46| Neuropsych Bite: Safely Resuming In-Person Neuropsychological Testing – With Dr. Laura Lacritz

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NAVIGATING NEUROPSYCHOLOGY

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Speakers: Laura Lacritz, John Bellone, Ryan Van Patten

Intro Music 00:00

John Bellone 00:17
Welcome, everyone, to Navigating Neuropsychology: A voyage into the depths of the brain and behavior, now brought to you by INS. I'm John Bellone...

Ryan Van Patten 00:26

...and I'm Ryan Van Patten. You heard us right. We are thrilled to announce that NavNeuro is now a proud partner of the International Neuropsychological Society, or INS. This has been a long time coming and we really could not be happier about it. There are a few different dimensions for the partnership, the most notable of which is that many of the previous NavNeuro episodes will now be offered for continuing education credits, and we will also add new episodes as they come out. If you're interested in CEs, you can go to navneuro.com/INS.

John Bellone 01:01

Yeah, so if you are a licensed clinician who needs CEs, and wants to simultaneously support the show, please consider listening to NavNeuro episodes for CE credits. And if you're a student or a trainee, consider mentioning this option to your supervisors. Again that link is navneuro.com/INS. And you'll certainly be hearing more from us about INS in future episodes. But, for now, we would like to thank a few people for their hard work and making this reality. In particular, Dr. Marc Norman was integral to getting this partnership off the ground. Also Melissa Lamar for spearheading the CE approval process. Everyone else at INS who contributed to this effort, the INS board of governors and all the staff. We also want to thank our own advisory board Drs. Beth Slomine, Tanya Nguyen, and Steve Correia. Finally our co-production coordinators Leslie Gaynor and Charles Moreno as well.

Ryan Van Patten 01:56

Today we bring you a Neuropsych Bite with Dr. Laura Lacritz, a board certified neuropsychologist at UT Southwestern, and a past president of the National Academy of Neuropsychology, or NAN. Laura has many achievements. For our purposes, today, she is on the front lines of returning to in-person neuropsychological evaluations in the context of the COVID-19 pandemic. This is obviously a timely and important issue, with many states currently looking to bounce back economically and reopen many businesses. We provide you with this information in order to give you ideas about how you might proceed with resuming in-person neuropsychological evaluations if you're interested. Of course, this is all meant to be helpful and suggestive rather than prescriptive.

One more piece of housekeeping. I do want to apologize for my audio in this episode, the quality is well below what you're accustomed to. This shouldn't be an issue going forward, so bear with us for this episode. And, without further ado, we now give you a conversation with Laura.

Transition Music 03:02

Ryan Van Patten 03:11
Okay, we're here with Laura Lacritz. Laura, welcome to NavNeuro.

Laura Lacritz 03:15
Thank you. I'm glad to be here.

Ryan Van Patten 03:17
So we're video conferencing with you right now, and I can see a mask in the background on your desk. [laughs] So I'm guessing that will come up at some point in the conversation.

Laura Lacritz 03:27
[laughs] Every time I leave the office, it goes on.

Ryan Van Patten 03:33
Yes, we will certainly get into that. So, to start, what are some of the pros and cons to returning to in-person services? And how are you approaching this task generally?

Laura Lacritz 03:43
Well, the pros, especially for those in private practice, is revenue related. But even for those of us in institutions, we have to be thinking about the bottom line. But, first and foremost, we also have to be thinking about our patients and that they're not getting the services they need which could be delaying diagnosis, services, or addressing other needed safety issues. And the cons is that if we can't return back to practice safely and in a measured fashion, we could be putting ourselves and our patients at risk. In terms of returning back to practice, every clinician has to make that decision for themselves considering federal, state, local guidelines, legal parameters, as well as those of us at institutions having to keep in mind what those policies are and work with those entities. In general, the collective wisdom is to start back gradually. For the private practitioner, they have to gauge their own comfort level, health issues, the physical environment in which they work, and the risk in their community, as well as the patients that they serve and what the risks are to them.

John Bellone 04:53
There's a lot of variables to juggle here clearly. What are some ethical principles that are at play?

Laura Lacritz 05:00
I think the first one is to avoid harm to patients. So as much as we want to get back to work, and are concerned about our own revenue and stability of our practices, we have to avoid harm to our staff, to ourselves, to our patients - that's a priority. Beyond that, we also have to be thinking about what's in the best interest of our patients. So that gets back to beneficence and non-maleficence versus justice. As we are resuming practice, we need to be thinking about informed consent and making sure that our patients are well informed about what we're doing, especially if there are some changes in our practices.

John Bellone 05:38
Right. You mentioned justice and, just for our audience, that's the ethical principle where we want everyone to have access to services equally across the board. So you know, people who don't have internet access right now, they have no way of communicating with us other than the telephone, which is not ideal for neuropsych. So we're constantly balancing those - to not do harm, but also making sure everyone has equal access to our services. Maybe this is going to be on the next ABPP oral exam. This is going to be the next ethical vignette that is on the exam. [laughs]

Ryan Van Patten 06:09
[laughs]

John Bellone 06:10
Without getting into politics, what do you see our responsibility to be when state or county policies don't line up with the threat that the virus poses? So, for example, if case numbers are concerning but the county's lifting the stay-at-home orders, what are our responsibilities here?

Laura Lacritz 06:31
Well, we do have that responsibility to avoid harm. And the fact that we're with patients for sometimes multiple hours at a time, in small spaces, the risk may be higher if your environment is not set up for that. So I think we have to weigh the risks, and make sure that we're putting in place proper precautions so that when we

do bring patients back into our offices that we, our patients, and our staff are safe. I think if you work at an institution, there's going to be some very clear policies for that, but if you're developing the policies yourself, you have to weigh all of those things. But you can also work with your leadership, even if you work in an institution. They don't know how we practice and what we do. So we have to educate and develop policies that make sense.

John Bellone 07:19
You mentioned precautions, what might some of those precautions be when we resume in-person activities?

Laura Lacritz 07:25
The four main recommendations that seem to be common across all guidelines that you'll read is the use of masking, so patients and providers and staff; employing social distancing, so keeping at least 6 feet away as much as possible; disinfecting frequently, and that goes beyond just your testing room, but all the other common areas and the places that patients may be in; and frequent hand washing or use of hand sanitizer. So those are common across all of the guidelines. When you're really thinking beyond that, how do you resume practice, you have to have a well-thought out plan. That includes thinking about what happens before the visit. So including a screening of patients beforehand and when they come in. Minimizing traffic in your office area that will allow for social distancing. Having clear disinfection processes put in place for before and after visits. And then setting up your office environment that will allow for social distancing.

John Bellone 08:27
Which might be hard given the nature of neuropsychological testing, right? We're usually very close to patients. We're right across the desk from somebody when we're testing them.

Laura Lacritz 08:35
Right.

John Bellone 08:36
So how do you implement some of those, in reality?

Laura Lacritz 08:40
If you have the opportunity to test in a larger room, such as a conference room, that's one way to do that. You can break the evaluation up into parts so that you're not spending so long with the patients. So maybe the interview happens at a different time and you do that via telephone or telemedicine in some way. Also trying to perhaps shorten batteries so that if you can't adhere to social distancing, you're not spending as much time with patients.

Ryan Van Patten 09:12
What are you doing in terms of the waiting room, scheduling patients, keeping people apart as much as possible while they're in your clinic space?

Laura Lacritz 09:22
We're staggering appointment times. So patients are coming at different times during the morning, so they're not all congregating at the same time. We have them call in ahead of time to check in, so the check in is on the phone. They wait outside until we're ready to see them and they're roomed immediately, so we put them straight into a room. We've also taken out chairs in our waiting room and created alternative waiting spaces. So if we have several family members there, you know, with different patients, they're waiting in different spaces. Part of the way we're able to do that as we're reducing the number of patients we see. So we've converted some other consult rooms to waiting spaces for patients.

Ryan Van Patten 10:05
Do you require that patients wear a mask when they come into your office?

Laura Lacritz 10:09
We do. We ask them to come wearing a mask. If they don't have one, we provide one for them. And, in fact, anyone that comes with them must wear a mask as well.

John Bellone 10:17
And you are wearing a mask as well as the practitioner? You had mentioned you were, right?

Laura Lacritz 10:21
Absolutely.

John Bellone 10:22
And that's even when you're doing test administration, I'm assuming.

Laura Lacritz 10:26
Yes. In fact, that's probably the most important time because when you're speaking, that's when you're at most at risk for particles that might come into the air.

John Bellone 10:34
Sure. I was wondering if that could impact standardized assessment? For example, on a verbal learning measure, if we're reading words, it could be different, it could be more muffled if it's coming through the mask. I don't know. Have you encountered that problem? Have you thought through that a little bit?

Laura Lacritz 10:51
We have, and it is a concern. I think anytime you go beyond standardized procedures in any way, you have to be worried about that. The biggest issue that we've come across is being able to hear the patients and the patients being able to hear us. So speaking loudly, really enunciating, and being clear is important. Possibly recording the patient while they're speaking so you can go back and listen to it later is another option. We also have a hybrid model. So some of our patients are doing video interface within our office. So they're in one office using the computer screen, and we're doing the administration of tests in a different room. So we're minimizing the contact in that way.

Ryan Van Patten 11:36
What tests do you do in that way versus tests that you give to them in the room with them?

Laura Lacritz 11:41
So most of the verbal measures we're able to do via that video interface, if that's the way we set up the visit. Some of our tests that have stimuli, we have those in a fashion that they can see it on the screen. So we have that stimuli scanned in so they can see it. And then there's also material that they have in the room that's in a folder that they're told to take out at a designated time where they can look at a form or use a form while we're giving them the instructions on the video.

Ryan Van Patten 12:15

Yeah, when you're talking about masks and the examinee hearing you, you also mentioned that you need to hear them. I'm thinking about verbal fluency tests, for example, if you aren't able to clearly hear what they're saying, obviously, that will be an issue. So I think you just said that most of the testing that is done in two different rooms, those are verbal measures. Are you doing that so that the patient need not wear a mask and you can actually hear them better?

Laura Lacritz 12:44

Correct. So, in that instance, the practitioner is not wearing a mask and neither is the patient. Some people could take issue with that and say that patients should have the mask on all the time. But, we've consulted with our infection prevention team at our institution and, if they're alone in the room, it's permissible to take the masks off. Although it's important to keep in mind that potentially the room itself becomes more dirty, if you will, and requires a little bit more cleaning afterwards.

John Bellone 13:14

Some people might be thinking, “Well, isn't this the same as just doing remote testing anyways?” But this is much different from doing in-home testing versus in-clinic. You're doing more of an in-clinic, sort of video testing, which is much easier to control the environment. And lots of privacy issues that would exist with the in-home testing don't exist in this in-clinic version.

Laura Lacritz 13:34

Exactly. Some patients don't have the right equipment at home to be able to do a home telehealth visit. We do offer that as well, but as you mentioned, we can't control that environment and we've had some audio-visual problems with either connection or being able to hear patients using that setup as well.

Ryan Van Patten 13:55

You can use all your tests, if they come into the clinic. You don't have to send them forms and hope that they'll send it back to you in the mail. You don't have to worry about test security. So it really is very different.

Laura Lacritz 14:04

Exactly. And we can - like, we've been able to do block design, for example, you know, providing the blocks to them and they can see the stimuli on the screen. So things like that become more possible. Granted, there is some deviation from

standardized procedures and we are taking all of that into consideration as we interpret the results.

John Bellone 14:27

Perfect. You mentioned you're doing many of the interviews remotely still by phone. I'm assuming also the feedbacks? You know, those are fairly easy to do - not ideal, but easier to do over the phone or via video conferencing. Is that still what you're doing?

Laura Lacritz 14:43

We are doing almost all of our feedbacks exclusively via telehealth for the time being and our plan is to continue to do that. We have a patient satisfaction survey that we had started to use with patients to assess how well they're responding to this modality and we've had an overwhelmingly positive response to feedback visits via telehealth. Patients don't have to leave home, it's easier to involve family members, and it's been very well received.

John Bellone 15:13

In terms of the social distancing while the patient is in your office space, or the waiting room, does this also apply to patients bringing a collateral source with them to the appointment? Do you limit how many people they can bring or where they can stay when the person is being tested?

Laura Lacritz 15:30

We do limit guests to one per patient to limit the number of people in general in our clinic space. As I mentioned before, we have some alternative waiting rooms. So we've designated three different areas where family members can wait. We've removed chairs from our central waiting rooms - there's actually only two chairs and they're more than 6 feet apart. Alternatively, a patient's family members can wait outside or in common areas. And we have their phone number and if we need to call them to come back in, they can do that.

John Bellone 16:02

Great. For any of the procedures that we've already talked about, do you think that those - well, of course, they are going to change if it's an inpatient case. I don't know if you're seeing any inpatients. But, even if you aren't, for those clinicians who do see inpatients, either for testing or just for a consultation, what advice do you have for those clinicians?

Laura Lacritz 16:23

Some of our clinicians do see individuals in the hospital and they will use a greater extent of personal protective equipment. So definitely they'll be masked. Depending on where they're seeing the patient that may also require gowns and gloves, depending on the level of risk that's involved. Some of our clinicians in the hospital are doing phone consultations with patients and even therapy by phone to avoid personal contact. So there are some alternative ways of providing services. But the most important will continue to be, for in-person/in-hospital visits, use of masks, washing hands, hand sanitizer, and then disinfecting anything that the patient may have touched while you've been in contact with them.

John Bellone 17:12

We should be doing that anyways. [laughs] Even before this. We should have been doing all that and maybe none of us were as vigilant as we should have been.

Ryan Van Patten 17:21

The personal protective equipment in outpatient settings, of course, would include a mask, as we've talked about. Are there ever circumstances where you recommend additional PPE in outpatient offices or is a mask sufficient for neuropsych?

Laura Lacritz 17:37

Well, a mask is first and foremost. Everyone should have gloves if nothing else for cleaning and handling the unclean materials while they're moving them from one space to the other. Face shields are something that people could consider, particularly if they can't employ social distancing, to still be within close proximity to patients. So that's another consideration.

John Bellone 17:59

I know my office is considering sneeze guards between desks, to separate people. I don't know what your thoughts are about that?

Laura Lacritz 18:09

We've looked into those. I know a number of people that are using those types of plexiglass dividers, and I think that's certainly something to consider. It would help to reduce transmission, potentially, although it doesn't completely separate you from the other person in the room at large - so particles could still be in the air. It definitely would not supersede the use of masks. So you'd still have to mask.

John Bellone 18:36
Yeah.

Ryan Van Patten 18:37
I'm wondering where you're at right now, Laura, here on May 20, how many patients are you seeing in-person versus via full telehealth right now? And what do you project you will be doing for the next few weeks and months?

Laura Lacritz 18:53
We're slowly increasing our volume in the clinic. This past week, we were about 30% full and most of those were still telehealth visits. So we're slowly increasing one or two in-person visits per day. We hope that by mid-June we'll be close to our full volume, although limiting the number of patients that come at any one time.

Ryan Van Patten 19:21
Gotcha. What do you imagine might happen if there's a flare up of COVID-19? So there's the political dimension to this and policymakers are choosing to open states or not. If we open up too much too soon, then there could be a spike. Might that impact us in neuropsychology if there's a spike in cases? Might we scale back after opening up? What do you think?

Laura Lacritz 19:46
I think, as a profession, we have to be prepared for that - and also as a country, for that matter. Those that are projecting models, you know, do predict that we're going to have flare ups. So I think we have to be prepared to scale back if the numbers go up, to have processes in place where we can employ more social distancing if we need to, if we have relaxed any of those regulations over time. The most important thing is to watch the numbers, and if the numbers in our communities start to increase, we have to weigh our options. Depending on the population that we see and what the risk is, we may have to scale back the number of patients that we see. For those of us that are already doing telehealth, be prepared to ramp that up. And for those that are not doing it, it may be an opportunity to start planning for that possibility in case we're faced with having to make modifications in our practices.

Ryan Van Patten 19:55
Yeah, to harken back to what you said earlier, it's a constant balance between doing good and not doing harm. But the situation changes, it's dynamic. So today, the best way to do the most good might be by providing neuropsych services, some

of which is in-person. But three weeks from now, if the risk of virus transmission is too high, the equation has changed and it might be too risky and not worth it, so we'd scale back.

Laura Lacritz 21:14

Absolutely. And I think we can't get too lax with feeling that everything's okay. So if the numbers in our community are starting to go up, we have to pay attention to that.

John Bellone 21:24

How have your patients responded to the transition now back to in-person testing? Have people been resistant to it? Have they been waiting for this moment for a long time? What has been your experience?

Laura Lacritz 21:39

For patients that have come into the clinic, it has worked fine. They have adapted to the masks. I think now everyone is getting used to wearing masks when they go out, so that doesn't seem so unusual the way it might have about a month ago. The inpatient telehealth visits for some patients have been difficult if they've been too impaired. So we've had to make some switches and switch to an in-person type of evaluation. So, overall, patients are responding to it. Although they're not clamoring to come into the clinic as readily as I might have thought once we opened up spots. So there are people that are still cautious about getting out at all. So our numbers are slowly increasing as I think patients will become more comfortable.

John Bellone 22:26

One other thing we should have maybe mentioned at the front end, what's your typical patient population? Age and type of referral question?

Laura Lacritz 22:34

We see a range of individuals. I'm at a medical center so we see anything from adult ADHD to all kinds of dementia. Probably 50% of our population are older adults with some concern for memory problems, either as a primary or a secondary diagnosis. So we do have a vulnerable population.

John Bellone 22:56

And do you take that into account at all? Are you scheduling certain types of patients right now versus others?

Laura Lacritz 23:04

We are keeping our patient population in mind. So we're continuing to do telehealth where we can. And also the in-patient telehealth visits are prioritized for patients where we want to reduce the amount of time that they're spending face-to-face with somebody. Beyond that, it really depends on the referral question. So those that we feel like are more urgent - presurgical kinds of evaluations - are getting priority for coming back into the clinic first.

Ryan Van Patten 23:31

Something else for us to consider is the cognitive demand required for the patient to follow the guidelines that we're now providing them, right? Someone who is cognitively impaired, who doesn't have a collateral source, might forget a mask or go into the wrong place. Right? These are added rules that we are including in order to keep everyone safe. But these are cognitive tasks, so we can make observations about the extent to which cognitive impairment in our patients is prohibiting them from following the rules. There's the safety piece of that, like, if they didn't bring a mask, and then there's just the clinical data as part of that.

Laura Lacritz 24:14

There is. I think first and foremost, we have to be clinicians and educate our staff of how we interact with patients. That, number one, this is an unusual circumstance and the way that we're doing business is not normal. Acknowledge that that can create some confusion in some patients, and also some anxiety and apprehension. So we have to instill confidence while at the same time ensuring safety and trying to provide, or just making sure that we're providing, a safe environment - taking those contingencies into consideration.

John Bellone 24:48

Just as we start wrapping up, what outlets do you recommend for up-to-date information and resources? I mean, there's so many different resources out there. I can't keep track of all the listservs and group messages and everything. But what are the few resources that you want to highlight for clinicians?

Laura Lacritz 25:04

It definitely can be overwhelming. I do recommend the CDC in terms of general information regarding safety issues and what kinds of ways to disinfect and keep our environment clean and in ourselves safe. The IOPC is amassing a lot of resources for clinicians about telehealth as well as how to resume back into in-person testing, so I recommend that as a source. APA has lots of resources. The AMA also has some good procedures that have been outlined. And Johns Hopkins has a risk calculator for returning back into business-type environments, which is interesting to put your environment into that risk calculator and look at the mitigation factors, and it has some recommendations for that. In addition to whatever your hospital and institution puts out, I think it's important to keep up with the local health department and state and local associations.

John Bellone 26:05

We'll link to those main ones that you had mentioned. That's great.

Ryan Van Patten 26:09

Yeah, we appreciate you sharing what you're doing, the research you've done, all the preparation you've done, Laura, in order to be able to start seeing patients in person and do so safely. We and our listeners will benefit from that.

John Bellone 26:22

And, Laura, before we jump to our bonus questions, is there anything else you wanted to say about this topic?

Laura Lacritz 26:28

The one thing I will leave listeners thinking about is that your plan really needs to be thinking about what happens before patients come into your office. And that's pre-screening questions, as well as screening them when they come in. Making sure that your office is clean and that you have the resources available, like hand sanitizer and masks for them. That you think about what happens when they come into your office, such as the virtual check in, having forms completed in advance so you're not handling a lot of paper, and rooming patients quickly. And then thinking about what happens after the visit in terms of the feedback visit, and how to do as much as you can remotely as you're easing back into practice.

John Bellone 27:11

Excellent. Be prepared and do as much as you can beforehand. I like that.

Ryan Van Patten 27:15

Before we let you go, we have bonus questions we like to ask all of our guests. So these are not specific to COVID-19 or returning to in-person testing, they're about neuropsych more broadly. The first one is: If there's one thing you could improve about our field, what would it be?

Laura Lacritz 27:33

This pandemic has underscored to me the need to be flexible, adaptable, and tolerant as a profession. There's been a lot of banter back and forth on the listservs, and some of it hasn't always been positive. We can get sort of set in our ways and the way we do things. So I do think we need to be open minded. There's different ways to do what we do, to perform assessments and be supportive of our colleagues.

John Bellone 27:59

There's always a balance to take. But I love the flexibility, and it's really needed in these times and going forward as well. What is one bit of advice that you wish someone had told you when you were training or maybe someone did tell you that really made a difference, just an actionable step that trainees can take.

Laura Lacritz 28:18

I'm not sure if this was said to me while I was training or after I had gotten finished with my training, early in my career. But a piece of advice, "Don't turn down a job until it's been offered to you". And you could substitute "job" for opportunity, experience, anything along those lines. Basically, be open minded. I started my career thinking I was going to work with pediatrics and ended up focusing on geriatrics. Had I not been open to experiences and something other than what I thought I wanted to do, I wouldn't have found my passion. So, keep an open mind. You know, even if it's not something you might want to do, it allows you to see what your worth is and to explore what's out there.

John Bellone 29:02

Great. Well, Laura, thanks for joining us here on NavNeuro. It's been great. I think it'll be really helpful to clinicians out there.

Laura Lacritz 29:08

Thank you both. I really enjoyed it.

Transition Music 29:10

John Bellone 29:14

Well, that does it for our conversation with Laura. We wish you all the best as you continue to provide neuropsych services for your patients in the COVID-19 era. And as always, join us next time as we continue to navigate the brain and behavior.

Exit Music 29:28

John Bellone 29:52

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Ryan Van Patten 30:03

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