Ten years ago, psychiatrist Steve Bauer, M.D., was spending a little too much time looking through a windshield. Every two weeks, he would drive four hours round trip between the Duluth-based Human Development Center, which he directs, and its outpost clinic in Grand Marais to see a handful of patients who lived in the area.

Then in 2004, the Center received a grant to purchase equipment for “telemental health” visits—consultations conducted remotely using video teleconferencing technology. Since then, Bauer has been able to log on to the system, connect with patients in a Grand Marais community health clinic, and do an assessment or check to see how they are doing and whether their medications need to be adjusted. Today, he sees those patients in Grand Marais face-to-face only about once every other month.

The system has worked so well that he and another psychiatrist, John Glick, M.D., are now also conducting telemental health visits in Two Harbors as well as in clinics in Lake, Carlton, St. Louis, Cook and Douglas (Wisconsin) counties. In total, the two psychiatrists spend roughly 20 hours a month doing televisits from their Duluth office. “The decreased in-person time with patients at those outposts is justified by the increase in the number of people I can now see with the several hours of provider time I’ve gained by not driving,” Bauer explains.

Telemental health care seems an obvious response to a big problem. The mental health needs in rural Minnesota are great. In 2005, the Minnesota Department of Health found that as many as 40 percent of women in rural areas suffered from depression, compared with 13 to 20 percent in urban areas—and people in rural communities who were treated for depression were three times as likely as their urban counterparts to be hospitalized. Compounding the issue is the fact that rural Minnesota has a paucity of psychiatrists, psychologists, and therapists and clinical social workers who can manage the needs of mentally ill individuals. The Health
In 2012, they began using telemedicine to find ways to use technology to improve care. In September of this year that Minnesota was short the equivalent of 171 full-time mental health practitioners and that 76 of the state’s 87 counties are considered Health Professions Shortage Areas for mental health.

Primary care physicians meet some of the needs of these patients, says Gary Davis, Ph.D., regional campus dean of the University of Minnesota Medical School Duluth and associate director of its Center for Rural Mental Health Studies. “But just like with many health problems, there will be patients who need to be referred for consultation because of the complexity of their case.” Although telemedicine technology can’t increase the number of mental health providers in the state, it is making care accessible to patients who need their services.

A good fit
The way telemental health visits work is quite simple: Patients living in rural areas check in at a primary care clinic close to home that is equipped with videoconferencing capabilities. A nurse or medical assistant takes their height, weight and vital signs (a requirement for reimbursement), then a staff member brings them into the exam room with the telehealth equipment. Meanwhile, a mental health practitioner in a distant “base” location logs into the system and connects with the patient. Psychotherapists can use the technology to conduct counseling sessions. Psychiatrists use it to discuss medication effectiveness and adjust prescriptions or to assess a patient and make a diagnosis.

Telemedicine is a good fit with psychiatry, according to Kathryn Lombardo, M.D., a psychiatrist and president of Olmsted Medical Center (OMC) in Rochester. “It isn’t that we don’t do an exam; it’s that those exams center around conversations more than physical contact with a patient,” she explains. As part of a multimillion-dollar Beacon grant awarded to southeast Minnesota in 2010, OMC and four other institutions were charged with finding ways to use technology to improve care. In 2012, they began using telemedicine to provide psychiatric services. Lombardo did her first telemental health visit in December 2012; two other psychiatrists and one social worker from OMC soon followed suit. To date, Lombardo, who is based in Rochester, has done about 30 telemental health visits with patients in nursing homes in Spring Valley, Chatfield and Pine Island and in OMC clinics in Preston and Spring Valley.

Just how widespread telepsychiatry has become is hard to assess. The U.S. Department of Veterans Affairs has had telemental health capabilities for two decades. By 2011, more than 380,000 VA patients were receiving care remotely. Other mental health providers have been slowly adopting the approach. According to data compiled by the American Psychological Association’s Center for Workforce Studies, the percentage of practitioners using videoconferencing for mental health visits increased from 2 percent to 10 percent between 2000 and 2008.

The positives
Psychologists and psychiatrists from the University of Minnesota Duluth’s Rural Telemental Health Network, which provides services in a dozen clinics throughout the state, have seen thousands of patients since the initiative launched in 2003. Participants on both sides of the camera are positive about it: A continuous quality-improvement initiative found 86 percent of patients served were “very satisfied,” and 91 percent of physicians, therapists and other providers considered the system “definitely useful.” Davis surmises that the majority of their patients either would not have received care or would have had to travel long distances to get it had it not been for the network’s efforts. Patients tell him that they like the system not only because it’s convenient but also because it eliminates stigma. Says Davis: “They get to go to their doctor’s office like everyone else and are put in an exam room like everyone else, only their room happens to have a telecommunications system that allows for a mental health visit. It makes it easier for them because they don’t have to go to a psychiatrist’s office. This can be especially important for someone residing in a rural community, and it actually increases the likelihood that they will follow the referral from the physician to the mental health provider.”

Psychiatrists and other mental health providers like the variety that telehealth provides them. “Seeing patients I would have not otherwise been able to see has made it a valuable and fulfilling addition to my practice,” Lombardo says.

Many of the technology issues that plagued telemedicine programs a decade ago—such as frozen or pixilated screens—have all but disappeared. Cost has also come down. Expenses used to hover around $5,000 per set, whereas today, they typically run $2,500 or less. “We’ve gone from using sophisticated equipment—a big-screen TV and separately controlled camera with a highly sensitive microphone—to essentially a commercialized, encrypted Skype-type system, which I use through my laptop,” the Human Development Center’s Bauer says. “While you lose a lot of the sensitivity and have some decreased quality of sound, the equipment doesn’t break down nearly as much.” In terms of information gathering and the effectiveness of the interventions, “we’ve determined there is not much of a difference [between in-person visits and videoconferencing],” Davis says. One meta-analysis of 10 randomized clinical trials involving more than 1,000 patients found no significant differences between...
face-to-face and telemental health consultations with regard to outcomes on symptoms, quality of life and patient satisfaction. The article was published in a 2010 issue of the Journal of Clinical Psychiatry’s primary care companion.

Bauer says they also use the system to consult with their patients’ primary care providers. “It allows us to ask questions, give updates and share ideas and information for many more clients in a shorter period of time,” he says.

The drawbacks
Although technology is bringing services to people in remote areas, users face challenges that are not insignificant. Bauer says he has difficulty getting medical records transferred back and forth between the “originating site,” where the patient is accessing the telehealth system, and the “distant site,” where the mental health practitioner is located, particularly because the Human Development Center is still using paper records. “Typically, they will fax me notes from the patient’s last two psychiatric visits [provided either remotely or in person]. But I don’t get the notes from the provider doing therapy on-site at the clinic, I don’t get the social worker’s notes and I don’t get the laboratory notes, so I am at a bit of a disadvantage, because when you are on site, you usually have all that information,” he explains. Bauer hopes some of those challenges will be ameliorated when the Human Development Center moves to an electronic medical record system later this year.

Another problem is that some patients shy away from the technology itself. “People who are paranoid and/or psychotic, which primary care providers prefer to have psychiatrists see, aren’t always happy using this technology,” Bauer says. “Some have delusions about being spied on, being wire-tapped, so trying to get them to use it is hard.”

Reimbursement realities
Those using videoconferencing technologies to see patients far away face the same challenges with reimbursement that other mental health care providers face. In most cases, telemental health visits are reimbursed at the same or nearly the same rate as face-to-face visits. (The site from which the patient accesses the videoconferencing technology also receives a “facility fee” for use of the exam room.) That’s the good news. The bad news is that mental health services—virtual or not—are historically under-reimbursed, particularly if the patient seeking services is enrolled in Medicare or Medicaid. “That’s the real rub on where psychiatry is today. The estimate is that Medicare or Medicaid pays just 20 percent of what the actual cost is on the dollar to have a mental health provider in a practice,” Bauer says.

That puts a financial strain on places such as the Human Development Center in Duluth, which has more than 30 therapists and 11 physicians and nurses, and where 60 to 70 percent of all patients are on Medicare or Medicaid. “In order for the clinic to pay for that provider, that provider would theoretically have to see 10 to 12 patients per hour,” Bauer says. “You can see how a practice could get ridiculously busy in a way that does not afford good patient care.”

The center’s providers must follow certain protocols in order to ensure that a visit with a Medicare or Medicaid patient is reimbursable. In Minnesota, for example, Medicaid does not differentiate between rural and urban settings for reimbursement of telemental health visits, which means that the patient can be located at a rural or urban facility, but coverage is limited to those services provided by a psychiatrist, psychologist or pharmacist. Medicare’s rules for reimbursement are even more stringent. A beneficiary can only use telehealth services in facilities that are located in certain federally designated rural areas—namely, those designated as Health Professional Shortage Areas or located outside a Metropolitan Statistical Area. And providers must be licensed in the state in which their patients are located. “That can sometimes pose challenges for providers,” Lombardo says.

Still, a shortage
Even those who are enthusiastic about telepsychiatry believe it is only a partial solution to the access problem in rural areas. “The central hurdle still remains: finding enough providers to provide the services,” Davis says, explaining that the schedules of psychiatrists across the state are already full. “If you have a full practice, why would you extend your practice to a different service population?”

Adds Lombardo: “We can’t expect telehealth to solve all of our problems because those problems are great. And it will take more than technology to fix them.”

Jeanne Mettner is a Minneapolis writer and frequent contributor to Minnesota Medicine.