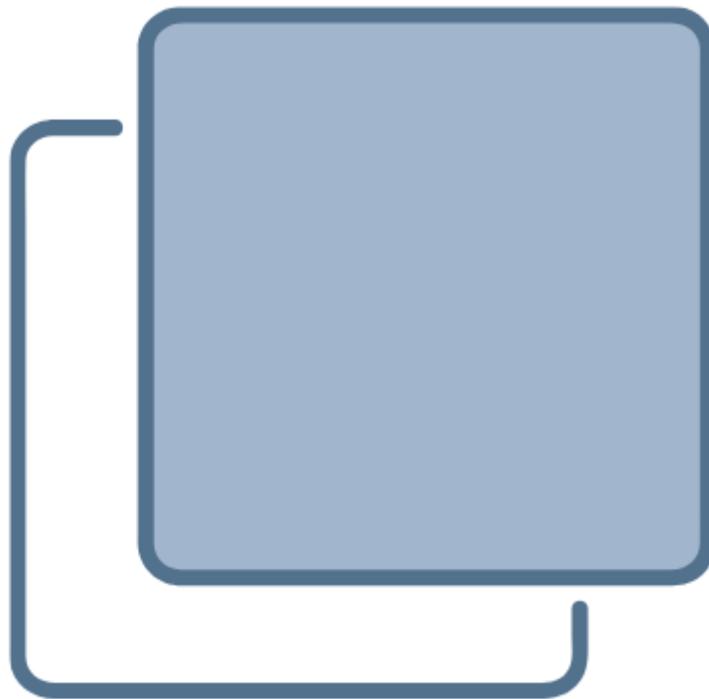# Pediatric Telepsychiatry Curriculum

Graduate Medical Education (GME) and Continuing Medical Education (CME)

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TABLE OF CONTENTS

INTRODUCTION

This curriculum was developed using Kern's 6-stage model of curriculum development.

KERN'S 6-STAGE MODEL OF CURRICULUM

1. Identification of the core need/problem and general needs assessment
2. Targeted needs assessment
3. Development of broad goals and measurable specific objectives
4. Development of educational content and method
5. Implementation
6. Evaluation and feedback at the level of the individual learner and the program

Thomas, et al. 2016

PROBLEM IDENTIFICATION AND NEEDS ASSESSMENT

The United States currently faces a dire shortage of child/adolescent psychiatrists (CAPs). While the estimated need is 30,000, only 8,000 CAPs are in practice nationally, and their mean age is 53 years. Most counties in the United States (US) have no CAPs, and the average wait time to see a CAP is 7.5 weeks (AACAP 2018). Telepsychiatry offers an opportunity to improve access to pediatric behavioral health care, and its effectiveness with children and youth has been demonstrated (Boydell et al. 2014).

In a survey of all US ACGME-accredited Child and Adolescent Psychiatry fellowship programs conducted in April 2019, 100% of respondents felt that it is "somewhat" or "very" important for telepsychiatry to be part of their program; yet 35% reported offering no telepsychiatry experience to their fellows. Of the 65% who reported having "some" or "a lot" of telepsychiatry experience, 60% reported they had no formal didactic curriculum. In a 2013 survey of general psychiatry residents, 72% of

respondents were "interested" or "very interested" in telepsychiatry, and 79% "agreed" or "strongly agreed" that telepsychiatry is important in training (Glover et al. 2013).

Current approach

Proposals and resources for national telemental health training programs exist in general psychiatry (Godlesksi 2012; Sunderji et al 2015; Hilty et al 2015; Maheu et al 2018). However, few resources specific to child psychiatry exist, and the uptake of **pediatric** telepsychiatry in both service and training nationally remains low and inconsistent. Dr. Kathleen Myers, Co-Chair of AACAP's Committee on Telepsychiatry, recently reported that a key remaining barrier is low uptake by training programs due in part to lack of faculty expertise (Myers 2018). She notes a disparity between the uptake of telepsychiatry in commercial settings as compared to academia. The result is that current CAP fellows are unprepared for the jobs that await them in the private and public sectors, and patients and families' mental health needs nationally continue to be inadequately met. Older child psychiatrists in practice currently lack the expertise to provide tele-psychiatric care and to supervise fellows.

Telepsychiatry offers the potential to improve treatment for youth by providing direct care; consulting to primary care (the integrated or collaborative care model) and other healthcare professionals; by consulting to non-healthcare settings (e.g. schools, juvenile justice); and by providing education, supervision and consultation to learners locally and nationally.

Ideal Approach

- CAP training programs should have a systematic, competency-based approach to teaching telepsychiatry in their didactic and their clinical curricula with defined sub-competencies and milestones for each level of developing competence.
- CAP training programs should have faculty expert(s) in pediatric telepsychiatry to serve as supervisors and teachers.
- Graduating CAP fellows should have expertise in Pediatric Telepsychiatry minimally at the level of Novice and preferably at the Competent or even Expert level so that they are prepared to meet the critical workforce need in child psychiatry and contribute to improving mental health access and equity across the United States.
- CAP Faculty and Staff should be able to develop competence in Pediatric Telepsychiatry through online and broadly disseminated curricular resources so that they can become teachers and supervisors of PTP.

- Curriculum should be based on recognized curriculum models, e.g. Kern's 6-staged approach
- Curriculum should acknowledge that child psychiatrists are mobile and may work from multiple settings, including home, while also maintaining a community of practice.

TARGETED NEEDS ASSESSMENT

Developers of this curriculum surveyed current CAP fellowship programs in the US (N= 138, response rate=35%) in March 2019 to better understand current needs and obstacles. A literature search on education in telepsychiatry was conducted and existing curricula in general psychiatry were reviewed. Additional experts (outside of the AACAP Telepsychiatry Committee) were identified and interviewed. The consensus that emerged from these sources included:

1. No complete curriculum in PTP currently exists; one that was nationally accessible and online would be helpful to training programs
2. The approach should be systematic, competency-based and include teaching and assessment methods
3. Formative and summative evaluation data about the effectiveness of the curriculum should be collected
4. While experts suggest ideal training includes both didactic and clinical components, CAP training directors expressed a preference for didactic educational resources, perhaps because didactics are easier to implement
5. CAP training directors identified top 5 content areas as the evidence base for PTP, getting paid for PTP, different applications and models of PTP (direct patient care, collaborative care, asynchronous consultation, education, etc.), psychotherapy treatment using PTP, and legal, regulatory and risk management considerations.
6. Current barriers to providing PTP training in programs include limited number of faculty with expertise, time, and funding to develop a curriculum

Our Approach:

This curriculum is based on the following educational principles:

1. Teaching should include a variety of educational methods, both didactic and clinical, and draw upon adult learning principles (Knowles 1990). We use:
   - Readings
   - Lectures
   - Large or small group discussion

- Problem based learning
- Debate
- Audio-visual recording and review
- Peer teaching
- Supervised clinical experience
- Reflection
- Role-modeling
- Demonstration
- Simulation
- Role play

2. The effort is to link the learner, teacher, patient and desired goals to specific knowledge, skills and attitudes; our belief is that there is no substitute for practicing the clinical skills under faculty observation and feedback.

3. **This curriculum is modular.** Training opportunities may be phased into a fellowship program over time, perhaps starting with didactics **(see p. 20-22 for examples).** The whole curriculum may be used in whole or in part, depending on the needs of the program and learners.

4. Learners 'clinical responsibility should develop and be evaluated over time, moving from observation and knowledge-building to simulation and role-play to clinical care under direct supervision and lower-complexity, lower-risk situations to indirect supervision and higher-complexity, higher-risk clinical situations.

5. Learning goals should be matched with appropriate instructional methods and evaluation tools.

6. Not all learners have similar professional goals; this curriculum distinguishes between suggested minimum training and aspirational or elective training activities. Programs should aim to have some of their graduates able to teach PTP to future trainees.

Graduates should be able to teach PTP to future trainees.

CURRICULUM OVERVIEW

This curriculum is intended as a modular approach to a variety of topics that can be adapted in whole or in small parts depending on time available and program needs. See pages 20-22 for a visual representation of the modular nature of the curriculum.

For example, one program may only want to use telepsychiatry for psychopharmacology as direct patient care and could choose to use Y1 Didactic 5 and Clinical Skills Session 5. Another program might only be interested in using telepsychiatry in consultation to primary care and could use Y1 Didactic 6 and Clinical Skills Session 3.

> **MODULAR CURRICULUM**
>
> - Variety of topics
> - Use curriculum in its entirety or only specific components
> - Introduce components in phases
> - Tailor curriculum to program needs

The curriculum combines didactics and clinical experiences over the two years of CAP training. Training in the first year assumes direct supervision takes a graduated responsibility approach. The second year covers more complex topics that may be elective in many programs, depending on how they are set up for PTP.

CAP Fellowship Year 1 includes approximately **six 50 to 60-minute didactic sessions** and **six clinical sessions** which may be done individually, in combined fashion or sequentially. Sessions can be compressed or broken up depending on the time and needs of the program. The clinical sessions offer an opportunity to apply what has been learned didactically. Year 1 didactic and clinical sessions cover core skills such as technological proficiency, conducting an evaluation, conducting a clinical consultation to health care professionals, maintenance treatment (pharmacotherapy and behavioral management), and treatment planning and management. The 6th didactic sessions introduces more complex skills.

CAP Fellowship Year 2 includes approximately **nine 50- to 60-minute didactic sessions** and **seven clinical sessions**. These, too, may be done concomitantly or sequentially, in whole or in part, compressed or broke up. Year 2 didactics attempt to cover more sophisticated topics (acute interventions, clinical challenges) and different applications of PTP, including in the community (schools, juvenile justice and patients ' homes). One session covers setting up a telepsychiatry practice as part of a private

practice career. Clinical skills taught involve greater clinical sophistication and less direct oversight of the patient, including consultation to non-healthcare sites; higher-level nonverbal communication skills; consultation to and teaching of others; quality improvement initiatives; issues around physical and psychological wellbeing; and practicing PTP in a global setting.

> **CAP2 CURRICULUM**
>
> - Hands-on clinic experience is **critical**
> - Trainees should have at least one experience in a nonhealthcare setting
> - Motivated fellows may acquire additional skills through elective experience

The CAP 2 curriculum acknowledges that many programs may have limited telepsychiatry services set up and/or available to them. While the didactic curriculum might cover a wide range of PTP models and experiences, the hands-on clinical experience, which we believe is critical, may be limited by what is available in the program. We suggest making every effort to offer at least one experience that involves consulting to a non-healthcare setting. For some motivated fellows, some of these skills might be acquired in an external elective experience.

GOALS AND OBJECTIVES

Competency/ Subcompetency	Milestones		
	NOVICE (Level 1-2)	COMPETENT (Level 3-4)	EXPERT (Level 5)
Technology			
TECH1 Technical Skills (Hilty et al. 2015 (Yellowlees & Shore, 2018)	After observing PTP, describes use of hardware, software and accessories; integration of various technologies; necessary accommodations	Operates hardware, software and accessories mostly without assistance; modifies patient and telepsychiatrist sites as needed to optimize care; performs routine trouble shooting at both ends of the connection; collaborates with information technology (IT) team as applicable	Optimizes use of all technologies Keeps apprised of and embraces new technologies as they develop Manages larger PTP systems Customizes development of system with IT
Patient Care			
PC1 Psychiatric Evaluation	Describes the process of evaluating children and families via PTP in direct [non-consultative] care	Conducts initial evaluation of children, adolescents and families via PTP using partners at patient site as appropriate, including: • Taking full history, including understanding baseline • Conducting focused physical exam (PE) with appropriate adjustments (e.g. using clinician who is with patient) • Conducting comprehensive mental status exam • Administering appropriate screening tools	Conducts initial evaluation of complex cases, including youth with psychosis, DDs, sensory deficits; very young or nonverbal children; medically ill children Teaches staff how to perform PE; trouble-shoots; develops means to

		• Integrating multiple sources and partner with team at patient site to obtain collateral data, including lab work and test results • Referring to additional services as indicated, incorporating interventions, e.g. de-escalating of agitated patient	obtain data when working at a distance
PC2 Psychiatric Formulation and Differential Diagnosis		Formulates case in biopsychosocial model, incorporating sociocultural factors particular to the patient site/location Demonstrates understanding of social determinants of mental health at the patient site/location Provides summary and recommendations to patient and inter-professional team	Formulates complex cases Consults to and supervises others
PC3 Treatment Planning and Management	Describes factors particular to PTP in developing treatment plan and managing care	Demonstrates consideration of locally available resources, treatment approaches, and community and cultural factors while adhering to treatment evidence base, standards and guidelines Establishes clear plan for follow-up, including means of communication between treatment team and patient/family and how prescriptions and emergencies will be managed Assesses risk and triages appropriately	Consults to and supervises others in providing clinical care Leads clinical teams in PTP Develops clinical innovations in PTP
PC4 Psychotherapy	Describes potential role of PTP in providing psychotherapy	Provides psychotherapy treatment of children, adolescents and families via PTP in a culturally informed manner	Consults to and supervises others in providing psychotherapy via PTP

PC5 Somatic Therapies	Describes potential role of PTP in providing somatic therapies	Provides medication treatment of children and adolescents via PTP adhering to standards of care [FN: See also PROF 1]	Via PTP, consults to and supervises others in providing somatic therapies
PC 6 Clinical Consultation	Describes various models of clinical consultation in PTP, e.g. direct observation, asynchronous video review, etc.	Helps establish and/or conduct a consultative PTP service at a variety of sites, including: A) Where a clinician is overseeing the patient at the originating [patient] site, e.g. primary care, satellite services, freestanding community clinics B) Where no clinician is overseeing the patient at the originating [patient] site, e.g. schools, forensic settings, patient's home	Leads in developing a consultative PTP service and/or team Provides consultation in global settings
Medical Knowledge			
MK1 Pediatric Telepsychiatry [new subcomp specific to PTP]	Describes core concepts and terms of PTP e.g. communication using PTP, adapting standard evaluation to PTP, medicolegal issues (Crawford et al. 2018)	Describes: • Evidence base for and against PTP: Access, cost, preference, quality of care, etc. • Applications and models of PTP • History of PTP • Session logistics • Administrative issues (coding, payment, etc.) • Legal, regulatory and risk management issues • How to set up a private PTP practice; business aspects	Teachers others about core concepts and terms of PTP
Systems-Based Practice			
SBP1 Patient Safety and Quality Improvement	Describes potential risk management and safety issues in PTP	Demonstrates understanding of risk management/safety issues as evidenced by appropriate management of safety concerns and efforts to assess and improve the PTP system	Leads quality improvement (QI) effort in a PTP service
SBP2 System Navigation for	Describes various models of PTP, e.g. in-	Demonstrates understanding of how the PTP network is organized, the steps by which a patient/family accesses the	Consults to other systems on PTP

Patient-Centered Care	person care, PTP care, and consulting care (both synchronous and asynchronous) and how models are set up at proximal and remote ends	service, and how the service is set up and administered at the originating and distant sites Demonstrates how to use the system optimally to advocate for needs of the patient, family, and community	
SBP3 Physician Role in the Healthcare System	Describes psychiatrist's role in improving MH care access and equity through PTP	Helps to establish and conduct a PTP service in healthcare settings (originating site) with clinical oversight/collaboration available from health or mental health professional who is with the patient e.g., hospitals, outpatient clinics, CMHCs, primary care settings, acute care settings Describes how PTP services fit into the overall network or system of care	Leads in establishing a PTP service and/or team in a healthcare setting
Practice-Based Learning and Improvement			
PBLI1 Evidence-Based and Informed Practice	Describes advantages and limitations of PTP, citing evidence	Integrates the current and developing evidence base for telepsychiatry (pros and cons) into clinical practice	Engages in research and scholarship to advance and disseminate the evidence base
PBSI2 Reflective Practice and Commitment to Personal Growth	Identifies gaps in own PTP knowledge/skills/attitudes and demonstrates interest in filling them	Assesses patient outcomes and own performance data to improve professional skills and systems using a QI model	Role-models reflective practice and personal growth in PTP
Professionalism			
PROF1 Professional Behavior and	Describes current legal, regulatory and risk management	Practices according to legal, regulatory and risk management requirements and recommendations (e.g. licensing, prescribing)	Consults to and teaches others about professional and ethical issues in PTP

Ethical Principles	requirements in own jurisdiction. Identifies common ethical and professionalism concerns in PTP, e.g. confidentiality, privacy.	Raises ethical and professionalism considerations and manages them appropriately (e.g. informed consent, privacy, confidentiality, boundaries, and scope of PTP framework)	
PROF2 Accountability/ Conscientiousness	Describes role of physician as advocate to promote PTP	Advocates for the use of PTP as a means to address healthcare inequities and improve access	Develops strategies and innovations to improve PTP in addressing healthcare inequities and improve access
PROF3 Wellbeing	Describes potential risks to wellbeing in practicing PTP	Attends to potential physical and psychological considerations of practicing PTP and identifies ways to prevent and address them, e.g., posture, technology fatigue	Innovates and educates about wellbeing issues in practicing PTP
Interpersonal and Communication Skills			
ICS1 Patient and Family-Centered Communication	Describes aspects of verbal and nonverbal communication via PTP important in promoting rapport and ensuring clear communication	Uses verbal and nonverbal communication skills to establish and develop telepresence and rapport to engage patient and family/caretakers Demonstrates flexibility (adjusting to technological and other needs), adheres to timeframe, incorporates family members appropriately Overcomes/addresses limitations in or obstacles to effective communication Considers aspects of diversity and demonstrates cultural humility in communicating across sociocultural differences within the framework of PTP Assesses need for interpreter and uses interpreter in sessions appropriately	Transitions from one modality to another (e.g. PTP to in person) appropriately Develops expertise in practicing PTP in specific sociocultural settings and/or patient populations; teaches/consults on this topic

ICS2 Interprofessional and Team Communication	Describes process for communicating with team during and outside of PTP session	Effectively runs a PTP session Incorporates team members appropriately during and outside of PTP sessions Establishes clear communication protocols for in between sessions	Role-models effective interprofessional and team communication in PTP
ICS3 Communication with Healthcare Systems	Describes key considerations in documenting PTP sessions Drafts a note based on observation of PTP session	Appropriately documents PTP encounters in both direct care and consultation Documents in the electronic medical record (EMR) in accordance with all compliance standards	Models concise, thorough documentation that meets all compliance standards Optimizes coding

CURRICULUM OUTLINE

Year 1 (Y1)

YEAR ONE DIDACTICS (Y1D)

Topic	Details
Session One The evidence base for PTP	Access to care, return on investment, patient preference, quality of care, pros & cons, etc.
Session Two Brief History of PTP Applications and PTP models/systems of care Integration of PTP into existing systems	History of telemedicine, synchronous versus asynchronous use, patient monitoring, education delivered to families/communities/providers, and use of hybrid models.
Session Three Creating a telepresence in a virtual therapeutic space Session logistics "Netiquette" or "webside manner"	Positioning, lighting, background, etc. Sustaining attention and eye contact, framing the session, etc.
Session Four Administrative and professionalism issues	Coding, payment, reimbursement etc. Legal, ethical, regulatory, and risk management issues.
Session Five Conducting direct clinical care via PTP	Evaluating and treating patients directly via PTP, including management of acute presentations.
Session Six Conducting clinical consultation via PTP	Consulting to healthcare partners via PTP (health and mental health).

YEAR ONE CLINICAL SKILLS (Y1CS)

Topic/Phase	Details
One Technical Skills	Operating equipment and software, trouble shooting, developing telepresence, etc.
Two Psychiatric Evaluations at originating site (with staff present) (PC 1)	How best to evaluate a child/adolescent remotely, including full mental status exam (MSE), vital signs, and management of an acute presentations. E.g., Integrated care at remote primary care office or affiliated satellite psychiatric site with physician or nursing staff with patient.
Three Clinical Consultation to Healthcare via PTP (PC 6)	Integrating the healthcare partners at patient site into the evaluation. May include: • Community Mental Health • Collaborative care with primary care • Emergency room satellite
Four[*] Medication and psychotherapy maintenance treatment of children and adolescents via PTP (PC 4, 5)	Prescribing via PTP Assessing therapeutic and side effects Behavioral management Cognitive Behavioral Therapy (CBT) Using play remotely as part of assessment and treatment.
Five Treatment planning & management (PC 3)	Developing treatment plan sensitive to culture and community resources while ensuring clarity in responsibility of psychiatrist.
Six Higher level skills (PC1):	Administering screening tools Conducting physical exam Integrating multiple sources and partnering with team at patient site to obtain collateral data, including lab work and test results.

*This session may be divided up into two, depending on the needs of the program and its use of PTP for medication management and/or psychotherapy. Programs using PTP for both may choose to devote more time to each.

YEAR TWO DIDACTICS (Y2D)

Year 2 (Y2)

Topic	Details
Session One Acute interventions via PTP (PC1)	De-escalating complex and agitated patients.
Session Two Special Considerations in PTP	Evaluation and maintenance treatment requiring extra care, including: youth with psychosis, developmental disorders including autism spectrum disorder, sensory deficits; very young or nonverbal children; medically ill children.
Session Three Consultation to remote non-healthcare sites: 1. School-based PTP (PC6B)	Three-part series on consultation to schools, juvenile justice settings, and community health centers.
Session Four Consultation to remote non-healthcare sites: 2. Juvenile justice (PC6B)	Sessions 3-5 May be incorporated into one session, depending on needs of program.
Session Five Consultation to remote non-healthcare sites: 3. Patient home (PC6B)	"Direct to Consumer" (DTC) care.
Session Six How to set up a PTP private practice	Practical tips for establishing an individual or group telepsychiatry practice.
Session Seven (elective) Consultation to remote healthcare professionals – Project ECHO™ model	Synchronous and asynchronous consultation to remote mental health professionals using a national model.
Session Eight (elective) Teaching and supervising via PTP	Consider teaching in Y1 and then using CAP2s as teachers.
Session Nine (elective) Global PTP (PC6B)	Use of videoconferencing to meet the global mental health needs of children and families.

YEAR TWO CLINICAL SKILLS (Y2CS)

Topic/Phase	Details
One Consultation to remote non-healthcare sites	Longitudinal clinical experience in consultation to at least ONE non-health care setting such as school or juvenile justice setting.
Two Practice-Based Learning & Improvement in PTP (PBLI 2)	Assessing patient outcomes, building own skill set, and making system improvements appropriately in a QI model.
Three Professionalism and wellbeing (PROF 3)	Integrating PTP into professional identity. Attending to potential psychological and physical impact of conducting PTP (e.g., technology fatigue, posture).
Four Consultation to remote healthcare professionals – Project ECHO™ model	Synchronous and asynchronous consultation to remote mental health professionals using a national model.
Five Teaching and supervising via PTP	Demonstrating mastery by utilizing higher-level communication skills to teach and supervise.
Six Higher-level Communication Skills in PTP (ICS 1-3)	Sophisticated use of verbal and nonverbal communication; specific socio-cultural populations; optimal documentation.
Seven Global PTP (PC6B)	Providing direct care, consultation, supervision, and education to sites outside of the US.
Eight (elective) Innovation and QI in technology	Designing, implementing, evaluating, and translating to promote innovation, growth, and sustainability in the field.

VISUAL REPRESENTATION OF CURRICULUM AS PROPOSED

Year 1 Didactics (Y1D)

Session 1 Evidence Base	Session 2 History and Application	Session 3 Telepresence/Logistics
Session 4 Administration and Professionalism	Session 5 Direct Clinical Care	Session 6 Clinical Consultation

Year 1 Clinical Skills (Y1CS)

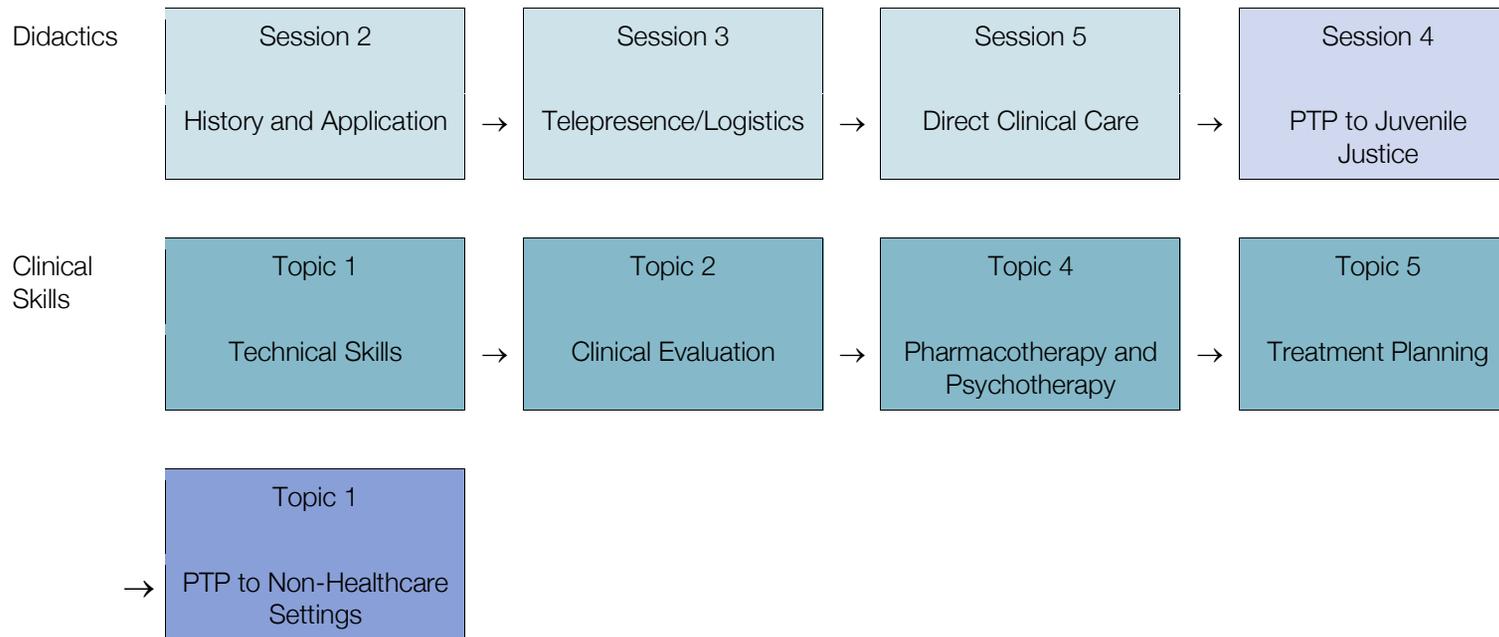| Topic 1 Technical Skills	Topic 2 Clinical Evaluation	Topic 3 Clinical Consultation
Topic 4 Pharmacotherapy and Psychotherapy	Topic 5 Treatment Planning	Topic 6 Higher Level Skills

Year 2 Didactics (Y2D)

Session 1 Acute Interventions	Session 2 Special Considerations	Session 3 PTP to Schools
Session 4 PTP to Juvenile Justice	Session 5 PTP to Patients' Homes	Session 6 Private Practice
Session 7 Consultation to Healthcare Professionals	Session 8 Teaching and Supervision	Session 9 Global PTP

Year 2 Clinical Skills (Y2CS)

Topic 1 Consultation to Non-Healthcare Settings	Topic 2 Practice-Based	Topic 3 Professionalism/Wellbeing
Topic 4 Consultation to Healthcare Settings	Topic 5 Teaching and Supervision	Topic 6 Higher Level Communication
Topic 7 Global PTP	Topic 8 Innovation and QI	

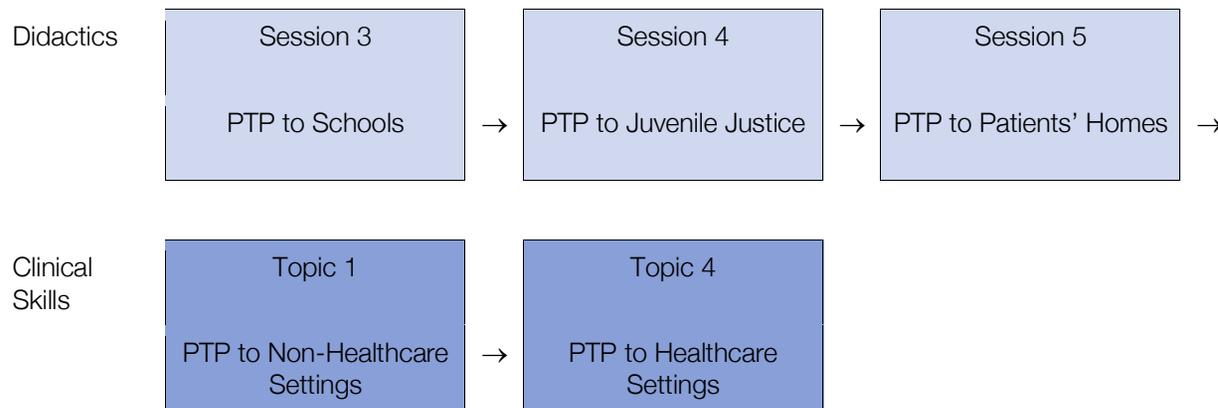## VISUAL REPRESENTATION OF MANIPULATION OF THE MODULAR CURRICULUM

Sample 1: This program has limited time for PTP in the curriculum and mostly only in the CAP1 year, and the only PTP clinical care service available as a training site is consultation to the juvenile justice system.

Didactics

Session 2		Session 3		Session 5		Session 4
History and Application	→	Telepresence/Logistics	→	Direct Clinical Care	→	PTP to Juvenile Justice

Clinical Skills

Topic 1		Topic 2		Topic 4		Topic 5
Technical Skills	→	Clinical Evaluation	→	Pharmacotherapy and Psychotherapy	→	Treatment Planning

→
Topic 1
PTP to Non-Healthcare Settings

Legend

Year 1 Didactics
Year 1 Clinical Skills
Years 2 Didactics
Year 2 Clinical Skills

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Sample 2: This program, also with limited time for PTP in the curriculum, wants to emphasize using PTP for consultation to healthcare and non-healthcare settings. The only PTP clinical rotation available is a Project Echo™ service providing addictions consultation to clinicians and teachers in remote rural settings.

Didactics

| Session 3 PTP to Schools | → | Session 4 PTP to Juvenile Justice | → | Session 5 PTP to Patients' Homes | → |

Clinical Skills

| Topic 1 PTP to Non-Healthcare Settings | → | Topic 4 PTP to Healthcare Settings |

Legend

Year 1 Didactics
Year 1 Clinical Skills
Years 2 Didactics
Year 2 Clinical Skills

CURRICULUM GUIDE

[SEE APPENDIX J for "How to Teach" guides for each didactic session in Y1 and Y2, available 12-20]

YEAR ONE DIDACTICS (Y1D)

a. Content by Session

i. <u>Session One</u> focuses on the evidence base for (and against) PTP. This includes data about clinical care (patient preference, quality), systems (access), and cost-effectiveness.

ii. <u>Session Two</u> focuses on a brief history of PTP, different applications, and systems of care integrating PTP.

> **Telemedicine:** face-to-face clinical care via electronic means in which patient and provider are in different locations
>
> **Store-and-forward/Asynchronous:** saving a study/image/video and transmitting electronically to distant provider for interpretation/review at a later time
>
> **Remote patient monitoring:** recording patient information at one location and electronically transmitting to provider at a different location for assessment (e.g., vital signs measured and data transmitted to provider through a patient portal)
>
> **Education:** using electronic means for transmission of information to community, providers, families, etc.
>
> **Collaboration/consultation:** collaboration with healthcare professionals (e.g., collaborative care with primary care providers) and non-healthcare professionals (e.g., school staff).
>
> **Hybrid model:** combining telepsychiatry with in-person care

iii. <u>Session Three</u> focuses on the logistics of setting up the clinical space in the provider's office and at the patient site. Important topics include:

- Virtual space – tech issues, audio-visuals, lighting, etc.
- Communication – verbal, nonverbal, pauses
- Developing rapport/telepresence
- Provider issues - posture, frequent breaks, etc.

- Clinical - managing more than 1 participant, incorporating the EMR, etiquette, redundancy measures, emergency back-up plan
- Time management and organization
- Patient orientation to logistics

iv. <u>Session Four</u> addresses administrative and professionalism issues. These include getting paid for PTP sessions (diagnostic and CPT coding, billing, insurance contracts) and legal, ethical, regulatory and risk management issues.

v. <u>Session Five</u> focuses on how to provide direct patient care (evaluation and maintenance treatment) using PTP.

vi. <u>Session Six</u> focuses on how to conduct a clinical consultation to healthcare partners via PTP. Examples could include consulting to primary care, community health clinic nurses, or to emergency clinicians at a satellite site. The emphasis is on understanding the clinical question from the team, collecting the necessary data both through history and examination and through collateral sources such as screening instruments and laboratory results, and integrating the data into a reasonable formulation and treatment plan for the remote site to be able to implement.

b. Methodology

- Webinars and Videos (e.g., APA Telepsychiatry Toolkit)
- Didactic by in-house or remote expert (See sample powerpoints in APA Toolkit).
- Journal Club (See References).
- Debate (pros and cons of PTP)
- Case-based and problem-focused facilitated group discussion (see cases)

c. Resources

AACAP Telepsychiatry and Quality Committee. Clinical Update: Telepsychiatry with Children and Adolescents. J Am Acad Child Adolesc Psychiatry 2017;56(10):875–893. https://www.jaacap.org/article/S0890-8567(17)30333-7/pdf

American Telemedicine Association (ATA). Practice Guidelines for Telemental Health with Children and Adolescents. March 2017.
https://www.americantelemed.org/resources/practice-guidelines-for-telemental-health-with-children-and-adolescents/

American Psychiatric Association and ATA. Best Practices in Videoconferencing Based Telemental Health, April 2018 and associated PowerPoint slides.
https://www.liebertpub.com/doi/pdf/10.1089/tmj.2018.0237

APA/AACAP Telepsychiatry Toolkit
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent
"The Evidence Base;" "The Return on Investment;" "History of Child/ Adolescent Telepsychiatry;" "Systems of Care;" "Developing a Virtual Therapeutic Space" and "Participant Arrangement ;" "Legal and Regulatory Issues."

Yellowlees P and Shore JH (ed). *Telepsychiatry and Health Technologies – A Guide for Mental Health Professionals*. Washington DC: American Psychiatric Association Publishing, 2018
Includes chapters on:

- "Evidence Base for Use of Videoconferencing and Other Technologies in MH Care," "Clinical Settings and Models of care in Telepsychiatry: Implications for Work Practices and Culturally Informed Treatment"
- "Media Communication Skills and the Ethical Doctor-Patient Relationship"
- "Data Collection from Novel Sources"

Regroup. Delivering compliant care – A guide to telepsychiatry law. April 2019.
https://blog.regrouptelehealth.com/delivering-compliant-care-a-guide-to-telepsychiatry-law

d. Assessment

Pre and post-quiz (See Section 8D)

YEAR ONE CLINICAL SKILLS (Y1CS)

a. **Content**

The exact content will be determined by what is available to the training program. Rather than suggesting content for individual sessions, we suggest a phased approach in which the fellow has an opportunity to gradually build up a skill set. Different fellows may require different amounts of time spent practicing and consolidating skills.

Topic/Phase one focuses on technical skills needed to operate equipment and software and perform basic trouble-shooting. Opportunities to practice and build confidence are critical.

Topic/Phase two focuses on conducting a psychiatric evaluation. While some initial learning may be achieved by observation, we believe hands-on, experiential learning is necessary to cement skills and confidence. While this learning could initially take place using simulation (e.g. a two-way mirror set up), we recommend an actual clinical setting in which an evaluation would typically be performed, e.g. remote emergency room, primary care consultation, direct care to a remote site.

Topic/Phase three focuses on consultation to a remote healthcare setting. Skills include communication, integrating healthcare partners into the evaluation, and developing a clear formulation and set of recommendations with a person responsible for follow-up for each of the recommendations.

Topic/Phase four addresses ongoing care, including medication management and psychotherapy. (May be divided into two sessions as required)

Topic/Phase five focuses on treatment planning and management. Key skills include developing knowledge about and sensitivity towards the resources and culture of the remote site; clarity about assigning roles and responsibilities;

developing a clear plan for care in between sessions and when/how to reach out to the psychiatrist when needed.

Topic/Phase six focuses on higher-level skills including incorporating screening instruments and adapting them as needed; conducting a focused physical exam including AIMS with the help of remote clinical staff; and obtaining and integrating collateral data including laboratory data, neuropsychological assessments, etc. Technological skills include screen sharing. Optimal documentation for direct care and consultation are included.

b. **Methodology**

A combination of role play, simulation and clinical service learning experiences is recommended.

c. **Resources**

Topic/Phase One - The "Technology-Specific Training Considerations" webinar on the APA Toolkit may be useful as preparation, in a flipped classroom model. Balog DJ, Narasimhan M and Shore JH. "Clinical documentation in the era of electronic health records and information technology." Hilty and Yellowlees 2018, pp. 227-250

Integrating Mental Health and Pediatric Primary Care – A family guide. NAMI, 2011.

http://www.dbhds.virginia.gov/library/children%20and%20family%20services/cfs-fam-Pediatric-primary-care-FG-Integrating.pdf

Topic/Phase 4 – Blog by Ariel Lundrum 03-15-20 on therapeutic interventions with children online.

https://www.guidancett.com/blog/interventions-for-online-therapy-with-children-and-youth-2020

d. **Assessment [see Section 8]**
- Mini Clinical Evaluation Exercise (CEX) for PTP (may be integrated into Clinical Skills Verification Exam)
- Retrospective review of videotaped sessions
- Formative oral and written feedback by supervisor/preceptor/peers/team members

- 360 (multi-informant) evaluation form
- Patient/family satisfaction and alliance questionnaires
- Reflective essay
- Self-assessment tool

YEAR TWO DIDACTICS (Y2D)

a. Content by session

i. <u>Session One</u>

This session focuses on setting up PTP in private practice.

ii. <u>Session Two</u>

This session focuses on acute interventions via PTP. This include patients who become acutely unsafe due to self-harm, agitation, aggression etc. Trainees may have cases from their practice they can discuss.

iii. <u>Session Three</u>

This session continues the focus on clinical management of patients via PTP including youth with severe hyperactivity, psychosis, developmental disorders, sensory deficits; very young or nonverbal children, and medically ill children. The particular challenges of each presentation and how to manage them are presented.

iv. <u>Session Four</u>

This session introduces a 3-part series on consultation to remote non-healthcare sites (schools, juvenile justice settings, and community mental health centers), at least one of which will be the focus of a clinical experience. Particular emphasis is places on considerations that pose new challenges from care in the health care setting.

v. <u>Session Five</u>

This focuses on consultation to the juvenile justice setting.

vi. <u>Session Six</u>

This session focuses on consultation to patients in community mental health centers.

vii. Session Seven

This session focuses on providing consultation to remote mental health professionals. One specific model to discuss is Project Echo™ model, which was first used to help treat hepatitis in underserved areas and is now a national model. Synchronous and asynchronous consultation can be discussed using cases.

viii. Session Eight

This session focuses on teaching and supervising child psychiatry using videoconferencing. Increasingly, supervision and teaching are happening remotely to reduce travel times and enhance efficiency. Uploading and discussing videotapes of clinical sessions with children and families can enhance the experience.

ix. Session Nine

This session focuses on using videoconferencing in global mental health to meet the mental health needs of children and families around the world.

b. Methodology

A combination of role play, simulation and clinical service learning experiences is recommended.

c. Resources

In Yellowlees P and Shore JH (2018). *Telepsychiatry and Health Technologies – A Guide for Mental Health Professionals*. Washington DC: American Psychiatric Association Publishing:

- Kaftarian E, Caudill RL, Malik T, Yellowlees P. "The business of telepsychiatry: How to set up a new practice or integrate technology in an existing practice."pp. 59-96.
- Yellowlees P, Shafqat S and Myers K. "Indirect consultation and Hybrid Care." pp. 251-288

APA/AACAP Telepsychiatry Toolkit:

Schools:

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/school-based-telepsychiatry

Juvenile Justice:
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/juvenile-justice

Community Mental Health Centers:
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/community-mental-health

Stephan S, Leer N, Bernstein L, Edwards S, Pruitt D. Telemental Health in Schools J Child and Adolesc Psychopharm. 2016: 26(3);266-272.

Roth D. 2016. Virtual School Visit – A guidebook for staff who administer and facilitate school-based tele-health services. Mind and Body Works, Inc.

Children's Hospital brings behavioral health care into schools.
https://www.childrenshospitals.org/Newsroom/Childrens-Hospitals-Today/Articles/2019/02/Childrens-Hospital-Brings-Behavioral-Health-Care-into-Schools

Project Echo Resources:
    APA/AACAP Toolkit:
    https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/project-echo
    https://echo.unm.edu/
    https://echo.unm.edu/about-echo/model/
    https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/project-echo.html

Aurora S et al. Outcomes of Treatment for Hep C Virus Infection by PCPs., N Engl J Med 2011;364:2199-207.

Boydell K et al. Using technology to deliver MH services to children and youth: A scoping review. J Can Acad Child Adolesc Psychiatry. 2014 May; 23(2): 87–99.

d. Assessment

Pre- and post-quiz. (See Section 8E)

YEAR TWO CLINICAL SKILLS (Y2CS)

a. Content

This section is divided into 7 topics. The first, consultation to remote non-healthcare sites using PTP, is considered essential for a novice in at least ONE non-healthcare setting (e.g. school, forensic, patient home, etc.). The second (Practice-Based Learning and Improvement) is required for competence (see Curriculum Goals by ACGME Competency). The last 4 topics (Higher-level Communication Skills, Consultation to remote healthcare professionals, teaching and supervision using videoconferencing, and Global PTP) are all encouraged but viewed as elective.

b. Methodology

Topic/Phase One

For consultation to non-healthcare settings, we recommend teachers and training directors piggyback on whatever service in their training program that is most amenable to PTP. For example, of the program has a well-developed school consultation rotation, integrating PTP into it may make the most sense.

Topic/Phase Two

We recommend integrating PTP into existing QI initiatives in the training program.

c. Resources

See resources above for Y2 Didactics.

For further guidance on QI, see Arbuckle MR and Cabaniss DL. Quality Improvement Curriculum – Engaging psychiatry residents in implementation and QI strategies. Available at: https://www.aadprt.org/training-directors/virtual-training-office

d. Assessment [See Section 8]

- Mini CEX for PTP (may be integrated into Clinical Skills Verification Exam)

- Retrospective review of videotaped sessions
- Formative oral and written feedback by supervisor/preceptor/peers/team members
- 360 (multi-informant) evaluation form
- Patient/family satisfaction and alliance questionnaires
- Reflective essay
- Self-assessment tool

EVALUATION TOOLS

INSTRUCTIONS

We recommend a 4-step evaluation process based on Kirpatrick's Model of Evaluation (1996):

Steps of Evaluation Process	Example of Evaluation Tool(s) to Measure
1. Learner Satisfaction	8K - Learner Satisfaction Survey 8G – Self-Assessment Tool
2. Acquisition of knowledge and skills	8D and 8E - Didactic Pre and Post Tests (knowledge) 8B Direct Observation of simulated sessions
3. Application of knowledge and skills to practice	8A – Multisource Feedback Tool 8B – Director Observation/Summative Feedback by Competency in clinical setting 8C – Mini-CEX 8H – Therapeutic Alliance Scales
4. Achievement of final goals (e.g. goals defined by program, department, healthcare organization)	8J – Patient and parent satisfaction surveys Achievement of pre-defined goals, e.g. improved patient access, reduction of no-show rate

360-DEGREE MULTI-SOURCE FEEDBACK TOOL FOR PEDIATRIC TELEPSYCHIATRY

Author: Sandra DeJong (10/2019)

Fellow's Name: Fellow's Year of Training: Date:

Evaluator's Name: Evaluator's Position:

Please rate the fellow on each of the following dimensions. Please mark n/a if you did not have opportunity to evaluate the fellow on a particular dimension. Your ratings should be based on your experience in working with the fellow in Pediatric Telepsychiatry.

1.   Communication during session (verbal and nonverbal)

        1   2   3   4   5   n/a

2.   Availability during and in between PTP sessions

        1   2   3   4   5   n/a

3.   Emotional intelligence

        1   2   3   4   5   n/a

4.   Decision-making

        1   2   3   4   5   n/a

5.   Relationships/rapport with patients

        1   2   3   4   5   n/a

6.   Relationships/rapport with family members, caregivers

        1   2   3   4   5   n/a

7.   Relationships/rapport with psychiatrists and other health professionals at the originating (patient) site

        1   2   3   4   5   n/a

8.   Relationships/rapport with their team

        1   2   3   4   5   n/a

9.   Technological facility

        1   2   3   4   5   n/a

10.   Comments:

SECTION 8B
DIRECT OBSERVATION AND/OR SUMMATIVE FEEDBACK FORM BY COMPETENCY
(TECH, PATIENT CARE, PROF AND ICS)

Author: Sandra DeJong, MD, MSc (2019)

Instructions to Observer/Rater: After observing a resident observing the use of or themselves using telepsychiatry to conduct a clinical session directly or indirectly (e.g. via videotape), please rate the resident on each of the following levels of competency. Check the appropriate box under the level that applies. If the competency is not applicable to the setting or you are unable to evaluate for some other reason, please check the box in the left-hand column.
This form may be also used as summative feedback at the end of a telepsychiatry rotation.

Resident's Name:

Date:

Clinical service:

Age/gender of patient:

Competency/ Subcompetency	Milestones		
	NOVICE (Level 1-2)	COMPETENT (Level 3-4)	EXPERT (Level 5)
Technology			
TECH 1 Technical Skills Check here if unable to evaluate or not applicable ☐	☐ After observing PTP, describes use of hardware, software and accessories; integration of various technologies;	☐ Operates hardware, software and accessories mostly without assistance; modifies patient and telepsychiatrist sites as needed to optimize care; performs routine trouble shooting at both ends of the connection; collaborates with information technology (IT) team as applicable	☐ Optimizes use of all technologies Manages larger PTP systems

	necessary accommodations		
Patient Care			
PC 1 Psychiatric Evaluation **Check here if unable to evaluate or not applicable** ☐	☐ Describes the process of evaluating children and families via PTP in direct [nonconsultative] care	☐ Conducts initial evaluation of children, adolescents and families via PTP using partners at patient site as appropriate, including: • Taking full history, including understanding baseline • Conducting focused physical exam with appropriate adjustments (e.g. using clinician who is with patient) • Conducting comprehensive mental status exam • Administering appropriate screening tools • Integrating multiple sources and partner with remote team to obtain collateral data, including lab work and test results • Referring to additional services as indicated, incorporating interventions, e.g. de-escalating of agitated patient	☐ Conducts initial evaluation of complex cases, Including youth with psychosis, developmental disorders, sensory deficits; very young or nonverbal children; medically ill children Teaches staff how to perform PE; trouble-shoots; develops means to obtain data when working at a distance
PC 2 Psychiatric Formulation and Differential Diagnosis **Check here if unable to evaluate or not applicable** ☐		☐ Formulates case in biopsychosocial model, incorporating sociocultural factors particular to the patient site/location Demonstrates understanding of social determinants of mental health at the patient site/location Provides summary and recommendations to patient and inter-professional team	☐ Formulates complex cases Consults to and supervises others

PC 3 Treatment Planning and Management **Check here if unable to evaluate or not applicable** ☐	☐ Describes factors particular to PTP in developing treatment plan and managing care	☐ Demonstrates consideration of locally available resources, treatment approaches, and community and cultural factors while adhering to treatment evidence base, standards and guidelines Establishes clear plan for follow-up, including means of communication between treatment team and patient/family and how prescriptions and emergencies will be managed Assesses risk and triages appropriately	☐ Consults to and supervises others in providing clinical care Leads clinical teams in PTP Develops clinical innovations in PTP
PC 4 Psychotherapy **Check here if unable to evaluate or not applicable** ☐	☐ Describes potential role of PTP in providing psychotherapy	☐ Provides psychotherapy treatment of children, adolescents and families via PTP in culturally informed manner	☐ Consults to and supervises others in providing psychotherapy via PTP
PC 5 Somatic Therapies **Check here if unable to evaluate or not applicable** ☐	☐ Describes potential role of PTP in providing somatic therapies	☐ Provides medication treatment of children and adolescents via PTP adhering to standards of care [FN: See also PROF 1]	☐ Consults to and supervises others in providing somatic therapies via PTP

PC 6 Clinical Consultation **Check here if unable to evaluate or not applicable** ☐	☐ Describes various models of clinical consultation in PTP, e.g. direct observation, asynchronous video review, etc.	☐ Helps establish and/or conduct a consultative PTP service at a variety of sites, including: C) Where a clinician is overseeing the patient at the originating [patient] site, e.g. primary care, satellite services, freestanding community clinics D) Where no clinician is overseeing the patient at the originating [patient] site, e.g. schools, forensic settings, patient's home	☐ Leads in developing a consultative PTP service and/or team Provides consultation in global settings
Professionalism			
PROF 1 Professional Behavior and Ethical Principles **Check here if unable to evaluate or not applicable** ☐	☐ Describes current legal, regulatory and risk management requirements in own jurisdiction. Identifies common ethical and professionalism concerns in PTP, e.g. confidentiality, privacy.	☐ Practices according to legal, regulatory and risk management requirements and recommendations (e.g. licensing, prescribing) Raises ethical and professionalism considerations and manages them appropriately (e.g. informed consent, privacy, confidentiality, boundaries, and scope of PTP framework)	☐ Consults to and teaches others about professional and ethical issues in PTP
Interpersonal and Communication Skills			
ICS 1 Patient and Family-centered Communication	☐ Describes aspects of verbal and nonverbal	☐ Uses verbal and nonverbal communication skills to establish and develop rapport with patient and family/caretakers	☐

Check here if unable to evaluate or not applicable ☐	communication via PTP important in promoting rapport and ensuring clear communication	Demonstrates flexibility (adjusting to technological and other needs), adheres to timeframe, incorporates family members appropriately Overcomes/addresses limitations in or obstacles to effective communication Considers aspects of diversity and demonstrates cultural humility in communicating across sociocultural differences within the framework of PTP Assesses need for interpreter and uses interpreter in sessions appropriately	Transitions from one modality to another (e.g. PTP to in person) appropriately Develops expertise in practicing PTP in specific sociocultural settings and/or patient populations; teaches/consults on this topic
ICS 2 Interprofessional and Team Communication **Check here if unable to evaluate or not applicable** ☐	☐ Describes process for communicating with team during and outside of PTP session	☐ Effectively runs a PTP session Incorporates team members appropriately during and outside of PTP sessions Establishes clear communication protocols for in between sessions	☐ Role-models effective interprofessional and team communication in PTP
ICS 3 Communication with Healthcare Systems **Check here if unable to evaluate or not applicable**	☐ Describes key considerations in documenting PTP sessions	☐ Appropriately documents PTP encounters in both direct care and consultation Documents in accordance with all compliance standards	☐ Models concise, thorough documentation that meets all compliance standards Optimizes coding

☐	Drafts an EMR note based on observation of PTP session		

SECTION 8C
MINI-CLINICAL EVALUATION EXERCISE (CEX) FOR PEDIATRIC TELEPSYCHIATRY - INSTRUCTIONS

ABIM, 1994; adapted for PTP by Sandra DeJong, MD, MSc, 2019

The Mini-CEX (ABIM 1994) is a Workplace-Based Assessment tool that has been adapted to the Pediatric Telepsychiatry setting. Its purpose is to promote CAP Fellows 'learning by providing structured feedback on performance within a real-life work setting. Fellows are assessed according to their expected developmental competencies for their stage of training.

What is the Mini-Clinical Evaluation Exercise?
The Mini CEX is a brief, validated method of assessment using real patients and providing real-time feedback and goals for learning. Self-reflection should be incorporated into this process.

Using the Mini-CEX for Pediatric Telepsychiatry
Items 1-7 are standard measure on the CEX.
Items 8-9 have been added for the PTP setting.

Guidelines
1. The fellow and the evaluator discuss which competencies will be assess during the patient encounter.
2. The Mini-CEX takes place during regular clinical supervision time. Observation should last 15-20 minutes, discussion/feedback 10-15 minutes, self-reflection 5-10 minutes, rating by evaluator 5-10 minutes.
3. The evaluator does not participate in the patient encounter unless necessary for safety.
4. The evaluator rates the fellow on the 1-9 scale, 5 being the expected standard for that stage of training.
5. Not all assessment criteria may be rated each time. Ratings should focus on the agreed-upon competencies.
6. Feedback should include identification of strengths and areas to work on, establishment of goals, and methods to achieve those goals.

Clarification of Specific Items

Item 9 "Appropriate adaption to PTP" is intended to assess the fellows '
capacity to make necessary adjustments to the non-in-person setting. For
example, the fellow should maintain awareness of the limited views that
patient and fellow have of each other and avoid use of noisy toys that may
impede clear communication.

Item 10 "Self-presentation" is intended to assess the professionalism of the
fellow's manner, dress, grooming, and office space.

MINI-CLINICAL EVALUATION EXERCISE (CEX) FOR PEDIATRIC TELEPSYCHIATRY

Adapted by Sandra DeJong from the Mini-CEX Workplace Based Assessment (RANZCP 2012)

Trainee Name:	Program Name:
CAP 1 ___ CAP 2____ Rotation:	Date of assessment:

Brief description of the case:
Learning Outcomes being assessed:
Performance Assessment: Basic: _____   Proficient: _____   Advanced: _____

Please indicate the activity in which the assessment is taking place:

Assessment of a psychiatric emergency Assessment of a high-prevalence psychiatric condition Assessment of a low-prevalence psychiatric condition Assessment of a response to treatment Assessment of a severe and enduring mental illness Other	Management of a psychiatric emergency Management of a high-prevalence psychiatric condition Management of a low-prevalence psychiatric condition Management of a severe and enduring mental illness Obtaining informed consent Other
Assessment of a psychiatric emergency Assessment of a high-prevalence psychiatric condition Assessment of a low-prevalence psychiatric condition Assessment of a response to treatment Assessment of a severe and enduring mental illness Other	Management of a psychiatric emergency Management of a high-prevalence psychiatric condition Management of a low-prevalence psychiatric condition Management of a severe and enduring mental illness Obtaining informed consent Other

Please rate the following aspects on the scale below. Point 5 represents the expected standard on completion of the trainee's current stage of training (6m period).

	Skill		Below standard			Meets standard			Above standard		
1	History-taking process	n/a	1	2	3	4	5	6	7	8	9
2	History-taking content	n/a	1	2	3	4	5	6	7	8	9
3	MSE Skills	n/a	1	2	3	4	5	6	7	8	9
4	Physical Exam Skills	n/a	1	2	3	4	5	6	7	8	9
5	Communication Skills	n/a	1	2	3	4	5	6	7	8	9
6	Data synthesis	n/a	1	2	3	4	5	6	7	8	9
7	Organization/Efficiency	n/a	1	2	3	4	5	6	7	8	9
8	Technological facility	n/a	1	2	3	4	5	6	7	8	9
9	Appropriate adaptation to PTP	n/a	1	2	3	4	5	6	7	8	9
10	Self-presentation		1	2	3	4	5	6	7	8	9

What aspects were done well?	Suggestions for areas of improvement
Agreed action/goals	How goals will be achieved
Evaluator's Name	Evaluator's Position
Evaluator's Signature	Date of Evaluation
Fellow's Name	Fellow's Signature

YEAR ONE DIDACTICS (Y1D)
PRE-TEST
STUDENT VERSION
(6 SESSIONS)

Session One

In a randomized controlled trial of treatment for ADHD using PTP (CATTS Study, Myers et al., 2015), treatment outcomes, including for inattention and hyperactivity, were

    a. better in the in-person setting (control)

    b. equivalent in both settings

    c. better in the PTP setting

    d. notable for decreased patient satisfaction in the PTP setting

According to a 2014 scoping review of the use of technology in treating children, a significant research gap is the need to demonstrate

    a. patient satisfaction

    b. provider satisfaction

    c. equivalent quality with in-person care

    d. effectiveness in long-term follow-up

Research in the use of PTP in the Pediatric Emergency Room Setting has found a reduction in all of the following EXCEPT:

    a. time spent on in-person evaluations

    b. length of stay

    c. rates of return to the ED within 24 hours

    d. charges per patient visit

Session Two

"Asynchronous" telepsychiatric care refers to the practice of

    a. seeing the patient through videoconferencing outside regular office hours

    b. video-recording a session and having a clinician review it later

    c. lags caused by internet service when providing both in-person and telepsychiatric care

    d. using electronic means to transmit information to providers and families

Regarding the history of pediatric telepsychiatry, which of the following statements is true:

    a. PTP began in the 1970's with a cable TV link between a hospital and a Child Guidance Center

    b. AACAP has yet to publish guidelines or policy statements about PTP

    c. PTP began in rural settings in the Northwest to provide care to children in remote areas

    d. The HITECH Act of 2009 increased access to PTP

Session Three (session logistics – lighting, room set-up, etc.)

When conducting PTP, child psychiatrists should ensure which of the following features about their own office space and the PTP set-up:

    a. The office should have lots of stimulating material on the walls to keep the patient awake

    b. The camera should be positioned to show a full head-to-toe view of the child psychiatrist

    c. The picture-in-picture view should be used to ensure proper framing and the child psychiatrist should ensure adequate visual resolution and microphone acoustics

    d. The child psychiatrist's hands should be kept out of the way and not engage in nonverbal communication such as virtual high fives

When conducting PTP, child psychiatrists should ensure which of the following features about the office space and the PTP set-up at the remote site:

    a. Space should be large enough to accommodate the patient, a caregiver, and 1-2 additional individuals

    b. Legos and other small-part toys are available and drawing materials are removed

    c. The patient is positioned at least 20 feet from the camera.

    d. The set-up should prohibit patients from leaving their chair to walk around or play on the floor

Session Four (Coding, legal/regulatory/risk management)

The Ryan Haight Act of 2008 was important for the practice of PTP because it

    a. Facilitated e-prescribing across state lines

    b. Placed restrictions on prescribing psychostimulants via PTP

    c. Advocated for innovative methods to facilitate e-prescribing via PTP

    d. Distinguished between inappropriate and appropriate prescribing practices for non-controlled substance medications

Child psychiatrists wishing to practice PTP in a given jurisdiction should consult
    a. State/jurisdiction laws and regulations
    b. federal laws and regulations
    c. their state/jurisdiction medical board
    d. their malpractice carrier
    e. all of the above.

Session Five (Evaluating and treating patients directly via PTP)

Before initiating an evaluation of a child via PTP, child psychiatrists should:
    a. Ensure the patient site is safe and private
    b. Have a safety plan in place for emergencies
    c. Equip the room with appropriate toys for quiet play
    d. Ensure equipment functioning
    e. Obtain consent from guardian for PTP and any videotaping performed as required (e.g., by state, payer, organization, etc.)
    f. Let patient and family know that the psychiatrist is in a private space (e.g., can pan camera around the room for a virtual tour if appropriate and set up allows)
    g. All of the above

Standard Operating Procedures for PTP should be established in advance of clinical care and include which of the following:
    a. Arrangements for care in between visits, including prescriptions and emergencies
    b. How the camera will be used
    c. Demonstration of use of the most up-to-date technology
    d. Assurance that the psychiatrist will be available for in-person visits

Session Six (Consulting to healthcare partners via PTP)

In consulting to healthcare partners, which of the following is true about documentation of a telepsychiatry session?
    a. There is no need to discuss documentation ahead of time since it is assumed the originating (patient) site will keep the documentation

b. HIPAA security rules do not apply to documentation of telepsychiatry encounters
c. Child psychiatrists never need to keep a shadow chart of sessions if the originating site holds the official documentation
d. CAPs should first clarify where and how sessions/consultations will be documented and who will own the record

When considering prescribing to a patient seen in consultation remotely via PTP, the child psychiatrist should consider which of the following?
a. The consulting psychiatrist should always collect collateral data by phone rather than having staff at the remote site obtain it
b. If the patient refuses baseline labs, the CAP should not prescribe.
c. The CAP should prescribe any psychostimulants regardless of whether the remote site has a qualified prescriber
d. Prescribing should be based on the CAP's role in the consultation relationship, the model of service delivery, and a risk/benefit analysis of each case

YEAR ONE DIDACTICS (Y1D)
PRE-TEST
TEACHER VERSION (ANSWERS IN BOLDFACE)
(6 SESSIONS)

Session One

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    a. better in the in-person setting (control)
    b. equivalent in both settings
    c. better in the PTP setting
    d. notable for decreased patient satisfaction in the PTP setting

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    b. provider satisfaction
    c. equivalent quality with in-person care
    d. effectiveness in long-term follow-up

Research in the use of PTP in the Pediatric Emergency Room Setting has found a reduction in all of the following EXCEPT:

    a. time spent on in-person evaluations
    b. length of stay
    c. rates of return to the ED within 24 hours
    d. charges per patient visit

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    b. video-recording a session and having a clinician review it later
    c. lags caused by internet service when providing both in-person and telepsychiatric care
    d. using electronic means to transmit information to providers and families

Regarding the history of pediatric telepsychiatry, which of the following statements is true:

a. **PTP began in the 1970's with a cable TV link between a hospital and a Child Guidance Center**
b. AACAP has yet to publish guidelines or policy statements about PTP
c. PTP began in rural settings in the Northwest to provide care to children in remote areas
d. The HITECH Act of 2009 increased access to PTP

Session Three (session logistics – lighting, room set up, etc.)
When conducting PTP, child psychiatrists should ensure which of the following features about their own office space and the PTP set-up:

a. The office should have lots of stimulating material on the walls to keep the patient awake
b. The camera should be positioned to show a full head-to-toe view of the child psychiatrist
c. **The picture-in-picture view should be used to ensure proper framing and the child psychiatrist should ensure adequate visual resolution and microphone acoustics**
d. The child psychiatrist's hands should be kept out of the way and not engage in nonverbal communication such as virtual high fives

When conducting PTP, child psychiatrists should ensure which of the following features about the office space and the PTP set-up at the remote site:

a. **Space should be large enough to accommodate the patient, a caregiver, and 1-2 additional individuals**
b. Legos and other small-part toys are available and drawing materials are removed
c. The patient is positioned at least 20 feet from the camera.
d. The set-up should prohibit patients from leaving their chair to walk around or play on the floor

Session Four (Coding, legal/regulatory/risk management)
The Ryan Haight Act of 2008 was important for the practice of PTP because it

a. Facilitated e-prescribing across state lines
b. **Placed restrictions on prescribing psychostimulants via PTP**
c. Advocated for innovative methods to facilitate e-prescribing via PTP

d. Distinguished between inappropriate and appropriate prescribing practices for non-controlled substance medications

Child psychiatrists wishing to practice PTP in a given jurisdiction should consult
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   b. federal laws and regulations
   c. their state/jurisdiction medical board
   d. their malpractice carrier
   e. all of the above.

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Before initiating an evaluation of a child via PTP, child psychiatrists should:
   a. Ensure the patient site is safe and private
   b. Have a safety plan in place for emergencies
   c. Equip the room with appropriate toys for quiet play
   d. Ensure equipment functioning
   e. Obtain consent from guardian for PTP and any videotaping performed as required (e.g., by state, payer, organization, etc.)
   f. Let patient and family know that the psychiatrist is in a private space (e.g., can pan camera around the room for a virtual tour if appropriate and set up allows)
   g. All of the above

Standard Operating Procedures for PTP should be established in advance of clinical care and include which of the following:
   a. **Arrangements for care in between visits, including prescriptions and emergencies**
   b. How the camera will be used
   c. Demonstration of use of the most up-to-date technology
   d. Assurance that the psychiatrist will be available for in-person visits

Session Six (Consulting to healthcare partners via PTP)
In consulting to healthcare partners, which of the following is true about documentation of a telepsychiatry session?
   a. There is no need to discuss documentation ahead of time since it is assumed the originating (patient) site will keep the documentation

b. HIPAA security rules do not apply to documentation of telepsychiatry encounters
c. Child psychiatrists never need to keep a shadow chart of sessions if the originating site holds the official documentation
d. **CAPs should first clarify where and how sessions/consultations will be documented and who will own the record**

When considering prescribing to a patient seen in consultation remotely via PTP, the child psychiatrist should consider which of the following?
a. The consulting psychiatrist should always collect collateral data by phone rather than having staff at the remote site obtain it
b. If the patient refuses baseline labs, the CAP should not prescribe.
c. The CAP should prescribe any psychostimulants regardless of whether the remote site has a qualified prescriber
d. **Prescribing should be based on the CAP's role in the consultation relationship, the model of service delivery, and a risk/benefit analysis of each case**

| YEAR TWO DIDACTICS (Y2D) |
| PRE-TEST |
| STUDENT VERSION |
| (6 SESSIONS) |

Session One (Acute interventions via PTP (PC1))
In conducting PTP, which of the following is necessary to ensure patient safety and appropriate intervention in the case of emergency?
Before the initial session, the child psychiatrist should

    a. Clarify with on-site staff what emergency resources are available onsite and locally

    b. Know local laws for civil commitment, duty to warn, and protect in the jurisdiction where the patient is located

    c. Develop a procedure in the event that a patient needs to be held or restrained

    d. Develop a procedure in the event that mandated reporting to child protective services is indicated

    e. Develop a procedure in the event that a child needs to be referred to emergency care, including knowledge of the physical address of the remote site

    f. Develop a back-up plan in the event of equipment malfunction or suboptimal technology impairing accurate assessment of agitation, substance use, etc.

    g. Emphasize the need for flexibility and team collaboration in the event of an emergency

    h. All of the above

If the patient is getting agitated, the CAP should deescalate the patient using which of the following techniques:

    a. Extending the session and talk them down

    b. Calling 911 and ending the session

    c. Raising their voice

    d. Sending the patient to the emergency department (ED) and waiting for the discharge

In addition to the safety of the patient, what else should the CAP consider if a patient escalates during a PTP session?

a. Safety of staff on site with the patient
b. Own reputation as a telepsychiatrist
c. Whether insurance will cover a session that goes over time
d. How to bill for the session

Session Two (Clinical Challenges in PTP)
In the event that a patient refuses to speak during a telepsychiatry session, the child psychiatrist should:
a. Immediately give up and try to engage the caretaker instead
b. Attempt to engage the patient on topics not related to the clinical presentation
c. Explain to the patient that there are likely to be negative consequences if they do not cooperate
d. Describe to the patient their concerns about their lack of participation

When working with a patient whose verbal skills are a relative vulnerability, the psychiatrist should make efforts to:
a. Communicate with nonverbal signals using the face and hands
b. Write questions on a pad of paper and hold it up to the camera
c. Learn sign language (ASL)
d. Rely solely on information provided by the parent or guardian

In preparation for assessing a hyperactive child via PTP, the psychiatrist should ensure that:
a. any potentially distracting furniture at the patient site (e.g. rotating chairs) have been replaced or removed
b. the caretaker understands that they will not be allowed in the room with the patient
c. screening instruments are not administered ahead of time
d. manipulable toys, electronic devices, and medical equipment are available for the patient to play with

Session Three (Consultation to remote non-healthcare sites: 1. School-based PTP (PC6B))
Which of the following concerns is particularly important to attend to in using PTP to treat youth in the school setting:
a. Disregarding the input of school personnel in assessing a child
b. Ensuring privacy of the setting and freedom from peer intrusion

    c. Requiring a team evaluation including cognitive testing be completed ahead of time

    d. Not apprising the parents of the PTP service since they might prevent access

In providing consultation to school-based clinics via PTP, child psychiatrists should comply with which of the following standards:
    a. SUPPORT for Patients and Communities Act
    b. Family Educational Rights and Privacy Act (FERPA)
    c. American Medical Association (AMA) Code of Ethics
    d. Federation of State Medical Boards (FSMB) guidelines for the use of social media

Session Four (Consultation to remote non-healthcare sites: 2. Juvenile justice (PC6B))
In providing consultation to juvenile justice settings, the child psychiatrist may particularly need to:
    a. Ensure the availability of quiet toys
    b. Have means to verify information provided by the patient, including his/her identity
    c. Abide by FERPA
    d. Avoid asking patients about their personal lives or interests

When prescribing medications to youth in juvenile justice settings via PTP, child psychiatrists should:
    a. Disregard the need for obtaining youth assent
    b. Obtain consent from the youth since they are residing separately from parents
    c. Contact the guardian (i.e. parent, protective services) for consent before prescribing
    d. Document guardian consent in shadow file but not in the official medical record

Session Five (Consultation to remote non-healthcare sites: 3. Patient home (PC6B))
Which of the following may be a particularly useful intervention to apply to home-based PTP?
    a. Assessment of psychosis

b. Behavioral management

c. Assessment of extra-pyramidal side effects

Which of the following is generally not a potential benefit of home-based PTP care?
   a. Learning about the home environment and family culture
   b. Facilitating the care of children with autism and other chronic conditions
   c. Reducing the burden on parents and caretakers
   d. Assessing and treating trauma via imaginative play

Which kind of patient might not be best suited to home-based PTP?
   a. Child with social anxiety who refuses to meet on camera
   b. Child with disruptive behaviors
   c. Adolescent who travels two hours each way for in-person visits
   d. Child with conjunctivitis or other infectious condition

Session Six (How to set up a PTP private practice)

Which of the following is true regarding billing for PTP encounters?
   a. CAPS can bill for whatever services they provide via PTP regardless of the state in which they practice
   b. No special codes or modifiers exist for clinical care delivered via PTP
   c. Only therapy codes (not E\M) can be billed when care is delivered via PTP
   d. Billing code requirements may vary by individual insurers and CAPs should comply with the requirements of each insurer

Components of informed consent for PTP include which of the following:
   a. Potential benefits and risks of care received via PTP
   b. Rights when receiving care via PTP, including the right to stop or refuse
   c. Contingency plan if technology or equipment fails
   d. All of the above

YEAR TWO DIDACTICS (Y2D)
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TEACHER VERSION (ANSWERS IN BOLDFACE)
(6 SESSIONS)

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      c. Contingency plan if technology or equipment fails

      d. All of the above

REFLECTIVE LEARNING

Author: Sandra M. DeJong, MD, MSc

Reflective learning involves providing opportunities for learners to step back and consider their own learning, including their thoughts, feelings and attitudes about the material and how they have engaged with it. Some vehicles to promote this process are:

Personal Essay
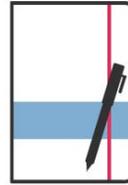
Journaling
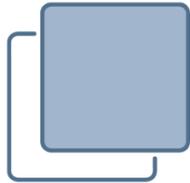
A work of literature: short story, poem

Art
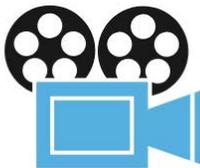
Video Clips

Patient Narratives

Personal Essay and Journaling allow for confidential reflection. Displacement of learners' experience can be facilitated by creating art, presenting video-clips, and recording patient narratives.

Methods can also be combined. For example, learners may be given a poem and then asked to write a personal essay in response to it.

Some settings may suit brief or longitudinal reflective exercises. For example, "Write down on an index card your biggest fear about this educational experience. Keep it until the end of the experience. Reflect on it when you are done. Did your fears come true? If not, why not? If so, why? In retrospect, could you have done anything to enhance your own learning experience?"

REFLECTIVE LEARNING - ESSAY TOPICS

Author: Sandra M. DeJong, MD, MSc

1. How can empathy best be demonstrated in a pediatric telepsychiatry session?

2. How can reflective listening be demonstrated in a pediatric telepsychiatry session?

3. What do you think are the biggest challenges and barriers to providing quality care using PTP and how can they best be overcome?

4. How can the child psychiatrist best assess the culture of the originating (patient) site in PTP?

5. Do transference and counter-transference matter in PTP?

6. How do you develop and assert your professional identity in PTP?

7. What is your biggest concern about using PTP in practice and how do you think you could address it?

8. How do you envision PTP being used in the future? What do you look forward to? What do you fear?

9. What is the best role for the CAP in consultation using PTP?

10. How do you adapt your own personal style to meet the expectations of the culture at the patient site?

SELF-ASSESSMENT TOOL FOR PEDIATRIC TELEPSYCHIATRY

Author: Sandra M. DeJong, MD, MSc (2019)

Fellow's Name: Fellow's Year of Training: Date:

Please rate how confident and competent you feel on each of the following dimensions. Your ratings should be based on your experience in working in Pediatric Telepsychiatry.

Communication (verbal and nonverbal)

| 1 | 2 | 3 | 4 | 5 | n/a |

Your availability during and in between PTP sessions

| 1 | 2 | 3 | 4 | 5 | n/a |

Emotional intelligence

| 1 | 2 | 3 | 4 | 5 | n/a |

Decision-making

| 1 | 2 | 3 | 4 | 5 | n/a |

Relationships/rapport with patients

| 1 | 2 | 3 | 4 | 5 | n/a |

Relationships/rapport with family members, caregivers

| 1 | 2 | 3 | 4 | 5 | n/a |

Relationships/rapport with psychiatrists and other mental health professionals at the remote site

| 1 | 2 | 3 | 4 | 5 | n/a |

Relationships/rapport with you team

| 1 | 2 | 3 | 4 | 5 | n/a |

Technological facility

| 1 | 2 | 3 | 4 | 5 | n/a |

Comments:

CHILD PATIENT SATISFACTION SURVEY

TASC–R and TASCP Items Therapeutic Alliance Scale for Children—Revised (TASC–R)
(Creed & Kendall, 2005; Shirk & Saiz, 1992)

1. I like spending time with my therapist.

   1   2   3   4

   Not true   Very much true

2. I find it hard to work with my therapist on solving problems in my life.

   1   2   3   4

   Not true   Very much true

3. I feel like my therapist is on my side and tries to help me.

   1   2   3   4

   Not true   Very much true

4. I work with my therapist on solving my problems.

   1   2   3   4

   Not true   Very much true

5. When I'm with my therapist, I want the sessions to end quickly.

   1   2   3   4

   Not true   Very much true

6. I look forward to meeting with my therapist.

   1   2   3   4

   Not true   Very much true

7. I feel like my therapist spends too much time working on my problems.

   1   2   3   4

   Not true   Very much true

8. I'd rather do other things than meet with my therapist.

   1   2   3   4

   Not true   Very much true

9. I use my time with my therapist to make changes in my life.

| 1 | 2 | 3 | 4 |

Not true   Very much true

10. I like my therapist.

| 1 | 2 | 3 | 4 |

Not true   Very much true

11. I would rather not work on my problems with my therapist.

| 1 | 2 | 3 | 4 |

Not true   Very much true

12. I think my therapist and I work well together on dealing with my problems.

| 1 | 2 | 3 | 4 |

Not true   Very much true

PARENT SATISFACTION SURVEY
Therapeutic Alliance Scales for Caregivers and Parents (TASCP)

1. I like spending time with my child's therapist.

| 1 | 2 | 3 | 4 |

Not true   Very much true

2. I find it hard to work with my child's therapist on solving problems in our lives.

| 1 | 2 | 3 | 4 |

Not true   Very much true

3. I feel like my child's therapist is on my side and tries to help me.

| 1 | 2 | 3 | 4 |

Not true   Very much true

4. I work with my child's therapist on solving our problems.

| 1 | 2 | 3 | 4 |

Not true   Very much true

5. When I'm with my child's therapist, I want the sessions to end quickly.

| 1 | 2 | 3 | 4 |

Not true   Very much true

6. I look forward to meeting with my child's therapist.

| 1 | 2 | 3 | 4 |

Not true   Very much true

7. I feel like my child's therapist spends too much time working on our problems.

| 1 | 2 | 3 | 4 |

Not true   Very much true

8. I'd rather do other things than meet with my child's therapist.

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Not true   Very much true

9. I use my time with my child's therapist to make changes in our lives.

    1   2   3   4

    Not true   Very much true

10. I like my child's therapist.

    1   2   3   4

    Not true   Very much true

11. I would rather not work on our problems with my child's therapist.

    1   2   3   4

    Not true   Very much true

12. I think my child's therapist and I work well together on dealing with our problems.

    1   2   3   4

    Not true   Very much true

EVALUATION AND DISSEMINATION OF CURRICULUM

The first draft of the curriculum was sent to seven peer expert reviewers, one training program, and the AACAP Committee on Training and Education. Reviewers' comments were incorporated into the current draft.

The current draft was then released in an open-access model to the AADPRT listserv, on social media, and the AACAP website.

It was also submitted to the AADPRT Model Curriculum Committee (May 2020) for consideration as a Model Curriculum in its current form that could be posted on the AADPRT Virtual Training Office. This form provides a curricular outline; teaching goals, methods and resources; and evaluations tools.

The authors are currently working on the development of downloadable video-based modules for didactic teaching (Appendix 13J) to enhance the curriculum. These materials should be available by December 2020.

The curriculum will then be annually revised and maintained based on ongoing feedback.

ACKNOWLEDGMENTS

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APPENDICES

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Competency/ Subcompetency	Description	Didactic v/ Clinical Teaching Setting	Teaching method (Hilty 2015)	Assessment Method (Hilty 2015)
Technical Skills				
TECH 1	Novice: After observing PTP, describes: use of hardware, software and accessories; integration of various technologies; necessary accommodations Competent: Operates hardware, software and accessories mostly without assistance; modifies patient and telepsychiatrist sites as needed to optimize care; performs routine trouble shooting at both ends of the connection; collaborates with information technology (IT) team as applicable	Y 1 Clin	Live demonstration in PTP clinical setting or training classroom Learner-initiated PTP under direct supervision/precepting	Supervisor/preceptor/peer Direct Observation feedback Standardized patients (Direct Observation Feedback) Mini-CEX for PTP
Patient Care				
PC 1 Psychiatric Evaluation	Novice: Describes the process of evaluating children and families via PTP in direct [non-consultative] care, including acute presentations	Y1 Did 5	Classroom case-based and problem-focused learning, including literature review and readings; role-play;	Pre- and post-tests

76

			APA PTP Toolkit; focuses case vignettes	
	Competent: Conducts evaluations of children and families via PTP in direct [non-consultative] care, including acute presentations	Y1 Clin 2	Clinical work in PTP setting with direct supervision (may include 2-way mirror for faculty/peer observers) Indirect supervision for reflection, deepening Simulation using videotaped or standardized patients Video-taped review of pre-recorded sessions during supervision	Formative oral and written feedback (may use Mini-CEX tool) by supervisor/preceptor/peers/team members during the clinical experience Written summative feedback at end using supervisor or 360 (multi informant) evaluation form Patient/family satisfaction and alliance questionnaires Reflective essay, e.g. on how delivering care via PTP differs from in-person care; meeting needs of distal community
PC 2 Psychiatric Formulation and Differential Diagnosis				
PC 3 Treatment Planning and Management	Novice: Describes factors particular to PTP in developing treatment plan and managing care	Y1 Did 1&2		

	Competent: Demonstrates consideration of these factors, establishes clear f/u plan, assesses and triages risk appropriately	Y1 Clin 5		
PC 4 Psychotherapy	Novice: Describes potential role of PTP in providing psychotherapy treatment of children, adolescents and families via PTP Competent: Provides psychotherapy via PTP	Y1 Did 5 Y1 Clin 4		
PC 5 Somatic Therapies	Novice: Describes potential role of PTP in providing somatic therapies. Competent: Provides medication treatment of children and adolescents via PTP within standard of care	Y1 Did 5 Y1 Clin 4		
PC 6 Clinical Consultation	Novice: Describes various models of clinical consultation via PTP Competent: Helps establish and/or conduct a consultative PTP service at a variety of sites	Y 1 Did 4-7 Y2 Clin 1		
Medical Knowledge				
Medical Knowledge	Novice: Describes core concepts and terms of PTP Competent: Describes	Y 1 Did 1	Live or web-based didactics by on-site or remote experts, e.g. APA/AACAP Telepsychiatry Tool Kit	Pre- and post-tests

	The evidence base for PTP: Access, cost, preference, quality of care, pros & cons, etc. Applications and models of PTP History of PTP Session logistics Administrative issues (coding, payment, etc.) Legal, regulatory and risk management issues How to set up a private PTP practice; Business aspects	Did 2 Did 3 Did 4 Y2 Did 1	Journal club Case-based and problem-focused facilitated group discussion Debate (e.g. pros and cons of PTP)	
Systems-Based Practice				
SBP1 Patient Safety and Quality Improvement	Novice: Describes potential risk management and safety issues in PTP Competent: Demonstrates understanding of risk management/safety issues as evidenced by appropriate management of safety concerns and efforts to assess and improve the PTP system	Y1 Did 4 Y 2 Did 2 Y1 Clin 2 Y1	Classroom role plays and case-based, problem-focused learning Clinical work in PTP setting with direct supervision (may include 2-way mirror) Indirect supervision for reflection, deepening Simulation using videotaped or standardized patients	QI project and write-up Mini-CEX for PTP Formative oral and written feedback by supervisor/preceptor/peers /team members during the clinical experience Written summative feedback at end using supervisor or 360 (multi informant) evaluation form
SBP 2 System Navigation for Patient-Centered Care	Novice: Describes various models of PTP and how models are set up at patient and telepsychiatrist site Competent: Demonstrates understanding of how the PTP network is organized, the steps by	Did 2 Y2 Clin		

			Video-taped review of pre-recorded sessions during supervision	
SBP 3 Physician Role in the Healthcare System	Novice: Describes psychiatrist's role in improving MH care access and equity through PTP. Competent: Helps to establish and conduct a PTP service in healthcare settings with clinical supervision/collaboration available from health or mental health professional who is with the patient. Describes how PTP services fit into the overall network or system of care	Y1 Did 1 Y2 Clin & Did		
Practice-Based Learning and Improvement				
PBLI 1 Evidence-Based and Informed Practice	Novice: Describes advantages and limitations of PTP, citing evidence Competent: Integrates the current and developing evidence base for telepsychiatry (pros and cons) into clinical practice	Y1 Did 1 Y2 Did & Clin	Direct and indirect supervision Review of documentation during supervision Use of appropriate outcome measures and development	Pre- and post-tests Supervisory evaluation Practice data metrics, performance improvement measures

Note: the first row "which a patient/family access the service, and how the service is set up and administered at both ends. Demonstrates how to use the system optimally to advocate for needs of the patient, family, and community." appears at top of SBP 3 row.

			of plan for improvement with supervisor	
PBSI 2 Reflective Practice and Commitment to Personal Growth	Novice: Identifies gaps in own PTP knowledge/skills/attitudes and demonstrates interest in filling them Competent: Assesses patient outcomes and builds own skill-set and makes systems improvements appropriately in a QI model			Reflective essay Self-assessment tool
Professionalism				
PROF 1 Professional Behavior and Ethical Principles	Novice: Describes current legal, regulatory and risk management requirements in own jurisdiction. Identifies common ethical and professionalism concerns in PTP Competent: Practices according to legal, regulatory and risk management requirements and recommendations (e.g. licensing, prescribing) Raises ethical and professionalism considerations and manages them appropriately (e.g. informed consent, privacy, confidentiality, boundaries)	Y1 Did 4 Y2 Clin	Direct and indirect supervision Case write-ups Direct and indirect supervision Direct and indirect supervision Use of ethical and professional guidelines and resources to address question/problems that arise in clinical work	Pre- and post-tests Supervisory evaluations Mini-CEX for PTP Reflective essays or journal
PROF 2 Accountability/Conscientiousness	Novice: Describes role of physician as advocate to promote PTP Competent: Advocates for use of PTP as means to address healthcare inequities and improve access	Y1 & 2 Did & Clin		

PROF 3 Wellbeing	Novice: Describes potential impact on wellbeing in practicing PTP Competent: Attends to physical and psychological impacts on self of working in PTP and adjusts physical and psychological factors appropriately	Y1 Did 4 Clin		
Interpersonal and Communication Skills				
ICS 1 Patient and Family-centered Communication	Novice: Describes aspects of verbal and nonverbal communication via PTP important in promoting rapport and ensuring clear communication Competent: Uses verbal and nonverbal communication to establish and develop rapport with patient and family/caretakers Demonstrates flexibility, adheres to timeframe, incorporates family members appropriately Overcomes/addresses limitations or obstacles to effective communication Considers aspects of diversity and demonstrates cultural humility in communicating across sociocultural differences within PTP Assess need for and uses interpreter in PTP	Y1 Did 3 Y1&2 Clin	Clinical work in PTP setting with direct supervision (may include 2-way mirror) Indirect supervision for reflection, deepening Simulation using videotaped or standardized patients Video-taped review of pre-recorded sessions during supervision Review of documentation during supervision	Supervisor/preceptor/peer observation and feedback Standardized patients Mini-CEX for PTP Patient/Parent satisfaction and alliance surveys

ICS 2 **Interprofessional and Team Communication**	Novice: Describes process for communicating with team during and outside PTP sessions Competent: Effectively runs a PTP session. Incorporates team members appropriately during and outside of sessions. Establishes clear communication protocols for in between sessions	Y1&2 Did Y1&2 Clin		Multi-informant evaluation (360)
ICS 3 **Communication with Healthcare Systems**	Novice: Describes key considerations in documenting PTP sessions. Drafts and EMR note based on observation of a PTP session Competent: Appropriately documents PTP encounters in both direct care and consultation. Documents in accordance with all compliance standards	Y1&2 Did Y1&2 Clin		Retrospective chart review

APPENDIX B
MAKING THE BUSINESS CASE FOR PTP

GENERAL PRINCIPLES
Adapted from the APA/AACAP Telepsychiatry Toolkit for Child and Adolescent Psychiatry
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/roi

o Telepsychiatry services offer significant financial savings to families and children in the form of direct cost avoidance, and fewer lost work/school hours. The families' return on the system's investment benefits both the family and their community.

o Telepsychiatry's return on investment varies across settings with emergency rooms having a particularly high return on investment.

o The return on investment must also consider the assistance that telepsychiatry renders in decreasing the burden on physicians in ERs and in small town medical practices.

o Psychiatrists may consider the return on investment in integrating telepsychiatry into their practices by reducing overhead expenses.

o As technology has continuously improved, the cost of telepsychiatry infrastructure has decreased; and, as telepsychiatry has grown, the increased competitiveness of telehealth platform vendors has further lowered the initial cost of the infrastructure increasing the return on initial investment for most healthcare systems and providers.

o The return on investment for telepsychiatry with youth must consider the potential benefits of supporting medical providers in under-served communities, potentially reducing "burnout" and attrition.

o Offering telepsychiatry in a Division of Child and Adolescent Psychiatry both as a service and as part of fellowship training can enhance the recruitment and retention of fellows and faculty.

References

1. Waugh M, Voyles D, and Thomas M. Telepsychiatry: Benefits and costs in a changing health-care environment, International Review of Psychology, 2015; 27(6): 558-568.

2. Hilty DM, Ferrer DC, Parish MB, Johnston B, Callahan EJ, Yellowlees PM. The effectiveness of Telemental health: a 2013 review. Telemedicine and e-Health 2013;19(6):444–454.

BENEFITS TO DIFFERENT GROUPS

Author: Bianca Busch, MD

There is a growing body of literature demonstrating the financial benefits of using telemedicine to deliver mental health care. The benefits relay a high return on investment for families, communities, trainees, private practitioners, and health care systems.

Families

•Telepsychiatry services offer significant financial savings to families and children in the form of reduced transportation expenses and fewer lost school and work hours.

Communities

•For rural and underserved communities, telepsychiatry offers increased access to Child and Adolescent Psychiatrists. This collaborative work may reduce burnout of general practitioners, leading to their retention in these areas of high need.

•Availability of this mental health expertise has the potential to reduce the burden of disease, thus reducing both direct and indirect costs and improving the quality of life for children, caregivers, and community as a whole.

Trainees

•There is increasing attention to the rates of and attempts at reducing physician burnout. Reliford and Adebanjo (2018) found that CAP Fellows using telepsychiatry while On-Call reduced face-to-face evaluations by 75% and saved 2 hours per call day. Telepsychiatry has the possibility to reduce burnout and improve wellbeing. Not only does this modality serve learners well while in training, experience with telepsychiatry broadens post-graduate employment opportunities. Offering telepsychiatry curricula has the ability recruit additional applicants to training programs.

Individual/Private Practitioners

•Similar to large healthcare systems, individual practitioners must consider operation costs. Offering care via telehealth may reduce or eliminate the need for physical clinical space, thus reducing overhead spending.

•The ability to offer convenient care creates opportunities for individual families and opportunities to collaborate with schools and other non-healthcare entities.

<u>Health Care Systems</u>

•There is a robust literature on the cost savings for Emergency Departments. Thomas et al (2017) found that when compared with standard care, pediatric patients seen by telepsychiatry in the emergency room experienced a reduction in length of stay (5.5 hours versus 8.3 hours) and incurred lower patient charges ($3,493 versus $8,611.)

•Telemedicine technology has improved, thus lowering the cost of infrastructure and reducing the time/patients needed to have a positive return on investment.

•It can be hypothesized that offering telepsychiatry in outpatient settings would reduce the no-show rate, thus increasing department revenue.

•Offering the possibility to deliver care via telemedicine presents opportunities for flexibility in scheduling and work locale. This flexibility may assist with recruitment, retention, and satisfaction of employee-physicians.

References

1. Ramtekkar U. Return on Investment. Child and Adolescent Telepsychiatry Toolkit. Washington DC: American Psychiatric Association; 2019 [cited January 12, 2020]. Available at https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/roi

2. Waugh M, Voyles D, and Thomas M. Telepsychiatry: Benefits and costs in a changing health-care environment, International Review of Psychology, 2015; 27(6): 558-568.

3. Hilty DM, Ferrer DC, Parish MB, Johnston B, Callahan EJ, Yellowlees PM. The effectiveness of Telemental health: a 2013 review. Telemedicine and e-Health 2013;19(6):444–454.

4. Thomas JF, Novins DK, Hosokawa PW, Olson CA, Hunter D, Brent AS, Frunzi G, Libby AM. The use of telepsychiatry to provide cost-efficient care during pediatric mental health emergencies. Psychiatric Services. 2017 Oct 15;69(2):161-8.

5. Reliford A, Adebanjo B. Use of Telepsychiatry in Pediatric Emergency Room to Decrease Length of Stay for Psychiatric Patients, Improve Resident On-Call Burden, and Reduce Factors Related to Physician Burnout. Telemedicine and e-Health. 2018 Oct 31.

APA-AACAP JOINT TELEPSYCHIATRY TOOLKIT FOR CAP 2019

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent

VIDEO TOPICS:

Introduction to Telepsychiatry in CAP

History of Child/Adol TP

My Telemental Health Journey

The Evidence Base

Legal and Regulatory Issues

Patient Safety

Training in TP in CAP Fellowship

Return on investment

Technology-Specific Training Considerations

Developing a Virtual Therapeutic Space

Participant Arrangement

Systems of Care

Community Mental Health

School-based telepsychiatry

Juvenile Justice

Team-based Models of Care

Cultural Considerations with Youth

Project Echo™

Behavior Management Training

SET UP FOR PEDIATRIC TELEPSYCHIATRY SIMULATION TEACHING SESSION

Authors: Deborah Brooks, MD and Shabana Khan, MD

Below are general instructions. The session takes about 60 min from start to finish.

10 min	groups and roles assigned
20 min	conduct simulation exercise, recorded by group member
15 min	small group review of recording and discussion
15 min	large group de-brief

Smartphones or tablets with cameras are required for this session, one per group.

Pre-preparation:

3 sets of 3x5 index cards

1) age and diagnosis of patient (two for each group)
2) family's clinical question/chief complaint (one for each group)
3) complication (up to 3 for each group)

2 sets of envelopes

1) Mark one "Fellow and Attending Supervisor" and put one age/diagnosis card.
2) Mark the second "Parent, Child and Therapist and put one age/diagnosis card and one clinical question card.
   Hold on to the complication cards; you will distribute these during the simulation exercise.

Goals of the exercise:

- Develop comfort with telepsychiatry
- Demonstrate good videoconferencing etiquette and "webside" manner
- Troubleshoot common problems that may arise during a virtual visit
- Develop comfort with consulting to a remote mental health care professional along with the patient and family

Teacher Instructions:

1. Divide learners into groups (3-5) and assign roles

e.g. child psychiatry fellow; attending supervisor (both at the provider site); parent; child; therapist (at the originating site)

2. Hand out correct envelope to each group.

e.g. Fellow and Supervisor: view the "Fellow and Attending Supervisor" envelope which contains only patient age and diagnosis

Parent, child, and therapist: view the "Parent, Child, and Therapist" envelope which contains patient age, diagnosis, clinical question

3. Explain what learner in each role will do:

Child psychiatry fellow: conducts the patient interview and only knows age and diagnosis

Attending supervisor: records the session using a mobile device (smartphone or iPad/tablet); provides clinical guidance as requested by fellow

Child: plays role outlined in patient presentation (age, diagnosis) and in complications distributed by teacher as in a real-life session

Parent: explains the clinical question to the child fellow as in a real-life session

Therapist: presents with the child and parent, arranges the telepsychiatry collaborative care consultation, and helps child and parent develop comfort with using this modality to see their doctor

4. Start timer and observe group interactions. After 5-10 minutes, as appropriate based on groups' progress, start handing out complication cards, up to 3 per group over the 10-15 minutes.

5. Stop simulation after about 20 minutes. Allow each group to view their videotaped simulation on the smartphone or tablet and discuss amongst themselves.

6. Come back into large group to de-brief. What did you learn? What was most difficult? How did you work through the clinical challenges?

Examples of Age and Diagnosis
16 y/o with sleep difficulty
6 y/o with ADHD
12 y/o with oppositional behaviors
13 y/o with anxiety
14 y/o with depression

Examples of Clinical Questions:
Child engaging in self-injurious behavior
Poor school performance; difficulty concentrating in class
"I think my child is bipolar."
"The meds aren't working."
Medication side effects

Examples of Complications:
Patient has suicidal ideation
Audio stops working
Patient starts playing with a loud toy
Parent won't let the child talk
Patient won't put down their phone/take out earbuds
Patient won't stay in the frame

CASES FOR PROGRESSIVE CASE DISCUSSION

Teacher's Version
Authors: Deborah Brooks, MD, Sandra DeJong, MD

Table of Contents

Case	Topic	For use in Didactic…
1	Sullen teenager who won't talk	Y1 Did 3, 5 Conducting Direct Clinical Care; Session Logistics
2	Hyperactive child with ADHD	Y1 Did 3, 5 Conducting direct clinical care; Session logistics
3	Video goes out mid-session	Y1 Did 3, 5 Conducting direct clinical care; Session logistics
4	Administering screening tools	Y1 Did 6 Higher level skills
5	Student with safety issues	Y2 Did 4 School-based PTP consulting
6	Youth who won't talk/misrepresents the truth	Y2 Did 5 Juvenile justice consultation via PTP
7	Negotiating medication treatment in a juvenile justice setting	Y2 Did 5 Juvenile justice consultation via PTP

YEAR 1 DIDACTICS
SESSION 3 CREATING A VIRTUAL THERAPEUTIC SPACE AND SESSION LOGISTICS
SESSION 5 CONDUCTING DIRECT CLINICAL CARE VIA PTP

Case 1: Initial evaluation of a sullen teenager who won't talk

Q: 15 y/o teenager presents with his father at a local community mental health center for a telepsychiatry evaluation. The patient sullenly stares at the ground, earbuds in his ears, arms crossed over his chest. How do you start?

A: Introduce yourself, who you are, and where you are located. Ask the patient his name and who accompanied him to the visit.

Q: The patient shrugs and doesn't look up. What do you do next?

A: Ask the patient to remove his earbuds.
> a. If he removes his earbuds, direct the conversation to him
> b. If he refuses to remove his earbuds, tell the patient (who is probably not listening) that you will begin by asking his father questions. Any time the patient looks up, try to engage him with a question. Discuss with patient that your preference is to speak with the patient 1:1, without father in the room, for part of the visit.

At the end of the session, discuss with the clinician or administration at the originating site that they should advise patients and families to not use electronic devices or ear buds during appointments.

Take-home points: Take control of the situation as much as you can both before and during the session. You can ask parents or staff to assist. Trying to force compliance from a child may jeopardize the developing therapeutic alliance and it can he challenging to enforce through telepsychiatry. The same ice-breaking strategies used in in-person sessions can also be effective in telepsychiatry: What are the patient's interests/strengths? Notice details of what patient is wearing (t-

shirt, jewelry, etc). In this case, what is the patient listening to? Ask questions to learn about his community.

Case 2: Hyperactive Child with ADHD

Q: You will be conducting an assessment of a 7 y/o child who presents with his mother for evaluation of inattention and hyperactivity. Your camera is set up and working. When you connect with the originating site, you see a harried parent, a therapist, and a child sitting in a wheeled office chair. How do you start?

A: Introduce yourself, explain who you are and where you are connecting from. Direct questions to the child.

Q: You ask the child if he has ever talked to someone on a screen like this before. He shrugs. You ask him if he knows why he is here. He begins to spin around in the wheeled chair and his mother is not making any attempts to redirect him or stop the spinning. What do you do?

A: Attempt to continue the interview, asking the child's permission to get the information from his mother.

Q: The child spins faster and you start to get dizzy. What do you do?

A: Ask mother or therapist to try to stop the child from spinning. If they are successful, ask the therapist to switch out that chair for a stationary chair.

If the child continues to spin, ignoring redirection, complete the interview as best you can. After the interview, have therapist remove the wheeled chair from the room and replace it with a stationary chair.

Take-home points: Collaborate with staff at the originating site to make adjustments to the room set up as indicated to optimize the telepsychiatry session. To help focus a child's energy, have developmentally appropriate play materials accessible in the room, ideally materials that aren't very noisy. Tools and paper for coloring, drawing, doing crafts, and a basket of fiddle toys can be helpful; toy

trucks, Legos™, and other toys that can make noise are not ideal because the sound can be amplified and disrupt the session.

Consider reducing the amount of time a younger child has to be on camera because it can be too stimulating; consider having the child step out of the room with the therapist to allow time for you to speak with the parent/guardian.

To make the evaluation more efficient, consider speaking with the teacher or having parents and teachers complete relevant rating scales before the session.

Pan-tilt-zoom cameras can allow you to pan the camera and follow the child around the room, however not all sites have this technology.

Case 3: The video goes out in the middle of a session

Q: You are conducting a psychiatric evaluation via telepsychiatry and about thirty minutes into the visit, the video stops working. What do you do?

A:
a. Try restarting your technology/devices and reconnecting
b. Call the originating site (patient) on the telephone to troubleshoot and have them also restart and reconnect
c. Contact IT support for assistance as indicated
d. Complete the session over the telephone

Take-home point: Such occurrences are not uncommon. Be flexible!

YEAR 1 DIDACTICS
SESSION 6 HIGHER LEVEL SKILLS - ADMINISTERING SCREENING TOOLS - VANDERBILT, CESDC, ETC.

Case: 4

Q: What is the best way of administering screening instruments for a child who you are seeing via telepsychiatry?

A: Potential options:

Email or fax scales/forms to the originating site prior to the appointment time and have parent/patient complete the form onsite

        Pros: results obtained in real-time, good if the patient is at a clinic site or there is a therapist present to help coordinate

        Cons: pre-planning required

Email scales/forms directly to parent or send to parent through a secure patient portal

        Pros: efficient - scales go directly to parent who can fill it out themselves and/or give it to the child's teacher(s) as indicated

        Cons: if emailing, must use an encrypted email; parent/patient will have access to your email address, which may not be secure

Email or fax scales/forms directly to school with instructions to return completed forms

        Pros: form gets directly to the teacher (theoretically), don't have to rely on extra step of parent giving the form to the teacher

        Cons: scales/forms may not get from the school office to the teacher

Have parent/patient complete the scale in-session (may be easier to do using screenshare function)

        Pros: get results in real-time during session

        Cons: use of session time to complete and score

Additional points:
You may need to use more than one method
Link to an online tool may streamline the process; you may be able to use a secure patient portal through an EMR

Case 5: Student with safety issues (basics)

Q: A 7 y/o girl is threatening self-harm at school. Staff are concerned the child might harm herself in session or before the next session. What do you do?

A: Before engaging in the telepsychiatry session, it is important to develop a safety plan.

a. Are there staff at the originating site that can support or redirect a patient that becomes aggressive or engages in self-harm during the session?
b. What is the direct phone number to reach staff at originating site if they are not in the room with the patient?
c. What are the relevant local emergency numbers (e.g., police department, fire department, local crisis line) for the originating site? Note: If you call 911 from your office, you will be connected to YOUR local emergency services, not those of the patient.
d. Is there a plan for keeping the child there so they do not leave?

Q: Staff raise the concern that the child is allegedly being physically abused at home. What do you do?

A:

a. In what state and county is the child? In what county did the alleged abuse occur?
b. What is the Child Protective Services' number for the county where the patient is located?
c. Is there a plan for keeping the child there so they do not leave? Who is the designated person responsible for the patient until emergency services arrive?
d. Remind school staff and originating site clinicians that they are also mandated reporters and discuss who is going to report.

Case 6: Sullen youth who won't talk or who misrepresents the truth

Q: You are seeing an incarcerated youth through telepsychiatry. He does not want to be there and is not telling you anything. What do you do?

A: Begin by introducing yourself, who you are, your location, and what your role is. Show familiarity with the patient's setting; for example, bring up a beloved staff member. Inquire about patient's experience in the program, food, outings, levels the patient is working on achieving. Be sensitive to the fact that incarcerated youth work with many adults whose job is to get information, not take care of them. Make sure the teen knows that you are here for them (if you indeed are).
State your allegiance: "I'm here to help you out, not to get you in trouble." Explain that you are can prescribe medications if clinically indicated.
Typically, you will have at least some information about the youth sent from juvenile corrections.

- Review the available information. Avoid repeating questions if you already know the answer.
- If you know why the youth is seeing you (trouble sleeping, poor concentration, etc.) address it directly. "It looks like you were having trouble sleeping."

Q: What if the teenager continues not to talk? What do you do?

A: If the youth is still not talking, you can address basic questions to the accompanying therapist (if present). If the patient is still refusing to engage, it may have been a win just having the youth see you for a few minutes. Explain to the youth you will reschedule them for your next available appointment to check in.

Q: What do you do if you have the sense that the teenager is beginning to warm up?

A: You may be able to push your questions a little more. But remember, it may be as much of a win to get the patient into the tele room so take the win and build on if for next time. Incarcerated youth have a high prevalence of psychiatric disorders. It

is important to use a patient-centered approach to engage the patient and this may take some time.

Q: What do you do if the youth is providing information you know is not true (e.g., a patient pretending to be someone else who is also incarcerated at the facility)?

A: Check with the therapist or staff bringing the youth to confirm his identity.

Case 7: Negotiating medication treatment in a Juvenile Justice (JJ) setting

Q: A 16 y/o male in detention has longstanding difficulties with aggression. He has tried selective serotonin reuptake inhibitors (SSRIs), alpha agonists and psychostimulants without positive effect. You would like to start him on a low-dose antipsychotic, preferably risperidone given the evidence base to support it. Haloperidol is the only antipsychotic available through the formulary for the JJ system in that state. What should the child psychiatrist do?

A: Typical juvenile justice youth have very few options in their daily schedule. They do have a choice whether to come see you and whether to take their medicine, so try to include the youth in the decision making.

If you know there is a medication that may work above all others, try to convince the youth, making sure to explain risks and benefits.

If there are medications with potentially equal benefits and risks, give the youth the option.

If they have an opinion (for example methylphenidate vs amphetamines) and there is no contraindication, giving the youth a sense of agency will likely increase the therapeutic relationship.

In terms of the medication choice, part of your role may be to advocate for out-of-formulary prescribing. Knowing the system at the patient's site and state is critical.

Author: Shabana Khan, MD

a. Patient connects with you by for a video visit while she is physically located in a state where you are not licensed (e.g., while on vacation)

b. Patient is discussing a confidential issue that he does not what his mother to know about. The telepsychiatry room in the school-based clinic is not sound-proof and the clinic doesn't have a noise machine or other device set up to ensure privacy. Patient's mother, who was sitting outside in the waiting room, hears the entire conversation and abruptly walks into the room to join the discussion.

c. You are seeing a young child via telepsychiatry in-home and he is playing with very noisy toys (trucks, blocks) which are located right by the speaker/mic. The sound of the toys is amplified by the technology, making it very difficult to hear the patient and family.

d. Poor lighting on patient end making it difficult to assess subtleties of affect, crying/tearing, tremors, extrapyramidal symptoms, etc.

e. Telepsychiatrist has a very cluttered and unprofessional background

f. Child with autism that is very difficult to engage. Telepsychiatrist asks what cartoon characters and superheroes he likes and use the screen-sharing function to bring images of these characters up on screen and this helps engage the child. The picture-in-picture view may help engage a child (but can also be a distraction!) Telepsychiatrist asks child/family to share pictures of pet(s) or projects they are working on (e.g., artwork, crafts).

g. Nonverbal communication to engage a child (e.g., telepsychiatrist using virtual high-fives and virtual handshakes)

h. Child with hearing loss – can use technology such as noise amplifying headphones

i. Teen presents to visit intoxicated – telepresenter at patient site smells alcohol on patient's breath and alerts telepsychiatrist prior to the visit

j. Camera placed to the side of the monitor on patient end so patient and family seem to be looking off to the side during the visit – consider proper placement of camera, minimize gaze angle, telepsychiatrist should periodically look up at the camera on his/her end to make virtual eye contact with individuals on the other end

CHILDREN'S SATISFACTION QUESTIONNAIRE

Date _____

CHILDREN'S SATISFACTION QUESTIONNAIRE (for children 7-12 years old; Adapted from Seattle Children's Hospital)

We would like to know what you thought of seeing the doctor over the TV.   Please check the boxes below that show how much you agree or don't agree with each statement. You will help us to make things better for you and other kids. Thank you!

Item	Satisfaction Item	Not at All	A Little	Some	A Lot
1	I could see the doctor on the TV screen really well.				
2	I could hear the doctor on the TV screen really well.				
3	I was not worried about anyone else hearing me.				
4	It was easy to talk with the doctor over the TV.				
5	I could talk about my problems easily.				
6	I understood what the doctor wants me to do.				
7	I feel OK about the doctor's recommendations.				
8	I think my friends and other kids would like the doctor on the TV screen OK.				
9	I am willing to go back to this doctor on the TV screen.				
10	I think that getting help over the TV screen was as good as getting help in person.				

Do you have any ideas about what could do better?

TEEN'S TECHNICAL SATISFACTION QUESTIONNAIRE

Date _____

TEENS' TECHNICAL SATISFACTION WITH TELEPSYCHIATRY SERVICES

Approximate number of telepsychiatry sessions (circle): 1 2 3-6 7-10 11-14 15-20 >20

Read each statement below and rate how strongly you agree or disagree with each one by circling a number from one to five on a scale ranging from: 1=Strongly Disagree to 5=Strongly Agree.

	Strongly Disagree			Strongly Agree	
1. I could talk comfortably with the telepsychiatrist on the television.	1	2	3	4	5
2. I could see the telepsychiatrist very well.	1	2	3	4	5
3. I could hear the telepsychiatrist very well.	1	2	3	4	5
4. I felt confident that my information was not being overheard by others outside the room.	1	2	3	4	5
5. I could understand the telepsychiatrist's recommendations.	1	2	3	4	5
6. I felt the telepsychiatrist was comfortable with seeing me over the television.	1	2	3	4	5
1. Telepsychiatry allowed me to see a psychiatrist sooner than waiting for in-person psychiatrist.	1	2	3	4	5
7. I would not have been able to see a psychiatrist without telepsychiatry.	1	2	3	4	5
8. I will receive the help I need because of visits with the telepsychiatrist.	1	2	3	4	5
9. The telepsychiatrist visit was as good as a regular in-person visit.	1	2	3	4	5
10. I would be willing to see a telepsychiatrist again in the future.	1	2	3	4	5
11. Overall, I am very satisfied with the quality of services provided with telepsychiatry.	1	2	3	4	5

TEEN COMMENTS: Please use the other side for additional comments or suggestions to help us improve the delivery of services through telepsychiatry.

PARENT'S TECHNICAL SATISFACTION QUESTIONNAIRE

Date _____

PARENTS' TECHNICAL SATISFACTION WITH TELEPSYCHIATRY SERVICES

Approximate number of telepsychiatry sessions (circle):   1-2   3-6   7-10   11-14   15-20   >20

Read each statement below and rate how strongly you agree or disagree with each one by circling a number from one to five on a scale ranging from: 1=Strongly Disagree to 5=Strongly Agree.

	Strongly Disagree			Strongly Agree	
1. I could talk comfortably with the telepsychiatrist on the television.	1	2	3	4	5
2. I could see the telepsychiatrist very well.	1	2	3	4	5
3. I could hear the telepsychiatrist very well.	1	2	3	4	5
4. I felt confident that my child's information was not being overheard by others not in the room.	1	2	3	4	5
5. I could understand the telepsychiatrist's recommendations.	1	2	3	4	5
6. I felt the telepsychiatrist was comfortable with seeing my child over the television.	1	2	3	4	5
7. Telepsychiatry allowed my child to see a psychiatrist sooner than waiting for in-person psychiatrist.	1	2	3	4	5
8. My child would not have received services of a psychiatrist without telepsychiatry.	1	2	3	4	5
9. My child will receive the help he/she needs because of our visit with the telepsychiatrist.	1	2	3	4	5
10. The telepsychiatrist visit was as good as a regular in-person visit.	1	2	3	4	5
11. I would be willing to have my child see a telepsychiatrist again in the future.	1	2	3	4	5
12. Overall, I am very satisfied with the quality of services provided with telepsychiatry.	1	2	3	4	5

PARENT COMMENTS: Please use the other side for additional comments or suggestions to help us improve the delivery of services through telepsychiatry.

Y1, Didactic Session One

Learning Objectives:

Overview: This session focuses on the evidence base for (and against) PTP. This includes data about clinical care (patient preference, quality), systems (access), and cost-effectiveness.

Materials needed:
APA/AACAP Telepsychiatry Toolkit
https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent
"The Evidence Base" (Myers) and "The Return on Investment" (Ramtekkar and Busch)

Yellowlees P and Shore JH (ed). *Telepsychiatry and Health Technologies – A Guide for Mental Health Professionals*. Washington DC: American Psychiatric Association Publishing, 2018
Chapters XX: "Evidence Base for Use of Videoconferencing and Other Technologies in MH Care"

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y1, Didactic Session Two

Learning Objectives:

Overview: This session focuses on a brief history of PTP and different applications and systems of care integrating PTP.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y1, Didactic Session Three

Learning Objectives:

Overview: This session focuses on the logistics of setting up the clinical space in the provider's office and at the remote site, including:

- Virtual space – Tech issues, audio-visuals, lighting etc.
- Communication – verbal, nonverbal
- Provider issues (posture, breaks, etc.)
- Clinical - managing more than 1 participant, incorporating the EMR, etiquette, redundancy measures, emergency back-up plan
- Time management and organization

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y1, Didactic Session Four

Learning Objectives:

Overview: This session focuses on administrative and professionalism issues. These include getting paid for PTP sessions (diagnostic and CPT coding, billing, insurance contracts) and legal, ethical, regulatory and risk management issues.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y1, Didactic Session Five

Learning Objectives:

Overview: This session focuses on how to provide direct patient care (evaluation and maintenance treatment) using PTP.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y1, Didactic Session Six

Learning Objectives:

Overview: This session focuses on how to conduct a clinical consultation to healthcare partners via PTP. Examples could include consulting to primary care, community health clinic nurses, or to emergency clinicians at a satellite site. The emphasis is on understanding the clinical question from the team, collecting the necessary data both through history and examination and through collateral sources such as screening instruments and laboratory results, and integrating the data into a reasonable formulation and treatment plan for the remote site to be able to implement.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session One

Learning Objectives:

Overview: This session focuses on setting up a PTP in private practice.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Two

Learning Objectives:

Overview: This session focuses on This session focuses on acute interventions via PTP. This include patients who become acutely unsafe due to self-harm, agitation, aggression etc. Trainees may have cases from their practice they can discuss.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Three

Learning Objectives:

Overview: This session focuses on This session continues the focus on clinical management of patients via PTP including youth with severe hyperactivity, psychosis, developmental disorders, sensory deficits; very young or nonverbal children, and medically ill children. The particular challenges of each presentation and how to manage them are presented.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Four

This session introduces a 3-part series on consultation to remote non-healthcare sites (schools, juvenile justice settings, and community mental health centers), at least one of which will be the focus of a clinical experience. Particular emphasis is places on considerations that pose new challenges from care in the health care setting.

Learning Objectives:

Overview: This session focuses on This session continues the focus on clinical management of patients via PTP including youth with severe hyperactivity, psychosis, developmental disorders, sensory deficits; very young or nonverbal children, and medically ill children. The particular challenges of each presentation and how to manage them are presented.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Five

Learning Objectives:

Overview: This session focuses on consultation to the juvenile justice setting.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Six

Learning Objectives:

Overview: This session focuses on consultation to patients in community mental health centers.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Seven

Learning Objectives:

Overview: This session focuses on providing consultation to remote mental health professionals. One specific model to discuss is Project Echo model,[TM] which was first used to help treat hepatitis in underserved areas and is now a national model. Synchronous and asynchronous consultation can be discussed using cases.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Eight

Learning Objectives:

Overview: This session focuses on teaching and supervising child psychiatry using videoconferencing. Increasingly, supervision and teaching are happening remotely to reduce travel times and enhance efficiency. Uploading and discussing videotapes of clinical sessions with children and families can enhance the experience.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors:

Y2, Didactic Session Nine

Learning Objectives:

Overview: This session focuses on using videoconferencing in global mental health to meet the mental health needs of children and families around the world.

Materials needed:

Session Outline (blow by blow):

Potential adaptations:

Assessment:

Authors