Hybrid relationships with your patients
How to care online and in-person

Peter Yellowlees, MD
UC Davis California, Department of Psychiatry
Disclaimer / Conflict of interest

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Objectives

Understand:

1. Why psychiatrists need to work differently
2. Collaborative Care Model: mental health integrated into primary care
3. How technologies can improve efficiency and effectiveness of psychiatrists
Abstract

Psychiatrists are in increasingly short supply, while most patients with psychiatric disorders are treated in primary care, without psychiatric input. Psychiatrists need to change the way that they work and increasingly work using an integrated care model with primary care providers supported by a range of technologies. This approach will make psychiatrists more efficient as they gradually increase the number of asynchronous consultations that they perform and manage larger panels of patients in a more effective way.
Where are the patients?

- Inpatient – corrections (CA reduced 30% of psych beds 1995 – 2012)
- Outpatient – primary care, county services for SMI and ED’s
- Numbers of insured and aging- 20% over 65 by 2030
Where are the psychiatrists?

- 40k total – deficit 10k now
- Mean age 56, 65% male, major retirements in next decade
- Replacements – 55% female (work 20% less) – rate of training static, so deficit increasing with population and demand increases
- Estimate 20% less clinical time available in 10 years
What is the solution?

Psychiatrists have to work differently........
- less time for individual care
- more integrated/primary care
- more team based
- more technology facilitated
- more population focused
Technologies in Psychiatric Practice

**BASE TECHNOLOGIES**
- E-mail/telephony
- Electronic medical record
- Videoconferencing
- Web-based apps
- Mobile phones, apps, & devices

**EMERGENT TECHNOLOGIES**
- Virtual reality treatments
- Social networking
- Artificial intelligence, machine learning, & cognitive computing
- Avatars
- Geospatial tracking

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Generational Changes

DIGITAL IMMIGRANTS

• Use Internet for information second rather than first
• Print out email
• Share computer content in-person
• Learn slowly, step-by-step, one thing at a time

DIGITAL NATIVES

• Parallel processing & multitasking
• Prefer graphics & visuals
• Instant gratification & rewards
• Prefer to be networked
• Learn with information fast, presented in a random fashion


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Psychiatric lectures via television - Nebraska Psychiatric Institute, 1956

Group telepsychiatry videoconference, 1961

Dr Menolascino telepsychiatry, 1966

*Photos from UNMC Archives, Special Collections Department, McGoogan Library of Medicine, University of Nebraska Medical Center, Omaha, Nebraska*
Boston/Logan Airport to Mass General 1967

Psychiatrists Office 2017

Fred Guggenheim MD
Original Research
The Empirical Evidence for Telemedicine Interventions in Mental Disorders

Roshid L. Bashshur, PhD,1 Gary W. Shannon, PhD,2 Noura Bashshur, MHS,3 and Peter M. Yellowlees, MD2

1University of Michigan Health System, University of Michigan, Ann Arbor, Michigan.
2Department of Geography, University of Kentucky, Lexington, Kentucky.
3Department of Psychiatry, University of California Davis, Sacramento, California.

Responsibility for the analysis, accuracy, and interpretation of the data is entirely that of the authors and not the National Library of Medicine.

Abstract
Problem and Objective: This research derives from the confluence of several factors, namely, the prevalence of a complex array of mental health issues across age, social, ethnic, and economic groups, an increasingly critical shortage of mental health professionals, and the growing need for advanced mental health care that are shown in terms of cost savings. Conclusion: There is substantial empirical evidence for supporting the use of telemedicine interventions in patients with mental disorders.

Key words: telemental health, telepsychiatry, telemedicine, evidence, mental health disorders

Introduction
This is the fourth in a series of articles reporting on the empirical evidence concerning the feasibility/acceptance and impact of telemedicine interventions in disease management and specified health disorders. This article focuses on the role of telemedicine interventions in mental health disorders, a major problem affecting over 450 million people worldwide, including over 60 million adults and 7 million children and adolescents in the United States. For diagnostic purposes, to qualify as a disorder, a mental or emo-
4m Telemedicine patients
USA 2015 (ATA)

• Direct to consumer Prim Care/Derm/Opthal – 750,000
• vICU’s – 650,000
• Telepsychiatry – 500,000
• Telestroke – 125,000
• Acad/Networks – 200,000
• VA – 750,000 (350k psych)
• DOD – 100,000
• Corrections – 250,000 (150k psych)
• Retail clinics – 20,000
• Remote Monitoring (card/nursing/home) – 650,000
Trends transforming US health care
(Deloitte 2016)

• Technology – genetic/nano/digital/cloud
• Demand for Value – quality, evidence and transparency for less – prevention/wellness focus. No more CPT
• Growing health economy – by 2030 20% aged over 65. Increased demand.
• Govt as influencer increased regs – ARRA, HITECH, ACA, MACRA
Provider value coordination chain

Move to the home:

- PCP/home
- Retail Pharmacy/clinic (doubled 2012-15)
- Urgent Clinic
- Hospital/Emergency Dept.
Doctor-patient relationship

Three Core components

1. Information (data collection) – H/P
2. Information (data analysis) - Dx
3. Communication and (project implementation) Rx planning and education
Virtual ‘hybrid” care

Boundaries – technical, psychological, physical, ethical – suggest ‘rules’ – and provider rights to privacy
Hybrid Care = In-person and Online

VIRTUAL SPACE

- Advantage for those with avoidant behavior, PTSD, and anxiety
- Convenient & immediate
- Provider can observe patient in their environment
- Indirect & off-hours care opportunities
- Modalities include videoconferencing, e-mail, text messaging & telephony

PHYSICAL SPACE

- Traditional in-person gold standard
- Immediacy & trust in interpersonal interaction
- Physical boundaries can be set for therapeutic frame
- Ample research and practice guidelines available for healthcare in the physical space

Diagram and illustrations by @StevenChanMD. Content based on Peter Yellowlees & Jay Shore.
Asynchronous Telepsychiatry

Clinician
Nurse, Counselor, or Therapist

Video routed to psychiatrist

Patient
ATP Summary of Findings

- Diagnostically reliable across differing language groups with translation
- Good for monitoring treatment progress
- Easier management admin/scheduling
- Improved communication between patient and reporting provider
4.7% of the population (over 5 years of age) had limited English-speaking abilities.

This is nearly the size of Illinois.

2010 U.S. Census
Live interpreters

- decreased error rate (22% ad hoc vs 2% trained)
- can clarify visual affect
- recommended by AAFP
- not always available
- increased encounter time
- perceived inconvenience
- variance in quality
Phone interpreters

- Economical: $2-$3/min
- Greater access to # languages
- Shorter wait times (in seconds)
- More efficient

- Lack of human presence
- Harder for elderly, hard-of-hearing, dementia
- No non-verbal cues
- Longer encounter time
Videoconferencing interpreters

- Can do ASL / hard-of-hearing
- Decreased confusion for elderly
- Quality of call (VOIP) vs phones (POTS)

- Newer, not implemented everywhere
- Requires fast Internet
- Requires buy-in of “conservative” IT staff
Asynchronous Telepsychiatry

- Generates subtitles for Telepsychiatry videos in real-time
- Interfaces with existing online and offline transcription and translation services
Real-Time Language Interpretation (Google Glasses)
REAL-TIME LANGUAGE INTERPRETATION
SMARTPHONES
Integrated Mental Health Care

• The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

• This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

From: AHRQ Integration Academy; Peek, et al: Lexicon for behavioral health and primary care integration
Continuum of Physical and Behavioral Health Care Integration

- ECHO Grand Rounds
- Consultation Telepsychiatry
- Collaborative/Synchronous Telepsychiatry
- Asynchronous Telepsychiatry

Coordinated Care:
- Screening
  - Navigators

Co-located Care:
- Co-location
  - Health Homes

Integrated Care:
- System-Level Integration

Kaiser Foundation Model of Continuum of Integrated Care
Types of Integrated Care

• Collaborative Care – individuals
  ▪ Embedded mental health clinicians as part of medical home team
  ▪ Synchronous/asynchronous virtual visits from specialist team
  ▪ Consultative advice, assessment, brief interventions – phone/video/EMR
  ▪ Uncomplicated mental illness advice and referrals, Substance Use Disorders, Other conditions (insomnia, stress, chronic pain, obesity, etc)

• Disease/patient specific Care Management - populations
  ▪ Guideline based treatment support, usually via phone/video
    ▪ Screening/populations algorithms and regular education programs for providers
    ▪ monitoring treatment adherence via EMR, - regular psychiatric reviews with care coordinators
  ▪ Stepped Care approaches to advice and visits
  ▪ Self-care monitoring and referral Management when indicated
UC Davis environment

- 550 bed hospital – regional level 1 trauma center N. Cal/Oregon/Nevada
- Busy ED – 10-20 psych beds and FT psych team
- PSM service
- Academic outpatient clinics – 15 residents child/adult
- Primary Care Network – 17 clinics, 140 pcp’s
- Constant inpatient bed shortage – County/Private
2010 Psych Referral options

- Curbside telephony
- Referral for in-person psychiatric assessment
- ED
How to make psychiatry available to patients in primary care?

- A menu of choices of direct and indirect consults
- Close collaboration with, and education of, PCP’s
- Changed referral triage process
The 2017 UCD psych referral choices: a “stepped care” menu

- PCP education – formal/informal/online/in-person
- Routine screening in PCN – PHQ-9, GAD-7, Audit
- Registry review – care coordination, panels, sentinel events, diagnostic groups, health coaching.
- Curbside telephony advice/consult - indiv
- Email/secure messaging/e-consult – indiv
- ATP to PCN
- STP to PCN
- In person consults – Psych in PCN/Spec OPD
- ED
Comparison Psychiatrist work practices

- **Traditional** – 30 patient care hours, 10% no show – sees 40 pt’s per week (4 new, 10 one hour, 26 half hour)

- **Future** – 30 patient care hours – no show time used for ATP. 15 hours spent traditional approach – 20 pts. 15 hours – team (4 new per hour – 5 hours) and ATP (2 new per hour – 10 hours) – 40 pts. Sees/consults 60 patients per week
### Staying sane with technologies

| **Set clear boundaries with patients.** | • Tell patients how and when they can contact you.  
• Discourage long e-mails, messages.  
• Use secure e-mail or EMR-tethered messaging systems |
| **No more playing “phone tag.”** | • Set phone appointments at specific times  
• Use e-mail or messaging instead of wasting hours attempting to call someone multiple times |
| **No writing letters or notes after hours.** | • Use templates & copy-paste functions judiciously  
• Write patient-requested letters during office visits  
• Speed up data input with voice recognition, dictation systems, or typing fast |
| **Use mobile tech to work wherever & whenever** | • Select smartphone-compatible cloud-enabled EMR, messaging, and storage systems  
• Reduces costs and enables you to work remotely. |

Content based on Peter Yellowlees & Jay Shore.
Psychiatrists are starting to work differently

The collaborative/integrated primary care model reaches more patients.

A range of technologies can provide more referral choices for PCP’s and patients

New models/technologies allow psychiatrists to be more efficient.
Thank You

sending virtual hug

loading...

hug sent!

pmyellowlees@ucdavis.edu