

DSHS Grand Rounds

April 9

Telepsychiatry: Breaking Barriers

Presenter: Dr. Avrim Fishkind, president and CEO of JSA Health Telepsychiatry and past president of the American Association of Emergency Psychiatry



Logistics

Registration for free continuing education (CE) hours or certificate of attendance through TRAIN at:

<https://tx.train.org>

Streamlined registration
for individuals not requesting CE hours
or a certificate of attendance

1. webinar: <http://www.dshs.state.tx.us/grandrounds/webinar-no-CE.shtm>
2. live audience: sign in at the door

For registration questions, please contact Annette Lara,
CE.Service@dshs.state.tx.us

Logistics (cont.)

Slides and recorded webinar available at:

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Questions?

There will be a question and answer period at the end of the presentation. Remote sites can send in questions throughout the presentation by using the GoToWebinar chat box or email GrandRounds@dshs.state.tx.us.

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Disclosure to the Learner

Requirement of Learner

Participants requesting continuing education contact hours or a certificate of attendance must register in TRAIN, attend the entire session, and complete the online evaluation within two weeks of the presentation.

Commercial Support

This educational activity received no commercial support.

Disclosure

Dr. Fishkind has disclosed that he serves as CEO and CMO of JSA Health Telepsychiatry, LLC

The planning committee have no relevant financial relationships to disclose.

Off Label Use

There will be no discussion of off-label use during this presentation.

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David Lakey, MD
DSHS Commissioner
is pleased to introduce today's
DSHS Grand Rounds speakers

Telepsychiatry: Breaking Barriers



Avrim Fishkind, MD
President and CMO of JSA Health
Telepsychiatry and Past President
of the American Association of
Emergency Psychiatry



Telepsychiatry: Breaking Barriers

Avrim Fishkind, M.D.
April 9th, 2014
DSHS Grand Rounds
Austin, Texas

Disclosures

* CEO and CMO of
JSA Health Telepsychiatry, LLC

Objectives

- Describe the history of telepsychiatry.
- Analyze the literature regarding telepsychiatry and emergency telepsychiatry.
- Summarize the benefits of adding telepsychiatry to different clinical settings.
- Identify barriers that can be broken down by using telepsychiatry.

Arthur C. Clarke

“The only way of discovering the limits of the possible is to venture a little way past them into the impossible... and any sufficiently advanced technology is indistinguishable from magic.”

Essential Advantages in Healthcare Reform: Flexibility and Access

- * Psychiatrist: more adaptive and more flexible to the needs of the community
- * By providing services to people who can't access them:
 - * frontier
 - * rural
 - * medically underserved urban areas
 - * patients with physical disabilities impairing movement
 - * patients below the poverty line
 - * patients who are incarcerated
 - * Patients overseas (or on the seas !)

Essential Advantages in Healthcare Reform: Integrating Technology

- * Communication evolves – email, Skype, texting, all acceptable as face to face to more generations.
- * High definition communication becomes virtually indistinguishable to a face to face communication and acceptance is extraordinarily high.
- * For those who enjoy psychodynamics, transference and countertransference reactions don't go away (though may be attenuated).

Essential Advantages in Healthcare Reform: Managing Limited Psychiatric Availability

- * Telehealth makes it possible for community psychiatrists to work at multiple institutions in the same day, across hundreds if not thousands of miles
- * Community institutions who need limited psychiatrist time can better manage their money
- * Purchase amount needed... when needed... where needed.

Essential Advantages in Healthcare Reform: Psychiatrist as Consultant

- * Provide treatment planning, education, training, and clinical supervision
- * Bring together needed team members to form multidisciplinary teams... CSW, consulting psychiatrists, parents at work, child at school.
- * Integrated into community health clinics
- * ED consultation

History of Telemental Health

1956:

Cecil Wittson of the Nebraska Psychiatric Institute, in the journal *Mental Hospitals*:

- * one way
- * closed circuit television transmission for psychiatric training to students at the Medical College of Nebraska
- * Expanded to two way audio in 1957 and three other states

1964 - 1968:

NIMH funds Dartmouth Department of Psychiatry to see patients:

- * Rural affiliate hospital
- * Audio and video
- * Physician could operate equipment
- * Microwave relay

History of Telemental Health

1973:

Dwyer at Massachusetts General Hospital:

- * closed circuit television
- * “See the patient” at a local airport
- * First use of term telepsychiatry
- * First use of pan/tilt/zoom camera

Mid to late 70’s

Nebraska network expands:

- * Individual patients
- * Group Psychotherapy
- * Mid 80’s Medical College of Georgia
- * Mid 90’s UC DAVIS, UTMB – hundreds of sites

Telemedicine Technology and the Environment

- * One Way
- * Two Way
- * Fax
- * Email
- * Text
- * IM
- * Chat rooms and Forums
- * Social Journaling
- * Robots
- * Asynchronous Interviews

Telepsychiatry and Healthcare Reform: Questions

- * Which conditions can be successfully treated using telepsychiatry?
- * Under which circumstances would telepsychiatry be an inappropriate choice for the patient?
- * Sole or adjunctive form of treatment?
- * Lost connections, failure of data transmission (e.g., sound comes through, but video does not)
- * Role in integration of behavioral and physical health

More Concerns: Compensation & Reimbursement

- * Is telepsychiatry covered?
 - * Patient's health insurance
 - * Is coverage limited to clinicians licensed in the patient's state?
 - * Doctor's malpractice insurance
 - * Is coverage limited to states in which you are licensed? If so, should you warn your patients?
- * How much should you charge per session?
- * Who pays for startup/upgrade costs?

Effectiveness: Where

Community Mental Health Centers:

- Outpatient Clinics
- Day Treatment Programs
- Partial Hospital
- Psychosocial Rehabilitation Programs

Psychiatric Emergency Services:

- Psychiatric Emergency Rooms
- Mobile Crisis Teams
- Crisis Stabilization Units
- Crisis Residential / Respite Units
- Crisis Counseling Unit
- Walk-In Crisis Centers

General Hospitals:

- Emergency Departments
- Intensive Care Units
- Consultation-Liaison

Correctional Services:

- Jails
- Court Ordered Evaluation
- Juvenile Justice
- Restoration of Competency
- Halfway Houses

School Based Mental Health:

- Consultation-Liaison

Skilled Nursing Facilities:

- Nursing Homes
- Rehabilitation Facilities
- Assisted Living

State / Private Psychiatric Hospitals

State Mental Health Living Centers & Other:

- Airplanes, Cruise Ships
- Off Shore Oil Platforms
- Overseas Employees / Active Military

Effectiveness: Who

Physician:

- Med Management
- Laboratory

Nursing:

- Nurse guided (EPS)
- AIMS
- Rating Scales

Psychology /Social Work:

- Psychoeducation
- Individual
- Group
- Family
- Couples

Licensed Chemical Dependency Counselor:

- The use of licensed chemical dependency counselors via telehealth has shown some success

Effectiveness: Cost

Hyer 2003:

- * Reviewed 12 published studies on cost effectiveness
- * 7/12 were cost neutral or better
- * 1 study showed increased costs
- * Most studies showed declining costs and modestly higher break even points

History of Emergency Telepsychiatry

- * 1997: Meltzer - Telemedicine in Emergency Psychiatry
- * 2007: Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. *Gen Hosp Psychiatry*;29:199–206
- * 2008: Yellowlees, P., M. Burke, S. Marks, D. Hilty, and J. Shore. “Emergency Telepsychiatry.” *Journal of Telemedicine and Telecare* 14; 227– 281.

Literature Review: Emergency Telepsychiatry

Meltzer 1997:

ED Docs / Nurses; ED patients respond favorably to behavioral telemedicine if:

- * Speech and visual images are synchronized
- * Reliable equipment
- * Reliable psychiatrists
- * Timely response

Literature Review: Emergency Telepsychiatry

- * 2007: Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. *Gen Hosp Psychiatry*;29:199–206

Literature Review: Telepsychiatry Management Guidelines

Administrative Issues

- * Remote site assessment
 - * Choice of treatment models
- * Determination of role and responsibilities
- * Establishment of protocols

Literature Review: Telepsychiatry Management Guidelines

- * Survey of local resources
- * Local experiences with emergencies
- * System collaboration
- * Pathways for collaboration

Program Examples

- * ED Level: South Carolina DMH Telepsychiatry Program/ Seton Hospitals
- * Pre-ED: Burke Mental Health Emergency Center
- * Clinic: UTMB Rural Pediatric Pilot

South Carolina DMH Telepsychiatry Program

- * November 2007: \$3.8 million dollars from Duke Endowment
- * Goals:
 - * Statewide ED telepsychiatry consultation service
 - * Timely assessment
 - * Early initiation of treatment
 - * Reduction in lengths of stay
 - * Potential cost savings to hospitals
 - * Community discharge planning

South Carolina DMH Telepsychiatry Program

- * First ED March 2009
- * Ended 2010 with 19 participating hospitals; 3,436 consults
- * Ended 2011 with 23 participating hospitals and 9,224 consults
- * 2013: 12.3 consults per day (16 hours)

South Carolina DMH Telepsychiatry Program

Outcomes:

- * 33% reduction in hospital admissions
- * Decreases in response time, time to administer medications, an increase in successful discharge planning
- * Weekend lengths of stay decreased from nearly three days to six hours
- * Decreased commitments requiring less court time and expense, decreased use of police and judge involvement

South Carolina DMH Telepsychiatry Program

Outcomes:

- * USC Medical School determined:
 - * Medical cost savings of \$1700 per episode
 - * Significantly more likely to make it to aftercare
 - * Significantly less likely to return to the emergency room
- * APA Silver Award Winner in 2011
- * Now being implemented in North Carolina

Seton Family of Hospitals

- * 6 Austin, Texas hospital emergency departments
- * Staffed by telepsychiatry 5:30PM – 8AM Mon-Th
- * Staffed by telepsychiatry 5:30PM Fri – 8AM Mon
- * Full hospital wide implementation – all medical floors, ICU and ED covering adults and children
- * Includes Dell Children's Hospital
- * Capacity for consults and follow-ups

Seton Family of Hospitals

> 1400 Consults Since Inception

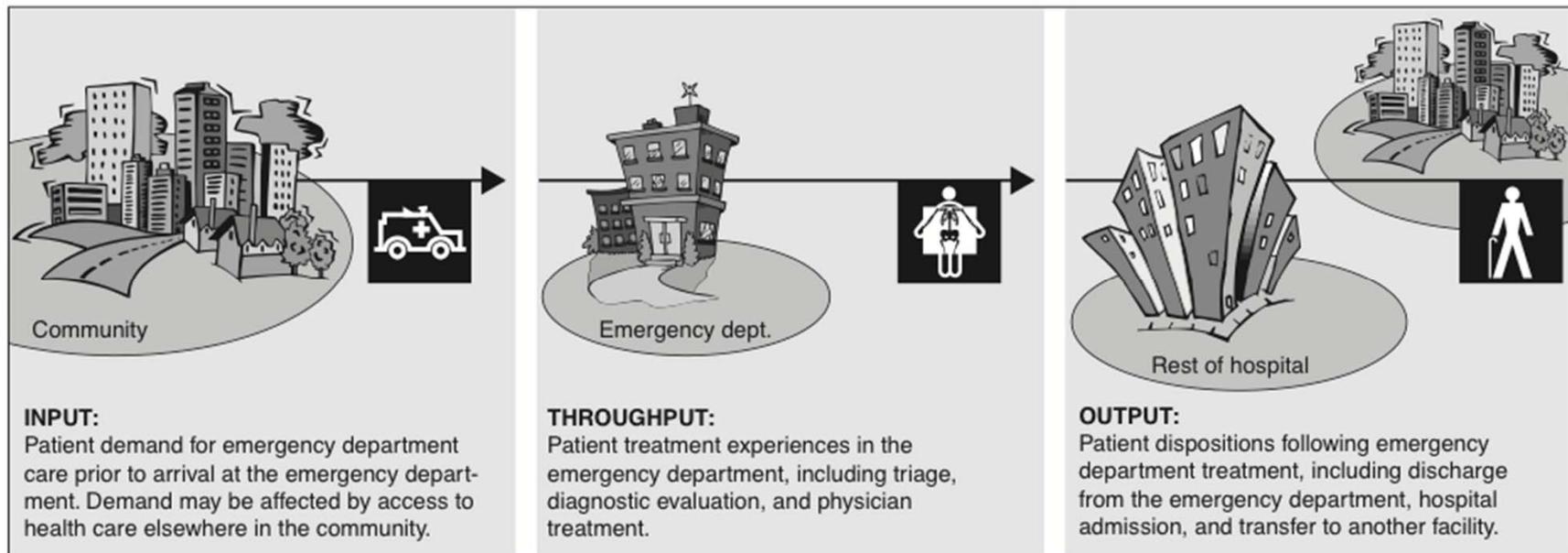
* Outcomes:

- * Physicians Very – Highly satisfied
- * Consumers Very – Highly satisfied
- * 32% reduction Cost/Case
- * 28% shortened LOS
- * Number of weekend holdovers = zero

ED Telepsychiatry: Healthcare Reform

- * Less Emergency Department Recidivism – important in accountable care including penalties
- * Less ED boarding time = less cost; risk management for suicidal and homicidal patients
- * Insurance: less ED cost, less hospital bed days, more use of outpatient preventative mechanisms
- * Hospital = decreased boarding and increased throughput; less sitter time, seclusion/restraint, injuries
- * Improved diversion from jail and other court/police related costs
- * Help psychiatric hospitals prevent returns
- * Patient Satisfaction = high, less coercive intervention and better access

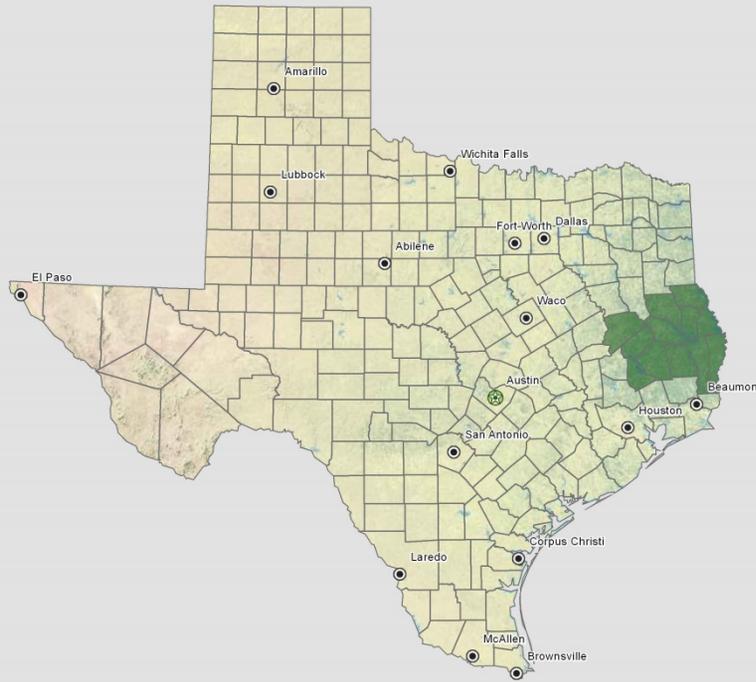
Emergency Telepsychiatry Benefits in the ED



Pre-ED: Burke Mental Health Emergency Center



Pre-ED: Burke Mental Health Emergency Center



Burke Center

- Based in Lufkin, Texas
- 12 Counties
- 11,000 square miles
- Population = 370,000

Pre-ED: Burke Mental Health Emergency Center

- * Funding cuts
- * Rising costs
- * > 20% uninsured
- * System at capacity
- * Medically underserved area
- * Health care professional shortage
- * Law enforcement challenges
- * Mental health care professional shortage
- * No other comprehensive providers
- * Lost 84 inpatient beds 1996-2001
- * No money, no ride

Pre-ED: Burke Mental Health Emergency Center

- * Not a hospital
- * Psychiatric care exclusively provided through video teleconferencing
- * Non-coercive: no seclusion/restraint
- * Rapid stabilization and return home – definitive treatment
- * Secure Extended Observation Unit – 8 beds – up to 48 hour stay
- * Crisis Residential Unit – 16 beds – up 14 day stay
- * Average length of stay = 4 days
- * Mobile Crisis F/U to decrease recidivism and increase successful linkage to clinics

Pre-ED: Burke Mental Health Emergency Center: Outcomes

Outcomes:

- * Transferred to inpatient psychiatric care: 14%
- * Reduction in state hospital bed usage: 32%
- * 14% for medical clearance; 1.5 % post presentation to PES
- * > 85% decrease in use of ED
- * Over 5,000 persons served since opening
- * 88% of persons served felt they very or highly improved
- * 82% were satisfied or very satisfied with telepsychiatry

Pre-ED: Burke Mental Health Emergency Center: Outcomes

Outcomes:

- * 30 day recidivism: ~ 6 %
- * Cost Comparison:
 - * Avg State Hospital Stay: \$11,629
 - * MH Jail Stay: \$10,960
 - * ER Visit: \$1265
 - * MHEC Stay: \$2584

Pre-ED: Burke Mental Health Emergency Center: Using Emergency Telepsychiatrists

- * Overcomes need to have face-to-face psychiatrist available 24/7/365
- * Cost savings substantial versus keeping the MHEC manned with a psychiatrist at all times
- * Using trained emergency psychiatrists makes doing more complex crisis and medical interventions doable in house and prevents mandatory ED medical clearance
- * APA Gold Award, National Council of Behavioral Healthcare Innovation Award

Pre-ED Emergency Telepsychiatry

More to come:

- * Use of iPads in the field
- * Recovery Based Crisis Services
- * In Home Monitoring Post Discharge
- * On Demand Consults for Primary Care, Jails, Schools, Skilled Nursing Facilities during crisis episodes
- * Integration with Urgent Care Clinics
- * Integration with EMS

Clinic Care

UTMB Pediatric Clinic Pilot

- * UTMB Network for Children (UTNC) program was set up to especially target rural areas that had "patients with high mental health need." Because the participating pediatric psychiatric clinics had varying levels of technological capabilities, a secure "virtual portal" was created to make the exchange of patient medical records more efficient and to increase the ease of communication between the clinics.
- * 8000 children and adolescents participated in the UTNC program, and almost 12,000 clinical appointments were scheduled.
- * 530 of the participants' parents or caregivers filled out surveys to measure the impact of the UTNC program.

Clinic Care

UTMB Pediatric Clinic Pilot

- * 60% had significant decrease in symptoms (dramatic improvement)
- * No show rate pediatric Medicaid = 32% - Lower than national average of 42 – 72%
- * > 85% were quite satisfied
- * General agreement that access was improved (88.5%) and participants would use telepsychiatry again (89%)
- * > 50% reduction in participants using the ED for care



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Questions and Answers



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For those in the auditorium, please come to the microphone to ask your question.

Our Next Grand Rounds

April 16

Friends, Followers and Retweets: The Impact of Social Media on Patients and Providers

Presenter: Michelle Malizia, MA, Asso. Director, National Network of Libraries of Medicine, South Central Region, Houston Academy of Medicine-Texas Medical Center Library

