Telemedicine PA Interactive Visit – Behavioral Health Grading Packet

PA /Evaluators Name_____ PA Student Name_____

Date of Visit _____ Time of Visit_____ max 30 minutes

Differential Diagnosis…… _____points

- Must name a minimum of 3 possible diagnoses and then note #1/"working" diagnosis

1.
2.
3.

Comments:

Exam Technique…… _____points

- Please consider both kinesthetic skill and communication of patient instructions.

Comments:

Organization and Flow of Exam…… _____ points

Comments:

Exam Appropriateness…… _____points

- Please note that class discussion taught that heart, lungs and abdomen are always appropriate as precursory exams

Comments:

Student is prepared for competency demonstrated by having all of their required equipment and being ready to go on time for their scheduled Zoom meeting…… yes no

Student is considered competent by virtue of your clinical Assessment for this case. Yes NO

Comments:

Case 4 – BH

Student Scenario

You are assisting your clinic by answering telemedicine consults. Your clinic implemented telemedicine to better serve patients without consistent transportation as well to decrease non-emergent and urgent clinic-based visits.

You are asked by the parent of a patient who had made several phone calls attempting to have their child seen in the BH clinic to contact them ASAP, but your clinic is not currently making face to face encounters due to CoVid-19. You are asked to complete a telemedicine visit to assess the patient and make the appropriate diagnosis and refer if needed.

Case scenario: Charley, 26-year-old, male/female who lives with his/her parents near the beach. He/she recently returned home from his/her second year of college due to CoVid-19. He/she has been staying at home with their parents for approximately 3 months. (feel free to replace he/she pronouns as appropriate for the volunteer.)

CC: "I've told them I can't go out due to the neurotransmitter, I'm being tracked".

Charley reports experiencing upsetting events daily throughout his/her time at college. He has frequently phoned home reporting that he is "being followed by his classmates" and just prior to coming home he phoned reporting that he was fired from his Audiovisual Work Study Assignment because he complained to management that his boss was "having him monitored".

Since he has been home, his mother has noticed a decrease in his hygiene, and she believes she has heard him talking to himself in the shower. When she asks Charlie, who he is talking to, he states he is talking to the Nubians through his tracking device.

Work through the case to reach a diagnosis and appropriately manage the patient through a telemedicine encounter.

Instructions: Place a check in front of each task that the student accomplished correctly. Do not place a check for any tasks that were forgotten, done partially or incorrectly.

<u>Telemedicine Required Identification/Consent/Documentation:</u>
The student:
_____ 1. Introduces yourself to the patient, confirm your identification and credentials, notes your affiliation ("X" PA Program), and your location.
_____ 2. Confirm the identity of the patient with 2 unique identifiers and note their location and address.
_____ 3. Explain the procedural aspects of the telemedicine visit and that it will be conducted in a similar but modified fashion from a clinic-based visit.
_____ 4. Explain the benefits and drawbacks of completing a virtual visit. Offering a future face to face alternative if the patient desires.
_____ 5. Assess equipment being used by the patient (including hardware/software and home medical equipment and document it.
_____ 6. Explain the cost of the telemedicine visit (for this visit none).
_____ 7. Explain the patients right to privacy and explain HIPAA changes in regard to ZOOM conferencing due to CoVid-19.
_____ 8. Ask the patient if they can see and hear with the technology they are utilizing (before you begin).
_____9. Makes any necessary adjustments for technologic issues (coach the patient to move camera when and if needed).
_____10. Verbalize that you will document the start time and the end time of the encounter.
_____11. Obtain verbal consent to proceed with the encounter.

<u>Interpersonal and Communication Skills, Includes the Four Habits.</u>

The student:
_____ 1. Builds the relationship (not rushed, introduction, eye contact, attention, empathy, asks how to address)
_____ 2. Establishes the agenda (elicits concerns, agrees upon agenda)
_____ 3. Facilitates understanding (speaks clearly, avoids medical jargon, high priority information)
_____ 4. Summarize and confirm understanding (summarizes plan, elicits questions, uses teach back)
_____ 5. Showed listening body language (leaning forward, looking at patient)
_____ 6. Used empathetic techniques (repeat feelings, legitimize concerns)
_____ 7. Appropriately admitted uncertainty, and, if applicable, offered to get more information for patient
_____ 8. Voices understanding of patient's context (cost, transportation)

Actor Script

The Scenario:

CHARACTER: Charlie Outback, 26

DRESS: Casual, you are at home

SETTING: At your home, connecting to your provider via telemedicine from your home device to their home device. Parent is in the room with you.

Affect: You feel very anxious and distressed, very tired due to lack of sleep. You are upset your mother is encouraging you to go outside and "get some fresh air".

Presentation: Anxious, hypervigilant

Case scenario: Charley 26-year-old, male/female who lives with his/her parents near the beach. He recently returned home from his second year of college due to CoVid-19. He has been staying with his parents for approximately 3 months.

CC: "I've told them I can't go out due to the neurotransmitter, I'm being tracked".

Charley reports experiencing upsetting events daily throughout his/her time at college. He has frequently phoned home reporting that he is "being followed by his classmates" and just prior to coming home, he phoned reporting that he was fired from his Audiovisual Work Study Assignment because he complained to management that his boss was "having him monitored".

Since he has been home, his mother has noticed a decrease in his hygiene, and she believes she has heard him talking to himself in the shower. When she asks Charlie, who he is talking to, he states he is talking to the Nubians through his tracking device".

1. _____How are you feeling? Have you ever felt like this before?

   Yes, ever since I got back home my mother has been hounding me. I keep telling her that I can't go out, because they will notice, but she keeps insisting.

   I have felt like this before. My old boss was hounding me at work. I used to show films for classes and help with audio/visual equipment. But my boss was having me followed. He kept trying to say I was skipping my classes on the schedule. He was having me followed so he could have me fired.

2. What was happening at that time? Have you talked to anyone about your concerns?

See above. My boss told me to see someone in our school MH department. He said I was paranoid. I didn't want to go.

3. _____What was the recommendation for your care at that time?

I was offered to see the psychiatrist, but I don't need a shrink. How is that going to stop them from tracking me?

4. _____Did you participate in any type of treatment?

None.

5. _____How have you been feeling recently?
   - *Reports experiencing intrusive thoughts. I am being contacted by the Nubians. They have been trying to warn me about the "externals", but I told them I can't remove the tracking device.*

6. _____Ask the parent, how long has he been felting this way?

At least the past 12 months… actually it really has been longer perhaps since he turned 18 or so. I just started to notice he was changing but I couldn't put my finger on it. Then he left for college. He did pretty well in undergrad, but since he started grad school things have been off.

7_____How has this been impacting all of you on a day to day basis?

I feel "scatter brained, he will not leave the house. He is constantly in the shower or in his room alone. He will not socialize. When we talk to him things don't make sense. First, he tells us one story then another. Sometimes he doesn't talk to us at all.

8_____Are you having any other symptoms?

Positive symptoms [4,5]

(should be reported as positive.)

- *Thought echo (hearing your own thoughts out loud)* +*
- *Thought insertion or withdrawal**
- *Thought broadcasting**
- *3rd person auditory hallucinations* +*
- *Delusional perception **
- *Passivity and somatic passivity**
- *Odd behavior +*
- *Thought disorder +*

- *Lack of insight +*

**These are also referred to as Schneider's First Rank Symptoms.*

Negative symptoms [5]

- *Blunted affect +*
- *Apathy +*
- *Social isolation +*
- *Poverty of speech +*
- *Poor self-care +*

Past medical/BH history- see the attached

- _____Previous similar episodes
- _____Previous Hx of Suicidal thoughts or wanting to harm yourself or others.
- _____Neurological conditions
- _____Cardiovascular risk factors:
- _____Hypertension
- _____Diabetes
- _____Hypercholesterolemia

"I don't have any medical conditions; I'm usually fit and well.

Family history

- _____Hx of BH problems, suicide **(Yes, his grandfather had a hx of schizophrenia and was in a facility after a suicide attempt.)**
- _____Other neurological conditions

There's no family history of any other medical problems."

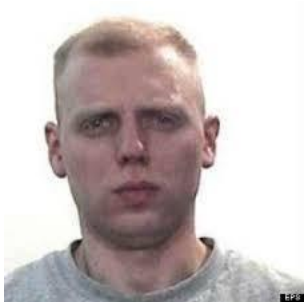
Drug/SH history

- _____ETOH (yes, drank a lot in college, but he doesn't seem to now.)
- _____Smoking (no)
- _____Other regular medication (no)
- _____Recreational drug use **(yes, he smoked marijuana in high school, but I think he stopped when he started playing rugby.)**

Overall, patient reports moderate distress and social impairment related to the symptoms.

The student may ask various other BH Questions not included in this document. Assure they move on to DX and Treatment Plan after approximately 20 minutes so that the encounter can be completed in 30 minutes total.

Do not lead the student away from the diagnosis of schizophrenia.



Show a picture of the patient to the student.

Include a general inspection of the patient:

Physical Exam Must include –

Modified Vital Signs based on patient equipment:

Obtains:

_____ Temperature (*WNL)*
_____ Pulse (*WNL*)
_____ Respiratory rate (*WNL*)
_____ Blood pressure (*WNL*)
_____ Pain (*0/10*)
_____ O2 sat if equipment is available and appropriate *NA*

Students should screen the patient for suicidal and/or homicidal thoughts. (None reported)

Assess Suicidal and Homicidal thoughts early and document it:_____

Use a screening tool if needed:

The student may use any tool or psychosocial assessment to further ask questions. Freely answer leading to the dx. Some items are filled in, you can freely answer others.

Opening the consultation

Introduce yourself
Confirm patient details – *name / DOB*
"I have to ask you some questions that may seem a little bizarre and may not make sense. These are questions we ask of everyone. Would that be ok?"

Auditory hallucinations
Do you ever hear noises or voices when there is nobody else there? ***Well someone is always there…***
Are the voices like you hear mine right now? ***More or less***
Can you hear them in your ears, or are they in your mind? ***I hear them the same as anyone else.***
How many voices are there? D*epends on how many show up.*
Do you recognize the voices? ***Yes, I know most of them.***
What do they say? ***They warn me about things, things to watch out for….***
Do they tell you to do things? (Do you obey?) ***Sometimes, and if it suits me…***
Do they tend to comment on what you are doing/thinking?
Are they present all the time?
Does anything make them better/worse?
Do you ever find yourself having a conversation with them? ***Yes, of course, I don't want to upset them.***
Do you smell or see anything at the same time that you hear these voices?

Thought withdrawal, insertion and interruption
<u>Thought interruption</u>
Do you feel able to think clearly?
Do you ever experience your thoughts suddenly stopping as though there were no thoughts left?
What is it like? How do you explain it?

<u>Thought withdrawal</u>
Is there anything like hypnosis or telepathy going on?
Is there anyone or anything taking thoughts out of your head?

<u>Thought insertion</u>
Are your thoughts your own?
Is there anyone/anything putting thoughts into your head that you know are not your own?
How do you know they aren't yours? Where do they come from?

Thought broadcasting
Can anyone hear your thoughts? For example, can I hear what you are thinking right now?
Do you ever hear your own thoughts echoed or repeated?

Somatic hallucinations

Do you ever feel that someone or something is touching you when there is nobody there?
Do you ever think there are insects crawling about inside your body?

Delusional perception
Do you ever feel that somebody or something is paying particular attention to you and what you are doing?
When you watch the television/listen to the radio/hear something, do you feel that the stories are referring to you or something that you have done?

Passivity
Do you ever feel as though you are being controlled by someone or something?
Do you ever think that someone or somebody is controlling you?
Are your thoughts/mood/actions under your control or is someone forcing you to behave in this way?

Management: schizophrenia
How would you manage this patient?

Identify and communicate the diagnosis of schizophrenia: help the patient/family to understand the disorder and start effective evaluation and treatment promptly.

Treatment for schizophrenia:
1._____The student suggests referral to a behavioral health care team and outpatient care once screening for suicidal and homicidal thoughts are negative

2._____Student should explain in layman's terms:

According to ICD-10[1], a diagnosis of schizophrenia requires…

1) A first-rank symptom or persistent delusion present for at least one month:
- Delusional perception
- Passivity
- Delusions of thought interference: thought insertion, thought withdrawal and/or thought broadcasting
- Auditory hallucinations: thought echo, third-person voices and/or running commentary

2) No other cause for psychosis such as drug intoxication or withdrawal, brain disease (including dementia/delirium/epilepsy), or extensive depressive or manic symptoms (unless it is clear that schizophrenic symptoms antedate the affective disturbance).

3) Other investigations may be completed to rule out the other causes of confusion/psychotic symptoms: [6]
- MSU to rule out UTI causing delirium
- Urine drug screen to rule out drug intoxication
- CT scan if an organic neurological cause is suspected
- HIV testing if applicable
- Syphilis serology if applicable
- Check lipids before starting antipsychotics
- Full physical examination
- Bloods including FBC, TFTs, U+Es, LFTs, CRP and a fasting glucose

3. _____Treatment
Teams involved
- Early intervention team (initial referral after the first psychotic episode)
- Community mental health team (provide day-to-day support and treatment)
- Crisis resolution team (for patients experience an acute psychotic episode)

Care Team program approach
Patients with schizophrenia will usually have a care program approach.
There are four stages to a CPA:
- Assessing health and social needs
- Creating a care plan

- Appointing a key worker to be the first point of contact
- **Reviewing treatment**

Reassurance and advice

- _____Reassure the patient/family that the condition can be managed with team based care and asks for questions

Advise the patient that: (Circle any noted)

- Gives ER precautions: If any thoughts of harming herself or others, call 911 or the National Suicide Hotline 1-800-273-8255.
- Advise they schedule an appoint with Circles of Care Mental Health Team or offer to assist with the referral.

Plan for F/u next telemedicine visit or clinic visit scheduled for:_____

_____ Notes Ending time of Call

_____ Mentions post call survey of both provider and patient.

Schizophrenia Info:

Definition

Schizophrenia is a long-term mental health problem which affects thinking, perception and affect.[1]

ICD-10 lists six key types of schizophrenia:

- Paranoid schizophrenia
- Hebephrenic schizophrenia
- Catatonic schizophrenia
- Undifferentiated schizophrenia
- Residual schizophrenia
- Simple schizophrenia

Epidemiology

- Schizophrenia affects about 1 in 100 people.
- It affects men and women equally and is usually diagnosed between the ages of 15 and 35.
- Age of onset tends to be slightly earlier in men (18-25) and later in women (25-35).
- There is a higher incidence of schizophrenia in urban areas and among migrants.
- The incidence is also higher in lower socioeconomic classes, but this may be a consequence, rather than a cause, of schizophrenia.[2]

Signs and symptoms

Symptoms can be divided into positive and negative. Positive symptoms tend to represent a change in behaviour or thought; while negative symptoms usually involve a decline in normal functioning.[3]

Positive symptoms [4,5]

- Thought echo (hearing your own thoughts out loud)*
- Thought insertion or withdrawal*
- Thought broadcasting*
- 3rd person auditory hallucinations*
- Delusional perception *
- Passivity and somatic passivity*
- Odd behaviour
- Thought disorder
- Lack of insight

*These are also referred to as Schneider's *First Rank Symptoms*.

Negative symptoms [5]

- Blunted affect
- Apathy
- Social isolation
- Poverty of speech
- Poor self-care

Aetiology and Risk Factors

The precise cause of schizophrenia is unknown but it is believed to be a consequence of a combination of psychological, environmental, biological and genetic factors. It is thought that people may have a susceptibility to schizophrenia and that emotional life experiences can act as a trigger for developing the illness.[3]

Family history and genetics

You are more likely to develop schizophrenia if there is a family history of the illness. For example, the monozygotic twin of a person with schizophrenia has a 50% chance of developing schizophrenia, while a dizygotic twin has a 15% chance. An adopted child still has a 12% chance of developing schizophrenia if their birth parent was a sufferer.[4] The chance is 48% for a child where both parents are affected.[6]

There is also some increased risk with advanced paternal age, where the father was aged over 55.[7]

Pregnancy

Malnutrition and viral infections during pregnancy increase the chance of developing schizophrenia. Other complications such as pre-eclampsia and emergency caesarean section also increase the risk.[6]

Drug abuse

Using cannabis is known to increase the risk of developing schizophrenia, particularly when used as a teenager. Many other drugs can also cause psychotic symptoms, including amphetamines, cocaine and LSD.[6]

Social and environmental
Schizophrenia is more prevalent in urban areas and among lower socioeconomic classes, but this may be a consequence of living with schizophrenia, rather than being a cause. Stressful life experiences are known to increase the risk of developing schizophrenia and this is seen particularly among first- and second-generation migrants. Those who have experienced physical or sexual abuse during childhood are also more at risk.

Ethnicity
In the UK, Afro-Caribbean men are more affected than other ethnicities.

Pathophysiology
Schizophrenia is believed to develop as a result of physical changes to the brain and to changes in neurotransmitters.

Neurodevelopmental hypothesis
People who experienced hypoxic brain injury at birth or who were exposed to viral infections in-utero are at greater risk of developing schizophrenia. Those with temporal lobe epilepsy or who smoke cannabis while their brain is still developing are also at higher risk. This suggests that brain development is implicated in the pathophysiology of schizophrenia. Imaging has shown changes in the brains of people with schizophrenia, including enlarged ventricles, small amounts of grey matter loss and smaller, lighter brains.

Neurotransmitter hypothesis
An excess of dopamine and overactivity in the mesocorticolimbic system is believed to cause the positive symptoms of schizophrenia. Dopamine antagonists are therefore used to treat schizophrenia. There is also thought to be less dopamine activity in the mesocortical tracts, causing the negative symptoms in schizophrenia. This is why dopamine antagonists are more successful at treating positive than negative symptoms.
Psychotic symptoms are seen in people with Parkinson's disease if they are overtreated with levodopa as this increases the amount of dopamine in the brain. Amphetamines and cocaine also increase dopamine release and lead to psychosis.
Dopamine is not the only neurotransmitter implicated in schizophrenia. There is also an increase in serotonin activity and a decrease in glutamate activity.[6]

Investigations
If a patient is suspected to have schizophrenia, they will be referred to the local community mental health team where a psychiatrist or specialist nurse carries out a detailed assessment.[3]