

Focus Areas of Telehealth Advocacy

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PALs United for Movement Disorders Telehealth Webinar

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The COVID-19 Pandemic
brought dramatic changes to
interaction between health
care professionals and patients



Main Goal when Being an Advocate for Telehealth

Critics of Telehealth miss the point: The question is not whether in person medical care is better than telehealth. It is whether a telehealth visit is better than no visit at all.

Benefits of Telemedicine

- Comfort and convenience
- Family connections
- Get glimpses of patients lives
- Primary care and chronic condition management
- Control of infectious illness
- Reducing the financial impact of care for patients
- Geographically broadened access to expert care
- Continued care for patients even after they relocate
- Potential creation of a new field of healthcare: The Telehealth Screener

Potential Limitations of Telehealth in Behavioral Health

- Interstate licensure challenges and other regulatory issues that may vary by state
- Situations in which in-person visits are more appropriate due to urgency, underlying health conditions, or inability to perform an adequate physical exam
- The need to address sensitive topics, especially if there is patient discomfort or concern for privacy
- Limited access to technological devices (e.g., smartphone, tablet, computer) needed for a telehealth visit or connectivity issues
- Level of comfort with technology for HCP and patients
- Cultural acceptance of conducting virtual visits in lieu of in-person visits by HCP and patients. We are seeing there are some differences in different ethnicities

Tardive Dyskinesia and Telehealth

Our study showed how to improve assessments of TD via Telehealth:

- Key screening questions to ask via Telehealth
- Providing screening tools to families
- Training families how to complete Abnormal Involuntary Movement Scale
- Comfort with beginning treatment for TD

TeleSCOPE: A 2021 Clinician Survey on Telehealth Services to Detect and Treat Tardive Dyskinesia in the Psychiatry and Neurology Outpatient Setting

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ABSTRACT

Background: Tardive dyskinesia and drug-induced movement disorders (DIMS) negatively impact quality of life and should be monitored regularly in all patients taking antipsychotics or dopamine receptor blocking agents (DRBAs). The COVID-19 pandemic caused a rapid shift from in-person to telehealth visits, which presented several challenges, especially in monitoring and evaluating DIMOs in patients. The observational study, "Real-World Tele-Health Evaluation of Tardive Dyskinesia Symptoms Communication/Observation Procedure Evaluation in Outpatient Clinical Settings" (TeleSCOPE), compared video/telephone calls with in-person visits to determine their impact on assessment and management of DIMOs.

Methods: Online surveys were conducted (May 14–Jan 21, 2021) with clinicians (psychiatrists, neurologists, NPs/PAs) who met the following criteria: ≥3 years of practice with ≥70% of time spent in clinic; prescribed a vesicular monoamine transporter 2 inhibitor or benzotropine for DIMD in the past 6 months; and conducted telehealth visits with ≥15% of patients from Dec 2020–Jan 2021.

Results: Respondents included 277 clinicians (psychiatry=168, neurology=109). COVID-19 decreased in-person visits in psychiatry to 13% compared to 38% in neurology. However, phone and video visits increased in psychiatry to 28% and 49%, respectively, during peak COVID-19. In both specialties, clinicians mentioned by family (82%) and trouble with gait (82%) were the most reported signs/symptoms that drove DIMO evaluations. Remote management presented challenges as 45% of clinicians reported the inability to assess these signs/symptoms during phone visits and 23% for video visits. Most patients medicated with DRBAs were not evaluated for DIMOs during phone visits (psychiatry=76%, neurology=97%) compared to video visits (psychiatry=45%, neurology=10%).

However, nearly 40% of patients at community mental health clinics could not complete video visits due to technical difficulties or lack of computer access. Across all practices, presence of caregivers during phone visits reduced difficulty in evaluating DIMOs. Lower functioning patients and those with no caregiver present were at higher risk of missed diagnosis and the most difficult to monitor via telehealth. Limited access to a computer was the top factor limiting ability of clinicians to diagnose DIMO via telehealth.

Conclusion: The COVID-19 pandemic significantly reduced clinicians' ability to evaluate, diagnose, monitor, and treat DIMOs. Although in-person assessments have been the gold standard for managing DIMOs, telehealth services in 2022 will remain essential for providing post-pandemic clinical care for certain patients whereas appropriate. Our study highlights specific limitations and challenges and provides considerations to help clinicians better assess and manage DIMOs in the context of telehealth services.

INTRODUCTION

- Tardive dyskinesia (TD) is a potentially disabling movement disorder associated with prolonged exposure to antipsychotics and other dopamine receptor blocking agents (DRBAs)¹
- Schizophrenia treatment guidelines from the American Psychiatric Association recommend clinical assessments for TD at every visit in all patients taking a DRBA²
 - Structured assessment (eg. Abnormal Involuntary Movement Scale-AMS) every 12 months in all patients²
 - Every 6 months in patients with higher risk of TD (eg. ≥55 years of age)²
- Patients, family members, friends, and/or other supportive individuals can provide additional information about TD symptoms and their impact,³ which may be especially important during telehealth visits⁴
- Throughout the COVID-19 pandemic, patient management has rapidly shifted from primarily in-person visits to an increased emphasis on telehealth, which affects the identification, assessment, and treatment of TD and other drug-induced movement disorders (DIMOs)⁵

OBJECTIVE

An observational survey study, "Real-World Telehealth Evaluation of Tardive Dyskinesia Symptoms Communication/Observation Procedure Evaluation in Outpatient Clinical Settings" (TeleSCOPE), was conducted to better understand how this shift affected the evaluation of TD and other DIMOs.

STUDY DESIGN

- Physicians, nurse practitioners, and physician assistants in psychiatry or neurology who met the following criteria were invited to participate:
 - Had ≥3 years of clinical experience
 - Currently treating mostly adults (>80% of patients), with ≥70% of time spent seeing outpatients
 - Prescribed a vesicular monoamine transporter 2 (VMAT2) inhibitor or benzotropine for DIMOs at least once in the past 6 months
 - Conducted telehealth visits with ≥15% of their patients from December 2020 to January 2021
- Study participants completed a 20-minute online survey with items related to their clinical practice and their recent experiences with telehealth, particularly with regard to the assessment and treatment of DIMOs
- Responses were periodically checked for quality and analyzed with no imputation of missing data

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RESULTS

Clinician Characteristics and Visit Types

- Of the 277 responding clinicians, 168 (61%) were psychiatry specialists and 109 (39%) were neurology specialists
- Psychiatry specialists tended to have smaller practices than neurology specialists: psychiatry, 86% with >250 outpatients; neurology, 92% with >500 outpatients
- Psychiatry and neurology specialists reported spending 45% and 57% of their time, respectively, in private offices, with psychiatry specialists also spending 27% of their time in community mental health clinics vs 2% for neurology specialists
- Use of telehealth was more common in psychiatry than neurology before the COVID-19 pandemic, but use of telehealth visits increased during COVID-19 in both specialties (Figure 1)

Figure 1. Telehealth visits before and at peak COVID by clinician specialty

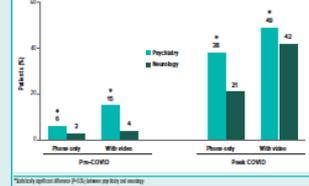


Table 1. Telehealth visits before and at peak COVID by clinician specialty

Patients Not Evaluated for DIMOs and Challenges of Assessment

- More than 2 out of 4 patients treated with DRBAs were not evaluated for DIMOs when the visit was limited to a phone call (Figure 2a)
- Evaluation, differential diagnosis, and monitoring of DIMOs via phone were all rated as somewhat/very difficult by 79% of responding clinicians (Figure 2b)

Figure 2a. Patients not evaluated for DIMOs by visit types

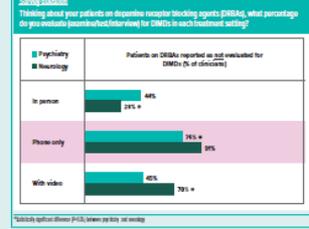


Table 2. Patients on DRBAs reported as not evaluated for DIMOs by visit types

Figure 2b. Difficulty of DIMO evaluation by visit type

Survey questions

- Please rate the difficulty of evaluating patients on DRBAs for DIMOs in each treatment setting
- Please rate the difficulty of differential diagnosis of various DIMOs such as parkinsonism vs. dystonia vs. tardive dyskinesia in each treatment setting
- Please rate the difficulty of monitoring patients for DIMOs (i.e., those who are past treatment initiation and are now considered stable) in each treatment setting

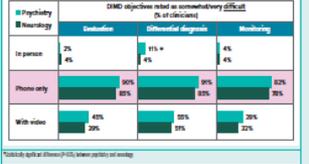


Table 3. DMO objectives rated as somewhat/very difficult by clinician specialty

Drivers of DIMO Evaluation and Telehealth Assessment Challenges

- The top driver for further DIMO evaluation during in-person visits was mention of tics or movements by family members or others (Figure 3a)
- Evaluation of gait/handwriting/standing was not available for virtual assessment via telehealth, particularly via phone (Figure 3b)

Figure 3a. Drivers of TD evaluation in DIMD patients during in-person visits



Table 4. Drivers of TD evaluation in DIMD patients during in-person visits

Survey questions

- What observed patient signs and symptoms drive you to evaluate (assess/monitor) someone for possible TD when you see patients with DIMOs in person?

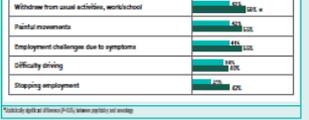


Table 5. Observed patient signs and symptoms that drive you to evaluate (assess/monitor) someone for possible TD when you see patients with DIMOs in person?

Figure 3b. Signs/Symptoms that are not available during telehealth visits

Survey questions

- What observed patient signs and symptoms drive you to evaluate (assess/monitor) someone for possible TD when you see patients with DIMOs in person?

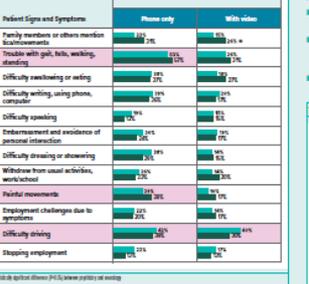


Table 6. Signs/Symptoms that are not available during telehealth visits

Patients at Risk of Missed DIMO Diagnosis by Clinician Specialty

- Patients without a regular caregiver and those with lower functioning had the highest risk of a missed DIMO diagnosis
- Psychiatrists were more likely to rate non-patients and those living in a private home at high risk of a missed DIMO diagnosis
- Neurologists were more likely than psychiatrists to rate patients living in a group home at high risk of a missed DIMO diagnosis

Figure 4. Patient at risk of missed DIMO diagnosis by clinician specialty

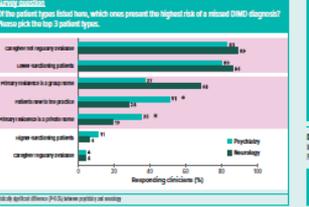


Table 7. Patient types that are at high risk of a missed DIMO diagnosis

Additional challenges included:

- The top three patient-related factors that limit the ability to diagnose DIMOs via telehealth include limited access to computers, living alone, and limited access to a telephone
- More than half of psychiatrists (58%) reported that they had not received training on how to engage caregivers as healthcare partners via telehealth

Additional Recommendations for DIMO Care via Telehealth

- Training clinicians to optimally engage caregivers and implement video visits effectively can mitigate several limitations associated with DIMO care
- Pre-emptive knowledge of patient-related challenges, such as lack of technical resources or absence of caregivers/family members, can help clinicians plan telehealth visits
- A summary of recommendations presented in Table 1 can improve telehealth evaluation and facilitate symptom capture during a telehealth visit

Table 8. Recommended prompts for improving telehealth queries

Best practices in detecting and monitoring DIMOs via telehealth visits		
Ask the patient and/or caregiver prior to your telehealth visit	Ask the patient about symptoms prior to and during your telehealth visit	Confirm with caregiver/family member (if possible)
Do you have access to a phone?	Partial tics/movements	Have you seen the symptoms on this list in middle column?
Do you have access to a computer?	Difficultly swallowing or eating	Do you have access to a computer or phone?
Do you have access to a caregiver or family member available for your visit?	Difficultly writing/using phone, computer	Can you be available for telephone call?
	Difficultly communicating (hearing or speaking)	

CONCLUSIONS

- During the COVID-19 pandemic, telehealth significantly reduced clinicians' ability to evaluate, diagnose, monitor, and treat DIMOs; these concerns were particularly acute when the visit was a telephone call
- Many factors associated with telehealth (eg. presence of a caregiver, functioning of patient, and patient-related) increased the risk of missed or missed DIMO diagnosis, potentially contributing to inappropriate or sub-optimal treatments
- Additional challenges to optimal telehealth effectiveness included lack of patient access to technology/resources and the need for more individualized training
- During telehealth visits, the presence of a caregiver can improve evaluation, diagnosis, and monitoring of symptoms in DIMO patients
- Pre-emptive knowledge of patient-related limitations can help clinicians better plan telehealth visits
- Use of pre-visit materials (eg. questionnaires, instructions for video visits) and specific questionnaires during virtual visits may improve communication and lead to increased likelihood of accurate DIMO diagnosis

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Outcome Data Necessary for Growth and Support of Telehealth

- Patient Outcomes - Better outcomes in specific areas
- Patient satisfaction
- Healthcare provider satisfaction
- Cost effective
- Telehealth reimbursement

Old Chinese Proverb that Fits Nicely for Telehealth Moving Forward

“It is better to take many small steps in the right direction than to make a great leap forward only to stumble backwards.”