the 322-mile round-trip in 1 day to conduct her visits. She contacted Peter Shore, PsyD, in 2010, then a clinical psychologist at the same VA who was conducting home-based TMH visits, and inquired whether it

would be possible to see veterans in the jail via a webcam and personal computer. That was the start of the first VA telejustice program.

Portland Pilot

The VJO specialist at the VA Portland HCS initiated this project in early 2012. The Portland TJP used the same technology, staff, and approach that had been implemented in December 2009 through the Home-Based TMH (HBTMH) pilot. The HBTMH pilot (2009-2012), which predated the national CVT-IH program, included about 40 mental health care providers. It was the first VA pilot to successfully connect providers with veterans in their homes via Internet, webcam, and personal computer. During this period, about 250 veterans were seen in an estimated 750 clinical encounters. About 80% of those enrolled indicated they would not have received any mental health treatment were it not for the availability of HBMTH.

Table 1. Known Telejustice Programs at the VA as of June 2015

Specialist	VA Site	Domain	Function	Stage
Dungan	Indiana (Marion, Muncie, South Bend, Fort Wayne, Indianapolis) and Battle Creek, MI	Court, jail, VAMC, CBOC, VA domiciliary, VA SARRTP, VA PTSD	Veteran court appearances from residential programs Jail outreach Program screens Veteran court assessments	I
Skinner	White City, OR	Court	Appearances	I
Maddy	Portland, OR	Jail	Outreach Follow-up Program screens	I
Shore[a]	Portland, OR, and VISN 20	State prison	Mental health C&P	P
Kennedy & Danze	Palo Alto, CA, and VISN 21	State prison	Mental health C&P	P
Webb	Alexandria, VA, and VISN 16	State prison	Prison outreach	D
Correale	Lyons, NJ	Jail	Jail outreach	I
Lanners	Las Vegas, NV, and VISN 22	State prison	Prison outreach and mental health C&P	I
Luoma[a]	Dayton, OH, and VISN 10	State prison	Mental health C&P	I
Neidlinger	Edinburg, IN, and VISN 11	State prison	Prison outreach and mental health C&P	P
Sichman	Middletown & Montgomery County, OH, and VISN 10	Court	Veterans court population	P

Abbreviations: C&P, Compensation and Pension; CBOC, community-based outpatient clinic; D, development stage; I, implementation stage; P, planning stage; PTSD, posttraumatic stress disorder residential treatment; SARRTP, Substance Abuse Residential Rehabilitation Treatment Program.
[a]Not a veterans justice program specialist.

In May 2012, Dr. Shore was awarded a VHA Innovation grant through the VA Office for Innovation to expand the HBTMH pilot to VISN 20 via VHA Innovation 669. The Portland TJP was able to expedite implementation through the grant. In addition to continuing the mission of the HBTMH pilot to deliver behavioral health services into the homes of veterans, the Innovation 669 program was established to focus on the advancement of clinical video visits into a variety of non-VA settings, using alternative technologies, including iPads, netbooks, and alternatives to Cisco Jabber (San Jose, CA), the VA-approved videoconferencing software.

The Portland VJO specialist saw the first veteran on November 27, 2012. Through May 28, 2015, she has conducted 28 assessments with incarcerated veterans via CVT. Among the 28 individuals were 15 army, 11 navy, and 2 marine veterans aged 24 to 70 years (mean 49.6 y). All 28 veterans were identified as male and white (non-Hispanic). Fifty percent of the veterans seen had at least 1 service-connected disability, and all 28 veterans had at least 1 recorded mental health diagnosis (Tables 2 and 3) (Belinda Maddy, LCSW, written communication, June 9, 2015).

Many of the veterans enrolled in the Portland pilot were able to successfully access services at the VA for substance abuse treatment, PTSD treatment, other mental health services, and/or medical services (Belinda Maddy, LCSW, written communication, June 9, 2015). Like the

Table 2. VA Disability Ratings of Veterans in the Portland Pilot (n = 14)

Concurrent Disorders per Veteran	Service Connected, %
Schizoaffective disorder	100
PTSD, knee condition, neuralgia of ulnar nerve, limited motion of ankle	80
PTSD, scars	70
Arteriosclerotic heart disease, inflammation of sciatic nerve, diabetes	70
PTSD, cervical strain, tinnitus	60
PTSD, tinnitus	60
PTSD	50
Flat foot condition, superficial scars, cervical strain	50
Arteriosclerotic heart disease, diabetes	40
Intervertebral disc syndrome	20
Foot pain, limitation on motion finger	10
Lower leg condition, ventral hernia, flat foot, scars	10
Tinnitus[a]	10

Abbreviation: PTSD, posttraumatic stress disorder.
[a]This row represents 2 affected veterans.

HBTMH pilot, the Portland VJO pilot has also yielded numerous unexpected patient outcomes, including access to services otherwise not available, access to community resources, enrollment in VA services, and an increase in social connectedness.

"This saved my life," said one veteran in a testimonial. "Now I have a chance to get treatment instead of prison." Another veteran noted, "I need to not live in this area to be able to learn how to be sober. Going to a long-term treatment program will help me learn how to live sober so I can stay out of trouble."

New Jersey Pilot

Similar to the Portland pilot, the VA New Jersey HCS VJP specialist spearheaded the pilot and in June 2013 visited with the warden at the Mercer County Correction Center. In November 2014, a year and a half later and with numerous steps in between, a memorandum of understanding (MOU) and telehealth service agreement (TSA) were signed (Mark Correale, LICSW, written communication, June 10, 2015).

For documentation, the New Jersey specialist established a VA MOU and a TSA; whereas the Portland pilot used documentation specific to the Innovation 669 program (http://vaww.visn20.portal.va.gov/sites/clinical/TH/TeleJustice/SitePages/Home.aspx). From the outset, the specialist explored the CVT-IH model of using an Internet connection, Jabber software, and webcam. According to Mr. Correale (June 10, 2015), VA telehealth-issued webcams and Jabber video used on a VA campus did not work. In testing, it failed to provide synced video and audio but was successful after switching to the Cisco EX90 (San Jose, CA).

Mr. Correale was able to get access to desktop technology in the jail, where a stand-alone monitor was connected to a network inside the facility. As of June 2015, the New Jersey pilot has successfully made 9 videoconferencing connections in Monmouth County and has an additional signed MOU for Hudson County.

Mr. Correale (June 10, 2015) indicated, "Dialing into a web-based system from the VA would have been outside the traditional VA telehealth arrangement and was therefore not pursued further." This indicated that the web-based system used by the Portland VJO specialist may not be accepted at all VA facilities.

In the New Jersey pilot, a video-telephone booth was used, which had an EX90 desktop monitor and connection to the jail's network. The VA information technology (IT) personnel obtained contact numbers for videoconferencing locations within the New Jersey justice system through an arrangement with the New Jersey State Parole Board. The specialist coordinated with the correctional officers (COs) responsible for escorting veterans to the chosen locations regarding privacy and visit scheduling. The CO would escort the veteran to the video-telephone booth in the jail. For scheduling and completing the encounter, the specialist scheduled the appointment time in VISTA, as did the specialist in Portland.

DISCUSSION

A key element of the Portland pilot was autonomy. The pilot was implemented in the context of a VHA Innovation grant, which reduced a number of required approvals. Utilizing a web-based solution also eliminated significant technical obstacles. A peer technical consultant was on-call during each scheduled appointment and provided all technical support. The peer technical consultant, who had logged 2,500 hours of volunteer services in the HBTMH pilot and who worked full-time as a contractor in the Innovation 669 program, was a critical component to the success of

Table 3. Portland Pilot: Veterans' Primary Mental Health Diagnosis (n = 28)

Primary Mental Health Diagnosis	Veterans, %
Alcohol dependence	74
Posttraumatic stress disorder	35
Amphetamine dependence	17
Cannabis dependence	13
Anxiety NOS, depression NOS	9
Polysubstance dependence, cocaine dependence, nicotine dependence	4

Abbreviation: NOS, not otherwise specified.

the Portland pilot. The Portland pilot demonstrated an effective, simple, and cost-responsible clinical pathway to connect VA providers with incarcerated veterans through telehealth technologies.

The New Jersey pilot also demonstrated a feasible pathway to connect with incarcerated veterans, achieved through a different approach. The New Jersey pilot accessed incarcerated veterans through the correction center's internal videoconferencing system, whereas the Portland pilot used VA-approved software over the Internet.

In both cases, the driver for success was the VJO specialist. The New Jersey specialist, Mr. Correale (June 10, 2015) suggested, "It's helpful to find out what works locally and try to adapt the telehealth model that's already working." It is also important for the VJO specialist to get to know local and VISN telehealth staff, as they potentially could provide access to a variety of resources, including assistance with the TSA, locating appropriate equipment, etc. In both pilots, the specialists were very flexible in amending their protocols, documentation, and/or clinic times.

Although there is no national mandate to establish TJPs, there is support from VJO leadership for specialists to investigate the need in their local communities. Information contained in this article and supporting documentation and resources available on the Tele-Justice SharePoint site can provide an adequate starting point for any VJO specialist to initiate their own pilot. Communication through the various VJO listservs is also another mode of acquiring information for those interested in pursuing similar telejustice services.

Compensation and Pension (C&P) examinations for mental health provide a rich opportunity for further exploration. Much of the same operational guidance in this article may be applied to a C&P for mental health clinics. The only significant difference would be the referral source and how the encounter is charted.

PROGRAM LAUNCH

A successful telehealth program launch is achieved through distinct development, planning, and implementation stages. Embedded throughout the process are building good relationships, consistent and transparent communication, and coordination. Clinical services drive the need for telehealth; telehealth should not drive the need for clinical services.

A descriptive analysis was approved as a quality improvement project by the institutional review board of the VA Portland HCS. Using information from the 2 pilot projects, the intent is to furnish practical guidance for those developing a TJP. If there is anything the reader should take away from the following guide, it is that implementing a VA TJP is very possible.

Development

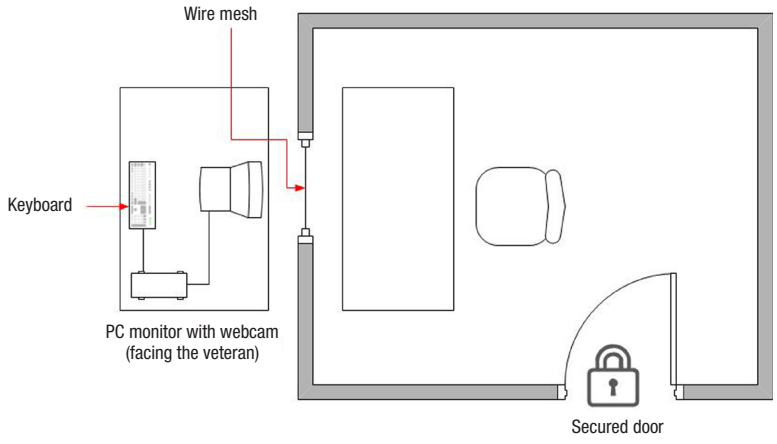
Identify the need. With every telehealth program comes a fundamental question: Is there a need to deliver clinical services from a distance? The need can be viewed in many ways, but at the core is access. Identifying a need can be any of the following: travel burden, a judge interested in addressing the increasing number of veterans on their docket, limited resources at the jail/prison for transporting veterans to court hearings, inability to identify a C&P examiner willing to see a veteran in a correctional facility, or a need for the VJP to increase the number of veterans served. In the New Jersey pilot, the local VJO specialist spent time with the New Jersey County Jail Wardens Association to describe how screening justice-involved veterans via telehealth may create more opportunities for veterans and positively impact recidivism.

Evaluate feasibility. Is there buy-in from local leadership and local telehealth personnel? Does the distant site (non-VA) administration agree to a telehealth program? Does the technology at the distant site permit a videoconferencing connection? Are there individuals at the court/jail/prison who can serve as points of contact to assist with a variety of tasks?

Planning

Coordinate with the local facility telehealth coordinator (FTC). All VAMCs have an FTC whose primary role is to implement telehealth programs at the facility. As with any relatively new initiative, the FTC may be unfamiliar with the feasibility of a TJP. It is important to work closely with the FTC to ensure all necessary steps are taken, consistent with national policy regarding telehealth in non-VA settings. For most, the national CVT-IH platform will be the logical approach to establishing a TJP.

Figure. Portland Pilot: Jail CVT Diagram



Abbreviations: CVT, clinical video telehealth; PC, personal computer.

In some instances, involvement with either the VISN telehealth program manager and/or the VISN behavioral health director may be recommended in addition to the VJP specialist's supervisor.

In general, the FTC will assist with all required documentation, establishment of a clinic, and ongoing technical support. The FTC may also provide needed guidance with logistics around technical specifications at the distant site.

Conduct a site visit. Meeting with administrative and technology decision makers at the site is an important part of the process and is an opportunity to alleviate any apprehension. They may want to hear more about how telehealth is used at the VA, telehealth research in general, and/or other active TJPs.

Identify a suitable space. There will be a variety of appointments that may be considered for the TJP. If the appointment is an encounter between the provider and veteran, it is recommended to find a space at the detention facility that is as private as possible. The law library, which has windows and a cage, was the designated space for the Portland pilot. The desktop computer and webcam were situated on the outside of the cage. The veteran entered the cage with the correctional officer, who established the Internet connection (Figure).

Identify a point of contact and staff at the distant site. As feasibility is evaluated, identifying a point of contact at the distant site is vital. During the site visit, it is important to meet with the point of contact to review any ongoing logistic issues. One or more staff members should be available to escort the veteran into the space where the telehealth appointment will occur. In some cases, a correctional officer will be on standby during the appointment to address any technical issues with the VA provider and/or in case of a medical or behavioral emergency. In most if not all cases, it is important for the staff member at the distant site to have telephone contact information for the VA provider and/or their respective technical support contact person.

Evaluate technology. Does the distant site facility have Internet access for the space under consideration? If it does, it is likely the FTC will follow the protocols outlined in the CVT-IH platform. Although Jabber is currently the only nationally accepted video teleconferencing software, VISN 20 has successfully used Vidyo (Hackensack, NJ) and VSee (Sunnyvale, CA) on iPads for VISN 20 mobile telehealth programs and is in the process to deploy alternative software solutions and iPads for all VISN 20 TJPs. If the jail/prison facility is open to discussing using their own videoconferencing technologies to bridge into the VA system, these efforts should be coordinated through the FTC. In some cases, the correctional facility will request a desktop computer or laptop with Internet access. The most common issue that prevents a program from being further developed is the lack of viable technology.

VA facility preparation. After the site visit is complete, the FTC should assist with the planning process. This will include identifying a telehealth clinical technician on the VA side and development of appropriate documentation and emergency management protocols. The planning package will also include a MOU between the local VA program leadership representatives and the institution/justice entity where the veteran is being served.

Emergency management protocols must include, at a minimum, a point of contact at the distant site and a contingency point of contact. Phone numbers for each should be acquired well in advance. At the beginning of each session, the provider should have access to those names and numbers in case an emergency arises during the session. At the same time, the VA provider should communicate the emergency protocols to the veteran receiving the services. In the event of an emergency, the provider should do whatever possible to remain connected via video with the veteran and call the distant site point of contact to

assist with the emergency. Importantly, participants should follow emergency protocols as outlined by the correctional facility. Readers may contact the author at shore@ohsu.edu for a copy of the Portland pilot emergency protocol.

A telehealth clinic will need to be built to capture workload. In most cases, this will be a CVT-IH clinic at the facility. Typically, the FTC will initiate the process with the facility clinical applications coordinator to establish the appropriate clinic build. As the program begins to take shape, an operations manual or practice guidelines will need to be created and updated regularly.

Implementation

After the setup documentation has been completed and before the first appointment, the technology support person and the distant site point of contact should be contacted to confirm the appointment and assist in establishing the Internet connection. (An implementation checklist is available at http://wp.me/p6jTLD-5.)

As the TJP grows, it will be important to evaluate and test the technology, technical support, staffing, and modifications to local protocols to ensure the safety and welfare of the veteran and the provider. Also consider whether the program will collect data and if so, what type.

The Portland pilot collected a variety of data sets, including provider and veteran perspectives on their experiences with the technology. The VHA Innovation 669 program used a brief technology impact questionnaire, designed to monitor how technology has impacted quality of care.[5] Data was collected iteratively and used in part to improve aspects of the program. This included both veteran and provider satisfaction, clinical outcomes, quality of life, and levels of occupational and social functioning.

CONCLUSION

Reaching incarcerated veterans sends an important message: The VA will go to great lengths to ensure that veterans have access to services to help ease the transition back into the community. Connecting with incarcerated veterans via telehealth takes the VA mission to a new level.

Given the wide array of technical solutions currently being used in correctional facilities, VA TJPs may benefit from exploring a consumer-based technology solution. However, one factor in expanding VA TJPs is that current telehealth systems rely on VA Office of Information and Technology resources that build systems within the VA network. There are privacy and security standards the VA adheres to in order to maintain a safe clinical video connection.

There are private sector companies that offer Internet-based access to secure video to connect physicians and mental health professionals. Given the significant variability in IT across correctional facilities, VA TJPs could expand their access into correctional facilities by deploying a web-based clinical video solution, similar to those currently available in the private sector. The technology already exists, and although taking this approach would need to be thoroughly vetted, it could significantly expand VA TJPs and eliminate several obstacles outlined in this article. ●

Acknowledgements

Joel Rosenthal, PhD, national training director for Veterans Justice Outreach programs, has provided enduring support to VJPs. To Linda Maddy, the Portland VJO specialist—Being the first to do anything in the VA takes courage and tenacity. To Mark Correale, the NJ VJO specialist, for his tireless efforts. A special thanks to the VHA Innovation 669 team: Chuck Brown, Kit Teague, Trevor Davis, Sean O'Connor, Tracy Dekelboum, and William "Bear" Cannon for providing ongoing support to the Portland telejustice providers and distant jail staff. Mary Lu is providing editorial and research support on this and other telehealth-related projects. This article is dedicated to justice-involved men and women who have served our nation and to those VA employees who dare to be disruptive in order to reach them.

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of Federal Practitioner, *Frontline Medical Communications Inc., the U.S. Government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*

REFERENCES

1. McGuire J, Clark S. *Veterans Justice Outreach Initiative (VJO)*. Washington, DC: Veterans Health Administration; 2009.
2. U.S. Department of Veterans Affairs. *Veterans Health Administration Fact Sheet. VA Services for Veterans Involved in the Justice System: VA's Veterans Justice Outreach Program*. Washington, DC: Veterans Health Administration; 2011.
3. Veterans Health Administration Support Service Center. *Homeless Services Briefing Book*. Veterans Affairs Intranet Website. http://vaww.fcdm.med.va.gov/pas/en/src/Proclarity.asp. Accessed June 8, 2015.
4. Veterans Health Administration Support Service Center. Virtual care and telehealth report. https://securereports2.vssc.med.va.gov/Reports/Pages/Folder.aspx?ViewMode=Detail. Accessed June 8, 2015.
5. Shore P, Davis T. Technology Impact Questionnaire (TIQ). http://wp.me/p2toog-1f. Published 2014. Accessed June 8, 2015.