Telehealth Doesn't Work for Tardive Dyskinesia[1] (TD)

Telehealth presents serious challenges for patients who may be living with TD

Tardive Dyskinesia is:

- An involuntary movement disorder caused by medications that help control dopamine, such as antipsychotics prescribed to treat people living with mental illnesses like schizophrenia, bipolar disorder, and major depression.
- A persistent, irreversible, potentially disabling neurological condition characterized by uncontrollable repetitive movements of the face, torso, or other body parts.
- Treatable if a patient receives proper, timely screening and diagnosis.

Nearly **75%** of the **600,000 Americans living with TD** are undiagnosed.[2]

Telehealth screening and diagnosis of TD and other medication-caused movement disorders is very difficult, and it **may be impossible over the phone.**

- Screenings for movement disorders require a physical assessment and visual examination of the body, and telehealth places substantial limitations on a provider's ability to conduct a thorough physical examination.
- The American Psychiatric Association's clinical guidelines for the treatment of schizophrenia recommend screening for TD at least every six months in high-risk patients, and at least every 12 months for others at risk of developing TD.[3]
- Preliminary data developed by Neurocrine Biosciences demonstrate the difficulty of telehealth assessment for movement disorders; in our survey, up to 91% of clinicians reported not screening for TD when the visit was conducted via audio-only telehealth.[4]

[1] For more information about TD, please visit: https://www.talkabouttd.com/ [2] 1. Cloud LJ, Zutshi D, Factor SA. Tardive Dyskinesia: Therapeutic Options for an Increasingly Common Disorder. Neurotherapeutics. 2014;11(1):166–176. | 2. Neurocrine Biosciences, Inc. Data on File. | 3. Correll CU, Schenk EM. Tardive dyskinesia and new antipsychotics. Curr Opin Psychiatry. 2008;21(2):151-156. | 4. IMS Institute for Healthcare Informatics. Report to Neurocrine Biosciences, Inc. 1992–2014. [3] See: American Psychiatric Association. Practice Guideline for the Treatment of Patients with Schizophrenia, 2021. https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890424841. [4] N = 277 neurologists, psychiatrists, and advanced practice providers, data on file.

You Deserve *Brave* Science™

NEUROCRINE® BIOSCIENCES

While telehealth has been a lifeline for many patients during the COVID-19 pandemic, **telehealth must complement, not replace, face-to-face care.**

- In-person visits give doctors and psychiatrists the opportunity to notice any abnormal movements and behavioral changes that a patient or provider may otherwise miss or overlook.
- Periodic, in-person visits provide critical opportunities for patients and providers to determine the appropriateness of telehealth services.
- There is currently a lack of evidence regarding the impact of telehealth, and in particular audio-only telehealth, on access, quality of care, and outcomes, particularly for those living with serious mental illnesses. Preliminary evidence suggests audio-only telehealth exacerbates existing health disparities.[5]

> "…there may be particular instances where visual cues may help a practitioner's ability to assess and treat patients with mental health disorders, especially where opioids or other mental health medications are involved (for example, visual cues as to patient hygiene, or indicators of self-destructive behavior)[7] … "
>
> **– Centers for Medicare and Medicaid Services**

Delivering healthcare and mental healthcare by **telephone is not appropriate for every patient.**

- Audio-only telehealth can be particularly challenging for people with complex needs such as serious mental illnesses or movement disorders.
- Policies that treat telemental health services, and audio-only delivery of services, as universally appropriate for people living with mental health conditions can lead to under- and misdiagnosis of patients living with TD.

Neurocrine recommends:

- Policies supporting in-person visits:
  - Once every 6 months, for mental health services provided via telehealth for certain high-risk patients.[6]
  - Once every 12 months for mental health services provided via telehealth for certain other patients.
- Audio-only services should be limited to circumstances when a patient would otherwise be unable to access care.
- Telehealth reimbursement policies should not unduly influence or incentivize certain modalities of care.
- Robust data collection and analysis should be conducted on the impact of:
  - Audio-only care delivery.
  - Continued reimbursement for all forms of telehealth at the same rate as in-person visits.
  - Telehealth on health equity and disparities.
  - Quality outcomes for all patients, especially for those individuals living with mental illnesses such as schizophrenia, bipolar disorder, and major depression.

[5] See: HHS Assistant Secretary for Planning and Evaluation (ASPE), National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services Issue Brief. February 2022. |https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf [6] Patients at increased risk for developing abnormal involuntary movements include individuals older than 55 years; women; individuals with a mood disorder, substance use disorder, intellectual disability, or central nervous system injury; individuals with high cumulative exposure to antipsychotic medications, particularly high-potency dopamine D2 receptor antagonists; and patients who experience acute dystonic reactions, clinically significant parkinsonism, or akathisia. Abnormal involuntary movements can also emerge or worsen with antipsychotic cessation. [7] CMS. Calendar Year 2022 Physician Fee Schedule Final Rule (2021-23972), p. 171. https://publicinspection.federalregister.gov/2021-23972.pdf.