Telepsychiatry In Rural Nursing Homes

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I have no actual or potential conflict of interest in relation to this presentation
Scope of Problem: Severe Unmet Need

- Over 5,000 rural/HPSA SNFs
- 75% of rural counties have no psychiatrist
- According to CMS, one in five Medicare patients discharged from a hospital are readmitted within 30 days.
- 2004 National Nursing Home Survey found that 40% of nursing home resident ED visits in the past 90 days were potentially preventable
Scope of Problem (cont.)

- Older adults account for 12-24% of all ER visits
- ER personnel have limited geriatric training
- 5% of elderly patients present to the ER for psychiatric reasons
- Psychosis, agitation, depression, suicidality and substance abuse are the most common reasons for elderly ER visits, with dementia the most common diagnosis
Appeal of Telepsychiatry

- Diagnosis and Treatment Usually Don’t Require Physical Contact
- Ability to See Residents in Several Facilities in One Day
- Ability to Work in More Comfortable Surroundings
- Much More Efficient: No Driving, no Searching for Charts and Residents, Fewer Distractions
Key Differences for Clinicians

- Easier to Let Our Guard Down During Sessions
- Involves Many Elements of Office Practice
- Nurse or Social Worker Usually Present For Visit
- Multitasking Possible (ie Scrolling through Facility EHR While Seeing Resident Simultaneously)
Background and Case Example

- Mental status changes and behavior problems are two key conditions that may lead to ED visits and hospitalization.

- Distant site board-certified geriatric psychiatrist referred to see residents through a HIPAA compliant telehealth videoconferencing system.

- Nurse or social services director present for visits, with occasional participation of family members, CNAs, and others.

- Records reviewed through EMR, secure email and fax, including nursing notes, lab results, medical and previous records.
Psychiatrist connected through home office computer with web cam, echo-cancelling microphone, and cable modem

Hands-free, automated user interface at facility

Life-sized image of doctor to patient, who is escorted to room for virtual visit

Psychiatrist uses one of seven national telehealth codes for billing: G0425-7 for initial visit, G0406-8 for follow-up, G0459 for med management

Scheduling and connection monitoring done in background
Case I.S. Issues Presented

- Verbal agitation in dementia: repetitive vocalizations, anxiety, significant distress
- Importance of thoughtful psychopharmacology
- Importance of nonpharmacologic strategies
- Staff reassurance in light of regular psychiatric telehealth visits
95 y.o. ww female admitted to NH June 2014

7-8 year hx. progressive memory decline, now with mod-severe dementia

Reported history of anxiety and depression

Descriptors of behaviors: “continuous questioning/yelling out “miss, miss, help.” “Continuously requesting food, bathroom, self-propelling into other residents’ rooms”
Homemaker, worked on farm, born in rural PA

8th grade education, 1 son, husband died 17 years ago

No history of ETOH or smoking

No previous formal psych hx.

Living alone prior to admission
Past Medical History

- Congestive Heart Failure, Osteoarthritis, Peripheral Vascular Disease, Hyperlipidemia, Hypothyroidism, Dementia
- Admission meds: Metoprolol, Furosemide, Levothyroid, Potassium Chloride, MVI, Nitroglycerin, Oxycodone/Acetaminophen prn, Diphenhydramine 25 mg qhs
- NKDA
Exam (7/31/14)

- well-groomed, appears younger than 95
- Extremely preoccupied with requesting to go to bathroom
- affect highly anxious
- No anhedonia, feels well-treated by staff
- Oriented to person, not year, month or place; couldn’t recall any of 3 words in 2 minutes, couldn’t follow 3 step command, good naming of keys and pen
- No current aggression or delusions
Impression: moderate-severe dementia, severe anxiety/perseveration, no obvious psychosis or depression

Recommendations: check labs, discontinue diphenhydramine, add trazodone 25 mg po qhs, add buspirone 5 mg po bid

Recommendations: nonpharmacologic strategies critical: distraction, redirection, reassurance, music, etc.
Follow-up Visits

- Every other week follow-up visits until October 2014
- First follow-up visit pt. doing poorly: severely anxious, restless, repetitive; decision made to start venlafaxine xr, titrate buspirone
- Staff agreed to not send patient to ER due to reassurance of close follow-up
- Sept. 11 f/u: moderate improvement noted, states she’s “not worried,” less restless, less agitated per staff; further titration of venlafaxine and buspirone
- October 2 f/u: good visit with granddaughter, more focused and redirectable, enjoying music from Broadway musicals; oriented to city and state; no med changes recommended
Virtual vs. In-person Nursing Home Visits

- Advantages of virtual visits: controlled environment, staff present to assist, residents comfortable with technology, less stigma, convenience for provider, reassurance for staff

- Growing evidence base for teleneuropsychology

- Disadvantages of virtual visits: culture/physical environment of nursing homes less accessible, relationships with local providers more challenging to develop