Dr. Laura Roberts (00:10):

Hi, I'm Dr. Laura Roberts, Editor-in-Chief for the Books Portfolio of the American Psychiatric Association, and welcome to the APA Books Podcast. Today we'll be discussing Telehealth and Psychiatry and the role that communication technologies can and do play in mental health today. While Telehealth generally has grown pretty rapidly in recent years, it's an area that was pioneered by Psychiatrists and which is really uniquely suited to the needs of our field and our patients. To help us learn about the role that communications technologies can play in clinical care today and in the future, I've invited both of the editors of the Book, Telepsychiatry and Health Technologies, a guide for Mental health professionals to speak with us. First, we'll talk with Dr. Peter Yellowlees, he serves as the Vice Chair for faculty development and a professor of Psychiatry at the University of California, Davis. He also is a world leader in Telehealth and presently serves as the president of the American Telemedicine Association.

Dr. Laura Roberts (01:07):

We'll also be speaking with Dr. Jay Shore, he's an amazing young leader in our field and he serves as a professor in the departments of Psychiatry and Family Medicine at the University of Colorado, Denver. So Peter, tell us about this wonderful Telepsychiatry Health Technologies book. It really envisions a very different future filled with hope for a lot of people living with mental health issues.

Dr. Peter Yellowlees (01:30):

I think that's true and it's interesting. I mean, we thought about calling this book almost hybrid Psychiatry originally or hybrid mental health, but we thought people wouldn't understand that.

Dr. Laura Roberts (01:40):

Well, what do you mean by hybrid?

Dr. Peter Yellowlees (01:42):

So what I mean by hybrid is how I practice. I see my patients both in person and online, and I see them online in several different ways, potentially via video or through eConsults or either synchronous or asynchronous consultations using video, potentially with secure messaging or email. So essentially, I'm a physician who works both in person and online. Patients can choose whether they come to see me in person or online. So if you come to the Psychiatry clinic at UC Davis now, you get offered the option of seeing people either in the clinic or assuming that your insurance supports it from your home, on video. And that's now the routine in our outpatient clinics. And so we train our residents to work in that way, we train them to use MyChart, which means they message with the patients and they're also seeing the patients at home on video.

Dr. Peter Yellowlees (02:38):

So this is the way we're going to be practicing the future. There's just no question about it. A younger generation in particular, anyone under the age of 30, who's what I think of as being a digital native. In other words, they've never known life without the internet. This is how they live and they want to see their physicians in this way. Increasingly, Psychiatrists are actually being very flexible about this and are actually working more in this way so that patients have better access to them and quite, I must say, I think you have a better relationship with your patients.

Dr. Laura Roberts (03:08):

How do you develop a better relationship with your patients through this hybrid approach?

Dr. Peter Yellowlees (03:14):

So it's actually a much more patient focused approach, if you think about it, because the patient can choose how they wish to see you. And they can see you in person or on video or they can connect with you via other different technologies. And so you have a much more flexible doctor-patient relationship. It's not just based on the fact that the patient's got travel to see you. So they have more choice and it's much more convenient for many patients. The interesting thing about seeing patients on video is that there is a group of patients where it's clearly better to see them on video than it is in person. Now that's counterintuitive clearly, most people assume that the gold standard, certainly for any psychiatric consultation should be an in person consultation.

Dr. Peter Yellowlees (03:57):

But I just simply don't believe that. If you think about any patients who are anxious maybe with agoraphobia, with some paranoid ideas or particularly patients who've been traumatized, there is a strong series of reports in the computer science literature of the fact that people are more relaxed and more honest if they can actually see people through a computer in some form or another. And that's not surprising. I mean, if you imagine that you'd been abused yourself, perhaps you'd had some sexual attack on you or something a week before, if you then have to come and see a male psychiatrist in a room, in a place that you don't know, a week later than that, you're going to be anxious about that.

Dr. Peter Yellowlees (04:42):

The actual distance, extra distance that you get through video is actually really allows more intimacy in many situations. One of the big differences that we found in, as we see more and more patients using technology is that you can actually get more intimacy through the video with certain groups of patients than you can in person. And that intimacy can really improve the relationship that you have and patients can then choose when they want to come see you using whatever modality. And so I used to argue that we should always try and prove that using Telepsychiatry was as good as the in person consultation, okay? Now I say to people that if you are not using this approach with at least some of your patients, you are not providing a best standard of care. That's a challenge for many Psychiatrists, but I think I will be found to be completely accurate on that.

Dr. Laura Roberts (05:39):

That's great. Could you comment a little bit on where we are in Psychiatry in relation to other fields of medicine and these kind of different technologies to help support this new model of healthcare?

Dr. Peter Yellowlees (05:51):

Sure. So Psychiatry is a leader in this area. And there were somewhere around between probably one and a half to two million patients treated using video last year, that's actually a lot of patients. If you look at the VA in particular, they as a system, saw something like 350,000 to 400 veterans for psychiatric reasons on video in the past year. So the same is true of correctional institutions. The CDCR in California, actually employs 35 full time Telepsychiatrist. So Psychiatry is actually a very advanced specialty, quite honestly, compared with most other specialties in terms of the use of these technologies and that's obviously because it's relatively straightforward, you don't need too much hands on.

Dr. Peter Yellowlees (06:44):

The message that we want to get across in the book is that, this is the way we should all be practicing. There's just no argument about that anymore. Our patients prefer us to be flexible and to be able to see them in lots of different ways. And we think that it's quite clearly evidence now that this is the best way of practicing. And if you're not using these technologies, you're really not practicing as well as you could be.

Dr. Laura Roberts (07:11):

So a real difference from when I saw my first patient through telemedium, it was a very primitive kind of televideo system in New Mexico and the computer was that it was primarily viewed as a strategy for reaching patients where they were geographically remote. So rural and remote frontier communities. What you're speaking to is just an entirely new approach. What relevant to urban populations as well as people who are in remote areas. Could you comment just a little bit on that shift from just viewing it as a rural health strategy to a mainstream every patient strategy?

Dr. Peter Yellowlees (07:49):

Yeah, I think that, that's exactly the case, and that's why I say, look, if you come to visit UC Davis, in our Psychiatry, our patients in the middle of Sacramento, if you live a mile down the road, you can still see us in your home if you prefer. And I think that that approach is sensible. I think actually the previous approach of it always being thought of as being just for long distances, has actually in some respects slowed down the actual integration of these technologies into normal clinical practice. But I think once you make that jump that obviously you've clearly made, that this is how you should be practicing with everyone, then it ultimately becomes a matter of patient choice.

Dr. Laura Roberts (08:40):

Right. I think one of the virtues of the book is that it does address some of the ethical issues that people are worried about. For example, confidentiality, secure methods of communicating with patients. Could you comment just a little bit about how to approach all of these many issues that people may feel a little overwhelmed by as they think to change their entire way of practice?

Dr. Peter Yellowlees (09:01):

I think that's a really important point. And the interesting thing about the whole area of Telepsychiatry is that patients have been wanting to work like this for years, that the problem children, quite honestly have been the adults, they've been the providers. It's been the physicians who haven't wanted to do this because as you correctly say, they're the ones who actually have to change much more. And so it is complicated, I mean, people somehow think that just sitting and doing a consultation in front of video conferencing must be simple, but there are a whole lot of regulatory issues, as you say. There are a whole lot of IT standards that you need to know. Now, the simple fact is that those are all in the book, it's all very straightforward if you know what you're talking about, but it can get you into big trouble if you don't.

Dr. Peter Yellowlees (09:47):

So if I use one example, the current opioid crisis, it is very difficult to prescribe, basically the medication assisted treatment, meds that you need to give to patients with opioid problems over telemedicine because there happened to be a set of rules that were put in place by Congress that were originally put there to try and shut down offshore pharmacies that were the source of too many narcotics. And so by chance, that led to some difficulties with prescribing controlled substances on over video. And so there

are a whole lot of rules and regulations you suddenly find you've got to know what there's a DEA do, why are regulations different in different states? What licensing things do you need to sort out? So it's complicated, and it changes all the time as well because particularly the states change their rules all the time. So again, it's important to know where to go to get that information.

Dr. Laura Roberts (10:55):

Right. And can you comment also on how billing practices may vary from state to state or system to system?

Dr. Peter Yellowlees (11:01):

Sure. The billing is a huge issue in this whole area. Interestingly, most insurance companies are actually pretty good at billing for Telemedicine and increasingly they may allow you to see patients at home, not just in somebody else's clinic. The problem people in the billing area are actually the Feds and Medicare primarily. So Medicare has very complicated unrealistic rules that basically say, you can only see someone on Medicare if they're in a defined rural region, and then only if they're in certain types of clinical environments. So Medicare has been a real problem, and I'm hoping when that's going to be changed in the future. Medicaid is different in every single state, despite the fact that it's a federally funded system because the states have put in different rules to support or otherwise their Medicaid program. So any provider who's going to do Telepsychiatry has to look at what are the rules for their own state and the rules are all different.

Dr. Peter Yellowlees (12:07):

Now, the American Telemedicine Association actually does keep an updated list of all the rule changes on its website, which is a really good reason for any Psychiatrists or other mental health professionals to actually join that association because these rules change over time. But as long as you're aware of what the situation is, it's ultimately not that difficult. But it's like every clinical process, you've got to be careful, which in reality is what we're all preaching about.

Dr. Laura Roberts (12:39):

So just think for one second. When you thought about coming for this interview, what other things do we want to touch upon?

Dr. Peter Yellowlees (12:45):

So one of the things that you'll find in the book is really a description of how you can be a hybrid practitioner, how you can see patients both in person and online and get away from this, I guess, historical view that it somehow has to be either video or in person. What I preach very much is it should be both. And so in my university office, I have a computer with three screens and I have a good camera and a good echo cancellation system that I don't need to wear headphones. I can see patients using that system wherever they are, or I can see them by just turning to my right and talking to them in person. And I think we've moved away from the time where you need to go to a telemedicine center or any special center to use this technology.

Dr. Peter Yellowlees (13:39):

And so we've recently put two screens on every single one of our resident desks here, and plus a camera and an audio system. So they can routinely do these consults from their own rooms. And so that's what we are really aiming to do now, is to essentially turn all of our practitioners into hybrid Psychiatrists.

Dr. Laura Roberts (14:00):

So Peter, one of the issues that I know many of our colleagues are thinking about is how to maintain kind of appropriate constructive therapeutic boundaries, professional boundaries with patients who may text them through the night, might text them every single day, would call every day. And that really isn't in the patient's best interest in terms of their own wellbeing. So how do you sync through the professional boundaries when you're using these different technological media?

Dr. Peter Yellowlees (14:32):

I think that's a really important issue, and it's something that we've described in the book with a series of basic house rules. But essentially, I mean, let me tell you what I do. I mean, on my card, that all my patients get, I have my cell phone number and my email address. I tell patients that I would prefer them to contact me either through MyChart system on the EMR or email. They have cell phone, virtually none of them ever use it. And I specifically tell them that I rather they didn't phone me because I travel a lot, I'm not around. I hate playing phone tag and try to catch people again. And I say basically, if they need to have a long conversation with me, then probably we should meet and we can meet either in person or on video. But if it's for something short and relatively easy and we just need to do a few short things here and there, then I'm happy to handle it on email or on secure messaging. We have secure email systems, so that's not a problem.

Dr. Peter Yellowlees (15:37):

So I actually deliberately untrain my patients to use the phone because it takes too much time, gets in the way too much. And actually that way around actually works very well for most patients. They love being able to email you or message and they accept the fact that the phone is more difficult and it's also awful for them sometimes. What I've done is change the way I practice, quite significantly, and actually, it keeps the boundaries more certain, to be honest.

Dr. Laura Roberts (16:08):

How about this emotionally distressed patient, a person who becomes suicidal? I mean, how do you work with those kind of very acute situations?

Dr. Peter Yellowlees (16:18):

So clearly you can't have an absolute rule. If there are ever situations around you clearly have to talk to people. And I'm not saying I would never do that clearly. But what I'm trying to say is I'm trying to get away from the majority of the phone calls that actually can be quite time consuming. But you clearly have to be able to do that. And that's actually one of the reasons people have my cell phone because I am potentially available like that. Does that cause love disruption? Is that a real boundary issue for me? It actually isn't, I mean, I'm personally used to having my email come to my phone. If I get the occasional phone from a patient directly to me, it's not a big drama. Most of us are getting used to the fact that our email is permanently there, and if I'm going to be away from the office, I deliberately put a message on saying, "You can carry on emailing me. Just don't expect to reply in the first 24 hours".

Dr. Peter Yellowlees (17:18):

So I think you need to have some rules, but like all other things, the rules have to have a degree of flexibility.

Dr. Laura Roberts (17:25):

Thank you. What else?

Dr. Peter Yellowlees (17:26):

So one of the things that I think we need to do as we increasingly work differently and work in this hybrid way is think about changing our roles more and more into becoming essentially educators, mentors, teachers and people who are not doing so much direct patient work, but are working in teams and working with groups off social workers, health coaches, psychologists, whoever it is, to increasingly give opinions and to manage groups of patients. So to manage all the patients in a health system who have bipolar disorder and who are on lithium and make sure they've had all of their labs done and that they're all up to date or to review the EMR for all of those people who have too many ED appearances or things like that. So we need to start thinking as Psychiatrists of how can we be more involved in population health, in managing larger groups of patients than we have in the past?

Dr. Peter Yellowlees (18:25):

And in reality, in spreading our skills and expertise much wider than we are able to do through individual therapy. And so, one of the things that we've done in the book is actually to do a calculation on how many more patients could we supervise if we started seeing more patients regularly using email or using asynchronous video consultations as well as doing some of these population health based approaches working with teams of social workers. And it's quite clear that we could be way more efficient and see a lot more patients and supervise the care of a lot more patients. Particularly patients in primary care, working with primary care teams in the primary care medical home model using collaborative approaches. So I would love to see more and more Psychiatrists working in primary care, working in this hybrid manner and thinking about populations of patients rather than just individual patients all the time.

Dr. Laura Roberts (19:30):

So tell me a little bit about your collaboration with Jay Shore.

Dr. Peter Yellowlees (19:35):

So Jay and I have been friends and colleagues for 20 years. I saw my first patient on video conferencing in 1991. He was a bit slow on me, I think he didn't see somebody until about 1995. And we have known each other for the last 20 years. We've written many papers together, we've had grants together, we've collaborated on a number of different activities over the years. And so Jay and I have always talked about writing a book together. And obviously, this was the opportunity. And so we decided to try and put together a book that would really be a guide for anyone who wanted to use a range of different technologies.

Dr. Peter Yellowlees (20:18):

So we've covered not just video conferencing, which everybody thinks was being Telepsychiatry, but we've covered email and messaging, we've covered apps, we've covered the Electronic Medical Record, we've looked at how you use systems for population health, so wide range of technology based

approaches in this book. So we've gone into great detail to basically have a how to book, and it's really a how to book for any individual practitioner up to anybody in a large system, how can they start using technology effectively in mental health.

Dr. Laura Roberts (20:51):

Beautiful.

Dr. Peter Yellowlees (20:53):

Make sense?

Dr. Laura Roberts (20:54):

Fabulous.

Dr. Laura Roberts (20:56):

Thank you for everything...

Dr. Peter Yellowlees (21:12):

Oh that's all right.

Dr. Laura Roberts (21:12):

For being such an inspirational power weekend. It's just I think it's awesome.

Dr. Peter Yellowlees (21:12):

Well, you are really kind.

Dr. Laura Roberts (21:12):

Really appreciate it.

Dr. Peter Yellowlees (21:13):

[inaudible 00:21:13]

Dr. Laura Roberts (21:13):

No, it's true.

Dr. Peter Yellowlees (21:13):

But don't worry.

Dr. Laura Roberts (21:12):

You're listening to Psychiatry Unbound, APA Publishing's Books podcast. We'll be back in a minute.

Dr. Laura Roberts (21:17):

So Jay, thank you so much for joining me today. I'm thrilled to have a chance to talk with you. So can I shift gears and talk just a little bit about stigma? Because my impression having worked actually in

several different communities now in the United States is that the introduction of Telehealth strategies for working with patients is really a wonderful way to dismantle some of the stigma barriers. And I'm just wondering if you see that in a similar way.

Jay Shore (22:01):

So I think there's a couple ways to slice that pie, so to speak. So one, in some ways with the technologies it does can create more privacy for patients, meaning that when you're seeing them in their home or their office and they're not having to come into clinics, it provides a more sense of privacy and they don't have to raise their hand and say, "Yes, I'm going into the clinic that says mental health on it". And then in rural communities, that's even more so, if there's only one mental health clinic. Additionally, in rural communities, I think it may help people feel more comfortable seeking treatment because it provides them with a provider that has more of a boundary with them. So I've been doing a lot of work with mental health professionals in rural communities, and I don't see any more boundary issues or violations, than you do in an urban community. But certainly on the patient's half, when you are doing therapy with someone that you're now going to run into two hours later in the grocery store or at your kid's soccer game, that's a different boundary.

Jay Shore (23:22):

So I think those two things, the technology may help decrease the barrier to access that may be a stigma on an individual level. It obviously doesn't decrease the actual stigma, the public stigma mental health treatment. I think on the other side, what's helped decrease the public stigma is just, I think as our culture has evolved, and I think you're seeing it slowly, it's just my opinion, I think we're certainly compared to where we were 20 years ago where much more a self disclosure culture, and I think people across multiple mediums now are much more comfortable than they were 20 years ago. And I think it's still evolving about talking about mental health issues. You see stars, celebrities talking about it, you see the press talking about it, you see people on Facebook being more comfortable about talking about it. I would argue it still carries a higher stigma than medical illness, but I see that coming down as well.

Jay Shore (24:32):

And then the third way, I think technologies has also provide innovative ways to educate the public around the things like streaming video clips, TED Talks. You could look at Peter's work and his group in virtual worlds where they created a program called Virtual Schizophrenia, which allowed people to experience what virtual hallucinations were like and it's open access. And so again, I think there's a number of different ways that technologies can be leveraged to address the stigma issue.

Dr. Laura Roberts (25:12):

Yeah, that's great. Let me just ask you, Jay, are there things that you would like to highlight about the book or things that you'd like to say to the audience who maybe listening to the podcast?

Jay Shore (25:22):

What I think is, you said, to what I'm really proud of and happy about the book is the... And case examples I think is a disservice because I think when you say that word, I think traditionally you think of a case report in the margin and the case examples about a surd or about clinical cases. But the other two surds are about administrative issues, reimbursement, funding, and what those case reports are intended to do. You read them and they really have a lesson learned at the conclusion in the bottom that links back to the core material of the chapter. And so what I hope, and we're in the early stages of

getting readership feedback, but I'm, what we really hoped in the design of that would really, as you said, bring things to life and make it seem pragmatic and real and approachable for people.

Jay Shore (26:26):

And I do think for those not involved in technology, there's two edges of the continuum. There's some people who think, "Oh, this is, yeah, I can start skyping immediately with patients", for example. And there's nothing else really more involved. And so they don't think about the licensure, the security issues, the change in clinical style, the emergency, the outreach and access. So there are some issues you need to be thoughtful about with any technology and understand. I think on the other end of the continuum is some people get so intimidated about all the things I just said. They're like, "Well, I'm not going to get involved and engage with this". And I think what I hope is that the book shows that as you said, "Look, this is doable. This isn't rocket science. If you're thoughtful and do a little bit of homework, that it's fairly accessible to begin looking for opportunities to better use more technology, engage with patients, have more clinical opportunities in this area. And there are more system level approaches."

Jay Shore (27:38):

So really in some ways looking at, hopefully that book decreases the barrier to people who aren't using technologies with their patients, but are very interested in, "Okay, what's this about and how do I approach this in a reasonable way? And it doesn't require me going back to school to do this. It requires me getting some additional education and knowing where some of the resources and supports are."

Dr. Laura Roberts (28:05):

Good. And then are there just other things that you wanted to be able to say as you imagined our conversation or...

Jay Shore (28:15):

So why I love this field so much and Telepsychiatry is when I've been doing this for about 20 years, when I first got started, and this is true with video conferencing and other technologies, we basically were trying to just replicate what we could do in person over video or another platform. Now, that's really changing and we're using the technology to actually change the models of care delivery, how we see our patients, how we team with other professionals. And so, both as an individual clinician, Telepsychiatry and technologies continue to evolve in their use. But stepping back at the systems level of care, they're really beginning to reach their potential as being enzymes and the engine of healthcare system change. And they're opening up some really exciting opportunities and there's really a growing number of examples of how this is happening.

Dr. Laura Roberts (29:22):

Do you want to comment on maybe one or two examples?

Jay Shore (29:26):

So one of the obvious and I would say getting to be well researched in a growing evidence based is integrated care, the provision of psychiatric care within a primary care clinic, we're using video conferencing to virtually embed Psychiatrists into other virtual teams and live teams. So these are also blended teams that are both virtual and in person and they're really looking at both providing care to individual patients, but increasing the mental health knowledge and capacity for the population of

patients in any one clinic. And that's an example where really the model of how we structure and deliver the care has been changed cause of the technology.

Dr. Laura Roberts (30:12):

Comment a little bit about, how much you love Peter?

Jay Shore (30:15):

I think I already have, but Peter Yellowlees in particular, for people don't know, I think there's a couple special things about Peter Yellowlees for the field of Psychiatry. First of all, he was one of the early adapters of telemedicine in the mid 90s for Telepsychiatry in terms of sustainable programs. I'll get back to one of the earliest adapters to in another comment. And Peter began using this in the outback in remote regions of Australia and also began writing on it and has been incredibly prodigious. And then he transitioned his career into America and throughout this whole career, Peter Yellowlees is incredibly generative and generous with this time to anyone really a real ambassador in the field.

Jay Shore (31:10):

And then, the follow up, the other, I think was really interesting is, in our introduction we got one of the first Telepsychiatry clinical pilots in the 60s, Dr. Fred Guggenheim who was Chair in Arkansas and he is actually here now in Colorado. He retired and he is here, some children and I just went over to his place one night and we sat down and we had some food and we began talking, I was just kind of interested about what his experiences was and he told me, which is highlighted in the introductory chapter the book of his early experience which is one of the first clinical Telepsychiatry pilot in Boston. And what really struck me, and I hope what is highlighted by that introduction, that case report that he discusses of his experiences.

Jay Shore (32:09):

The technology has changed a bit in video conferencing, more than a bit, but the human experiences and some of the questions that we even asked today were things that were coming up then and the feeling that, yeah, it's a little different than in person, but if you adapt your style, you can maintain the overall quality of the relationship and get equally effective outcomes and really the transformative power of the technology. But also dealing with the technical challenges in Telepsychiatry to me are always the integration of the technology with the system. It's not the challenges around firewalls and making sure your microphone's off and all things that need to be addressed. But it's really the systematic integration of the distances into the billing, the workflow and all of that. And we still have to work pretty hard on that. And when they started that service in Boston, those were the same issues they were identifying. So I think that's a really niche highlight that starts the book out.

Dr. Laura Roberts (33:25):

That's great. Thank you so much Dr. Shore for joining us to talk about Telepsychiatry. I'm thrilled with this wonderful book that you and Peter have put together and really so delighted to have the chance to speak with you today.

Jay Shore (33:37):

Thank you so much for having us on and supporting the book.

Speaker 4 (33:45):

Our host is Dr. Laura Roberts. She is the Katherine Dexter McCormick and Stanley McCormick Memorial Professor and Chairman of the Department of Psychiatry and Behavioral Sciences, at The Stanford University School of Medicine. She is also Editor-in-Chief of the Books Program at American Psychiatric Association Publishing. Recording, Engineering and Music by Willa Roberts, Coordinating producer Kyle Lane-McKinley, Executive Producer Tim Marney. This podcast is made possible by the generous support of Stanford University. We are a production of American Psychiatric Association Publishing, John McDuffie, Publisher. Be sure to check out other APA Publishing podcasts, including AJP Audio and Psych Services. We are available across all podcast platforms, including Stitcher, Google, iTunes and Spotify. To purchase copies of this book or other books by our guest or host, please visit www.appi.org. That's A-P-P-I .org. If you'd like to contact us, drop us an email @bookspodcast@psych.org. We hope you enjoyed this podcast and thank you for listening.