

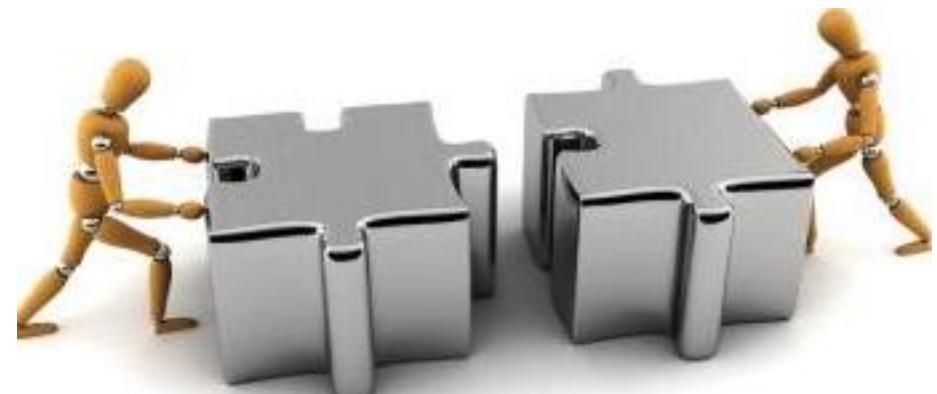
Integrate and Educate: how your peers are educating their residents in integrated care, and how you can too

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Outline

- Background
- Survey results
- Example best practices
- Summary recommendations
- Discussion

- No disclosures except those individually mentioned during talk

What are the types of integrated care?

- Traditional psychiatric consultation in primary care and/or other medical/surgical outpatient settings (“co-located care”)
- Population-based approaches such as collaborative care
- Telepsychiatry consultation to medical colleagues
- Provision of both primary medical care and psychiatric care by psychiatry residents

Context for residency training

- Many barriers to traditional psychiatric care exist:
 - Lack of availability of specialists
 - Long wait times for appointments
 - Poor follow-up
 - Stigma
- Health care reform: includes incentives for management of the health of *populations* of patients, eg, via patient-centered medical homes

Freedman 2009. Psychiatric Services.

Konrad 2009. Psychiatric Services.

Unutzer 2006. Psychiatric Services.

Huang 2013. UW-Madison Dept of Psychiatry Grand Rounds.

And the new motivator: milestones!

SBP4. Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic)					
A: Distinguishes care provider roles related to consultation B: Provides care as a consultant and collaborator C: Specific consultative activities					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Describes the difference between consultant and primary treatment provider 2.2/B Provides consultation to other medical services 2.3/C Clarifies the consultation question 2.4/C Conducts and reports a basic decisional capacity evaluation	2.1/A Describes differences in providing consultation for the system or team versus the individual patient 3.1/C Assists primary treatment care team in identifying unrecognized clinical care issues 3.2/C Identifies system issues in clinical care and provides recommendations 3.3/C Discusses methods for integrating mental health and medical care in treatment planning		4.1/B Provides integrated care for psychiatric patients through collaboration with other physicians ¹ 4.2/C Manages complicated and challenging consultation requests	5.1/B Provides psychiatric consultations to larger systems 5.2/B Leads a consultation team
					
Comments:					
Footnotes:					
¹ Provides communication back to the primary care physicians in the outpatient setting, including collaborative and co-located settings such as a medical home.					

Relevant advanced milestones: PC3

- 4.1: Devises individualized treatment plan for complex presentations
- 4.2: Integrates multiple modalities and providers in comprehensive approach
- 5.1: Supervises treatment planning of other learners and multidisciplinary providers

Relevant advanced milestones: MK2

- 4.3: Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders
- 4.4: Demonstrates sufficient knowledge to systematically screen for, evaluate, and diagnose common medical conditions in psychiatric patients and to ensure appropriate further evaluation and treatment of these conditions in collaboration with other medical providers

Relevant advanced milestones: SBP4

- 3.3: Discusses methods for integrating mental health and medical care in treatment planning
- 4.1: Provides integrated care for psychiatric patients through collaboration with other physicians

Relevant milestones: ICS1

- 4.2: Leads a multidisciplinary care team

Relevant milestones: ICS2

- 4.1: Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent
- 4.2: Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent

The current state of integrated care training for psychiatry residents

- 2014 AADPRT survey of general and CAP psychiatry residency programs

Integrated Care Curricula for Psychiatry Residents

CONSENT FOR A RESEARCH STUDY EXAMINING INTEGRATED CARE CURRICULA IN PSYCHIATRY RESIDENCY PROGRAMS

INVITATION

You are invited to participate in a research study, approved by the University of Wisconsin-Madison IRB, examining integrated care curricula currently used by U.S. general psychiatry and child and adolescent psychiatry residency programs. The purpose of this study is to provide information available to psychiatry residency programs for further development of their own integrated care curricula. For example:

- psychiatric consultation in primary care and/or other medical/surgical outpatient settings (this may also be called "consultation-liaison" services; health services being located in the same building; primary care consults psychiatry in the same manner that psychiatry consults primary care)
- population-based approaches such as collaborative care (in this model, psychiatrists work together with primary care physicians to manage the care of a population of patients; this may include use of objective rating scales, adjustment of care based on rating scales, and management involvement)
- telemedicine to provide psychiatric consultation or collaborative care for other medical colleagues

WHAT WILL BE DONE?

Your participation in this project will be limited to completing one Internet-based survey. This should take approximately 15 minutes.

Does your program offer a rotation(s) in integrated care for your residents?

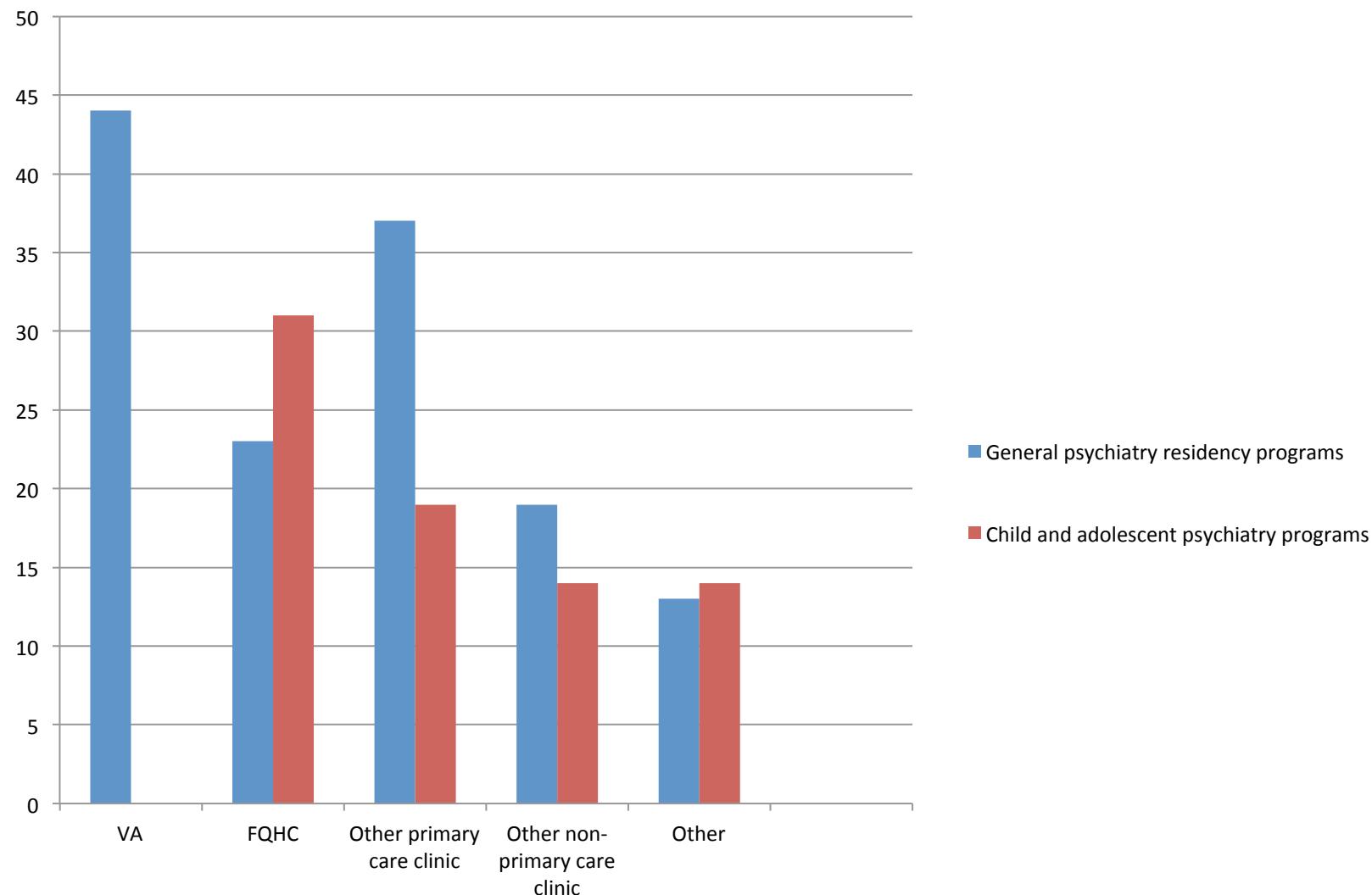
- General: 78% yes
- CAP: 72% yes

Types of integrated care offered

- #1 (most common): Traditional psychiatric consultation within primary care clinics
- #2: Population-based approaches such as collaborative care
- #3: Psychiatric consultation within other medical/surgical outpatient settings
- #4: Telepsychiatry
- #5 (least common): Provision of both primary medical care and psychiatric care by psychiatry residents

**The majority of all of these are offered to *upper-class* residents

Percentage of programs offering various venues for integrated care rotations



Are your integrated care rotations required?

- General: 35% required
- CAP: 60% required

Which faculty provide supervision?

- Psychiatrist: 95%
- Psychologists or social workers: 18%
- Dually-trained physicians: 18%
- Primary care physicians: 16%

How do psychiatrist supervisors spend their time?

- On site full time during clinic and sees EVERY patient: 47%*
- On site full time during clinic WITHOUT seeing every patient: 42%*
- On site for PART of the duration of clinic WITHOUT seeing every patient: 28%
- Reviews cases with residents AFTER clinic at OTHER location: 25%

*59% of supervisors who are on site full time during the clinic also do other clinical activities besides supervision (their own direct patient care, supervision of care coordinators, consultation without seeing patients)

How are psychiatrist supervisors paid?

- Psychiatry department: 52%
- Via billing revenues generated in integrated care clinic: 43%
- By the primary care or other med/surg department: 22%
- Grant money: 17%

Integrated care didactics

- 43% of all programs provide didactics
- How provided:
 - By psychiatry/mental health faculty in usual didactic format: 98%
 - By non-psychiatry colleagues: 33%
 - Multidisciplinary group supervision: 16%
 - By psychiatry residents or other residents: 14%
 - Jointly attended by psychiatry residents and primary care or other residents: 9%

Other themes

- Programs without such rotations are wondering how to ‘start small’
- Programs anticipate starting with senior residents in elective format until sustainability of experience can be established
- Programs have concerns about establishing funding perceived as stable enough to attract quality physicians
- Small number note that they do not embrace integrated care as the right direction for psychiatry

Resources

- AADPRT Virtual Training Office Integrated Care Resources (log in required):
[http://www.aadprt.org/pages.aspx?
PageName=AADPRT Integrated Care Resources](http://www.aadprt.org/pages.aspx?PageName=AADPRT%20Integrated%20Care%20Resources)



The AADPRT Integrated Care Task Force was established with the charge to collect, review, and post, as a member resource, a listing of rotations and curricula in integrated care that capture the myriad of ways in which adult and child psychiatrists consult to our medical peers. Integrated care models within psychiatry residency programs include:

Teaching Collaborative Care: University of Washington

Anna Ratzliff, MD, PhD

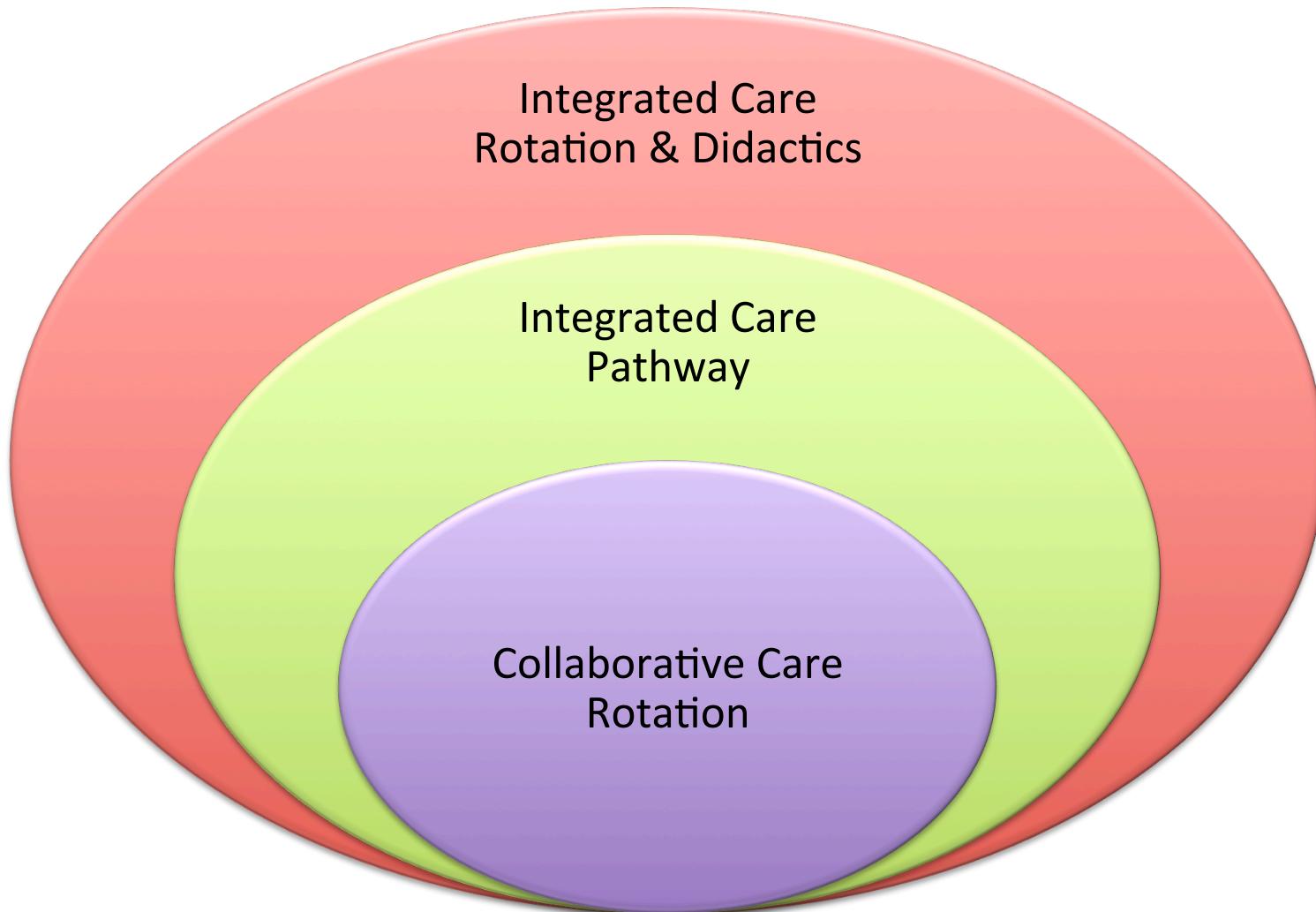
Assistant Professor

Associate Director of Education, Division of Integrated Care & Public Health

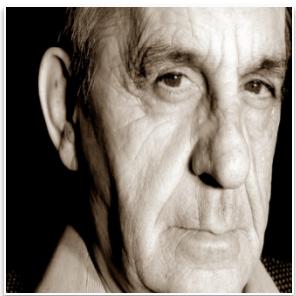
Department of Psychiatry & Behavioral Sciences

University of Washington

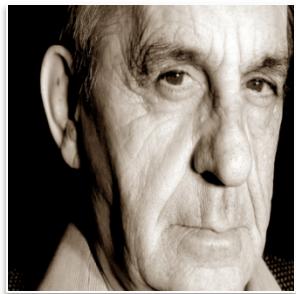
UW Psychiatry Resident Integrated Care Training



Sample Didactics



No Treatment



Primary Care Provider



Mental Health Provider

Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, Arch Gen Psychiatry, 62, June 2005

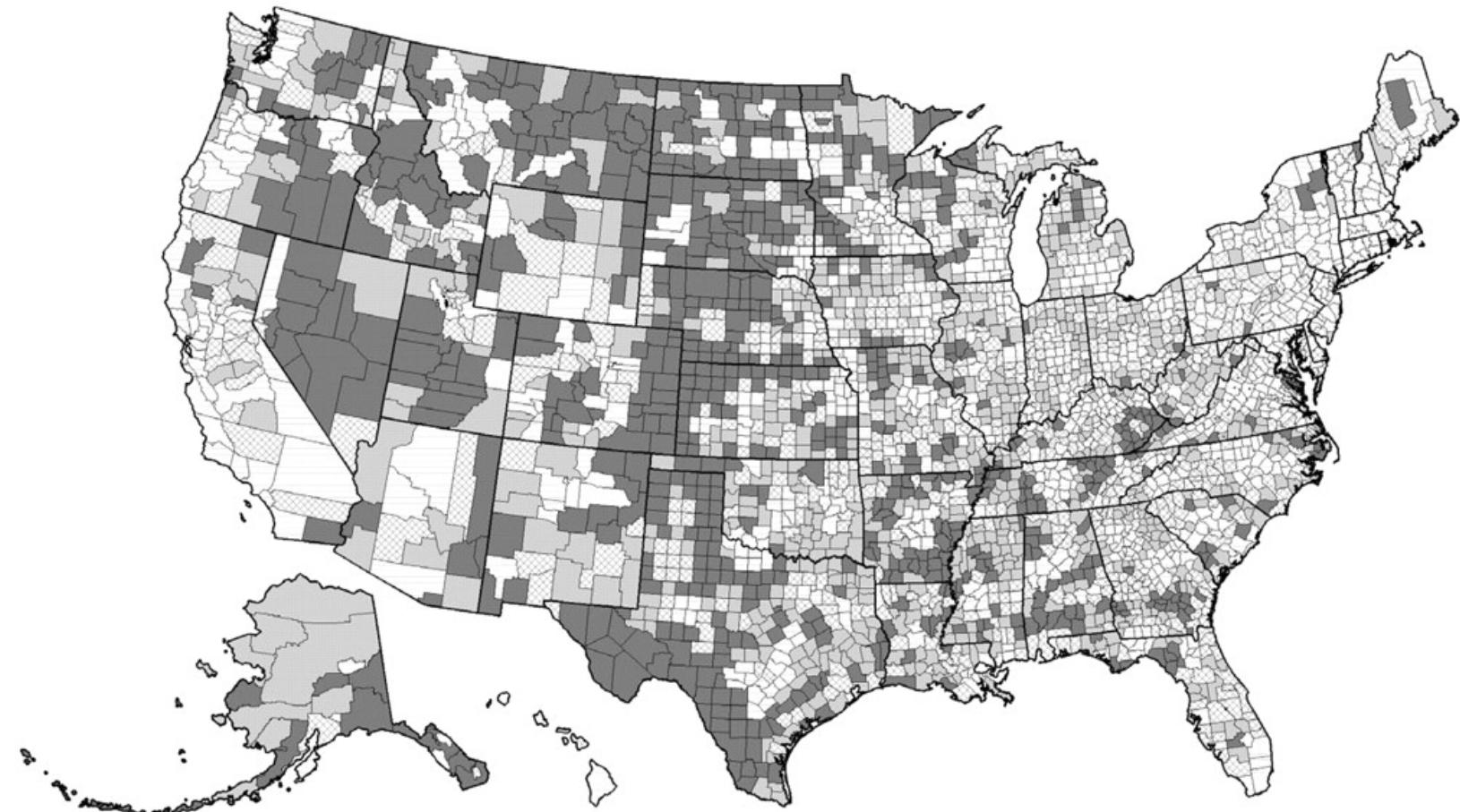
Why not just refer?

$\frac{1}{2}$ do not follow through

2 visit mean

Grembowski, Martin et al. 2002
Simon, Ding et al. 2012

Why not just refer?



Lexicon of Integrated Care Terms



Adapted from: Peek, CJ - A family tree of related terms used in behavioral health and primary care integration.

<http://integrationacademy.ahrq.gov/lexicon>

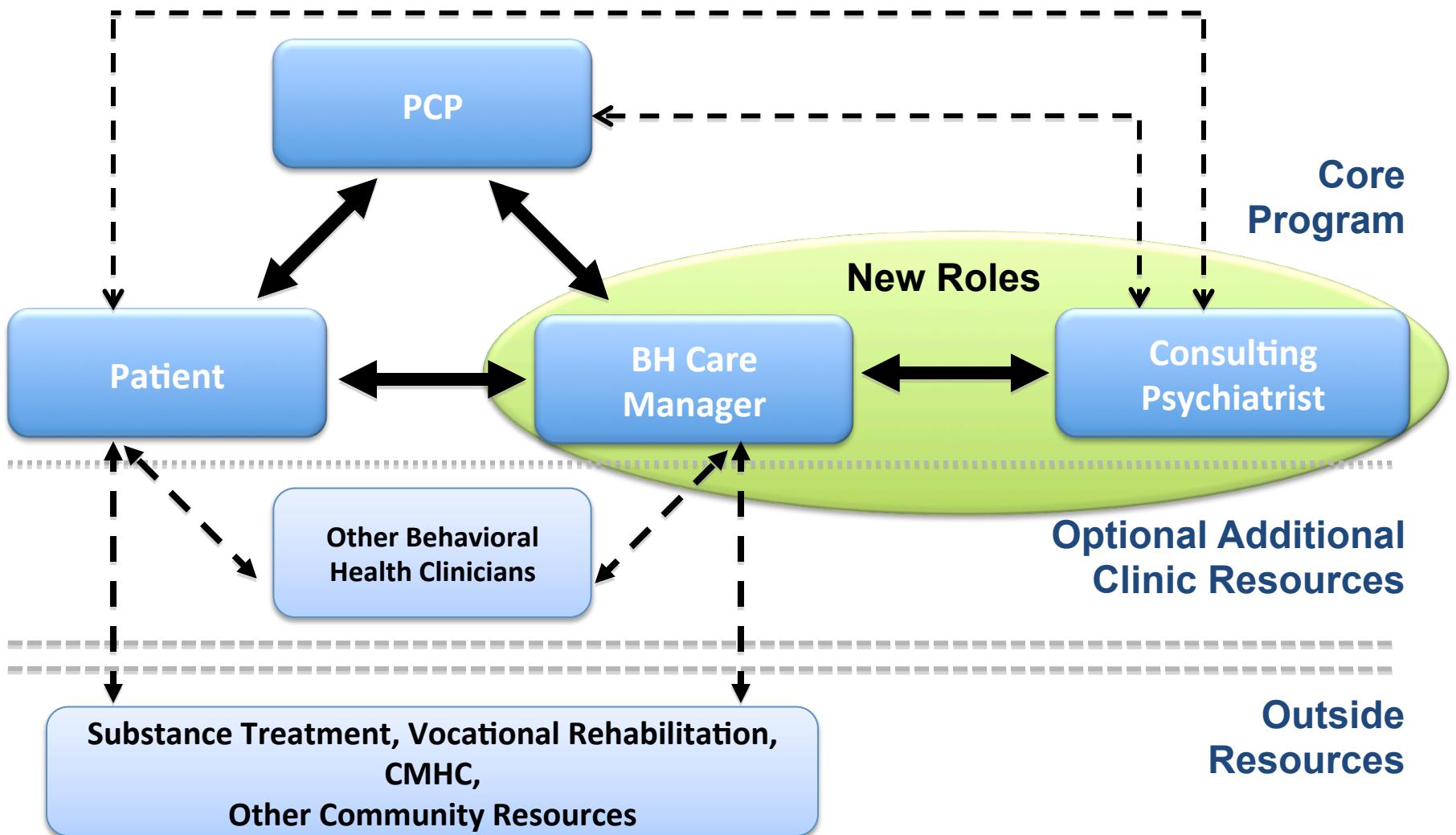
Collaborative Care: The Research Evidence

- Now over 80 Randomized Controlled Trials (RCTs)
 - Meta analysis of collaborative care (CC) for depression in primary care (US and Europe)

→ Consistently more effective
than usual care

- Since 2006, several additional RCTs in new populations and for other common mental disorders
 - Including anxiety disorders, PTSD

Team Approach



Principles of Effective Integrated Behavioral Health Care

Patient Centered Team Care / Collaborative Care

- Co-location is not Collaboration. Team members learn to work differently.

Population-Based Care

- All patients tracked in a registry: no one ‘falls through the cracks’.

Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

Evidence-Based Care

- Treatments used are ‘evidence-based’.

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Collaborative Care Rotation

Structure:

1-2 hours working with a care manager (located in a primary care clinic) in weekly phone consultation

1 hour of combined didactics and supervision about the cases and the consultation process

Residents are responsible for writing case reviews which are reviewed by consulting psychiatrist before being released to clinic

At least one clinic visit to primary care sites to provide in-person consultation and primary care provider education

Can be combined with a half-day research elective

Teaching Methods: Consultation

Psychiatric Consultation

Weekly Supervised
Consultation

Increasing
Responsibility

Develop Integrated
Care Plans

On site visit

Six Core Modules

Individualized Study

Evaluation

Teaching Methods:

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Six Core Modules

Objectives

Readings

Slide Sets

Discussion and
Reflection Questions

Additional References
and Resources

Individualized Study

Evaluation

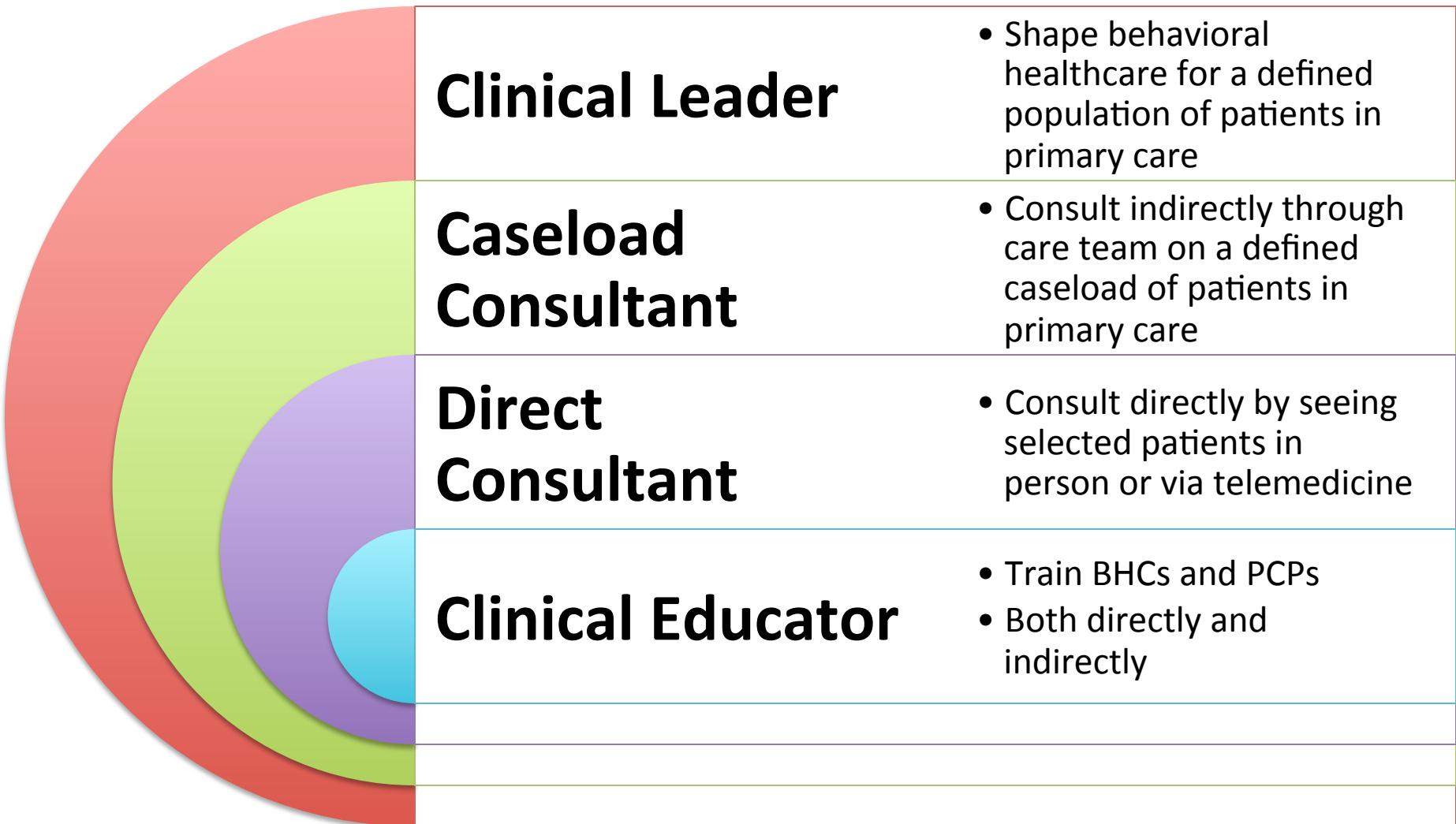
MATERIALS

OVERVIEW OF ENTIRE SERIES:

[Collaborative Care Consultation Psychiatry: A Clinical Rotation Curriculum for Psychiatry Residents](#)

- Module 1: Psychiatry Resident Training: Introduction to Collaborative Care
- Module 2: [Psychiatry Resident Training: Introduction to MHIP](#)
- Module 3: [Psychiatry Resident Training: Collaborative Care Teams](#)
- Module 4:
[Psychiatry Resident Training: Case Finding, Differential Diagnosis and Case Formulation](#)
- Module 5:
[Psychiatry Resident Training: Making Recommendations and Treating to Target](#)
- Module 6:
[Psychiatry Resident Training: Team Building, Workflows, and Quality Improvement](#)

Roles of the Primary Care Consulting Psychiatrist



Teaching Methods: Individualized Study

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Psychopharmacology

Special Populations

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On site visit

Evaluation

Pre-test

Post-test

Standard Evaluation of
Resident

360-Degree Evaluation

Standard Evaluation of
Rotation and Attending

Future Directions

- Update UW Didactics
 - Working in a team; Supporting a care manager
 - Discussion about integrating education and maintaining expertise
 - Overview of systems issues and types of leadership
 - Brief behavioral interventions
 - Clinical conditions in primary care
- New elective in Advanced Collaborative Care Implementation?
 - Shaping an implementation
 - Leadership in integrated
 - Quality improvement project
- Other?
 - Integrating education with medicine residents
 - Online learning experiences

www.aims.uw.edu

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Example best practice: Yale (Barkil-Oteo and Huang)

- “Teaching Collaborative Care in Non-Collaborative Settings”
- Didactic curriculum available on AADPRT website
- Especially useful for programs without integrated care clinics available

PSYCHIATRIC NEWS

Professional News

January 29, 2014

DOI: 10.1176/appi.pn.2014.2a19

Preparing Psychiatry Residents as 21st Century Psychiatrists

Hsiang Huang, M.D., M.P.H.; Andres Barkil-Oteo, M.D., M.Sc.

Psychiatric News

Volume 49 Number 3 page 1

Collaborative care presents new opportunities for psychiatrists to contribute to the evolving health care system. Curricula that teach psychiatric residents how to work effectively with primary care providers, like the one being developed by the authors of this column, will help us build a new behavioral health workforce ready to care for the millions of people with common mental disorders who have limited access to mental health specialists.

—Jürgen Unützer, M.D., M.P.H.



These days, collaborative care or integrated care is increasingly being talked about at national meetings. Collaborative care—in which primary care providers, care managers, and psychiatrists work as a team and take a population-based approach—is a rapidly growing field of behavioral health care. More than 70 randomized, controlled studies have demonstrated the efficacy as well as cost-effectiveness of this approach. Collaborative care

Teaching Residents Collaborative Care in Non-collaborative Settings

AADPRT 2015

*Andres Barkil-Oteo, MD, MSc
Assistant Professor of Psychiatry
Yale School of Medicine*

Yale SCHOOL OF MEDICINE



Disclosures

None

Rational of the curriculum

- Collaborative care is not just about the way care is organized; it requires a dramatic change in the way psychiatrists *think* about their role
- Current clinical psychiatric training is largely focused on the *direct* provision of patient care
- Many residency programs has no access to collaborative care clinic settings

Description of the curriculum

- Two one hour lecture on the basics of Collaborative care (Different roles for psychiatrists, Population focused, measurement based care)
- Online videos simulating a consultation session between a psychiatrist and behavior health manager
- In class practice of consultation role with clinical cases in PCP settings
- In class practice of delivering clinical scales

Description of the curriculum

- AADPRT model curriculum (in addition to posting on AADPRT Integrated Care Resources page)
- Under review at MedEdPORTAL
- Paper describing implementation and assessment under review

Preparing for the Milestones

- Curriculum delivered to 46 psychiatry residents in 5 New England area psychiatry programs.
- PGY1=5
- PGY2=10
- PGY3=22
- PGY4=9

Milestones: SBP4

Describes the difference between consultant and primary treatment provider

Describes differences in providing consultation for the system or team versus the individual patient

Provides consultation to other medical services

Clarifies the consultation question

Assists primary treatment care team in identifying unrecognized clinical care issues

Discusses methods for integrating mental health and medical care in treatment planning

Provides integrated care for psychiatric patients through collaboration with other physicians

SBP4 CURRICULUM PRE SURVEY

1-How comfortable are you in your current skills with the following aspects of the Consultation role:

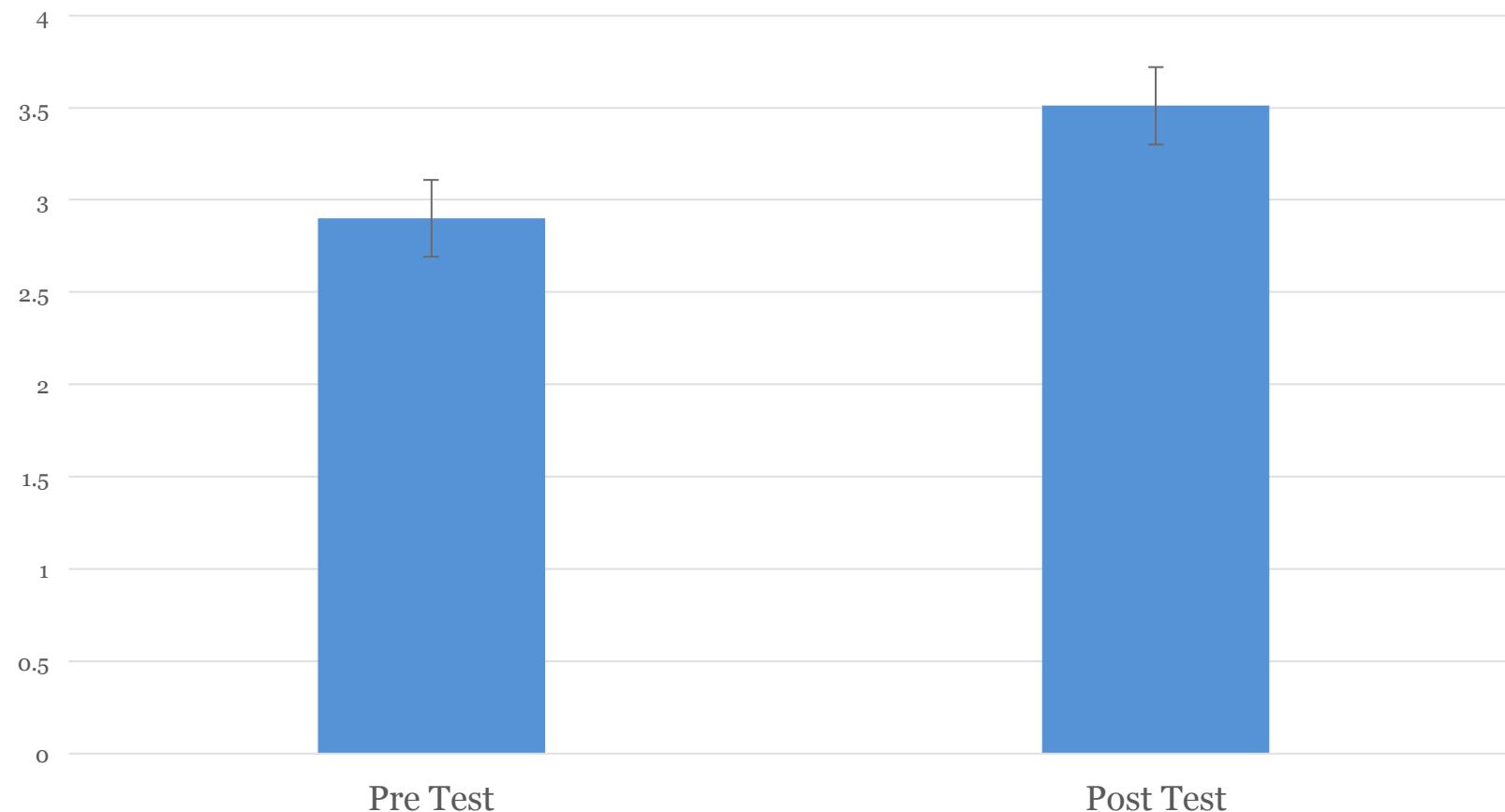
Statement	Not at All	Slightly	Moderately	Extremely
Describes the difference between consultant and primary treatment provider				
Describes differences in providing consultation for the system or team versus the individual patient				
Provides consultation to other medical services				
Clarifies the consultation question				
Assists primary treatment care team in identifying unrecognized clinical care issues				
Discusses methods for integrating mental health and medical care in treatment planning				
Provides integrated care for psychiatric patients through collaboration with other physicians				

2- What year of training are you in? PGY1__ PGY2__ PGY3__ PGY4__ PGY5__

3- Have you had any prior experience in consultation in primary care ? ____ Yes ____ No
If yes, please describe:

Not at all=1, slightly=2, moderately=3, extremely=4.

SBP4 Milestones Knowledge



N=46. p< 0.0001

Feedback

- “Great presentation: did not realize this model existed”
- “Cases are great and illustrative”
- “This topic was something we get no training on. It’s good to get information about the future of psychiatry.”
- “This was great information about an area of patient care and care systems that we are not exposed to here.”
- “Great that cases were included. Could be great to have examples within {residency program} of collaborative vs co-located care.”

Challenges?

- Examples change depending on year of residency training (e.g. PGY-2 vs PGY-4)
 - “When you were working on the CL service, have you ever...?”
- Balance between public health/population focus and traditional consultations
 - “I *need* to see this patient or I am not providing good care”
- Skepticism of measurement based care
 - Does CIDI *really* work for bipolar disorder?
- Where to practice skills after the workshop?
 - At the end of the day, few opportunities to practice collaborative care skills

Challenges?

- Evaluation: subjective improvement on milestones is not an optimal assessment

Summary Recommendations

- Use AADPRT VTO materials
- VAs and FQHCs often have settings amenable to residency training in this model
- Programs wishing to offer telemedicine opps for residents may consider the VA for this, since there is a VA Telemental Health Training Program widely available to VAs across the U.S.
- Upper level residents may be better prepared than earlier residents for this experience
- Multidisciplinary group supervision or joint case conferences between psychiatry and primary care or other medical residents may represent excellent opps for further modeling of the multidisciplinary teamwork that is integrated care
- A minimally resource-intensive way to provide didactics may be for primary care residents and psych residents to lead seminars for each other and for other clinic staff within integrated care clinics

Audience discussion

- What challenges or successes have you found in funding integrated care resources?
- What have been your experiences with psychiatrists vs other disciplines providing supervision of these experiences?
- Any experiences with interdisciplinary group supervision led by residents?
- What challenges or successes have you found with providing didactics on integrated care?
- Any other comments or questions you have are welcome!

Thank you!

- Questions? cldreardon@wisc.edu
- AADPRT Integrated Care Task Force:
 - Kim Best
 - Deborah Cowley
 - Kristen Dunaway
 - Marshall Forstein
 - Emily Frosch
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 - Jeralyn Jones
 - Tanya Keeble
 - Robert McCarron
 - Claudia Reardon
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