Advanced Topics in TeleMental Health

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Disclosures

- There are no financial or conflict of interest disclosures to report for
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TeleMental Health Programs within VHA

Overview of the TeleMental Health Services and the National TeleMental Health Center

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TeleMental Health Timeline

1959 – University of Nebraska – telemental health first documented¹

1968 – University of Nebraska connected to Omaha, Lincoln and Grand Island VA facilities²

1970 - Massachusetts General Hospital linked with Bedford VA for telemental health³

VHA TeleMental Health Services

- Funding provided in 1997
  - Almost 2.5 million encounters to over 400,000 Veterans
- Used to treat almost every DSM diagnosis
- Several treatment modalities
- Delivered by multiple mental health professionals
- Sites for care
  - VA Medical Center and Community Clinics
  - Homeless shelters
  - Supervised housing
  - Home
The National TeleMental Health Center (NTMHC)

- First national network of expert clinicians focused on complex, difficult to treat cases
  - Expert consultation and in depth clinical assessments
  - Extensive psychopharmacologic evaluations and recommendations
  - Specialized individual and group therapies
- Over 18,500 encounters for over 5000 Veterans
- 33 states and Okinawa, Japan
  - 155 program sites
- Satisfaction Data
  - >90% satisfied with telehealth service; prefer telehealth
## NTMHC Programs

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Referrals to the NTMHC through August 2016
NTMHC TeleSubstance Abuse Consult Service and VA Connecticut “Local” TeleBuprenorphine Program

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Overview

- Two Programs:
  - NTMHC Tele-substance Abuse Consult Service
    - Nationwide program, 3 time zones, coast to coast
  - VA Connecticut “local” tele-buprenorphine clinic
    - Within the CT system, from main facility to the second largest 40 miles away

- Highlight the structural and functional differences and the type of care provided
VA National Tele-Mental Health Center Tele-Addictions Consult Service

- Primary Goal: to increase access to specialized addiction care for veterans

- Additionally, to provide support for VA clinicians and make it easier for them to provide good care/better outcomes

- A longitudinal consult service; repeated video visits can be scheduled over 6 months

- Video and phone consultation can also be provided for the referring clinicians to discuss the case with an expert
What is it and how does it work?

- Addictions experts at Yale/West Haven VA conduct a thorough evaluation face-to-face with video teleconferencing
- History reviewed with chart and referring provider
- Consult service provides detailed advice on options for treatment (medications, psychotherapy etc.) and ongoing management
- Includes written treatment plan recommendations in medical record
- Control over management stays with referring provider, as does prescribing (final decisions)
What type of patient would be eligible

- Any patient with a substance use disorder (SUD) is eligible (very inclusive)

- Also those with co-occurring psychiatric illness (i.e., dual diagnosis) including PTSD, depression and SMI

- Co-occurring pain/addiction issues

- We have demonstrated these types of patient can be seen successfully via this program
Psychotherapy Component

- Brief individual psychotherapy program: 6-8 sessions of brief Motivational Enhancement Therapy (MET/MI) with CBT-coping skills

- Evidence-based treatments in a flexible format

- Optional for patients that want to participate
Outcomes

- Have seen 38 unique consults, 212 encounters

- 23 (60.5%) completed 3 or more encounters suggesting successful engagement

- Systematic review of telehealth/telemedicine- shows tele-substance abuse care comparable to in person care (Ohinmaa et al., 2010)

- New program so still working on incorporating outcomes measures
Local TeleBuprenorphine Clinic

- Differs from consult model; direct care, 1082 encounters of 71 unique veterans in 2 years
- Patients required to attend groups and individual counseling with on-site face-to-face support staff
- Support staff (nurses, counselors) act like case managers assigned to patients
- Patients required to submit routine breathalyzer and urine toxicology samples to staff
- Slightly lower volume than face-to-face clinic
Local TeleBuprenorphine Clinic - Format

• Meet briefly with tele-addictions doc video call

• Prescription given for 1-4 weeks depending on how they are doing, ordered at tele-site, dispensed by pharmacy at receiving site

• Weekly virtual rounds with team to discuss cases and changes needed to treatment plan

• Co-occurring disorders can be managed to some degree in same visit

• SMI cases need on site additional psychiatric services
Limitations/Specific Challenges For TeleSubstance Abuse Services

- Psychotherapy is fairly seamless- almost like in-person
- Can’t smell alcohol on breath
- Still have visual and verbal (slurred speech) cues to intoxication
- Must rely on others to gather toxicology and breath alcohol
TeleMental Health for Psychotic Disorders

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The VA National TeleMental Health Center Tele-Psychosis Program

OVERVIEW OF PROGRAM

• **Nationwide clinical consultative services** for Veterans with psychosis
• Consultation and psychotherapy all done through **videoconferencing at the VA**
• Mission: provide diagnostic evaluation, treatment recommendations, medication side effect management, and Cognitive Behavioral Therapy
• Evaluated nearly **150 Veterans**, over **475 visits** to date
  – broad age range: **20s-70s**
  – range of diagnoses and of illness severity:
    • schizophrenia, schizoaffective disorder
    • affective disorders, PTSD, personality disorders, substance use, **dementia**
    • many with **Serious Mental Illness** or **on disability** for psychosis
    • some on VA ‘**high risk**’ for suicide’ list or have history of aggression
Benefits of Videoconferencing for Psychosis

• Improves access to care, especially when patients and clinicians are far apart or patients have limited access to transit

• Our qualitative experience suggests rapport can be easier to establish with some patients with psychosis, who are at times paranoid and/or reluctant to be judged for conventionally stigmatizing symptoms

• Some patients more likely to reveal personal information about substance use and psychosis via videoconferencing:
  – “There’s no way I would have told you this if we were in the same room!” - patient with schizophrenia who admitted more substance use to us than to face-to-face provider
No Evidence that Videoconferencing Causes or Worsens Delusions

• Common concern among providers about clinical videoconferencing:
  – “My patients with schizophrenia will think the TV really is talking to them!”

• No evidence for this concern in the literature. Videoconferencing assessments are accurate and safe for psychosis

• No patient has reported this to us or been nervous to see us for that reason

• Patients with delusions that the TV insulted them and those with delusions that institutions used electrical means to communicate with them have tolerated appointments and been very agreeable to having continued videoconferencing appointments with us
Tips to Promote Thorough Videoconferencing Evaluation of Patient with Psychosis

• Few patients have been uncertain about their ability to use a computer, given their limited experience with it
  – We have shown patients the equipment and room ahead of time
  – Emphasize that no experience with computers is needed for participation

• To do movement for monitoring antipsychotic-induced movement disorders, ensure:
  – Field of view is large enough to observe patient from head to toe and allow patient to walk to assess gait
  – Room is large enough to assess gait
  – Ability to move camera and zoom in on fine movements of fingers and mouth is helpful for evaluation of tremors and tardive dyskinesia

• Large field of view also allows you to see what/who else is in the room
• Cannot use your sense of smell so need other ways to gather information about grooming, intoxication
Summary: Videoconferencing for Psychosis Treatment Safe and Beneficial

- Clinically equivalent to face-to-face encounters
- Can treat patients with delusions, history of suicidality or aggression, and serious mental illness
- Can do movement exams but adequate equipment and room for patient very helpful for this (large enough field of view and large enough room)
- No evidence that it worsens psychotic symptoms – is safe
- Some patients more at ease with videoconferencing than face-to-face encounters
- While telehealth is increasingly used, and it is safe and has great potential to be helpful in management and treatment of psychosis, evidence suggests it is still relatively underused for patients with psychosis

Advanced Topics in Telemental Health: Bipolar Disorder

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Bipolar Disorder in VHA

- Bipolar disorder is the single diagnosis most highly associated with completed suicide among Veterans\(^1\)
- Per year:
  - 100,000 Veterans seen
  - 2% suicide attempt rate
  - 24% of those treated hospitalized
- Medication adherence not adequate

Bipolar Disorder Telehealth (BDTH) Program

- Oct 2011: National, consultative program established
- Interdisciplinary team of experts in bipolar disorder
- 4 provider sites, 42 patient sites, 12 states, 3 time zones
- >1000 consults to date

- Core Components:
  - Psychopharmacologic evaluation
  - Evidence-based psychotherapeutic treatment: manualized self-management skills enhancement (Life Goals Collaborative Care (LGCC))
Collaborative Care Chronic Models (CCM)

- Randomized controlled trials show that collaborative chronic care models improve outcome in bipolar disorder

- Diffusion into clinical practice is limited by the need for patients and specialty providers in the same locale

- Clinical video-teleconferencing (CVT) may overcome these limitations
BDTH Outcomes – First 400 Consults

• CVT participation rates - similar to those of the facility-based face-to-face bipolar CCMs

• PREDICTORS OF PROGRAM PARTICIPATION:
  – CVT intakes: significantly more likely to be married; less likely to have been hospitalized (prior year)

  – LGCC completers vs. eligible non completers: No difference on any of the demographic characteristics analyzed

BDTH Outcomes – continued

• **CLINICAL IMPACT**
  – Improvements in mental quality of life as well as manic, depressive, and perceived conflict symptoms

• **PATIENT SAFETY**
  – No associations with lapses in patient safety.
  – Care model likely increased vigilance
  – Enhanced response $\implies$ lack of reduction in hospitalizations in the year before versus after consultation?

• **QUALITY OF CARE**
  – Improvements in quality of care indices were seen in the year after BDTH consultation
BDTH Outcomes - Conclusion

High risk & complex patients can be seen and benefit from specialty consultation services delivered via CVT
BDTH Clinical Experience: Lessons Learned

• Individuals are:
  – Receptive and comfortable with treatment via CVT
  – Eager for help, to learn more about their diagnosis and to change
  – May view diagnosis as a relief and/or may feel stigmatized

• With CVT:
  – Rapport can be established and maintained
  – Homework can be managed
  – Patients may disclose more or different information
  – Safety issues, though rare, can be managed and addressed
Coordination of Care

- Work with other providers (local or remote)

- Secure communication
  - Messaging (email and instant)
    - Including via patient health record (PHR) portal
    - Facsimile

- Read their progress notes

- Meet regularly, including via videoconferencing
Working with Population At Risk for Suicide using CVT

- Have emergency procedures and contacts available
  - Electronic and paper copies
  - **Calling 911 – may not work!**
- Patient in non-CVT (e.g. at home)
  - Get patient into a pipeline
  - Stabilize the patient while they wait for transport
- Patient in CVT
  - Assess for suicide risk
  - Intervene with psychotherapy and/or medications changes
  - As needed, coordinate warm hand off for risk assessment
Current Life Goals Resources

- **Group-Based (original)**
  - Structured Group Psychotherapy for Bipolar Disorders. The Life Goals Program; Springer, 1996 & 2003

- **Self-Guided Workbook: focus on modularity**
  - Overcoming Bipolar Disorder (New Harbinger, 2009)
  - 30 modules, 15-30 minutes each
  - Expanded content to address “unwanted co-travelers”: psychosis, co-morbidities, enhanced CBT for depression/anxiety

- **Web-Based Modular Delivery (in process)**

- **Life Goals Collaborative Care Website** www.lifegoalscc.com

- **Article**
Regulatory Topics in TeleMental Health

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Licensure Standards

- Federation of State Medical Boards supports the “interstate compact” licensure system
- The American Medical Association supports the existing state-based licensure system
- The 10th Amendment of the United States Constitution grants the individual states control over establishing and enforcing licensure requirements for health care professionals (Kramer and Luxton 2013)

http://www.theimaginativeconservative.org/wp-content/uploads/2012/05/tenth-amendment.png
Security and Privacy – HIPAA and HITECH

• A process demonstrating due diligence to protect patient privacy and data
  – Compliant technology vendor
  – Check relevant state privacy laws that may have more stringent privacy and security requirements

• The American Telemedicine Association has highlighted the importance of obtaining informed consent with patients in real-time (Yellowlees et al. 2010)
  – Confidentiality and limits to confidentiality when using electronic communications
  – Emergency plan
  – Documentation and storage of information
  – Potential for technical failure and procedures for coordination of care with other professionals
  – Protocol for contact between sessions
  – Conditions under which services are terminated and a referral for face-to-face care made (Kramer and Luxton 2013)
Procedures and Clinical Guidance - Pharmacotherapy

- Medications regulated by the Drug Enforcement Administration (DEA) can be prescribed consistent with methods used in traditional practice.

- Review the policies and medical practice laws for all sites involved.

- Ryan Haight Act, regarding controlled substances:
  - The Ryan Haight Act specifies whether an initial face to face visit is required by law before prescribing controlled substances.
    - Drug Enforcement Administration Final Rule implements this statute and defines telemedicine (Department of Justice 2009).
Emergency Care

• Emergency procedures should be established prior to initiating services and discussed with the site and patient at the initial encounter or as part of informed consent (Shore et al. 2007)
• Local civil commitment laws and duty to warn/protect requirements vary
• Know the local requirements, procedures, and phone numbers
  – Providers should identify procedures and staff at the patient site to involve in crisis situations
  – Providers should abide by state regulations at both the patient and provider sites
• Special issues with children:
  – Age of consent
  – Mandated reporting of child endangerment vary by state
Liability Issues

• Malpractice insurance carriers may cover such services
  – Not stated explicitly in a policy

• Potential TeleMental health providers should examine their policies and/or discuss coverage with their carrier
  – Coverage for patients physically located out of state
Massachusetts Specific Issues

Bill H.3650:

- SECTION 161. (a) The health policy commission shall implement a 1-year regional pilot program to further the development and utilization of telemedicine in the commonwealth.

  (b) At the conclusion of the pilot program, the commission shall evaluate the success of the program, including but not limited to: (i) cost savings; (ii) patient satisfaction; (iii) patient flow; and (iv) quality of care. The commission shall make appropriate policy recommendations to the joint committee on health care financing based on their findings.


Provision of Services Via Electronic Means

Originally adopted in March 2005
Updated October 2015

- In response to inquiries from licensees and other interested parties, the Board would like to share its current thinking with regard to provision of services via electronic means. The Board recognizes that this is an evolving practice issue, and its policy may be updated from time to time. However, there are some issues and policies that the Board believes are important to share, even as this area evolves. The Board believes that psychologists should recognize that as he or she loses the kind of direct contact with a patient/client that occurs in an in-person, face-to-face office, the psychologist incrementally loses much of the richness of interaction which, as any psychologist knows, comes with traditional face-to-face contact.
Additional Links and Resources

- American Telemedicine Association: www.americantelemed.org
- Center for Connected Health Policy: http://cchpca.org
- Center for Telehealth and e-Health Law: http://ctel.org/
- Telehealth Resource Centers: www.telehealthresourcecenter.org/
- Centers for Medicare and Medicaid Services: www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/index.html
- Patient-Protection and Affordable Care Act: http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html
Questions?