Telepsychiatry for Vulnerable and Underserved Populations

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When timely psychiatric care or consultation is difficult or impossible to obtain, telepsychiatry may be an acceptable, economical, and effective alternative.

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Many patients or their referring physicians often find it difficult or impossible to obtain competent and timely psychiatric care or consultation. Although this is more common among rural cohorts, urban or inner-city residents may also have to wait weeks or even months for an appointment.\(^1\) Delivering care via telepsychiatry may be an acceptable, economical, and effective alternative. Telepsychiatry facilitates psychiatric care or education across distances using available technologies. The first scholarly publications about telemedicine were in telepsychiatry. For example, one report described a comparison of videoconference-delivered psychotherapy with face-to-face (FTF) care and found that therapist choice and group member selection were important predictors of outcomes, but the technique used (ie, FTF vs videoconference) had no significant effect on outcomes or patient satisfaction.\(^2\) Another reported its usefulness in bridging the gap between public sector and academic psychiatry by showing improved patient services at a state mental hospital as a result of increased academic medical center specialist availability through telemedicine in addition to enhanced research and administrative collaboration between the 2 facilities.\(^3\)

Reports of telemedicine used for psychiatry consultations emerged in the 1970s. One report described a consultative model in which a primary care provider briefly described his or her patient to a consulting psychiatrist followed by an interview with the consultant and a subsequent discussion of findings and recommendations with the consultee. This method had high patient and provider acceptance.\(^4\) Similarly favorable responses from psychiatrists and psychiatry residents were reported when the technique was used for psychiatry consultations from Massachusetts General Hospital to a distant medical station in Boston.\(^5\)

Is telepsychiatry effective?
An ongoing challenge for telemedicine is demonstrating its efficacy and/or equivalence to FTF care in large, well-controlled studies. However, many smaller telepsychiatry studies have shown its effectiveness, cost-saving potential, and acceptability.\(^6-9\) Moreover, there are increasing numbers of studies of its usefulness for performing diverse cognitive assessments from a distance. For example,
consider rural nursing home residents, a significantly underserved population with respect to access to timely psychiatric care. This group has higher rates of many mental disorders and psychiatric morbidity compared with their counterparts, due in large part to decreased access to care.

To address this deficiency, our group has provided telepsychiatry consultations for rural nursing home residents since 2002. The estimated potential cost and time savings for 278 individual telepsychiatry encounters was estimated to be as much as $253,040 and 843.5 hours, respectively. We successfully diagnosed and treated or managed many conditions, including depression, delirium, and dementia, and had high patient, family, and staff satisfaction. Most important, we provided a service that would not otherwise have been available.

Similarly, Southard and colleagues reported that telemedicine is an effective intervention for patients who presented to the emergency department of a rural hospital. Time data were analyzed for 212 days prior to a telemedicine intervention (n = 24) and for 184 days following the intervention (n = 38). The researchers found that mean and median times to consultation were reduced from 16.2 hours and 14.2 hours to 5.4 hours and 2.6 hours, respectively, and concluded that telemedicine promotes timely access to mental health evaluations.

A reliability study of telepsychiatry used to administer the Abnormal Involuntary Movement Scale examined 50 patients who had been exposed to antipsychotic medications for at least 10 years. No significant differences between the local and distant raters were found. The researchers concluded that it would be possible to perform a reliable neuropsychiatric assessment via telemedicine if primarily visual data were collected and analyzed.

Galusha-Glassock and colleagues found that the Repeatable Battery for the Assessment of Neuropsychological Status (RBRANS) could be administered via videoconference, with similar scores obtained when the RBRANS was administered FTF. A recent comprehensive review of more than 35 telemedicine interventions in mental disorders, which included many randomized clinical trials, examined feasibility, acceptance, efficacy, and cost savings and concluded there is considerable firsthand evidence supporting its use in patients with psychiatric conditions.

**Getting started**

Perhaps the single most important concept to keep in mind when starting a telepsychiatry program is scope. This is especially true for a clinician about to start a new program, who may have little or no experience with the instrumentation, how to troubleshoot, or whom to call for help. Therefore, as is true for medication dosing in the medically ill, start low and go slow. This is accomplished by starting off modestly, perhaps with a single videoconference apparatus in one’s office (ie, the “hub site”) and a few (ie, 1 to 3) apparatuses at a few remote (ie, “spoke sites”). The distant or hub site is the site at which the physician or other provider is located at the time a telemedicine service is provided; the spoke site is the location of the patient at the time the telemedicine service is provided—this is also called the “originating site.” Choose these sites based on several parameters including:

- True enthusiasm for telepsychiatry from colleagues at each spoke site
- Equally passionate support from administration and staff
- Ability/ease to make an onsite visit “just in case”

Start with a few patients with simpler conditions and work up to more complex cases as you become more comfortable with the equipment.

While most patients and clinicians readily accept telepsychiatry, some will be suspicious or dismissive of the technology or reluctant to use it. There are no specific patient or clinician types or psychiatric conditions for which this approach is contraindicated. Therefore, clinicians should use common sense when deciding for whom this approach is best suited and for whom another approach makes better sense. For example, a depressed veteran with PTSD might be a very good candidate for this technology; a paranoid, suspicious, highly agitated person with schizophrenia might not accept or like the technique.

The vast majority of telemedicine clinicians would agree that there is no patient type for whom a telemedicine approach is absolutely contraindicated. Most, if not all, patients and clinicians will accept the technology if it is well explained, privacy and confidentiality are ensured, and technical problems are acknowledged and managed quickly and efficiently.

Some important domains to consider when starting a telemedicine service include liability issues, licensure, reimbursement, and training. Many insurers do not automatically protect a clinician who delivers care via telemedicine. Before providing any care using this technology, make sure you inform your insurer or other appropriate personnel of your intentions. Request written documentation that you are appropriately covered.
Reimbursement concerns remain a significant impediment to more widespread use of telemedicine. Medicare will reimburse for services provided to rural originating sites but not to sites in urban or suburban locations. Private insurers may not reimburse unless compelled to do so by statute, although many have accepted telemedicine as a way to improve care and outcomes and to keep costs down. As is the case for FTF care, make sure you get pre-approval for your telemedicine services if required, and work with your patients and referring providers to increase insurer acceptance.

Moreover, clinicians who provide telepsychiatry must be licensed in the state where the patient is located when receiving that care. This location is (somewhat confusingly) called the originating site. For example, you will need a Florida license to treat your Vermont patient when he or she moves to Florida for the winter. Some exceptions may apply, such as in the case of a true emergency, but these are infrequent. Make sure you know what the licensure requirements are at the originating site and make sure your insurance covers you for out-of-state patients.

There are no specific telemedicine training programs as yet, although this is a major area of interest and exploration for the American Telemedicine Association, Telehealth Resource Centers (see Sidebar), academic medical centers, and telemedicine entrepreneurs. Most telemedicine training occurs by way of “mini-apprenticeships” using the “see one, do one, teach one” approach. Although this is far from standardized, most telemedicine users get up to speed pretty quickly—if you can use a cell phone and a television remote control, you can become proficient in telemedicine without too much trouble.

Telepsychiatry is a collaborative endeavor. To be successful, a telepsychiatry program requires support from and cooperation with many individuals and services, including physicians or other providers, nurses (especially nurse facilitators at the spoke site), hospital or health center administrators, referring providers, and family members. In addition, it requires significant patience, as the telepsychiatrist and his or her support team, consultees, and patients learn how to work together and adjust to the instrumentation. Telepsychiatry is in many ways as good as (or better than) FTF care, but it is different and the differences need to be acknowledged and managed competently.

Most telepsychiatry consultations are performed by a remote psychiatrist who consults on a patient at one of several sites including the patient’s home, a general hospital, a rehabilitation facility, a physician’s or another provider’s office, a community health center, or another venue equipped for telepsychiatry. Regardless of the site, understanding the minimal requirements for a successful and safe telepsychiatry encounter will help to ensure the best possible outcome.

Table 1 describes key telepsychiatry models that will help providers decide which approach best suits the needs of referring colleagues and patients. Table 2 presents some essential domains to consider for a successful telepsychiatry service.

**Conclusion**

Telepsychiatry has the potential to deliver competent psychiatric care to many who are vulnerable and/or underserved, including the very poor, rural citizens, inner-city persons, persons who are shy or avoidant, and those with disabilities who cannot travel far or who are homebound. Moreover, it is an interesting and satisfying approach to care delivery that stimulates providers to develop novel approaches to solve problems related to the equitable delivery of limited resources.

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Table 2 – Telepsychiatry essentials

Disclosures:

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References:


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