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Extending Telehealth to the Underserved

Editor's Note: *Long before telehealth finally broke widely into consumer markets, innovators in health delivery in Colorado were experimenting with ways to use technology to provide access to hard-to-reach places and hard-to-reach people. Douglas Novins, MD, is associate professor of psychiatry in the Centers for American Indian and Alaska Native Health and the Division of Child and Adolescent Psychiatry at the University of Colorado School of Medicine, and also head of psychiatry at Children's Hospital Colorado. At each of these places, Novins and colleagues for years have reached out through video connections to locations near and far in search of more humane and efficient care. We talked with Novins about how early telemental health efforts have evolved over the years.*



Douglas Novins, MD

What was the first video-health effort you were involved in?

We received funding at (the University of Colorado Anschutz Medical Campus) around the year 2000 from the U.S. Department of Agriculture, which had put out an ad for people to work on telemedicine and mental health in rural communities. The technology had gotten better, and it seemed feasible with their funding. It allowed us to buy these big, bulky CRT videoconferencing units, bundling six standard land lines and use them as a single pathway; with six lines you could get a decent – but not great – video connection. We did that to five tribal communities from our building at the Anschutz campus.

The services we started early on were a child mental health consultation to a hospital in South Dakota run by the Indian Health Service. They'd had 10 years of child psychiatrists working in the hospital as part of the federal pay-back-your-medical-school-loans program, but after that they couldn't get a new person to come there. So they'd built up a clinic of all these kids and a good reputation at the reservation they served. Then all of a sudden it was gone. They had a general psychiatrist, but they were not necessarily comfortable with certain age groups or needs. They also had a nurse practitioner who needed more support. So we started a consultation service. Families would come in struggling, and we'd do clinical sessions with the family and provider in the room, and a treatment plan – often one-time consultations. We did that program for about seven years. It was a two-way conversation.

Another early program was geriatric consultation to a hospital in Alaska. There we were focused on a pretty ill geriatric population, and there was not a lot of native mental health expertise at the time. They were consulting to internal medicine folks on people with complex neuropsychiatric cases, and that ran for a few years.

You've also pioneered some work with the U.S. Department of Veterans Affairs.

The one we've done with the VA is the biggest. It really took off. We started with service on one reservation in South Dakota. Now the VA runs it and it has six reservations: in Oklahoma, Arizona, Wyoming, Montana and Idaho. At those reservations, there's basically nothing for mental health services for Native Americans, and no expertise in veterans' mental health issues. So we do it around videoconferencing. A psychiatrist here does weekly clinics, supported at the remote location by a tribal representative who is a VA employee. That tribal representative is key on the other end – they help the veterans get their proper benefits. And a tribal outreach worker is the eyes and ears of the psychiatrist on the ground. It's a veteran who is well-respected and well-connected in the community, makes sure people are doing OK, lets people know about the clinic, encourages them to seek care. If they miss, (tribal outreach workers) go out and find them. That's been a critical component. The psychiatrist is doing the assessment, the clinical care, the psychotherapy and medication management, and doing it from a room at Anschutz.

Have you tried video health in the important area of substance abuse?

It's a relatively newer thing, started in about 2005 to 2006. There's a residential substance abuse facility in Alaska. We help the providers there with psychiatric assessments. And we help with medication management; we provide supervision and backup. We do like visiting in person if there is funding. Each psychiatrist involved from here has to get up there twice a year. We get to see about two-thirds of our patients in person at some point in their care. But meeting people in person in addition to the video is particularly important to establishing and maintaining

relations with the other providers and staff up there. We can provide stability – we're now the longest-serving members of that residential treatment program on the clinical side. We can provide that continuity, and institutional history, even 2,500 miles away. A lot of rural communities may get a provider that will move on in a couple of years. Sure, we get trained in cities and we like cities. That's where we want to stay. The chances of luring one of us to a rural community for 10 years or more is pretty low.

How has any of this work or experimentation translated to different kinds of health care consumers in Colorado, as the technology improves and the demand changes?

I took over as head of psychiatry at Children's Hospital a couple of years ago. We've been a little slower than I'd like, but there are a few things going on. So the first is an internal need: We now have a network of emergency and urgent care facilities across the Front Range. It's a network of care; as we open those facilities, people come in with their kids for a variety of issues, including kids in a mental health crisis. The standard practice before was put that kid in an ambulance and transport to the Aurora hospital to see an emergency psych staffer. It was very expensive, very inefficient and tough on families. After waiting where you first came and then the transport and then waiting in Aurora, it could take six to eight hours to be evaluated. Then there's a 50 percent chance you will go home anyway, and it's 12 hours later. Or we admit you and send you to the inpatient facility back to where you came from in Highlands Ranch. So early in 2015, we started doing them all by telemedicine. We get a call, we set up videoconferencing, and see the kid and the family by video wherever they have first come in for care, and figure out where they need to go. It's made care much more efficient, and in fact, families like it a lot, which was a concern by many in the hospital system.

Another thing we are working on right now – how can we support rural primary care facilities with pediatric mental health? We have a pilot program with a pediatric practice in Durango. We have a psychiatrist who is doing consultation with practitioners down there. It's grant-supported. Our child psychiatrist is both seeing the patient through video link and talking with the local provider.

Are there other areas that look promising with home telehealth services?

We are working on some telehome services. We have patients in highly specialized subsets like the eating disorder unit and autism spectrum disorders and intellectual disabilities with mental health crises. So how can we use that expertise to support kids when they go back home? Can we do telehome or have primary clinics host a clinic that we provide remotely?

When you began some of those efforts more than 15 years ago, did you expect video health would be happening faster?

In some ways, I've been very surprised how slow the uptake has been. For us, it has worked so well since we first started. The technology in 2000 was clunky, but the tech turns out to be the easy piece of it. More of it is the long distance – making that still work – and how you structure clinics. We were able to figure out those things very quickly, from our perspective – create effective and efficient services just as if we were there. There was a lot of resistance. Lots of questions whether it was equivalent to in-person care, privacy, technology. Things didn't really tip in the acceptable direction until about five years ago. It's still not moving as quickly as I think it could, at least in parts of the system. Diffusion of innovations in health care, it takes a long time – 15 to 20 years – for these things to get out. If I wear my research hat, that's what I'd say.

Overall, patients really like it. On average, they find it very convenient when you consider what they'd have to go through to see us face-to-face. We had patients coming up from La Junta to Denver for VA services. To not have to do that really long drive is a big change. People feel they can form a good relationship with us, and we feel the same way. Patients have been much more comfortable with this than I think providers have been. Resistance has come mainly from providers and their comfort with the program. In Alaska, once every 24 months or so, the patient really resists it and struggles getting comfortable with the video unit. But it's the rare exception now.

Have there been other challenges to video health that were a surprise?

There are still insurance reimbursement issues for some services. And there are also liability issues. What happens if you're working with a child and there's an emergency, and they're in a home 150 miles away and you don't have the backup you would if you were working with a pediatric practice? How do you plan for those kinds of contingencies?

Have you encountered any cultural differences with the communities you serve that have implications for long-distance telemedicine or telepsychiatry?

There are inherent cultural challenges in doing telemedicine. The biggest is that you've got urban providers giving service to a rural community they've never visited and may not understand very well. So they need to have a sense of the community and what's important there: the local calendar of events, what's coming up, visiting websites for local news, asking questions about what's going on in the community, knowing how important school settings are in a small

community – that kind of thing.

Any other lessons learned that you'd like to share?

Here's one thing people don't realize about telemedicine: Unless we change the way we practice, it's a zero-sum game. I spent two hours yesterday on my clinic to Alaska – that's two hours less of me practicing in Denver. That's redistribution, and it's good for rural areas. But if in child psychiatry we don't have enough people to take care of patients that are here in Denver, then you're not really changing things from a whole-population perspective. So a question is how can we use telemedicine to expand the number of providers? One answer is that I can use it to help other people who are providers, even if I'm not there.

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