Fletcher Allen Health Care’s (FAHC) telepsychiatry program was developed in 2002 as a response to needs identified by the former medical director of the telemedicine program, Michael Ricci, MD. The FAHC telemedicine program, which has been in operation since the early 1990s, provides various telemedicine specialty services for patients in a wide catchment area including all of Vermont and upstate New York, as well as occasional telemedicine services internationally. Because the telemedicine program reaches so many patients and providers, the medical director became aware of psychiatrist shortages in many rural locations.

We decided to provide tele-psychiatric services to one of the most vulnerable and underserved populations, rural nursing home residents. Without our telepsychiatry program, most of these residents would never receive psychiatric care. We have served more than 300 individual patients, and more than 500 individual encounters have occurred.

Most patients receiving tele-psychiatry services have some degree of cognitive impairment. In addition, many have mood or anxiety disorders or some degree of acute confusion. Most consultations are performed with family members present and they, in addition to their loved ones, appreciate the time and effort we put forth to perform these consultations and the obvious savings in both time and travel costs.

By performing psychiatry consultations from a distance, we are able to diagnose psychiatric conditions, treat them successfully, and improve the overall quality of life for this cohort. Moreover, by providing these consultations by videoconference we are able to significantly decrease the waiting time for a consultation, save patients and care providers time and travel expenses, and completely prevent the discomfort associated with transporting frail elders over long distances.

What circumstances moved you to develop this clinical service?

Some of the hospitals receiving FAHC telemedicine services in other specialty areas told us that many of their patients were not getting necessary psychiatric services. The hospitals
needed psychiatric consultations for their general medical and surgical patients, their emergency departments, and in some cases, for their affiliated nursing homes.

We decided to target nursing home residents because we felt they might be among the neediest of patient groups. In addition, I had years of experience treating elders as Director of the Psychiatry Consultation Service at FAHC.

How did you attempt to get buy-in for the project at your site and at the referring site(s)?

Buy-in was not a problem because it was a "seller’s market." That is, there were many programs/patients that needed psychiatry services and they were never enough providers available in local rural areas or who were willing to travel long distances to make "house calls."

What were the biggest hurdles to getting an agreement to go forward?

The biggest hurdle, but one that was easily negotiated, was getting a New York State medical license. Although there was no difficulty in obtaining a license, the application process took about nine months to complete. Other minor hurdles included getting appropriate privileges at the nursing homes and affiliated hospitals.

What convinced staff to participate?

It did not take much to convince staff to participate from my side as all staff participants came from the nursing home side of the videoconference participants. Nursing home administrators identified interested nurses and social workers and there have been no changes in telemedicine personnel due to dissatisfaction with the program.

What was your original design for the service?

Because most of the nursing home residents treated have some degree of cognitive impairment, it is imperative that a facilitating nurse be present at all times at the originating (i.e., patient) site. The nurse might leave the telemedicine room if a patient or family member requests more privacy; however, this has happened on very few occasions. In addition, a member of the social work services is almost always present to provide important and useful family information.

I have a three-hour slot for telepsychiatry consultations built into my schedule every other week. We schedule 60 minutes for new consultations and 30 minutes for follow-up consultations. My assistant manages scheduling, in consultation with the facilitating nurse or designated scheduler at the originating site. It is not uncommon for consultations to run longer than expected and we always build time into the schedule to accommodate such needs.
Prior to my first visit with any patient, I receive his or her initial and most recent completed Minimum Data Set (MDS), a complete list of medications, a complete medical problem list, and the most recent progress notes for review. These are currently sent via fax; the nursing homes to which I consult do not have a shared of electronic medical record with our facility.

What changes did you make to the original service design and why?

The original design works very well and we have not made many changes since the telepsychiatry program was started. We learned very early that many patients had vision and hearing problems that impacted their ability to participate in the consultation. In some cases we were able to overcome these difficulties by providing amplified headphones for the patients. We use 32” or larger monitors to lessen the impact of patients’ vision problems on their consultations.

What types of equipment / instruments do you use?

We use Polycom equipment at both the origination and provider sites. This in no way is meant to suggest a preference for this equipment. It simply is the consequence of a logical growth pattern of our telemedicine program that began with the use of Polycom equipment. We continue to use Polycom equipment when possible, to increase the likelihood that newer equipment will seamlessly interface with older equipment and that all apparatuses will "talk" effectively with each other.

When we began the telepsychiatry service several years ago we used ISDN@ 384 kbps for our interconnection path. In order to make the program more affordable, particularly for smaller institutions, we migrated to IP connectivity (512 kbps, or better if the local infrastructure allows). Most facilities now have some type of IP service that can be utilized for consultations, often cable or DSL service.

What are the sequential steps you go through for each case?

I try to review cases with the received information described above before I have a real visit with the patient. Time constraints do not always allow this to take place, however.

Following my personal review of the case, I meet with the nurse facilitator and social worker to learn about every new patient or to receive follow-up information about established patients without the patients present. Following this, I examine the patient and make recommendations to the patient and if present, to his or her family, at the same time making sure that the nurse facilitator and social worker understand and carry out my
recommendations. For some cases, they also meet with the nurse and social worker after the patient and his or her family are discharged.

What safety precautions are necessary for this particular specialty service?

Safety issues are of utmost important in mental health care. This is particularly true among nursing home residents who may harm themselves and attempt or commit suicide. Therefore, the nurse facilitator and social worker help to ensure patient safety at all times during the telemedicine encounter. In addition, each nursing home has built-in safety procedures that may be followed in my absence. Each nursing home knows how to reach me 24/7 if necessary. Regarding patient privacy, the telemedicine equipment we use has HIPAA-compliant encryption software.

How and where do you document the results of the consult?

I fill out a brief consultation form during and immediately after each patient visit. This is sent via fax to the patient's nursing home immediately after my consultation. A longer dictated note is sent within 48 hours.

What lessons have been learned from providing this service? What did not work well? What worked well? Biggest hurdles?

The biggest lesson I have learned is that many more patients and families like telemedicine than I had predicted. Of more than 200 individual patients seen, only a handful objected to our videoconference approach and an equally small number did not understand or appreciate the telemedicine condition; even many patients with cognitive impairments knew what we were doing.

The biggest hurdle to the use of telemedicine that I have encountered has been reluctance from some providers to accept this technology. Many feel that the approach is not as good as face-to-face contact with patients, even though they have never tried it or seen it in action.

What do you think has been the impact of this service?

The impact of the service is obvious. We have saved time, money, and in some cases, lives, as a consequence of our telepsychiatry consultations. Over the years we have seen patients with delirium due to medication misuse or overuse that was not recognized by nursing home personnel. In addition, many patients who were first thought to be demented and in need of behavioral interventions were found to be depressed; once appropriate antidepressant therapy was begun the behavioral problems resolved.
Families are also very happy with the service. They appreciate the instrumentation, the time, the personnel, and the attention to detail required for the telemedicine approach and virtually all families feel that their loved ones benefit from our care.