Flexible Passport Style Telepsychiatry Curriculum

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Introduction and Problem Identification:

Prior to COVID-19, there was a steady growing interest in telepsychiatry in order to reach underserved communities and provide specialty access. In addition, telepsychiatry has evolved over the several decade and has become identified as important modality to include in graduate psychiatry training. While telepsychiatry and telehealth technologies have been identified as an educational need, less than a forth of psychiatric training programs offer formal telehealth training. While some programs have or are creating training programs in response to the expansion of telepsychiatry need during the global pandemic, these interventions tend to be limited to minimal functional needs such as access to basic equipment and how to use it. This basic understanding of telepsychiatry does not address the strengths and limitation of telepsychiatry. Nor does it adequately exposure trainees to the breadth and depth of telehealth modalities that now exist including: inpatient-to-inpatient consultation, asynchronous consultation, e-consult, mobile applications, and Project Extension for Community Healthcare Outcomes (ECHO). Most healthcare systems develop and use multiple modalities of telehealth at the same time, exposing trainees to only one modality, like direct real-time teleconferencing encounters with patients, will not sufficiently prepare them to enter the workforce.

A need for tele-psychiatry training exists. However, several barriers exist to implementing a traditional rotation in graduate medical training. The first is one of time. Graduated medical education is often very full. Adding a new topic requires a decrease in another. The second issue is that other modalities may occur inconsistently or around other attending work. This is especially true as a new modality is just starting and the frequency of referrals is low.

One way other medical specialists have dealt with these issues are through the creation of clinical passports rotations. Several specialities outside of psychiatry have used clinical passports to teach and engage trainees for orientation to a new site, track completing of procedures, and make sure there was enough clinical exposure to rare events during the course of a rotation. To our knowledge there are no specific published psychiatric passport style curriculum targeted toward teaching telepsychiatry. In addition to utilizing a passport style curriculum, we discuss how we used the flexible nature of this modality to three different groups of learners: a six-month rotation for non-ACGME PGY-5 Collaborative Care Fellows (ICTP fellows), a one week rotation as part of a PGY2 Population Health Rotation, and a few hours to day experience for PGY2 residents during a risk week.

Needs Assessment:

While all trainees should have exposure to telepsychiatry during training, not all need a deep dive into it. At the University of Washington Department of Psychiatry, we identified three training groups who would benefit from telepsychiatry training: non-ACGME PGY-5 Collaborative Care Fellows (ICPT fellows) who rotated through a six month telepsychiatry block, PGY2 psychiatry trainees who were rotating through a one month population health rotation with one week dedicated to telepsychiatry, and PGY2 psychiatry trainees who were rotating through a one week risk pool where one or two half days were dedicated to telepsychiatry. We hypothesized that a

passport style curriculum could be used for all three of these learner groups with tailored options available to meet their education time & needs.

ICTP Fellows

The Integrated Care Training Program (ICTP) fellowship was launched in the fall of 2016. As part of this launch, a full formal curriculum creation process was used. During this process, telepsychiatry was identified as a key component of population health and little was available formally about how to incorporate it into collaborative care. Incoming fellows were surveyed on their experience in this area which showed an interest in the topic and two rotation sites were identified. A six month block at the Veterans Administration Hospital in Seattle that included a standard realtime televideo outpatient clinic and a six month block at the University Hospital that included a telepsychiatry collaborative care clinic that was just starting. To further refine our initial curriculum and identify areas of opportunity we survey the first class of fellows, we created a 12 question survey that was provided during the last day of their fellowship (See appendix # 3).

In addition to two ICTP fellows, we surveys and three Consult liaison fellows who participated in the didactic series. While there was a perceived competence to practice telepsychiatry over the fellowship year (*Pre-Fellowship M* = 1.4; *Post-Fellowship M* = 3.8), there was also qualitative feedback that suggested the fellows overall wanted more exposure to models beyond collaborative care via telepsychiatry and realtime video conferencing consults. We then surveyed the sites across UW to see which clinical rotations were available, how busy they were, and how best to incorporate them into the fellow's schedules. We identified the following additional rotation opportunities that could occur during the course of our internal review: eConsult, Project ECHO, and telephone consult lines. In addition, we found several self study resources that were identified and self reflection opportunities were added during monthly meetings. In addition, we restructured one of the six month blocks to be a passport style rotation to allow fellows to attend all of these clinical activities that occurred on different days of the week and with different patient need frequency.

PGY2 Population Health Rotation

As part of a one month population health rotation, PGY2 psychiatry residents spend one week focusing on telepsychiatry as it relates to population health and collaborative. While PGY2 psychiatry residents would benefit from an introduction to these two overlapping concepts, they do not need the amount, depth or breadth of exposure to all the models that the ICTP fellows need. In addition, most PGY2 resident do not have many opportunities to use telepsychiatry until they start their third year of treating. Therefore, PGY2 residents also need some introduction to telepsychiatry basic principles in addition to its use in population health. Several rotation and curriculum descriptions exist that expose residents to telepsychiatry. However, none discuss a way to include collaborative care and population health principles with telepsychiatry. With this review, we returned to what we had created for the ICTP fellows and identified several key opportunities that could be supported and fit within the week of a passport style rotation including: a focused telepsychiatry 101 introduction lecture (see appendix #1), attending Project ECHO, and focused self study opportunities.

PGY2 Risk Pool Rotation

As part of the PGY2 year, psychiatry residents spend one week in a risk pool. As part of this week, they are expected to spend several hours to a day being introduced to telepsychaitry concepts. This rotation requires flexibility as the residents maybe called into cover a clinical service that is short staffed. With this rotation, it is impossible to formally schedule an in person clinical experience as the residents are often working unpredictable hours and in unpredictable locations. We again reviewed the ICTP fellow curriculum and identified self-study material that could be completed anytime during the week depending on their other clinical needs.

Goals, Objectives & Curriculum Overview:

ICTP Fellows:

The goal of the telemedicine curriculum is to provide trainees with clinical experiences within the breadth and depth of telemedicine beyond direct real-time consultation. Psychiatrists are asked to rapidly adapt and function clinically in this evolving world. Psychiatrists should understand the strength, weaknesses, and opportunities available with different telemedicine modalities and gain a working knowledge of how to work clinically with these modalities. Over a 6 month block fellows will rotate through a series of clinical experiences and have guided readings/reflections about the different telepsychaitry modalities and how they can be used within collaborative care.

Learning Objectives

1. List the different available telepsychiatry modalities
2. Explain how to apply the different telepsychiatry modalities in different settings (inpatient, ER, specialty clinics, assisted living, etc).
3. List the strengths and weakness of each tele-psychiatry modality.

PGY2 Population Health Rotation

The goal of this telemedicine curriculum is for residents explore the use of telemedicine modalities as a population health tools. During one of their four assigned weeks of the population health rotation, they will work through a list of telehealth experiences and meet with experts in the field.

Learning Objective

1. List the different available tele-psychiatry modalities that can be used in population health

PGY2 Risk Pool Rotation

The goal of this telemedicine rotation is to provide an introduction to telemedicine for residents who are imminently going to use telemedicine. PGY2 residents will spend 1 to 1.5 days during their risk week working through self paced reading.

Learning Objectives

1. List the key components of a tele-psychiatry encounter.

Curriculum Outline:
ICTP Fellows: Fellows spend one half day a week completing the following activities over the course of six months in any order.

Activities:
The clinical rotation includes the following activities:
1. Meeting with rotation supervisor twice per month to review progress
2. Readings/Online modules (APA tool kit, credentialing, selected readings - See Appendix #2)
3. Identifying and summarize 2 more articles to add the select readings
4. Passport clinical exposures (minimum 2-3 clinical days each)
    1. Project ECHO
    2. E-consult
    3. Provider Access Lines
        1. MOMS
        2. PALS
        3. Adult
    4. MHIP

Assessment: Rotation evals at 3 & 6 month, addition of 2 articles summaries that are added to the reading list, & facilitated Reflection during the supervision meetings

PGY2 Population Health Rotation: PGY2 residents spend one academic week of their four week population health rotation completing the following activities in any order.

Activities:
The clinical rotation includes the following activities:
1. Introduction lecture to telepsychiatry practice
2. Meeting with rotation supervisor once during the week and as needed to review progress
3. Attend Project ECHO once
4. Attend MHIP once
5. Meeting with a faculty member who runs the administration for Provider Access Lines/Project ECHO
6. Readings/Online modules (APA tool kit, credentialing, focused selected readings, but access to the full list - See Appendix #3)

Assessment: Addition of 1 article summaries that are added to the reading list & end of rotation evaluation combined with the rest of the population health rotation.

PGY2 Risk Pool Rotation: PGY2 residents spend 1 to 1.5 days completing these activities in any order during their one week risk pool rotation.

Activities:
The clinical rotation includes the following activities:
1. Meeting with mentor at the beginning of the week and email check in at the end.
2. Readings/Online modules (focused list of APA tool kit offerings, credentialing, 4 articles related to policy, substance abuse & tele, provider wellness - see appendix # 4)

Assessment: Residents self reported completion of articles.

Rotation Experience Facilitator Guide

Clinical Experience Overview: Trainees are provided a list of locations that are actively using a different telemedicine modalities. They reach out to the attending at that clinic and schedule the required number of days to observe at each site. Clinical fellows would contact each supervisor to arrange two-three clinical days during the month to attend that clinical site. While visiting that service, the attending providers would share their experience with starting, sustaining, and keeping up-to-date on clinical practice in that modality of telemedicine. The fellows participated in and observed clinical interactions that occurred during that day and compare them to standard in-person clinical encounters and the other telemedicine modalities they had already experienced. Each experience can be discussed in the order that the fellow is able to complete them during the supervisor meetings.

Project ECHO:
Psychiatry and Addiction Case Conference-ECHO series (PACC), is a Project ECHO program. Project ECHO is a 90-minute weekly provider-to-provider education and case discussion line. This form of telemedicine provides fellows exposure to current practices in primary care communities, common primary care provider consultation questions, and consult communication skills. Fellows attended PACC-ECHO weekly, presented one case for discussion, and presented one didactic. Through PACC-ECHO, fellows gained experience in teaching primary care providers via telemedicine, managing real time provider-to-provider consultation and facilitating group interactions. While this evolved into its own rotation for the full time fellows, this telecurriculum provides fellows with addition reading and 2 to 3 days to reflect on the role of team delivering the education.

Guided Reflect Questions:
1. How is it different providing consultation via Project ECHO vs in a traditional clinic/other clinic models you have observed?
2. How does the expert panel engage the community in discussion/group learning?
3. What are the limitations of this model regarding: # of cases, time it takes, funding, and community engagement?
4. How can Project ECHO be used to support collaborative care?
5. How do you imagine using a program like Project ECHO as a model in your future practice?

E-Consult:
E-Consult is an asynchronous message system that allows primary care providers to ask consultation questions to psychiatrists. Fellows learned to define when a case should be referred to be seen urgently, how to formulate a response to asynchronous questions, to anticipate probable clinical challenges and provide next steps. Fellows reviewed messages, created focused responses, and identified consultations that needed to be referred for a direct assessment.

Guided Reflect Questions:

1. How is it different providing consultation via E-Consult vs in a traditional clinic/other clinic models you have observed?
2. What challenges do you imagine or did you observe with shadowing someone who was completing E-Consults?
3. How where/do you think you could overcome those challenges?
4. How can e-Consult be used to support collaborative care?
5. How do you imagine using an E-Consult as a model in your future practice?

Provider Access Lines:
Provider access line are phone call centers that provide clinicians in the community a consultation line to call to access specialist expertise. There are two dominate staffing models for these line: asynchronous and real-time. In an asynchronous model, the community provider calls and leave a message which is answered by the staffing team during designated hours. In a real-time model, the community provider is connected with a clinician who can discuss their question immediately. Three different provider access lines are available across the fellow's training sites: Perinatal (MOMS), Child, and general adult. Fellows participate by discussing consultation questions submitted during the week. When they were able to, the also helped answer phone calls. This allowed fellows to learn how to formulate answers to complicated clinical questions that face community providers.

Guided Reflect Questions:
1. How is it different providing consultation via provider access lines vs in a traditional clinic/other clinic models you have observed?
2. How do the providers you observe balance enough information with too little information?
3. What challenges do you think you might/did encounter during your observations? How did they/you overcome those challenges?
4. How can or cannot provider access lines be used to support collaborative care?
5. How do you imagine using a provider access lines as a model in your future practice?

Indirect Collaborative Care Consultation (MHIP):
Indirect collaborative care consultations are a key component of collaborative care. Psychiatric consultants meet with a care manager to review patients on the clinic's population caseload. There are additional layers of complexity to these cases when they are conducted remotely by phone. Often medical records are harder to access, patients are seen indirectly, and the clinic culture has to be assessed as part of the case review. In addition, fellows may have to provide feedback and teaching to a behavioral health care manager that they have never met in person. Fellows observe and review patient caseloads by telephone. This experience teaches a core skill in collaborative care and it re-enforces indirect consultation skills, caseload review, and care manager interactions. The addition of telemedicine provides the additional skills of assessing the function of a program and clinic remotely as well as the remote development and review of workflows.

Guided Reflect Questions:

1. How is it different providing consultation via MHIP vs in a traditional clinic?
2. How was this different than your other collaborative care experiences?
3. What challenges do you imagine or did you observe with shadowing someone who was managing patients via MHIP? How were/how do you think you could overcome those challenges?
4. How do you imagine using MHIP as a model in your future practice?

Telehealth 101 Lecture Facilitator Guide

This didactic provides information about how telemedicine has evolved since COVID-19. It is an interactive discussion of telehealth/medicine before COVID and since. In addition, we reflect on common barriers/challenges that occur during the telepsychiatry encounters.

Objectives

1. Discuss how COVID-19 has changed what is being seen by telemedicine.
2. List a differential for 3 common tele-interaction break downs.
3. Identify strategies for address common telepsychiatry challenges.

Overview

The purpose this lecture is to provide an introduction to telepsychiatry, the modalities used, and then begin to discuss challenges medicine has faced since the pandemic, general communication considerations, and discuss potential reflection questions that residents can bring to their clinical experience sites. First, we introduce the term telehealth and the common telehealth modalities that exist at the University of Washington. We then introduce the evidence map for telehealth prior to COVID-19. We then discuss telehealth/medicine challenges that exist that can interrupt communication between patients & providers/ providers & clinics. We finish by discussing strategies to overcome these challenges and reflection question for the resident to think for the remainder of their week of telepsychiatry.

Faculty Notes:

Slide 4: Telehealth & telemedicine has specific definitions because of funding sources such as CMS. In practice and literature, these terms are often used interchangeably. For the purpose of a literature review, these terms are often used interchangeably in the literature. Clinically, these terms are also interchangeable. When you hear either term, you need to be prepared to ask what people are doing to see & interact with patients.

Slide 5: This slide shows the common modalities that are used at UW for telemedicine.

Slide 6 &7: These two slides are cluster maps that show how telemedicine was used and for what health related complaints. Pre-COVID, telemedicine was used for a variety of conditions for preterm birth to mixed conditions. The most common ways it was used was counseling/remote monitoring.

Slide 8: COVID has changes all of this. As people have started to use it for everything, its important to think about the posted questions. As part of that there are inevitable communication challenges that can occur.

Slide 10/11: Discuss the case presented. Language can mean very different things even in your back yard. Attempt to discuss/elicit multiple reasons for the patient not wanting to present such as lack of internet access, trouble with childcare, etc, ect. Ultimately, this case came down to the word Eastside meaning something very different across the city. The teaching point of this case is that if there is any possibility of a communication issue, ask clarifying questions.

Slide12/13: Discusses a case of a patient who is technologically phobic. The teaching point of this case is that if technology phobia is not predictable by a chart review.

Slide 14/15: Discusses a case of a patient with an odd affect. There are several reasons that this could happen. I.E. there something in the room that distracts them, they could be playing with their phone, they could see themselves in the camera. Trainees should be encouraged to think of these examples. In addition, camera settings matter. The teaching point is to be prepared to ask follow up questions and confirm what we are seeing clinically.
Slide 16: Reviews ways to manage these challenges
Slide 17: Discusses that clinics can be unique and we need to be aware that some of the challenges that exist with patients can also exist with clinics. As trainees work across clinics, they need to be prepared to anticipate & adapt to the new clinic staff/needs.
Slide 18: This slide contains reflection questions. Residents are encouraged to reflect their experiences to date and take these questions with them as they see other clinical settings.

References:
1. Totten et al. Telehealth: Mapping the evidence for patient outcomes from systematic reviews. AHRQ June 2016.

Evaluation Methods:
While there is overlap in content and experiences, each of the rotations have the following assessments.

<u>ICTP Fellows</u>
Assessment: Rotation evals at 3 & 6 month, addition of 2 articles summaries that are added to the reading list, & facilitated Reflection during the supervision meetings.

Outcome data to date:

Telepsychiatry		
	average score	n
Provided me with relevant readings and encouraged me to consult the literature to improve patient care	5/5	4 fellows 8 evals
Gave me clear feedback and specific, constructivesuggestions for improvement on at least two occasions(halfway through and at the end of the rotation)	4.91/5	4 fellows 9 evals
Please rate the overall quality of your attending/supervisor's teaching	4.91/5	4 fellows 12 evals

Fellow Reported	Strengths	Weaknesses

Telepsychiatry	• Well organized • Perfect introduction to telepsychiatry • Learned a lot through the rotation, especially about challenges and techniques • Very practical, good experience to have for job applications • Psychiatry is moving toward telehealth, so very good experience to have	• Increase volume of patients • Would like to experience at home/ home-based telehealth appointment • PACC overlapped with case review meeting with faculty

Telepsychiatry Qualitative Feedback
Very well organized rotation
I feel I learned so much about telepsychiatry through this rotation, despite the low patient volume. It was nice to see how much the veterans appreciated not having to come all the way out to the VA in Seattle. Having never had exposure to telepsych before, this was the perfect introduction. I feel the didactics supplemented the clinical rotation very well.
I really liked this from the standpoint of an implementation experience; I think it's fortunate that I did the rotation while it was starting because I learned a lot about different challenges and techniques along the way.
Great to see this type of model, as there's so many potential applications for this. Glad I have this experience in case I want to get involved/ start this in the future.
Great rotation! Love the experience with telepsychiatry. It's a really good experience to have in my training.
Good overview of tele-health capabilities
Even though we did not see patients via telepsychiatry, I felt I learned a great deal about implementation of telepsychiatry. I appreciate having that experience.
The PACC lectures were very educational. It was also a great opportunity to be able to present one of the lectures for PACC.
Telehealth experience has been a bonus in every job I applied for, so I'm glad I have had that.
Doing telepsych is a core component of where psychiatry will be moving to - being involved in the team meetings to see how a program grows + actually doing it is invaluable.

Strengths included the availability to fellows of multuiple [sic] very interesting forms of telepsychiatry and getting to see these modalities first hand.

PGY2 Population Health Rotation:
Assessment: Addition of 1 article summaries that are added to the reading list & end of rotation evaluation combined with the rest of the population health rotation.

Outcomes:
N = 4 completed rotation to date.
N= 4 articles added to the summaries page.

End of rotation assessments are pending with the rest of the Population Health Rotation assessment.

PGY2 Risk Pool Rotation:

Assessment: Residents self reported completion of articles.

Outcomes:
N= 11 residents competed rotation to date.
N=11 reported reading an average of 3 articles.

Peer Evaluation
This curriculum was peer reviewed as part of University of Washington Department of Psychiatry and Behavioral Sciences external peer review process of scholarly curriculum products of our Clinician-Teachers. The curriculum was sent for external review and was very well received by the external reviewers who made few suggestions. Based upon the feedback, the survey was updated to reflect different language.

Adaptability/portability:
The use of passport-style curriculum to teach telepsychiatry was one that was born out of our need to expose our trainees to the breadth and depth of use of technology. In addition, the limitations of low patient volume and irregular work at clinical sites proved difficult to assign trainees to any one modality and a have consistent content exposure. As a result, the rotation style was used to create a highly portable and scaleable experience across our three learner groups. We would anticipate that it could easily be used across a variety of topics or institutions for these same reasons.

One of the strengths of this style of rotations is that it can be scaled up to 6 months or down to core components to cover a self-study day. While we have not done this, it is also possible to add parts of the rotation to existing rotations that a trainee needs to complete. For example, if they

had an outpatient in-person telepsychiatry rotation that was only real-time televideo conferencing, several days of that rotation could be blocked to allow the addition of passport activities. Finally, the overall faculty time devoted to this rotation is fairly small once it has been established.

The key components of this curriculum are:
1. Supervising faculty member who is spending a maximum of 2 hours a month per trainee to engage sites and supervise trainees. Ideally, this person would be a content expert in telemedicine or at least have a background experience in the subject matter.
2. 2-6 clinical sites that run different telepsychiatry modalities and can have trainees shadow them for 1-2 days per rotation.
3. A list of online resources & articles for focused self-study
4. A flexible amount of time in a resident's schedule (1 day to 6 months)

If there are a different number of clinical sites available, the trainee can be assigned to spend a smaller or larger amount of time at each depending on the need.

Innovation:
The use of passport-style curricula is a novel approach to teaching in psychiatry and telepsychiatry. The portability, adaptability, and time requirements allow this form of rotation to be tailored to different learners needs and unpredictable patient volumes.

Acknowledgements:
The UW Integrated Care Training Program is funded and supported by the Washington State Legislature and the Safety-Net Hospital Assessment, working to expand access to psychiatric services and behavioral health workforce throughout Washington State.

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11. Read TE. Clinical Skills Passport: A Method to Increase Participation in Clinical Skills by Medical Students During a Surgery Clerkship. *J Surg Educ*. 2017;74(6):975-979. doi:10.1016/j.jsurg.2017.05.015
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Appendix #1
ICTP Fellow/Population Health Reading List

Table 1. Self Study Material	Domain
APA Telepsychiatry Toolkit https://www.psychiatry.org/psychiatrists/practice/telepsychiatry	Telemedicine
Fortney, J. C., Pyne, J. M., Turner, E. E., Farris, K. M., Normoyle, T. M., Avery, M. D., ... & Unützer, J. (2015). Telepsychiatry integration of mental health services into rural primary care settings. *International Review of Psychiatry*, *27*(6), 525-539.	Telemedicine
The State and Sustainability of Telepsychiatry Programs. Lauckner. C J Behav Health Serv Res. 2016 April ; 43(2): 305–318. doi:10.1007/s11414-015-9461-z.	Telemedicine
Archibald, D., Stratton, J., Liddy, C., Grant, R. E., Green, D., & Keely, E. J. (2018). Evaluation of an electronic consultation service in psychiatry for primary care providers. *BMC psychiatry*, *18*(1), 119.	E-Consult
Hensel, J. M., Yang, R., Rai, M., & Taylor, V. H. (2018). Optimizing electronic consultation between primary care providers and psychiatrists: mixed-methods study. *Journal of medical Internet research*, *20*(4), e124.	E-Consult
Arora, S., Kalishman, S. G., Thornton, K. A., Komaromy, M. S., Katzman, J. G., Struminger, B. B., & Rayburn, W. F. (2017).Project ECHO: A telementoring network model for continuing professional development. *Journal of Continuing Education in the Health Professions*, *37*(4), 239-244.	Project ECHO

Table 1. Self Study Material	**Domain**
Zhou, C., Crawford, A., Serhal, E., Kurdyak, P., & Sockalingam, S. (2016). The impact of project ECHO on participant and patient outcomes: a systematic review. *Academic Medicine*, *91*(10), 1439-1461.	Project ECHO
APA App Evaluation Model **https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model**	Mobile Applications
McNiel, D. E., & Binder, R. (2018). Current regulation of mobile mental health applications. *The journal of the American Academy of Psychiatry and the Law*, *46*, 204-211.	Mobile Applications

Appendix #2
Risk Rotation Reading List

Table 1. Self Study Material	Domain
APA Telepsychiatry Toolkit https://www.psychiatry.org/psychiatrists/practice/telepsychiatry	Telemedicine
Vogt, E. L., Mahmoud, H., & Elhaj, O. (2019). Telepsychiatry: implications for psychiatrist burnout and well-being. Psychiatric Services, 70(5), 422-424.	Telemedicine
Yellowlees, P., Nakagawa, K., Pakyurek, M., Hanson, A., Elder, J., & Kales, H. C. (2020). Rapid conversion of an outpatient psychiatric clinic to a 100% virtual telepsychiatry clinic in response to COVID-19. *Psychiatric Services*, *71*(7), 749-752.	Telemedicine
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Appendix # 3
Telepsychiatry Experience Questionnaire

3) Since finishing I had experience used telepsychiatry:
   a) Every Day
   b) Once per week
   c) Once per month
   d) I have not used any telepsychiatry since graduating

2) I am a psychiatry fellow with:
   a. ICTP
   b. Psychosomatics
   c. Other_____

3) During my fellowship academic year, I worked in a telepsychiatry clinic:
   a. Yes (where)_____
   b. No

4) I felt confident in my ability to practice telepsychiatry prior to fellowship:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

5) The ICTP Telepsychiatry Didactic Series increased my confidence in using telepsychiatry:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

6) My telepsychiatry clinic experience on fellowship increased my competence in telepsychiatry:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

7) I was satisfied with using telepsychiatry during fellowship:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

[Continue on Other Side]

8) I feel my fellowship prepared me to practice telepsychiatry:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

9) I plan to continue to use telepsychiatry as part of my career:

N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

10) Looking back on my fellowship telepsychiatry experience, what I found most helpful about the telepsychiatry didactic series was:

11) Looking back on my fellowship telepsychiatry experience, what I found least helpful was:

12) Other comments suggestions or thoughts for improvement: