Behavioral health integration webinar series: Virtual BHI

On Oct. 22, 2020, at 7 p.m. Central, the Behavioral Health Initiative (BHI) Collaborative held the third webinar in the Overcoming Obstacles webinar series: "Keys to Success: Implementation Strategies for Virtual Behavioral Health Integration."

View the video or the webinar slides (PDF).

About the event

 In this webinar, physician experts will explore how physician practices can virtually support the behavioral health of their patients. Experts will examine when it is appropriate to employ video and/or telephonic telehealth technologies, and the steps needed to ensure they best support patients (adults, adolescents, and children) across a variety of care settings.

Moderator

- David Leszkowitz, DO–Medical director of outpatient addiction services, Department Chair of Family Medicine, Pontiac General Hospital Pontiac, MI; medical director of inpatient addiction services adult substance and detox facility, Connor Creek Life Solutions in Detroit, MI; addictionologist, Western Wayne Family Health Centers (FQHCC)

Speakers

- Jay Shore, MD, MPH–Director of telemedicine, medical director, Steven A. Cohen Military Family Clinic at University of Colorado Anschutz Medical Campus
- Frank Degruy, MD, MSFM–Director of primary care outreach and research, Steven A.Cohen Military Family Clinic University of Colorado Anschutz Medical Campus
- Barry Sarvet, MD–Medical director, Massachusetts Child Psychiatry Access Program and professor/chair of psychiatry at University of Massachusetts-Baystate
- Brenda Anders Pring, MD–Atrius Health, chief of pediatric urgent care (Kenmore), pediatrician at Atrius Health (Copley), lecturer at Harvard Medical School

Transcript

Cynthia Payne Keller: Good evening and welcome to the BHI Collaboratives Overcoming Obstacles Series, sustaining behavioral health care in your practice. My name is Cynthia Payne Keller, and I am the senior director of physician services at the American osteopathic association. And as a member organization representative of the BHI Collaborative, I am very pleased to welcome you to our third webinar in this series. Before we begin I have a few housekeeping items to go over.

So first I want to tell you to please utilize the chat box for any questions you may have. We encourage attendees to interact and share comments or questions in the chat box while our panelists are presenting. Please note that this webinar is being recorded and that both the recording and the slides will be shared in an email following the event.

A survey will also be included. And then the staff of the Collaborative encourages you to share your feedback, as we plan future events. Following the presentation, we will take the question and answers that you are typing in. So next slide, please. This educational series is a part of a suite of ongoing activities by the BHI Collaborative dedicated to equipping physicians with necessary knowledge to sustain a whole person, integrated an equitable approach to physical, mental, and behavioral health care in their practices during the COVID-19 pandemic and beyond. Next slide.

As I mentioned these webinars are Collaborative product of eight of the nation's leading physician organizations established to catalyze, excuse me, effective and sustainable immigration of behavioral and mental health care into physician practices. With an initial focus on primary care, the collaboration is committed to ensuring a professionally satisfying sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patient's mental and behavioral health needs.

Today's webinar titled, Keys to Success Implementation Strategies for Virtual Behavioral Health Integration, will examine how practices can virtually support the behavioral health of their patients. At the end of tonight's discussion as I said, we will have a Q and A with our experts to explore common

issues, and, or concerns that you may be experiencing in your own practice.

Before I introduce our speakers, I would like you to just take a few moments to look through this disclaimer, just again, noting that today's webinar is being made available to the public and is being recorded. The purpose of this webinar is informational only, and of course you should consult a professional advisor for specific medical, legal, financial, and, or other advice.

And then without further ado, I am pleased to introduce our speakers. Our moderator for this evening is David Leszkowitz DO, Dr. Leszkowitz is the medical director of outpatient addiction services department, chair of family medicine at Pontiac General Hospital in Pontiac, Michigan. He is also the medical director of inpatient addiction services, adult substance, and detox facility. at Connor Creek life solutions in Detroit, Michigan, and then addictionologist at Western Wayne family health center. An FQHCC.

Dr. Jay Shore is the director of telemedicine and a medical director at the Steven A Cohen Military Family Clinic at University of Colorado Anschutz Medical Campus. And then his colleague, Dr. Frank deGruy is the director of primary care outreach and research at the Steven A. Cohen Military Family Clinic at University of Colorado Anschutz Medical Campus. Dr. Barry Sarvet is the chair of the Department of Psychiatry at Baystate Health and professor and chair of Department of Psychiatry at University of Massachusetts Medical School, Baystate. And Dr. Brenda Anders Pring, who was the chief of pediatric urgent care at Atrius Health, Ken Moore and pediatrician at Atrius Health Copley. And we're very pleased to have them all with us this evening, and with that, I will turn it over to Dr. Leszkowitz.

Dr. Leszkowitz: Well, thank you. Thank you all for attending. Thank you for the moderators and thank you all for coming in today. I'm really excited to introduce this webinar by the BHI Collaborative, on the Keys to Success in Implementation Strategy in what is so important and available to all of us today, virtual, again, virtual behavioral health integration. My name is Dr. Leszkowitz, I am the founder of primary care practice in Michigan that offers integrated primary care, behavioral health and addiction treatment.

Most of my life, I was a traditional osteopathic family physician. Over 10 years ago, I became board certified [in] addiction medicine, and at which point I had started serving as addiction services director in two federally qualified health care centers, also known as community healthcare centers or government clinics.

Most recently we faced challenges in opening up more government sites during this COVID period. And we can get into that a little bit later. But behavioral health integration is so key in my field and addiction services to have all of us to be able to have family medicine psychiatric services, talktherapy integrated, and to leverage this into virtual care is a critical issue during this period. And I'mgrateful to have this opportunity to be on the webinar, to encourage all of us, to participate intelemedicine, to provide these services.

As a starting point let me just share a few statistics and thank you for sharing these with me, according to SAMHSA, close to 19% or one in five, U.S. adults suffer from mental illness and I feel this is just gotten more lately and sicker patients nearly 19 million or one in 12 American adults suffer from substance use disorder.

Again, I feel that we're getting sicker patients, some of those not being able to have care, but with virtual medicine and integration, we are all fortunate. The good news is the proportion of substance use disorders patients that are now being able to receive MAT, or medication-assisted treatment is finally increasing. And looking at the pediatric population as our pediatric specialists will tell us, 3.2% of children aged three to 17 are diagnosed with depression. 7% with anxiety, 7.4% behavioral disorder, however, a concerning share of these patients, unfortunately, do not receive therapy.

Meanwhile, during this COVID-19 period, it has categorized us to using virtual care, telemedicine in one platform or another in the last eight months in a way that no one could have ever foreseen shifting according to CMS or Medicare. 9 million Medicare beneficiaries receive telehealth services during the public health emergency for mid-March to just mid-June prior to March, just 13,000 telemedicine visits were conducted each week.

This is providing a great, great opportunity to reach more patients. And I encourage all of you, whether it's the standard tele docs ... or now the fact that some of these are being waived, even FaceTime or Skyping, meet with your patients, and more efficiently, connect with them with the needed services, even if it's through the phone. This is true across the spectrum of behavioral health patients, which my respected colleagues, my psychiatrists were starting earlier, even before the epidemic, primary health care was just starting to ring the epidemic. And it's true across all spectrums, including patients seeking treatment for substance use disorders who might care for as an addiction specialist.

So after this shortly, I will introduce and Dr deGruy and Dr. Shore will follow me then we'll be followed by Dr. Barry Sarvet and Dr. Pring. Now what I want to say, although I've had the opportunity working for a federal qualified health care center, which offers so much services, I have noticed that even in my small primary care practice, we can provide great services and look to the community.

So three last talking points before I hand this over, having a strong, strong collaboration on my team with both clearly defined roles, each clinician or member of our team has that, but we also do work as

a team. If somebody is out ill, we clearly define some nurses who will conduct an intake, they'll conduct a history and an initial screening on a platform basis. Then what we call is a warm handoff. They will then hand it off to a physician assistant, a nurse practitioner, an MD or a DO when working with these patients to provide comprehensive care in the community is especially critical for the medication-assisted treatment patients.

And what we've all noticed is a unique challenge because it's hard, especially with the new patients, not to be able to see them live. So we'll get into that in little bit. In 2019, a systemic review of research on telemedicine or teletherapy for patients with substance use disorder found that many models of care delivery result in a high patient satisfaction. So if we can't provide face-to-face, at least we can provide that.

Secondly, my second talking point is building strong relationships. Yes, you folks out there may not have all the resources I do in the community government clinic, but if the MAT patients I see very often come in with comorbid mental health conditions, we can treat certain patients within our practice. We do not need to refer unless they have more severe conditions.

In these cases, we have developed strong relationships with the psychiatrist, with a social worker, with a peer coach in the community, and we will actually make the appointment, we will make the appointment for our patients to see them after they see us. We will also give them the demographics to make it easy. So with MAT patients, especially those with comorbid mental conditions, loss to follow up is always a concern. So this warm handup, when you make your connections with the community, since you may not be able to provide those services is key.

And lastly detailed interviewing is needed to successfully build a relationship with the patient. When working to support these patients in a virtual world that we are in today, a little extra effort is necessary to build that relationship, especially with the new patient that you don't know that well. We take every effort, especially the critical patients when we work to meet the mental health needs of our patients to this end, my team and I will often set aside a few extra minutes with our newer patients so that we can learn, we can look at them and get a sense because we do not judge and we take everyone that comes before us, no matter what background.

So if I have to stress one last thing, building the relationships with the community is key to delivering successful care. While all our practices are facing challenges in this time, it is key to take this opportunity to embrace technology using Virtual Care. And before I leave you all, it has taken, it's not just that we're being reimbursed finally over three and a half decades of my life, finally, in practicing medicine, but we can use all the tools that we have, whether it's the phone, whether it's telemedicine, I want to embrace all of you to please try to integrate this and go ahead and use your telemedicine skills. This being said, I'd like to carry on with meeting our next speakers our psychiatry friends, Dr. deGruy, and Dr. Shore, please go ahead and take over.

Dr. deGruy: Thank you, Dr. Leszkowitz. I'm Frank deGruy, turns out I'm a family doc and not a

psychiatrist. I chair the Department of Family Medicine at the University of Colorado on the Anschutz Medical Campus where I've been for 20 plus years. Jay is a card carrying psychiatrist, a professor in the Department of Psychiatry and the director of telemental health services there. One of my closest and dearest colleagues and someone with whom I work very closely to develop advanced models of care, both in the primary and the mental health setting. Next slide, please.

You can read and so there's no use in my reading it. Next slide, please. These are the objectives that Jay and I hope to accomplish today. We first want to characterize how we're using telemental health care in primary care, and we next want to describe the advantages of telehealth. We've all sort of been forced into using it much more extensively than was true eight months ago, but even eight months ago, the advantages of telehealth were emerging very clearly. And so we're going to try to describe what some of those advantages are and under what circumstances you can use telehealth services to maximum benefit. Next slide, please.

Now I want to make a point before we get started in describing how we use telehealth services. This is a slide which describes the most recent of many descriptions of the models of integrated primary care that are at play in the U.S. and really in the world today. This is data that just came out, a couple of weeks ago, two weeks ago. It's from a sampling frame of over 500 primary care practices that represent care for over three million patients who get access to integrated care services.

Over half of those were safety net clinics, and if you look at the right hand column, what you'll see first of all, is percentages that total up way beyond 100%. What this should say before we even describe the particular models of integration that these primary care practices use is that most of them use more than one model.

I'll give you a quick example of that. PCBH stands for primary care behavioral health, some variation of a model, which includes primary care clinicians integrated with Embedded Behavioral clinicians who function in the clinic as primary care clinicians, primary care behavioral clinicians embedded in a team-based model of care. That does not preclude the use of, and the design of Collaborative Care, which as you probably know, consists of a primary care clinician, a care manager, and a Consulting Psychiatrist, that is a model that often co-exists with a PCBH model. And you can see the other MAT expert, marriage and family therapy, addiction, a specialty medication, there are a range, bewildering range of variations and combinations of primary care that is subsumed under the label of integrated care. Next slide, please.

These are the basic elements of all of those variations. In some form or another, what you see at the 12 o'clock position, our primary care clinicians, those are family docs, or general interns, or general paeds, NPs, and PAs and others. The primary care clinicians are at the heart of the core primary care chain. At the three o'clock position you'll see embedded primary care, behavioral clinicians, psychologists, social workers, MFTs, and others. At the six o'clock position, you see primary care psychiatrists, a role that Jay will describe in much more detail in just a moment. These are

psychiatrists, psych MPs, and others like that who do deep end or difficult primary care work as part of the team. And then at the nine o'clock position you see care manager, a position that's dedicated to integrating these positions into a coherent team. Next slide, please.

And I'm going to turn this over to Jay at this point, so that he can describe for you within that universe of clinicians that constitute the team what's done in a direct physical person to person space and what's done in a virtual space. Jay, I'm going to go on mute.

Dr. Shore: Thank you Frank. So I think we're all right now pretty much working in a virtual world and certainly is the opening remarks, the acceleration of us using Telehealth because of COVID both the current acceleration, but I don't think things will go back to the way they were before. And what that means is all providers will really be working in this hybrid care model, meaning we will work and use multiple different technologies and median in dealing with patients.

So we'll hold relationships virtually, via video conferencing, telephones, email, patient portals and we'll see patients in a variety of settings in person. And I will sort of get back to this, but it's really in this context of the hybrid universe that we need to begin to be thinking about virtual integrated care. Next slide.

So this is a figure that I like from the Kaiser Family Foundation that sort of simplifies these models on a continuum of integrated care, everything from really on one end of the continuum where you're just doing some mental health screening to a fully integrated care clinic and there's various definitions of this. And I'll return to this chart in a minute, but really what's happened particularly with technology is we've... Next side, please. We use just really this host of technologies that I mentioned both patient facing, medical team facing, mental health facing, to interact and begin to overlay the ways that technology can enhance this integration into these models. Next slide.

So we return here to this slide and you can see that at the very one end of the basic level of the continuum where you have coordinated care patient education, you have echo style grand rounds moving up a continuation, you have things like e-consultation or direct telepsychiatry consultation, things like Tuft store and Ford telepsychiatry and then at the full end, is this full virtually enabled integrated care model. Next slide, please.

Where again this is an illustration of different ways and pathways that technologies can connect the different types of professionals, everything from the providers and case managers with the patient or patients. And it's really within this web that a virtual integrated care exists to give just a very brief example of this. Next slide.

In Colorado, we have something that we call integrated behavioral care plus. And this is a model as Frank described, it's foundation is having an embedded Psychologist who used to be, and now everything's virtual, but before COVID was physically embedded in this behavioral health team, along with other behavioral health support in case management, and then the full compliment of the primary

care team, and then layering in on top of it was Psychiatry, which was coming in virtually and doing a step care approach to a touch with the patient, starting with e-consults, provided a provider consultation via email, phone, and in video, all the way up to doing co consults or team meetings with the patient in and out of the room. And then all the teaming approaches that are needed to solidify the teamwork of integrated care. Next slide please.

And this is actually a model from one of our clinics that really shows how this really gets put together and operationalized on a pragmatic level. So you see that this is integrated care service across seven family medicine clinics. So you can see family medicine clinic A has its family medicine providers, it has this embedded Psychologist and other, and then you can see up top, it has telepsych coordinators, MAs, and other support, and then on the psychiatry team, you have this lead clinician and they're doing weekly team TeleSign huddles, discussing cases, seeing patients directly as individuals and as team members, and then you can see on the other side of that bubble that lead that clinic A Psychiatrist is part of a larger psychiatry team that's also servicing other clinics using the same model. And that team also has a weekly meeting.

And so this is really about sort of gaining the details of operation. Next slide, please. And I'll let Frank start off, but we'll to talk about just some of the common sort of pitfalls and challenges of doing this well.

Dr. deGruy: Thank you, Jay. So Jay showed you a set of slides that describe the hierarchy, the levels of integration, and what really in truth is a fairly complex set of relationships with between the behavioral clinicians, to the primary care clinicians, patients, the care managers, but it can be reduced to a fairly simple and straightforward set of principles. If those principles are not followed fairly carefully the proposition for integrated telebehavioral health and primary care can easily come unraveled. So I'm going to talk about some of these on the primary care side of the river and Jay we'll talk about them on the behavioral or psychiatric side of the river.

If the primary care clinic is led by someone who is clear and consistent and who can make decisions that represent the best input and the best data from the team and can commit to following through on the decisions that can be made telehealth has a chance of working, but you absolutely have to have a clear and decisive leadership that listens and makes use of all of the team members.

One of the most important means by which making use of all the team members occurs is represented by the second bullet under communication to effective teamwork, we'll break telehealth and telemental health very quickly. It requires a team that is flexible in which the hierarchy is relatively flat in which any member of the team can go in the lead in terms of taking care of the problem that the patient is representing, according to whoever is best suited for dealing with the problem at hand.

There's also a need for having a fairly careful and fairly well-documented workflow. The capacity for workflow needs to be laid out and it needs to be understood by all of the team members, how, and under what conditions a televisit occurs, what it takes in order to do that, and it needs to not only be

clear, but it also needs to be very flexible because in the primary care setting, stuff comes up out of left field all the time.

And finally, you actually have to have someone on hand who's mastered the technology so that televisits can happen so that you can actually see each other on the screen and that you can sign on and sign off and make that part of the electronic health record clearly. Those are the pitfalls without which telehealth is difficult to do. Jay.

Dr. Shore: And very much in a parallel manner on the psychiatry side, and particularly for Psychiatrist it's sinkholes or pitfalls include of a hierarch or call approach many of us have been trained in more hierarchical model, and don't get a lot of team-based care training and hopefully that's changing.

But being able to be flexible to be able to demonstrate leadership on a team but not taking a hierarchical approach, really facilitates the important work that needs to happen for team management and dynamics. And psychiatrists have a unique sort of leadership role, but leading doesn't mean always being in charge and I think that sometimes takes a lot of experience for clinicians to come to terms with.

And then I think the other really critical point is not having a really good understanding of primary care. Really understanding the pressures of your colleagues in primary care in their perspective, so you really can be of service to them as you're working full for and it gets back to understanding the culture of primary care, as well as the specific clinic and workflows as my mentor Frank deGruy says, "Good integrated care obviously needs good workflows and structure, but it also is a bit of an art and it becomes a dance and a really a good dance." When you first start to dance with a partner, you may step on each other's toes, but if you keep practicing, it becomes a fluid and a thing of real beauty, but that takes time and sort of willingness to let your toe maybe occasionally get stepped on when you're learning the first few steps. Next slide and Frank, I believe this is your,

Dr. deGruy: Yeah, I don't need to belabor this slide, but I wanted to put it up here because I described pitfalls on the one hand, this is the converse of that. If you are getting into the business of doing telemental health care, these are the issues, these are the domains, which you need to pay attention, learn, and acquire mastery in order to succeed. And remember that the point of doing this is to produce a comprehensive and a coherent or integrated personal care plan for the patient. Next slide. This is, [crosstalk 00:32:49]

Dr. Shore: I would just end with saying that the teams and each team member needs to always display a high degree of tactical flexibility. Those may recognize this slide as the dread pirate, Roberts battling the giant Fezzik in the Princess Bride and he was able to overcome the giant because he just got used to fighting large groups of people and had it honed his one-on-one skills. And so it's really important to have a good degree of tactical flexibility when doing integrated care. Next slide.

I believe you'll have access to the slide. So this is just some resources here and both for

telepsychiatry and some integrated care, some starting points. And then next slide is also just our contact information for follow-ups or questions. If you wake up at 3:00 AM and have a burning question that didn't get answered on the webinar, Frank and I would be happy to help cure your insomnia, although we may not respond at that time. So thank you and I believe we go onto the next segment.

Dr. Sarvek: Hi everybody. Good evening. So we can move on to the next slide, which will be kind of the welcome slide for the talk. So, Dr. Pring and I are from Massachusetts and we're going to talk with you about the Massachusetts Child Psychiatry Access Program. The Massachusetts Child Psychiatry Access Program, which we refer to in Jordan as MCPAP, is part of a larger context, is the first program of its kind. But now we talk about this term, CPAPs which is one of the general term, and this is a model that's been spreading across the country

It's a remote population-based Collaboration Model and it is considered to be a Telehealth type service. But we should emphasize that, unlike other kinds of Telehealth, it's really not a very kind of technology kind of dependent service because the remote aspects of it are basically telephone conversations and involves seeing patients as well.

And of course, we're just like everyone else, seeing all of our patients through a telepsychiatry, a televideo, a video conferencing technology, it doesn't have to be that way. And, so it is a remote type program. It's a public health infrastructure model really because it really is a model that's almost always funded by States or municipalities. It really is devoted to practices that are distributed across a geographical region.

And so I'm going to talk a little bit about the program model. We've been doing this since 2004, it's proven to be sustainable and it has spread to 38 other States. And so, if you throw out a dart at the map of the U.S. you're likely to hit a State that has as one of these programs. Dr. Pring is going to talk about the experience of being a pediatric primary care provider, really on the other side of the Collaboration relationship. Next slide, please.

So the purpose of MCPAP and pretty much all CPAPs is really to support the role of pediatric primary care providers and addressing the mental health needs of kids in the primary care setting. And it really does that through connecting practices to the, actually there's a typo on this slide. I should say, "I made a typo in this slide." It's not just there, to the Psychiatric healthcare system. So it really kind of create connections between primary care practices and the whole world of psychiatry and the whole system of care and willingness to improve the quality of mental health service delivery in the primary care setting.

And essentially, I think this point really needs to be emphasized and along the lines of it being not a technological sort of program per se, it really is like a system supporting the building and the cultivation of relationships, between child psychiatry folk and pediatricians and historically, we have to acknowledge that the relationships have been pretty lacking. Next slide please.

So this is basically how it works, at least, clinically, these programs usually have a hub and spoke model, and there are these teams that are located centrally within a region, and then their primary care practices throughout that region, it's a catchment area when you answer the notion of a public health model. And so all of these practices have access to a hotline.

And whenever they have a question, whenever they're seeing a patient that has a mental health need they can call the hotline and they always get initially a telephone consultation, and then the telephone consultation can actually be provided by a child Psychiatrist who's on call all the time and really dedicated to this work. They're also multidisciplinary teams, so that we have therapists that are providing telephone consultations, as well as care coordinators who can help with resource navigation.

And then after that initial telephone conversation we can go on and see the patient in person with a face-to-face evaluation again during the pandemic, it's almost always over video conferencing, we can actually do some interim Psychotherapy with a patient and then we usually pass some work over to a care coordinator who can help the pediatrician and their practice with trying to access resources. And so the whole purpose of this is really to help primary care providers to have the tools that they need to take care of their patient. Next slide please.

So the services of these programs, I already mentioned several of them, the one that I didn't mention is training and education. And actually the training and education piece comes in two ways. One of them is through a traditional CME program because the CPAP programs usually have a whole strategic plan to offer CME products and different kinds of services to pediatricians. They're really designed specifically for primary care providers, but every telephone consultation and every face-to-face assessment really is kind of a teachable moment practice-based kind of educational service because again, the care is being provided by the primary care provider and all the advice and consultation that we give is educational in nature. And we're not sort of dictating what the plan is going to be from patient, we're giving advice, and then the pediatrician can decide what to do. Next slide, please.

So we like to think of these programs as, really relying on this notion of a three legged stool in the sense that there's no one thing that's really enough of the services that I described, telephone consultation as the starting point, but it's never enough, because you're answering questions over the telephone and almost always the answer the question is not all that the pediatrician needs. So sometimes you can't answer the question because we don't have enough information. And we don't have enough knowledge of what's going on clinically to really give a good answer to questions.

So all these programs really need to have provisions to be able to do a face-to-face consultation, which is the direct patient evaluation, which is expedited and really designed to provide kind of a confirmatory consult or really to help with diagnostic accuracy so that we know what we're treating. And then referral resources that we can have all kinds of great ideas as far as what to do. The pediatrician always has their prescription function.

But the pediatrician is unlikely to be doing psychotherapy and almost all care of children with mental health problems requires a team. Because you have to have a treatment plan, you have to have a team and pediatricians really need help with resource navigation. So it is a three legged stool, and I think without one of those components, the programs don't tend to function very well. Next slide please.

So this is just some data. I want to keep this practical, but the point is that we've studied the program and we've found that there's been significant enhancement and the pediatrician's really are feeling of confidence and competency in terms of being able to take of kids with psychiatric problems. I should mention that we don't support the idea that pediatrician shouldn't have to take care of every patient with a mental health problem.

We're really kind of focusing on what we consider to be potentially within the scope of practice and primary care. And we kind of help triage sometimes on these telephone consultations that patients who really need to be seen by a specialist. That's a fluid kind of distinction because in some areas the sort of child psychiatry scarcity is much worse than others. And so we have to take into considerations for the resources and also the interests of Pediatricians and their kind of sort of willingness to take on this role. Next slide.

So just a few things about best practices of this program. So again, it's a relationship type program and it really depends upon pediatricians having the motivation to call so that the practices that call often get a lot better service from CPAPs because the services really provided at the prompting of the pediatrician and reaching out and calling. We do some outreach and we're actually developing models of outreach so that we don't have to wait until the Pediatrician knows that they have a question because of course not everyone knows what they don't know. But this notion of these telephone conversations that really over time when there are many of them, it really builds a very rich relationship and we're able to cultivate very warm, clean jobs. Sometimes so nice in that pediatricians who we've never actually seen oftentimes in the sort of with our eyes, that we've interacted with them, but sometimes they maintain relations with us where we talk with them about their own personal needs and issues and there's a sense of trust that builds up. And it is derived from a time honored tradition of curbside consultation. Next slide, please.

So, I mentioned that every telephone consultation is an educational encounter, but I would also say that the face-to-face consultations is like precepting for anybody who's been involved in residency education, I'm sure everyone has done a residency and has had experience precepting and so it's

one thing to hear a case and to have advice, to give advice, but it's another to have a telephone conversation and then see the patient and then have another conversation to really go over what the pediatrician thought and what we thought and compare, and that's a powerful learning tool. Next slide.

So I already talked about the fact that these telephone consultations really build the relationship. And there's lots of pieces to the craft of doing this that makes it work. It's not for every child Psychiatrist because some child psychiatrists literally make pediatricians feel nervous because they focus more on kind of the complexity and not on the things that are sort of straightforward. And so there's different best practices about how to make these telephone calls a positive experience so that you get calls again. Next slide.

And then finally, I just want to sort of point out that we recognize one of the biggest limitations. I think the biggest limitation is of the CPAP model is that if the PCP doesn't know that they have a question and doesn't really have kind of a very active engagement with patients around behavioral health needs, because they may not be interested, they maybe afraid, then it doesn't work because the PCPs won't call and then they won't get the services, their patients won't get the services of program.

And so one of the solutions to this that we've really worked on is to try to develop some hybrid models with some of the other integration models. So one of the most exciting ones that I'm really interested in and have been working on piloting in Massachusetts is to utilize this infrastructure of the CPAP to deliver an adaptation of the impact or a collaborative care model, which involves an embedded clinician, a behavioral health clinician care manager, working in the practice and the child psychiatrist instead of waiting for calls would have a weekly meetings with the embedded clinician to go over the case load and then generating ideas that could be shared and what would be shared with a pediatrician about things that can be done medically.

And so that's kind of one of the most exciting frontiers I think, of MCPAP and other CPAPs. But I think I'm going to go ahead and hand it over to Dr. Pring as a next step.

Dr. Pring: Thank you. And yes, I'm a general primary care pediatrician, I practice in Boston and I've had the great opportunity to have a lot of helpful experiences with MCPAP. So as Dr. Sarvek said, the program, and you can go to the next slide please, is really sort of, I see it there, I think he was a stool and we had all of those parts, but there's sort of the educational component and also the practical component, which then gets back to the educational component. So in my large practice in Boston, believe it or not, Boston, which has a ton of physicians, we also have difficulty with access to child and adolescent psychiatrists. So we do find this program to be very helpful. And some of those things that Dr. Sarvek was talking about, the offering of different types of resources, I just received in my email today very timely about a webinar on Wednesday next week at lunchtime for primary care physicians and pediatricians.

And so MCPAP does these periodically on top of having a very useful website and then really some really great other general basic to the psychiatrist and the audience will think is super very basic

bread and butter psychiatry, but for some of us pediatricians it's a little bit more basic things on how clinical pearls for handling ADHD and starting a new antidepressant and sort of diagnostic checklists and the treatment algorithms or types of medications we want to use. And for many people that might seem like something that's very easy we prescribe antibiotics all the time and know which one's the best one, but when it starts with, well, which antidepressant or [anxilant 00:49:46] should I go for? I think that these are great resources.

I will just advertise, it's probably hard to read on camera, right above my desk and when I was preparing for this talk, I went around to my colleagues offices, and they all have this really great book that MCPAP sent to us. So I just think some of the learning is the interactions and some of it continues to go on. Next slide please.

And so, my experience really, as I talked about, some of this is learning, but also really the consultation process, which obviously builds learning and as we all know, we learn more from experience than from just textbooks. And I decided to share a specific example I have with you, I know we want to get to your questions and as a general pediatrician, I think I've had the benefit of learning a lot from these interactions with MCPAP. Next slide please.

So I thought I would just sort of share a typical case for you in a primary care physicians in the audience may have gone through this kind of experience where it's late in the day, I have a new patient on my schedule. This happened to be a 15 year old comes in with his father. He had recently relocated from Maryland, where he lived with his mother and had been in some kind of group home for quite some time and had transmoved to Massachusetts father hadn't really been that involved with his care in the past, but knew he had maybe a diagnosis of a mood disorder, and ADHD and some ticks, and had a bag of sort of medicine bottles with prescriptions that were kind of running low and had run out and the child at this point was starting to become more angry and very sleepy and his tics were starting to act up.

And so here I was in sort of that typical situation where we need to do the right thing, I know I'm not necessarily the right person for this, but this patient needed a lot of help and needed it quickly in a sort of a setting where we didn't have instant access to the right kind of specialists for a visit in person. So I was able to reach out to MCPAP who right away following that great flow sheet that you saw, all sorts of things happened, what seemed to me, very seamlessly and I don't know what happens on the backend, but I was able to speak with a child Psychiatrist who was able to help me this patient had been on Risperidone, which I had never prescribed gave me some recommendations for dosing, what labs I needed to run an EKG management and things that really would have overwhelmed me and I would have another situation just probably turn the patient away and said, "I can't help you." I'm not turning away, but not even just wouldn't have felt comfortable writing a prescription for medication without that kind of support.

And then, what was really wonderful is they were able to get him in quickly for a consult. And then,

even more amazingly, in my opinion was, feedback back to me with information on sort of what we should do about the medications that were sort of affecting this child that were making him sleepy, or making him angry or the lack of some of those medications, and then able to give me and the patient, a list of providers that took his insurance and they had an open practice.

And that was really impressive. I just think that doesn't always happen so much. And then I just felt overall that it was a really warm handoff and a really great sort of wraparound care with a great opportunity. And that was just sort of one example of the way that the relationship was MCPAP can start with one patient and then continue on to others. Next slide please.

And so I thought that was probably all that I wanted to sort of highlight as just how it really can be a lifeline. I think a lot of pediatricians and primary care physicians are comfortable with some treatments, but like Dr Sarvek said, "There are certain ones of us that are more comfortable and certain that aren't" And this really helps us sort of become more comfortable. With that I think I will pass it on back to Dr. Leszkowitz

Dr. Leszkowitz: Well, thank you everybody. I want to thank all the participants, and are there any questions from the chat? I see, myself one of the questions I may have for all the pediatricians and the psychiatrists, as far as telemedicine and in your field often, we are faced one of the largest diagnosises is attention deficit or hyperactivity, or not sitting still, not doing good in class, creating stress with the family, et cetera. So in person it seems there's some easier, but I would imagine you've been faced with some obstacles with telemedicine, can you maybe briefly go over those obstacles and maybe what you do in your models to try to face those, Dr. deGruy? Or can you hear me?

Dr. deGruy: Yes, I can hear you. Was that a question specifically for the pediatric practices?

Dr. Pring:

Pediatric practices in particular with telemedicine, I would imagine has there been some challenges, or I'm sure there are as opposed to having that child there in front of you?

Dr. deGruy: At the risk of being inappropriate, it might be that Dr. Sarvek and Pring would be better equipped to deal with that question since they live more completely in the pediatric space.

Dr. Pring: I guess I'll just say, in terms of the pandemic and from face-to-face, we actually are seeing a fair amount of patients in the office, but something like ADHD, I think for us we do a lot of diagnosis based on the symptoms and that actually is probably easier to manage with sort of questionnaires and things like that from the parents as a remote. So the face-to-face versus in-person for that, I don't think is as challenging. I'm not sure if Dr. Sarvek has anything to add.

Dr. Sarvek: ... It's not clear to me sort of that we have trouble with kind of pitfalls or troubleshooting

kind of needs with this program again, because it's an old fashioned relationship program. So we don't depend upon the vagaries of technology so much and certainly with video conferencing, and also we're not trying to take care of the patient remotely either, we're really trying to be able to offer good direction and advice to the pediatrician.

And it's true that telehealth for psychiatry ... I'm sure Dr. Shore can speak to this more eloquently, but, we actually don't touch patients very often. And we try not to. And so having that distance is actually okay. It becomes very challenging for young children.

I will say that when you have toddlers it's very difficult to keep their attention, keep them engaged, that when we're in the office taking care of young kids, we're kind of following around a room and trying to play with them and trying to attract their attention with toys and things like that and that becomes very difficult. But otherwise, I think, we haven't had much trouble utilizing different kinds of tactics to really understand sort of what's going on with patients from a distance.

Dr. Leszkowitz: Great. Thank you. Thank you, Michelle for the kind words and Patricia, Miss. Gibson, to answer your question the insurance companies the government has waived the Ryan's laws so that we can use telemedicine. I've noticed that some of the copays are being waived and all insurances, as far as I know, have been kind enough to pay a decent fee for telemedicine.

So you may want to reach out to your insurance companies or to your organization, but from the billers, I know at the private practices, small practices are doing very well with telemed. Just there may be a code to add, I don't have off head, but I will get that for you and encourage you to do that.

And the biggest points from tonight was the Collaboration with the pediatricians, the psychiatrist of primary care, and early on we heard that virtual medicine is here to stay. I don't think we're ever going to go back, so I encourage all of you as you solely or go out and integrate to reach out and to continue to use these phone calls and telemedicine platforms if that's works best for you. I want to thank the people who put this on the AMA the AOA and all our presenters today. Thank you all the attendees for being here, and I want you all to have a really good night. Thank you.

Keller: Okay. Thank you all. We are at the end of our time for today's discussion. The next webinar in the series is scheduled for Thursday, November 12th and at that one we'll be financial planning strategies for BHI. If you were unable to attend any of the previous webinars in this series, the link to the page is in the chat box, and thank you all again, and hope you enjoy the rest of your evening.

Dr. Leszkowitz: Thank you. Have a good night.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

About the BHI Collaborative

The American Medical Association along with seven leading medical associations have established the BHI Collaborative, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices.

With a focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

The medical associations include: the American Medical Association, American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and the American Psychiatric Association.