

Rural Promising Practice Issue Brief: Interdisciplinary Clinical Video-Telehealth for Geriatrics and Dementia

Executive Summary

In 2010, 500,000 Veterans were diagnosed with dementia, and this number is steadily increasing.¹ Dementia, a class of disorders that impair an individual's cognitive abilities (e.g., memory, language, insight, judgment, planning capabilities, etc.) affects mainly older adults and has been linked to Traumatic Brain Injury (TBI), making older Veterans especially susceptible.²

Dementia is often not seen as a health care priority and there is a lack of recognition for dementia symptoms aside from normal aging.³ To complicate matters, Veterans with dementia living in rural areas face additional barriers to care due to long driving distances to access specialty care, poor health status that may make independent transportation impossible, and the possibility of caregiver strain (especially when caregivers take on the role of primary transporter and provider).⁴

To help rural Veterans with dementia more easily receive specialty care, in 2011, Veterans Integrated Service Network (VISN) 19 rolled out the Interdisciplinary Tele-Geriatrics Program, a telehealth program that provides remote video consultation in rural areas where there may be limited geriatric expertise available. The main goals of the program are to optimize medication prescribing, provide education, and provide caregiver support.

At the root of this program is a geriatrics specialty team, made up of a social worker and a geriatrician, who collaborates with Primary Care Providers (PCPs) at rural clinics. Using telehealth technology, the team completes thorough patient background checks, conducts cognitive and physical assessments, and discusses care goals.

Although the program's initial focus was on dementia, its reach has expanded to include other geriatric ailments, such as frailty, polypharmacy (simultaneous use of multiple drugs to treat a single ailment or condition), and tele-palliative care. Over the years, the program expanded to meet these additional needs of the geriatric population and their referring providers.

Within three years, the number of program consults grew from twenty to one hundred per year. Additionally, the thorough polypharmacy review has led to an ability to reduce by half the medications that patients are currently using and fosters care discussions with patients and their caregivers.

Who Can Use This Rural Promising Practice?

Geriatric specialists and care teams who manage complex assessment of dementia, geriatric syndromes, or palliative care are well suited for this rural promising practice. Rural hospital executives, social workers, and Primary Care Providers (PCPs) or teams who work with complex patients might benefit most from this program. Social worker support is integral to the success of the program. Individuals with dementia diagnoses and their caregivers living in rural areas would benefit most from the support provided by this program. The social worker role supports caregivers directly by providing supportive case management for coordination of care as well as connectivity to critical resources for care.

The Interdisciplinary Tele-Geriatrics Program currently functions well to serve its purpose; however, there are additional staff that are suitable for this rural promising practice. In addition to the support from the social worker and the expertise provided by the geriatrician, the program would benefit from the support of a dedicated neuropsychologist or geriatric neuropsychologist. A medical support assistant could also be useful to handle the time-intensive administrative tasks, such as scheduling appointments and providing appointment reminders.

The ideal facility to provide this rural promising practice is one with a good working relationship with PCPs in underserved areas. To be successful with the program, providers are encouraged to occasionally visit facilities where PCPs operate to communicate with them and receive feedback on how to tailor the program.

Need Addressed

The Interdisciplinary Tele-Geriatrics Program eliminates the travel barriers encountered by rural Veterans using remote health care services. Individuals save time and costs by accessing specialty care services virtually, rather than traveling long distances to receive services at a VA Medical Center (VAMC), where specialty care is available.

The Interdisciplinary Tele-Geriatrics Program was developed to be a telemedicine program, not just consultation. The video consults are conducted with the expectation that any geriatric issues will be addressed through the geriatrician's ordering and prescribing of necessary medications. Though the program started out as a telehealth program for dementia, the preference is now to expand the program to treat frailty or polypharmacy patients, meeting additional needs of a geriatric population. Services have also been expanded to include tele-palliative care consultations. In response to this expansion of services, there has been an increased burden on the program to meet the demands of the population. Difficulties with administrative tasks, such as scheduling appointments and limited availability of the program social worker, were cited as the main challenges for the Interdisciplinary Tele-Geriatrics Program in accommodating patients.

One of the initial reasons for providing this program was to increase support for caregivers of Veterans in rural areas. When working with this unique population, it is important to directly involve caregivers in all aspects of care. The Interdisciplinary Tele-Geriatrics Program places equal focus on caregiver and patient. During the program, caregivers are invited to appointments and are spoken to directly by the provider during the visit.



Implementation

VISN 19 rolled out the Tele-Geriatrics Program in 2011. Any rural elderly Veteran with a dementia diagnosis in the VISN 19 service area is eligible for enrollment in the program, with scheduling being the only limiting aspect in receiving access to care. Significant outreach in communities was conducted to build relationships with interdisciplinary staff at rural clinics.

The initial visit involves the use of an extensive social work template to engage the patient and obtain a thorough medical history, including Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), social supports and activities, and a depression evaluation. The geriatrician assesses frailty and cognitive/functional issues and provides recommendations for any additional evaluations to the PCP at the local facility.

To accommodate the needs of this specific population, the Interdisciplinary Tele-Geriatrics Team utilizes best practices to reduce the number of no-shows for appointments. First, the team ensures that appointment scheduling is not completed too far in advance; otherwise, patients are likely to forget when they are scheduled. Additionally, the reminder calls are provided frequently to ensure that patients will be able to attend their scheduled appointments. Special care is given to patients who may experience delusions or hallucinations and who may be disoriented by receiving telemedicine through a televised system.

After the visit, providers discuss diagnoses, changes in medications, and education about geriatric syndromes. A written summary is often provided by mail. The social worker links with a community contact and plans to share information with the Veterans and connect them to the appropriate community resources. Additionally, the social worker discusses completing an advance directive and provides a concrete plan for the patient to follow up.

Promising Results

Increased Access: The Interdisciplinary Tele-Geriatrics Program yielded results demonstrating a positive impact on improving access to and quality of health care provided to rural Veterans. Data from the Interdisciplinary Tele-Geriatrics Program reflect a measurable improvement in access to care and/or services with a significant reduction in in-person provider visits per year, about 100 reduced visits. This equates to approximately 2,000 saved travel miles for patients and their caregivers. The reduction in travel also benefits this specific population because many are limited in their driving ability, which places greater strain on caregivers to provide access to care. Additionally, Veterans, their caregivers, and their providers all benefit from being able to access medical specialists to whom they would not otherwise have access.

Strong Partnerships: Close collaboration between the members of the Interdisciplinary Tele-Geriatrics Program and their local community resources ensure strong working relationships. The program's social worker formed partnerships with a local Alzheimer's Association and Program of All-Inclusive Care of the Elderly (PACE). This was beneficial in linking patients and their caregivers to the appropriate community resources within an extensive network of partnerships to facilitate their care.

Evidence of Clinical Impact: Several positive results for rural Veterans emerged. Reported benefits include reduction in nursing home placement, improved documentation of advance directives in VA record, and a reduction of highly anticholinergic medications used in elderly Veterans. Of the 211 Veterans seen in the Interdisciplinary Tele-Geriatrics Program, there were only four nursing home admissions within the past three years. All the measures of clinical impact were verbally confirmed and general observation, although they were not measured in objective quantified data.

Return on Investment: Return on investment is one criterion that does not have a great deal of data available yet. Current program costs include a part-time social worker and provider time for clinical contact. Administrative support costs are minimal. The video telehealth infrastructure is maintained by the health care system. The measures demonstrating return on investment that have yet to be elucidated include saved travel expenses, decreased medication use, and nursing home costs averted by use of the program. Evidence in previous studies has shown that documenting goals of care leads to a decrease in utilization of health care resources.

Office of Rural Health

Rural Promising Practice Criteria

Increased Access: Measurable improvements in access to care and/or services. Examples include reduction in distance traveled to care, reduction in wait times, improved care coordination, and reduction in missed appointments.

Evidence of Clinical Impact: Positive results on outcomes of importance to rural Veterans based on evaluations conducted during the implementation of the program and at the end of the pilot period.

Customer Satisfaction: Increased patient, provider, partner, and/or caregiver satisfaction.

Return on Investment: Improvement in health system performance by 1) reducing the per capita costs of health care, and 2) improving or at least maintaining health outcomes, and/ or 3) positively impact the health care delivery system.

Operational Feasibility: Implementation is feasible and known barriers and facilitators of success could easily be shared across implementation sites.

Strong Partnerships and/or Working Relationships: Inclusion of VA and/or non-VA partners to maximize the efficacy of the intervention.

Operational Feasibility: The Interdisciplinary Tele-Geriatrics Program demonstrated operational feasibility through a multitude of strategies to overcome barriers and facilitate successful outcomes. Telehealth service agreements define the scope of the clinic and delineate provider and facility responsibilities. Telehealth scheduling systems are in place to ensure that the clinician, patient, room, and technician for the program are all coordinated to take place simultaneously. Upon receiving an extensive review of patient medical history and other background information, the team may request additional evaluations, such as full neuropsychology cognitive assessments.

Customer Satisfaction: Customer satisfaction was not measured due to burdensome data collection practices. However, Veterans and their caregivers regularly report their preference for this program and are vocal in their appreciation for the providers' ability to understand cognitive changes associated with dementia and how to interact with patients through telehealth strategies. Additionally, patients and their caregivers vocally expressed their appreciation for the program having saved travel time by receiving care at a local facility,

rather than having to drive 250 miles away for care. The Interdisciplinary Tele-Geriatrics team reported that Veterans and caregivers regularly thank the team for education about cognitive changes and how to navigate interactions with family members, regularly stating that this program is their favorite to attend.⁵

Adoption Considerations

Several needs emerged from working with this specific population, indicating areas of consideration for adopting the program. One of the most critical points to consider is the need for provider training on delivering challenging news (such as suspension of driving privileges or an initial dementia diagnosis) in an empathic way through virtual communication. It may also be necessary to have a technician physically present when patients and their caregivers receive such challenging news to help with emotional expression.

Additionally, hearing challenges often faced by the geriatric population require a specific plan to accommodate these needs. The Interdisciplinary Tele-Geriatrics Program utilized pocket amplifiers to assist in overcoming hearing challenges for patients; however, a concrete plan for use of these devices is required to prevent patient and provider frustration. Additional support from the local technician may also be necessary to help with hearing difficulties.

Appropriate planning is required to accommodate care on days where there are predicted adverse weather conditions. Providers of the Interdisciplinary Tele-Geriatrics Program prepare and complete telephone consults on days where the technology may be less reliable (such as windy weather or stormy conditions). Flexibility in provision of care is required to meet the needs of this population despite challenging circumstances.

Flexibility is also required to accommodate assessment objectives. Occasionally, the needs of the patient require a more extensive physical assessment than may be conducted by video. Engagement on the patient side of the program requires either a nurse or a trained technician to facilitate exam maneuvers.

The geriatric provider team also has a need for travel time and marketing materials to facilitate the outreach process. It is recommended that they visit each of their satellite locations in person to meet staff face-to-face, visit the telemedicine room, and strengthen overall collaboration. This would encourage program enrollment by those in need of the provided specialty services.

Additional resources that might be useful in care coordination communication involve including an occupational therapist on the team to conduct home visits. During the program, rural home safety evaluations were completed through community partners and relayed back to VA staff. While it was not financially feasible to hire an occupational therapist into the Interdisciplinary Tele-Geriatrics Program in VISN 19, it would improve program efficiency through facilitating home safety evaluations and modifications.

Conclusion and Next Steps

Future evaluation efforts should look at return on investment. To facilitate a comprehensive evaluation of the program, it is necessary to track and measure saved travel costs, reduced nursing home admissions, and patient/caregiver satisfaction rates. These measures require appropriate data collection to demonstrate the value of geriatric care to an audience that likely would not see the inherent benefits.

To expand the program, there are several additional considerations. To support caregiver needs, it may be appropriate to more formally assess caregiver support and strain. Additional measures that might be useful when adopting the program include: outcomes from occupational therapy assessments, data regarding falls, and a more in-depth pharmacy evaluation of potentially inappropriate medications. Ability to collect and report data for these measures will enhance the visibility of geriatric care benefits for rural Veterans and potentially increase partner buy-in.

Despite the stigma that geriatric patients are incapable or not well suited for telehealth strategies, the conclusion that these patients and their caregivers are tolerant of virtual visits is apparent.⁵ The feasibility of using virtual visits allows rural Veterans to access specialty expertise that they would not otherwise be able to access. The care provided focuses on functional needs, medication issues, and driving abilities, which are all crucial to the patient's care.

The VISN 19 Interdisciplinary Telehealth Program plans to expand this resource across the VA network of care, eventually reaching other VISNs where geriatric care is not readily accessible. Additionally, the future focus of the program will be on the inclusion of PCPs to provide education on the most critical principles of geriatric medicine.

Subject Matter Expert

Susan T. Bray-Hall, MD, FACP
Eastern Colorado GRECC Associate Director for
Clinical
303-399-8020 x2388
Susan.Bray-Hall@va.gov

To Learn More

The Rural Promising Practices initiative is overseen by the U.S. Department of Veterans Affairs (VA) Office of Rural Health (ORH) as part of its targeted, solution-driven approach to improving care for the 3 million Veterans living in rural communities who rely on VA for health care. As VA's lead advocate for rural Veterans, ORH works to see that America's Veterans thrive in rural communities. To accomplish this, ORH leverages its resources to increase rural Veterans' access to care and services. To discuss implementing a Rural Promising Practice at your facility or to learn more, visit www.ruralhealth.va.gov or email rural.health.inquiry@va.gov

References

1. Kunik, M.E., Bass, D., Snow, A.L., Judge, K., Wilson, N., & Morgan, R.O. (2008). Partners in dementia care: Implementing and evaluating coordinated VA and Alzheimer's Association services. Paper presented at: Alzheimer's Association International Conference; 2008 Jul 28; Chicago, IL.
2. Hurd, M., Martorell, P., Delvande, A., Mullen, K., & Langa, K.M. (2013). Monetary costs of dementia in the United States. *The New England Journal of Medicine*, 368(14), 1326-1334. <http://nejm.org/doi/pdf/10.1056/NEJMsa1204629>
3. Jones, R. (2005). Barriers to optimal intervention and care for people with dementia. *International Journal of Clinical Practice*, 59, 266-267. doi:10.1111/j.1742-1241.2005.0511c.x
4. Buzza, C., Ono, S.S., Turvey, C., Wittrock, S., Noble, M. Reddy, G., Kaboli, P.J., & Reisinger, H.S. (2011). Distance is relative: Unpacking a principal barrier in rural healthcare. *Journal of General Internal Medicine*, 26, Suppl 2, [648-654](http://doi.org/10.1007/s11606-011-1762-1). <http://doi.org/10.1007/s11606-011-1762-1>
5. Interdisciplinary Telehealth White Paper, provided by Dr. Susan Bray-Hall, MD

VA



U.S. Department
of Veterans Affairs

