Telepsychiatry in Private Practice

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KEYWORDS

• Telepsychiatry • Private practice • Costs • Financial modeling • Barriers • Adaptations

Telepsychiatry is being increasingly adopted in private practice and is predicted to play an important role in increasing access to care in rural communities and other underserved areas. The growing evidence base supporting the comparative validity of diagnoses[1–3] and efficacy of treatment[4–8] has served to increase interest in this method of care delivery. In the past, low reimbursement rates and high technology costs have confined the use of telepsychiatry to major academic institutions and hospitals. However, as more insurers pay for telepsychiatry services and connectivity costs are reduced, the landscape is changing. With the current level of need, it is unlikely that all of the required services can be fully met through existing telepsychiatry practitioners. Thus, in light of this new research and the significant needs of rural communities, this article looks at challenges that are unique to the private practice setting and proposes adaptations to increase provider comfort and the success of the endeavor in that setting.

The barriers most likely to impede the implementation of private practice telepsychiatry can be broken down into 3 broad categories: (1) concerns about adequacy of support, (2) provider comfort with care delivery in this medium, and (3) concerns about financial feasibility. Some of these concerns are not unique to private practice because all providers face similar challenges in becoming comfortable with a new medium of care delivery. However, private practitioners often do not have built-in access to integrated information technology (IT) services or colleagues who are already engaged in telemedicine. In addition, many practices have limited access to institutional or grant funding that early programs used to subsidize technology costs. However, costs for technology are diminishing greatly and there are new means of getting technological support. Increased use of telemedicine across a broad array of services is contributing to a growing evidence base that allows for additional information to be brought to bear on these concerns about costs. This article examines historical barriers to adopting telepsychiatry in private practice and offers adaptations

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based on a large case series derived from the clinical practice of the author as well as a review of scientific literature on telepsychiatry.

Throughout this article, the term provider site refers to the psychiatrists providing services through telemedicine. The term remote site refers to the place where the patient sits, and is used interchangeably with the term patient site. Videoconferencing (VC) refers to the use of secure telemedicine technology to see patients. Face to face (FTF) refers to traditional care settings in which both the patient and physician are present in the same room.

LITERATURE REVIEW

A Medline search in March 2010 using the keywords private practice and telepsychiatry yielded 1 article describing the setup of a nongovernmental network in India, but did not directly relate to private practice as typically conceptualized in the United States.[9] Informal surveys at national meetings indicate that there are many providers doing telepsychiatry in private practice. However, this has not been addressed formally in the literature. Initial studies focused on the use of structured instruments not commonly used in private practice settings. However, as the studies have continued, there has been an increased focus on naturalized treatment similar to evidence-based care in private practice. There has also been a move to create practical guidelines for implementing telemedicine that transcend practice setting.

Studies comparing the use of FTF assessments with those carried out through VC have consistently shown good reliability[1] and agreement[3] between the two settings. In general, the methodology has been to compare assessments of the same patient through both VC and FTF while randomizing the psychiatrist performing the evaluation and the order in which the assessment is provided (ie, half of the patients having VC first and the other half receiving FTF first). Studies have differed on whether they used naturalized assessments similar to what is typically done in private practice, or whether they used structured instruments. In the child literature, Elford and colleagues[2] completed a randomized controlled trial of 23 patients, aged 4 to 16 years, who completed naturalized assessments, and found 96% agreement across the 5 psychiatrists completing the evaluations. Similar results were found in the adult literature with 2 studies that showed substantial agreement on axis I diagnoses, both when they used naturalized assessments and when they used structured instruments such as the Structured Clinical Interview for DSM Axis I Disorders.[1]

Although many studies had positive results regarding diagnoses, some studies have raised questions about the ability to discern subtle nonverbal cues through direct observation versus relying on patient reports of symptoms, especially through low-bandwidth technologies.

One of the first studies to detect this difference between observation and patient report was 1 by Zarate and colleagues[10] comparing the Brief Psychiatric Rating Scale (BPRS) across FTF and VC assessments of patients with schizophrenia. The study used varying bandwidths as low as 128 Kb/s. They found that global severity and the overall severity of positive symptoms were reliably assessed regardless of connection speed; however, higher bandwidth was better for detecting negative symptoms and was preferred by patients.

A further study using low-bandwidth technology was completed by Jones and colleagues[11] using the BPRS in a geriatric population. They found significant agreement on findings on the BPRS between the two settings (FTF and VC), with higher reliability for items that relied on patient report rather than direct observation. Private practices considering the use of low-bandwidth technologies may find that it affects