Mental health counseling for physicians and APPs
AMA STEPS Forward® podcast

Mental Health Counseling for Physicians and APPs

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In this episode of the AMA STEPS Forward® podcast, Rob McGregor, MD, chief medical officer and pediatric hospitalist at Akron Children’s Hospital, shares his experience creating a strategic program that provides free and confidential mental health services for physicians and APPs. Get resources on burnout assessment.

Speaker

- Rob McGregor, MD, pediatric hospitalist and chief medical officer, Akron Children's Hospital

Host

- Jill Jin, MD, MPH, senior physician advisor, American Medical Association

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Transcript

Speaker: Hello and welcome to the AMA's STEPS Forward® podcast series. We'll hear from health care leaders nationwide about real-world solutions to the challenges that practices are confronting today. Solutions that help put the joy back into medicine. AMA's STEPS Forward® Program is open access and free to all at stepsforward.org.
Dr. Jin: Hi everyone and welcome to the podcast. This is Dr. Jill Jin, senior physician advisor at the AMA and I'm your host for today. Today on the podcast, we are joined by our guest, Dr. Rob McGregor, a pediatric hospitalist and chief medical officer at Akron Children's Hospital. Our topic of discussion is a mental health counseling program for physicians and advanced practice providers that he established at his hospital. Dr. McGregor, thank you so much for joining me today.

Dr. McGregor: It's my pleasure.

Dr. Jin: Why don't we start with you telling our listeners a little bit about yourself and your background.

Dr. McGregor: As Dr. Jin said, I practice as a hospitalist, a pediatric hospitalist, but I started as a hospitalist before there was such a thing as a hospitalist. I've been a pediatrician for over 40 years and I've been the chief medical officer at Akron Children's for 10 years. But really my passion doing administrative work came through being a medical educator and a pediatric residency director for decades over two different organizations. So, I've always had an affinity towards education and helping learners maximize their learning, and I saw plenty of mental health challenges and stresses well before the pandemic. So, when this opportunity presented, it just seemed like a natural fit.

Dr. Jin: Gotcha. So, you described this mental health program for clinicians at Akron Children's as a concierge program. Can you explain what this means and how the program works?

Dr. McGregor: Sure. I'd just like on the onset to make it known that I did this in collaboration with an adult psychiatry colleague across town at Summa. So, Dr. Joe Varley was my partner in developing this concept and then moving this to fruition.

Dr. Jin: Gotcha.

Dr. McGregor: So, at Akron Children's, the medical education department actually came to me and said, "We'd really need to have some resources that are outside of our program and outside of our hospital." Because what happens in many children's hospitals is if somebody suggests a colleague's having a problem, they go to faculty in the hospital, which are pediatric psychiatrists, generally, not adult psychiatrists, although they have some expertise. And we then have the whole issue of confidentiality and residents getting involved with someone that might evaluate them when they do a rotation. So, I've had that challenge in other organizations where I work.

So, I was very sensitive to that when my head of the medical education said, "I think we really need to do this." And he pitched the concept of doing opt-out counseling for all new residents. I like the concept, but because I've had some experience before where the boundary between faculty and friend and treating physician got blurry, I was sensitive and said, "I need to reach out and call a friend," who's a very good friend now. At that time, it was almost a cold call when I called Dr. Varley and said, "Would you help me do a program where I'm giving mental health treatment to my residents and my
faculty?" So, I took the liberty of taking the piece about the residents and say, "Why would we stop there? Why would we not offer this to the faculty as well?"

So that was how the idea was born. And we started about a year and a half before COVID hit, fortunately, working through this idea and working through getting buy-in from our administrative teams to move forward with the model and get some funding to stand this up. And fortunately, when the pandemic hit and much of our clinical operations on both sides were disrupted, we had this wonderful project that felt very positive and really helped build my resiliency. I acted as the physician in charge of our COVID response. So, it was a welcome diversion and the birth of this project has been really pretty powerful.

Dr. Jin: Wow. Yeah, and I didn't realize that it covered both trainees and practicing clinicians, so that's wonderful. And so just on a practical level in terms of how the program runs—so if I am a clinician, I want to reach out to somebody, what do I do and how does that work?

Dr. McGregor: So you have multiple ways to access, but essentially you either text a dedicated phone number or you can go in on a URL that we have on most of our brochures that we hang around the hospitals that allow you to get immediate access. If you would prefer to email, there's also an email address. And then our lead psychologist will get back to you almost always within 24 hours, but it's pretty much been same-day service that I've been told by the people that use it. If you're accessing because you have a problem, what we try to do is get upstream though so that every new faculty member that joins the medical staff at Summa or the medical staff at Akron Children's actually has an appointment pre-scheduled that they can opt-out of, but to have an introduction and have a query about what do you do to take care of yourself because this is a challenging profession, so that they meet our therapists when they're not in crisis.

And it turns out that that has really blossomed. We got a lot of pushback from faculty initially, but residents were quick to adapt it. And then when we presented some of our early data after a few weeks of action, I had faculty members demanding opt-out counseling. So, we said, "All right." So, we've now built that into onboarding for both our APPs and our other medical staff at both organizations. So that's been a good add. I think that's a pearl that I would've liked to have taken credit to design that on the front end but we listened to our users.

Dr. Jin: Yeah. I love that concept so much. At what time point is this opt-out counseling offered?

Dr. McGregor: It's usually in the first three months, first 90 days of employment.

Dr. Jin: Got it. Two important parts of this program, as you've alluded to, is that one, it is confidential and two, it is free. So how do you fund this program and how do you ensure confidentiality?
Dr. McGregor: Okay, so the barriers that we researched why docs don't get help is they don't want an electronic footprint anywhere. They fear problems with medical boards, which most states have worked past that, but anybody over 40 has that fear because many of the states did make you report that you were getting treatment, not that you were not impaired, as most progressive states have done now. So, they don't want a health insurance record, they don't want an electronic record, they don't want a referral track that can show up, they don't want a session limit. So, once they get involved, they don't want to be told, you get two of these and now you've got to pay. So, the way we funded this has been really initially on the backs of our two organizations. We told them that we wanted to make a separate 501(c)3 because my wish someday is that we're totally self-sufficient through philanthropic support and we can wean ourselves from the parent organizations.

However, in the beginning, we didn't know what we didn't know. Each organization fronted three hundred grand, which is a pretty small part of their annual budgets, and we created a not-for-profit. So, the other piece that I think is imperative for those of you who are trying to think about replicating that is: find yourself a legal champion that understands the whole issues of medical malpractice and the risk of standing up a treatment plan that's not actually within the hospital, that it's separate because that was really, really valuable advice that probably saved us from making mistakes along the way. So, we started with the seed money and then the hospitals, once we decided we were not going to have any employees but we were going to purchase services from each other, so legal and finances purchased by this entity called Akron Physician Wellness Initiative, APWI for short.

And the P could be providers, but at that time, there wasn't consensus among both medical staffs that they wanted physicians in the title because they thought they could get more people behind it more quickly. And my advanced practice professionals, when I approached them said, "Can we use the services?" I said, "Absolutely." They said, "You can call it whatever you want." So, it's the APWI. We stood this up about 18 months ago. So, in the middle of the pandemic, we were able to make this functional both with virtual visits and in-person visits at a neutral site that we rent. So, I purchased this, well, I'm the chairman of the board—the inaugural board—and our board purchases services from the adult psychiatry system. And now we have two dedicated psychologists, a hundred percent dedicated to us. When we started, we had one psychologist and about a point two psychiatrist that we purchased services from.

And we quickly recognized that the interest that was shown by our faculty and our residents, especially the trainees, exceeded our capacity and we had to expand. So, we've already gone to a community mental health support agency and secured a grant. And we've had some individual grateful users donate money, as well as individual members from my board have contributed on an annual basis, so that we are building up some momentum. I don't know that we'll ever be completely independent, but just for your listeners, our run rate of these shared purchase services comes in at less than 400 grand. And if any of you listeners and if your listeners have ever tried to recruit a surgeon who burned out and then replaced them, 400 grand is nothing in an annual budget.
Dr. Jin: Yeah, it's probably double that at least to onboard a new physician, not even a surgeon, any physician. So back to the confidentiality component. So, nothing is tracked, sounds like.

Dr. McGregor: So, we have a paper record that we keep and we've made sure that there's really ... the only challenge we had so far that we're still trying to work it out on the other end and we warn our providers that should they need a medicine that some of the different pharmacy chains will automatically dump information into your EMR. So, while we don't use an EMR, they probably have an EMR with their primary care doc, so that was a surprise. And we're still working with those pharmacies and we just make sure that our docs and APPs and residents who need prescriptions are aware of that and that has not been a big disappointment or a barrier to them.

So, we have a paper record, we do our own internal reviews with chair of psychiatry, can sit in on those and make sure that the teams are doing things that would certainly meet our quality metrics. And it's internal paper lockdown. We've even designed the flow in our office so that you come in one door, you go back to your appointment and you exit another door. So, I've had a few providers say to me, "Are people really using this? Because there's never anyone there." And I said, "Well, that's by design." So fortunately, we've been able to make sure there's a 15-minute lag between appointments, so we don't have that overlap and that's been a really well-received piece.

Dr. Jin: Yeah, it's fantastic attention to detail. And so, it sounds like the uptake has been very good so far. Do you have a sense of the numbers in terms of what percentage of your clinicians have used this service?

Dr. McGregor: So, I can tell you that I didn't see this month's usage yet, but I got a sneak preview last night that we are up to 180 providers, from all disciplines, have used this. And what's really telling to me is that over a number of them have continued multiple sessions after accessing. And the relative percentage, it's more highly adopted by trainees. And I'd say at this point in time with the two hospitals, about 28% of eligible trainees have access to this, not counting the opt-out sessions. We track those separately because we just wanted to make sure the no-show rate was improving, which implies that it's being more and more acceptable in mainstream. And then in our faculty, we're still low, although we didn't add the Summa faculty until we hired a second psychologist just about three months ago. So, we really only had an end of about 1,300 potential folks using it. And we had 39 staff physicians that accessed it. Now that we've upped that, our percentage of faculty using it is only 3% but we were sitting more like 6% before we increased the denominator.

Dr. Jin: Right, right. And so, without breaching any confidentiality, I'm curious what sorts of issues your clinicians are talking about at these sessions.

Dr. McGregor: Well, it's interesting, and again, I'm not in the EMR or in the paper record, so I really try to make sure that as a board chair I'm more governance than I am management. But because it's at a very important topic to me, we do track the themes. And many of the themes are...
common—depression, anxiety. What's interesting is many physicians have a perfectionistic trait that is giving them dysfunctional coping. So, some of it is counseling people who have a less-than-perfect outcome and helping them recognize are their own expectations realistic. Some of the other issues that have come up through the pandemic is personal relationship problems, whether it’s at home or whether it’s with a colleague. And I think during the early parts of the pandemic when stress was high in all sectors, I think that was a larger theme.

We have had, anecdotally, I'll share two stories. It's about three different providers. Two, when they landed on our doorstep, now we're not an emergency service, we make that very clear. If you access us, we're available Monday through Friday, nine to five at this point. So that we did have two providers schedule a routine appointment and required escalation into inpatient therapy. And I'm very happy to say that after a brief inpatient stay, they were able to reenter their medical staff without incident. The other story that I'll share is a colleague who has come forward as a testimonial giver because he's so enthralled because he was such a doubter on the friend end. He described himself as fiercely independent and he would never ever talk to anybody about those kinds of problems because he was raised where if you complained, you were a wimp, if there was a problem, you must be the problem.

And he had a less-than-perfect outcome on one of his favorite operations. He went through his peers to try to get solace and just found himself just spiraling downhill. He was about to quit his surgical privileges and just become a non-operative orthopedic surgeon, when one of his colleagues said, "What do you got to lose? Try this out." He's the poster child now and has often, if I'm speaking about this in public and he's in the audience, he'll stand up and let people know because it gives credibility, it decreases the stigma and normalizes the fact that we're human and we're not always as okay as we need to be, to be the best for our patients and families.

**Dr. Jin:** There is such a stigma still, and a lot of us clinicians still think, "Oh, don't be weak, just get through it. Don't complain." I think part of what you were saying, how this program, it being so easily accessible, that's the key difference, as opposed to going to see your doctor and ask for a list of therapists or going online and searching. It takes out all of those extra barriers to accessing mental health care.

**Dr. McGregor:** Well, when I talk to the residents and they talk about relocation, that by itself is stressful—especially if they're not from the area where they come in—and they don't have the time to figure out which place could they go on their insurance and then get time off. It's a huge advantage for our trainees and I think they're learning to appreciate that not everybody has that.

**Dr. Jin:** Yeah. And in terms of the time off, how does that work for the trainees in particular?

**Dr. McGregor:** So for the opt-out counseling that's built into their schedule. So, if you're working in the intensive care unit, but your onboarding opt-out session is Tuesday afternoon, you're scheduled off. Now, if you decide to opt out, we'll pull you back in. We try to keep hands off so that we may not even
know that unless they post on Instagram that they're at a baseball game, that sort of thing that sometimes people will do. But then when they do their other sessions, they schedule it and they can find some time that that works. The chief residents have been remarkably helpful and accommodating because they're big champions of this and the faculty members, they do work that out within their divisions to be able to have uninterrupted time for the sessions. Now, they can also do it virtually. Before COVID, there was some pushback by my psychiatric colleagues that they said if we really want that personal face-to-face, the non-verbal cues are important.

However, once COVID hit, we now have moved about 50% of our sessions are virtual. And for an organization like Akron Children's, we really have providers in 25 counties in Ohio. Some are very remote, as far as two hours away. So that was really an imperative that as the chair of the board, I inserted that as something we really had to put in. And as we track it, we now have seen an uptick, but it's stabilized. And I think one thing I'd like to share is we do survey our clients as they leave because we don't take electronic information, we don't do any of the validated instruments that would send reminders and ask you, "What did you think? Was a beneficial?"

So we've really balanced walking between that. But what we do is we ask them, initially we started with just questions like, "What's the reason that you came? If we didn't have this resource, would you have still sought treatment?" And all those elements. At the beginning, the number one reason that this worked for them was that they sought providers who had experience with physicians and APPs in health care and that was their main focus. So, they felt that the people really identified, understood immediately and were able to help them out. And I think a very important statistic is that 56% of our clients that were surveyed said without APWI as a resource, they wouldn't have sought treatment. They would've continued to suffer in silence because of the other perceived barriers that we discussed earlier.

Dr. Jin: Yeah. That is telling. In terms of measuring outcomes or whatnot, so as you've mentioned, it is challenging because that's what you're intending not to do, but have you seen just on a global level any impact on burnout scores or turnover or anything?

Dr. McGregor: What's interesting, when we started this journey, part of why I was sensitized is we had done the AMA survey on physician burnout and found like many of my colleagues across the country is that before COVID, 50% of our faculty were at risk or burning out. And it seemed to be, for us, our demographic that was at highest risk were female physicians in their first 10 years of practice, especially if they were involved with shift work, so my hospitalist colleagues, the ER docs, the PICU docs, the NICU docs seem to have a preponderance of challenges. So, I was really worried about that. We've now adopted the well-being index that's been developed at Mayo Clinic and a validated tool that's seven questions that you can answer monthly or we ask our docs to answer quarterly. It's anonymous, de-identified. You do identify with a group. I identify as a hospitalist, so my composite data would roll up into a hospitalist bucket as long as there's more than five people using this tool.
So, we've just adopted that five months ago and our uptake isn't high enough to give us true trends yet, but I'm hopeful that that will help us measure. And the other thing that we're playing with in our psychology department of APWI is we're using the, it's called a brief adult outcome questionnaire, ACORN 11. It's usually electronic, but we've adapted it to paper that's a 13-item checklist that shows that at least of our providers who are using the service, if they're using it and have a repeat visit within a month, their scores have dropped from 17 to 14 and if they continue to use it on their third or fourth visit when they're scored, they're down to 12.8. Now that's a relatively new tool and the trend is important. I can't tell you that's statistically significant yet, but we're making attempts to measure without invading their privacy.

**Dr. Jin:** Yeah, yeah, exactly. And I mean, anecdotally, I can't imagine it is not having impact, like you said, with that surgeon who has his story and all these people who keep on coming back.

**Dr. McGregor:** And that's what my psychiatry colleagues say that there are things ... double-blind placebo control is certainly the standard we want to strive for best evidence, but sometimes when you're dealing with mental health, if they use it and they come back, it's providing some benefit. Now, could I take that to a donor? I don't know. But I think if I tell anybody the story about my pediatric ortho that was about to quit operating and now he's got joy in medicine and he's really much healthier in his own self-criticism, I think they would think that's a win. And that's worth three hundred grand a year ever, always.

**Dr. Jin:** A hundred percent, yes. What are your visions for this program in the future?

**Dr. McGregor:** So, I would love to see this get deeper, wider, offer it to more people. And I'd also like to be able to help educate and replicate it. So our board met recently for a retreat after a year just to touch base because many of us had never met each other in person and all our providers. And our original mission was to provide barrier-free mental health services to physicians and advanced practice providers as a foundation for them delivering compassionate care. We now added to disseminate our model beyond our parent organizations, whether that is expanding our own stable and offering it to other organizations, other med staffs, other residency programs or whether it is to develop standard work and lessons learned in a white paper. We're working on both those strategies.

**Dr. Jin:** Excellent. I definitely think it is a need in this country and among other organizations to have a similar program. And I'm actually thinking, I didn't ask this earlier, but how does it differ from a peer support program? Which many organizations do have now or at least are developing them.

**Dr. McGregor:** So, a peer support program, you have some colleagues that have taken additional training in peer support typically, but it's still a colleague. It's still someone that you're going to consult when you're in the service or they're going to consult you and that is a perceived barrier. Whether it translates, I don't know, but I think like my orthopedic surgeon, he went to his team members and tried to use that even though they're not trained in peer support and they were supportive, but it didn't cut
through his dysfunctional perfectionism. So, I think peer support is important. That's another tool that we have started playing with but we're in our infancy.

My goal was before I surveyed the faculty and saw their burnout was worse, I needed to have something standing up that I could offer to those who were at risk or in crisis. So that's why we didn't continue doing periodic surveys because the literature also say if you over-survey, you contribute to burnout. So that's a fine line too. So that's why we're trying to go with the self-monitoring on my well-being index that we just roll up and get a good look at where hotspots might be so we can design specific interventions.

Dr. Jin: Yeah, definitely. Well, you've given many practical tips and words of wisdom. Any final pearls for our listeners or anything that we didn't touch on yet?

Dr. McGregor: Well, if your listeners are from a children's hospital, I think it's really important to get that adult partner. I know that Oregon University of Health Sciences had done a similar program internally that's worked well and actually, we did a site visit to look at how they were doing things. But as a freestanding children's hospital, the model that we've done has been helpful, and my fellow psychiatry colleagues say it's also helpful for their team because they don't feel like, yeah, there's no medical record, but we're in the clinic where everybody else is and it's not a specific service.

Now that they go to a different place or they do it virtually, it's unique and I think it's helped up uptake on both sides of the hospital. So, you need to develop a partnership, not a transactional model. I think the secret to our success is we really have a common mission. We had a common vision. We did a lot of brainstorming and visioning before we got started, and now we are all a hundred percent committed to the same mission and vision. It's like going to work with friends, which certainly helps those of us that are doing this work have more resiliency.

Dr. Jin: Yeah. And at the end of the day, that culture of wellness, that feeling of going to work with people you like and being on the same team and working towards the same goal, that's what we're aiming for, that's what all our work is all about. All right. Thank you so much for joining me today, Dr. McGregor.

Dr. McGregor: Well, my pleasure. Thank you very much.

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