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[Edited for grammar and clarity by CAMH]

Episode #9: What all physicians need to know about the rapid virtualization of mental health care – and the post-pandemic future

[Musical intro]

David Gratzer: *"If we can use apps to order dinner and video chats to stay in touch with family, we can use new technology to keep each other healthy."*

So commented Prime Minister Justin Trudeau in May when announcing nearly a quarter of a billion dollars to support virtual care and mental health tools that would be online. So is our new COVID world, where people are talking about virtual care and where us, clinicians, are using virtual care more than we've ever done before.

I'm speaking today from the Centre for Addiction Mental Health, where we've seen virtual visits increase eight hundred and fifty percent from March to April. Joining us to talk about what could be our digital moment is Dr. Jay Shore. Dr. Shore is a psychiatrist. He's the chair of the American Psychiatric Association's Telepsychiatry Committee. And he's a professor in the Department of Psychiatry and Family Medicine at the University of Colorado. Dr. Shore, welcome to *Quick Takes*.

So back to the question of the hour. Are we having a digital moment?

Jay Shore: I certainly would agree that we are. Particularly with the COVID situation. In fact, we're having a digital moment probably in medicine and behavioural health like one we have never seen.

David Gratzer: Now, you have been in the telepsychiatry space for some time. You are obviously a practitioner, a working doctor, but you've also published dozens and dozens of papers. When did you do your first telepsychiatry consult?

Jay Shore: Wow. I think it's either around my senior year of residency or right when I first graduated. I don't want to date myself, but approximately 20 years ago.

David Gratzer: And at that time not that many people were sharing this space, correct?

Jay Shore: You know, certainly telepsychiatry has gone through multiple phases of development. So many people don't know that the first telepsychiatry service was in the late 1950s. The first paper is 1959, University of Nebraska. So the concept is not sort of radical or innovative. But certainly what we saw in the 90's, and when I got involved was that it was really centered in big institutions. Like, in America at least, like the Department of Veterans Affairs or the Indian Health Service was doing it. And in big universities. Some of the prison systems. But it was certainly not widespread. And certainly in the programs that I started it was one of the first sort of specific services working with the populations I was working.

David Gratzer: And things have very much changed in the last handful of weeks.

Jay Shore: Yes, and I'd even say prior to that, in America. I'm already beginning to speak this way, but I think we'll look back at least over this time period and we'll talk about telepsychiatry in terms of pre-COVID and post-COVID. And pre-COVID for us in the States is March 2020. And so I would say in February 2020 telepsychiatry was widespread in its use, but sort of diffuse and sporadic. Some systems were doing a fair amount and some systems weren't really using it. And of course, in March that radically changed. And it's hard pressed for me to think of a provider or an organization that I know or work with it, that isn't using some form of telepsychiatry, if not 100 percent, right now.

So it was it was probably 10 years in implementation work that occurred in March. Like you said, this digital moment for all of us in the field of behavioural health.

David Gratzer: You've talked about the pre-COVID moment and, of course, what's going on with COVID right now. What do you think we'll see in the post-COVID episode?

Jay Shore: I think post-COVID, whenever that occurs, I think we'll see some really wonderful opportunities to enhance behavioural health and technology. And of course, like everything, there'll be significant challenges. I think the opportunities will come particularly in the field of video conferencing and other technology. I think we are beginning to evolve to try and understand this concept of hybrid care, which is the concept that we hold as providers, but even as human beings in our individual lives.

You know, we manage relationships through multiple different mediums and technology. So I have relationships with people in person, over video, over telephone, texting, patient portals, social networking. And so it's understanding how to use the technologies to form good, strong relationships for clinical care, trying to understand which technology to use with which patient and when.

Right now, I mean we can't do a lot of in-person because of COVID, but in-person will come back into the mix post-COVID. And those things will be really critical for the field to understand and, I think, create tremendous opportunities.

I think on the challenges side, we're looking at radical transformations in all countries of our healthcare systems and the resources that are available to that system. The pressures will be both unique and shared.

David Gratzer: Sweeping changes in a short period of time. Your comment in another podcast was "rapid virtualization." But for a guy who's enthusiastic about this technology and has been a practitioner for decades, you've also had a cautionary note or two in your writing. You co-wrote a piece that's very good for *JAMA Psychiatry* in which you asked a series of questions and you started with this one. "How much virtual care is too much?" Dr. Shore, do we have too much virtual care right now?

Jay Shore: And that, I think, is a question we if we want to have databased answers. We don't know the answer. And there's certainly a lot of anecdotes. I think in the popular press you're hearing this concept and it's labeled "Zoom fatigue." You could call it, to be generic and not endorse any one product, you could also call it "video conferencing fatigue." And it's blamed on video conferencing.

I think it's a much more complex phenomenon right now. I think it's very hard to tease out the fatigue of doing a new thing with rapid implementation with maybe not adequate tech training and support, versus also the fatigue that I think we're all under around COVID and quarantine's and the general stress in our society. But again, I certainly think that will be the opportunities about how we optimize what's virtual and what's not.

David Gratzer: In thinking about populations, I mean everyone right now is getting virtual care for the most part because we don't have an alternative. This isn't a true system it's an accidental happenstance system, so to speak. Who do you think would be well served by virtual care? And who do you think we're more concerned about perhaps, to use the old expression, "falling through the cracks?"

Jay Shore: Well, I think there's a number of groups that can fall through the cracks. And I think the first thing may also be, it's a concept in the United States I'm not sure if you have these discussions in Canada, but we used the term the digital divide. And it's about certain populations, rural, underserved, under-resourced, having access, access to the technology, both the actual physical technology to run or connect with health care providers, as well as the bandwidth in the public infrastructure that is needed to support that bandwidth. And right now, not to be overdramatic, lack of that access can mean whether you have access to health care right now. And it can be a matter of life and death for certain individuals. And so it is a significant concern. It's something that's been talked about for years. And I think COVID in particular highlights these challenges of the digital divide particularly in places like the United States and Canada. Certainly, geography plays a part in it, but there's also many other components about that access.

David Gratzer: You've touched on inequities in access. There's a great JAMA paper, which you didn't co-write, which talked about some 30 million North Americans that don't have access to the Internet or bandwidth. How might we address some of these inequities if we do embrace more virtual care over time?

Jay Shore: Well, and that's really beyond medicine. It's a bigger task than medicine. I think we can be an advocate, but really, if you're talking about 30 million people – and I think it's probably a larger number because, again, adequate bandwidth assumes that you have the resources for the type of technology need and you have the tech literacy also to be able to use it. And so I would say that's maybe an underestimate. But it's going to occur at the policy level or an investment in public infrastructure or incentivization of private companies to support that infrastructure. And so these are really big societal issues that aren't you know, if they were easy to tackle because we've identified them, someone would have found a solution. But it is really important. It's critical now. And I mean, we're dealing in societies with so many critical issues, issues like that sometimes get triaged sort of down the list. But it's, I think, important for us to keep on the front burner for action.

David Gratzer: Now, you've mentioned people who might be hurt by these changes. Who do you think will benefit when we get more data in terms of populations that would maybe be more adherent of care and treatments when we talk with the mentally ill?

Jay Shore: Well, I think if done right, even those populations that may have this digital divide – potentially all populations – if you could get them access to technology. Even if once you get them access, there are still things like tech literacy and support. There are multiple ways to address that. So really, I think when you do digital health right everyone benefits.

And again, there's stories and great examples of stressors when digital health is not done correctly. Right. Digital health is just a tool. And it's like a hammer. If you hammer a nail, you're doing something constructive. If you hammer your finger it's not the hammer's fault it's the person yielding the hammer. We've got to be very thoughtful of what how where we're aiming that hammer. That's probably a poor metaphor, but there I went.

David Gratzer: We've talked about the future state. Let's talk about the present state. Many of our listeners, most of our listeners, are psychiatrists who are in practice right now. So let me ask you about some tips for practice. You've brought up Zoom fatigue. Some of my colleagues have complained about this. What are some recommendations you'd make for beating Zoom fatigue?

Jay Shore: So this is just the very practical right, and some of this may seem intuitive, but one in particular is multiple monitors. I can't work without two monitors and I typically have three. More than that overwhelms me. But having to click back and forth between screens and EHRs and patients all day is mental work that you don't need to do. Having a comfortable, well-lit environment. And because we are working in a virtual world that actually adds some flexibility to your schedule. And so maybe creating space in your day, maybe you go a little longer or slightly off hours, and that creates space in your day to go for a 30 minute jog or a walk. Building in those little breaks. Also when you're in an office, is always this constant human interaction that you may not account for as you get up and go get a drink of water or go down and fax a prescription. And I think when you're working at home alone, we rely a little more heavily on email and texting and not those sort of casuals. So picking up the phone and talking to two to three minutes with a colleague, maybe

seeing that, hey, they have some downtime. Shoot them a message and then getting on the phone and having that sort of interaction to reset yourself. Making sure that you do get some training on the technology you're using. You do have to adapt your style. A lot of people have just started doing video conferencing, but there is nuance about interacting with patients and using technology. So getting some training, reading some articles, taking some time to be prepared, organized and strategic can help decrease the fatigue that people are feeling. And again, doctor, heal thyself. Right. Practicing what we're telling patients about pacing themselves, interacting with their families, getting exercise, getting sleep, being moderate in our consumption of alcohol. Those types of things are all easy to say. But often I see my colleagues struggle to put those into practice.

David Gratzer: You provided tips for providers. But what about our interactions with patients? What might what advice you might give about maintaining a good connection for a person you might not ever physically meet?

Jay Shore: So with video conferencing, I found that you've got to modify your style. You have to work a little harder. We call it sort of this virtual space. Right. And there are things you can do as a human being to overcome virtual space, which means maybe, and it depends on your all of us have an interpersonal style, but particularly if you're soft spoken and maybe a little bit maybe a little bit more reserved is to maybe go one hundred and five percent. Right. Just turn it up a little bit. Also making a little bit more small talk and checking in with the person as a human being as you would in the room, obviously maintaining boundaries around personal lives with your patient, but particularly with distance. You know, the basic conversations. We talk about the weather and it's sort of a joke, but it's an easy intro topic and it tells the person at the other end, you're sort of interested about what's going on in their local environment that day. And sort of those human exchanges in that connection. You do have to work at. But, you know, I've been doing this for 20 years. I've had patients for decades I've never met in person. And, you know, at the beginning, you work harder on the relationship in subtle ways. But after you been working with someone for five or 10 years. Right. It doesn't matter whether what medium you're really holding their relationship to. I found those foundations are as strong as if you started out in person.

David Gratzer: Dr. Shore, it is a *Quick Takes* tradition to close with a rapid fire minute. We're going to put a minute on the clock. Are you ready?

Here we go. One minute.

Dr. Shore, what's the biggest surprise for you about COVID in digital care?

Jay Shore: I think sort of the level of conversation around Zoom fatigue. I didn't anticipate that.

David Gratzer: Biggest worry?

Jay Shore: Sort of on that theme that that Zoom fatigue is complex and not just about video conferencing. And there may be a backlash when we get out of COVID.

David Gratzer: We've talked lots about telepsychiatry and virtual care and also that includes other things like apps. Do you have a favourite app?

Jay Shore: A favourite, a favourite, app? I don't. I try not to endorse any one app. This is off the top of my head. I use My Fitness Pal a lot, which helps me actually helps me do some discipline around losing weight and keeping on exercise regime as best I can. But I have put on the COVID 19, as they say.

David Gratzer: At the buzzer, one last quick question. We opened with a quotation from the prime minister of Canada. Do you find him dreamy?

Jay Shore: I certainly think that you've got a very charismatic prime minister, but I think that's easy to do when you're young. For us that are a little bit older, I really appreciate all the elders among us who can pull off a little charisma as well.

David Gratzer: Andy Rooney, the American humorist, once joked that youth is wasted on the young.

Jay Shore: It certainly is as I've gotten older.

David Gratzer: Dr. Shore, we very much appreciate your time and your insights. Thank you for joining us today on *Quick Takes*.

Jay Shore: Thank you for having me.

David Gratzer: And that's everything for today's podcast. Thanks very much for joining *Quick Takes*. My name is David Gratzer.

David Gratzer: That's this episode of *Quick Takes*. If you liked this topic and you want to do a deeper dive, we would point out that this is now part of a larger digital mental health certificate course, which you can find more information on, on our web page.

Outro: *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at porticonetwork.ca/web/podcasts. If you like what we're doing here, please subscribe. Until next time.