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Developing a collaborative care training program in a psychiatry residency

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Abstract

Collaborative care is an evidence-based approach for improving quality mental health access in primary care settings. Although job opportunities will grow over the next decade, few psychiatry residencies have established curricula to train the next generation of psychiatrists to work in this expanding model of care. In this paper, the authors describe the collaborative care training experience at a safety-net academic institution to provide a template for psychiatry residencies designing curricula to prepare psychiatry residents for collaborative care practices.

Keywords

Consultation Liaison Psychiatry; Primary Care; Collaborative Care; Integrated Care; Education

Introduction

Collaborative care is an evidence based delivery model that improves the quality of depression treatment in primary care settings (1). In this model, a consulting psychiatrist works as part of the primary care team to provide population-based mental health care. This is accomplished by weekly meetings between the psychiatrist and the behavioral care manager (who delivers brief psychological interventions and manages a registry (2)) to discuss patients whose symptoms are not improving on specified outcomes (such as the PHQ-9 for depression) (3). Based on these case reviews, the psychiatrist makes treatment recommendations that are conveyed to the primary care team. Collaborative care holds the promise of meeting the Triple Aim of improved patient experience of care, cost savings, and better health outcomes (4). Positions in collaborative care will become increasingly available as reimbursement for this model has been approved by the Center for Medicare and

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Medicaid Services, making workforce development a priority. Thus, psychiatry residency programs will need to provide the requisite training experiences in collaborative care (5).

Currently, there is little guidance on how to create such educational experiences for psychiatry residents. A previous paper has described the characteristics of five psychiatry training programs (adult, child and adolescent, and med-psych programs) that have developed varying degrees of integrated care training experiences for residents (6). This paper explores in detail the collaborative care training experience at one of these programs. Cambridge Health Alliance (CHA) is a safety-net academic medical center and a developing accountable care organization located in Massachusetts that comprises 3 community hospitals and 12 primary clinics (7). Over the past years, the primary care clinics have transitioned from a co-located psychiatric consultant model to a collaborative care model. This concise guide aims to describe the experiences of the CHA adult psychiatry residency in building a collaborative care experience for trainees with the aim of providing a template that can be used by other psychiatric residencies.

Faculty development in collaborative care

It would be difficult to provide a collaborative care training experience without faculty members who are able to supervise and mentor residents in this subspecialty area. Psychiatrists who are working in primary care may find it challenging to teach and supervise residents when they themselves have not been trained in the model. A couple of papers may assist the consult psychiatrist in creating the conditions for collaborative care learning (8–10). The American Psychiatry Association and the Advancing Integrated Mental Health Care Solutions (AIMS) Center have partnered to deliver the CMS funded online and in-person Transforming Clinical Practice Initiative(TCPI) trainings on collaborative care with the goal of training 3,500 psychiatrists (including psychiatry residents) (11). Some psychiatrists may be reluctant to work in collaborative care systems because of the nature of the work, i.e. largely providing population-based care in which the psychiatrist does not directly evaluate the patient. Others may be wary of the model because of perceived risks of such work. To learn more about the risks of practicing collaborative care, review a position paper developed by the American Psychiatric Association (12).

The clinical experience

In 1987, as a response to the AIDS/HIV epidemic, CHA developed a care model in which primary care providers, nurses, social workers, and psychiatrists shared clinical space and worked as a team. Each clinical session was preceded by a team meeting in which patients' cases were reviewed for both medical and psychiatric concerns. This model also paid attention to the social determinants of health, such as food insecurity (e.g. the clinic developed and ran a food pantry), cultural and linguistic barriers to care (e.g. there were providers with language facility in Haitian Creole, Spanish, and Portuguese-the major non-English languages spoken by patients at CHA), and financial insecurity (e.g. access to supportive community based organizations that helped with rent). In addition, given CHA's longstanding commitment to community psychiatry and supporting the efforts of our

primary care colleagues, we have had co-located psychiatric consultants in many of our primary care sites since 1990.

The CHA psychiatry residency developed a creative way of incorporating an ambulatory consultation experience into training by breaking up the consultation experience required by the Accreditation Council for Graduate Medical Education (ACGME). In this model, PGY2s traditionally rotated 6 weeks in the general hospital learning traditional inpatient consultation-liaison work, while PGY3s spent 2 (full time equivalent) weeks rotating through primary care or outpatient specialty clinics such as women's mental health, psycho-oncology clinic or the HIV clinic (4 hours per week over a 6 month period). In 2013, the program changed the outpatient consultation-liaison component in order to offer PGY3s a more longitudinal experience of consulting exclusively in primary care clinics (the "integrated care rotation" that comprises 6 months of weekly half-day sessions), employing a stepped care approach (13), in which they provide direct consultations and brief treatment or bridge patients' psychiatric needs to specialty mental health or addictions care. In 2014, behavioral care managers were hired, allowing the resident to have the case review experience (using a mental health registry) once weekly. In the beginning of the 6 month integrated care rotation, the attending psychiatrist models how the case reviews are performed. As the rotation progresses, the PGY3 has the opportunity to run the case reviews with the behavioral care manager with the attending psychiatrist providing guidance as needed. Fourth year residents are able to spend more time in primary care or rotate in specialty consultation clinics as electives. In 2015, an integrated care chief position for a PGY4 was created to meet the educational needs of interested senior residents in this model of care.

Measurement based care (MBC) using validated instruments is an essential component of collaborative care and can improve the quality of mental health care (14). Systematic depression screening using the PHQ-9 (15) is part of the workflow across all primary care clinics at CHA. Thus, psychiatry residents have the opportunity to use baseline and longitudinal depression scores to help guide the depression treatment of their patients. Residents who have rotated in primary care often tell us that they bring the practice of measurement based care to their outpatient psychiatric clinics (where the use of instruments is not routinely done). This finding is supported by one study that has shown that exposing MBC to psychiatry residents resulted in an increased use of instruments for patient care (16).

Didactics and classroom teaching

It is important to help all psychiatry residents understand why collaborative care skills are relevant for their careers. One paper is able to briefly summarize the history of and public health need for collaborative care (3). We share this paper liberally with residents and early career faculty when talking about this topic. We have also found that many of our global mental health minded trainees are particularly interested in this model given the problem of the severe shortage of mental health specialists in many countries around the world. Another very useful resource is a video developed by the AIMS Center. This 7 minute video describes the experience of Daniel, a patient treated in collaborative care along with treatment team members involved in his care (consulting psychiatrist, care manager, and

primary care provider) (17). Watching this video helps many residents to understand and connect with the practice of collaborative care.

Two readymade modules are also available that can be delivered by interested faculty members to teach collaborative care to psychiatry residents. Both have been approved by the American Association of Directors of Psychiatric Residency Training (AADPRT) approved model curriculums and have detailed facilitator guides (18). Either general psychiatrists with an interest in collaborative care or consult psychiatrists can deliver these talks. At CHA, the collaborative care talks are covered in the consultation-liaison seminar. Residents who desire further training in collaborative care are encouraged to attend the CMS funded TCPI course described above (11).

The case review (consulting) sessions between the CM and the consult psychiatrist is a critical component of collaborative care, however, the process is often difficult to describe. One of the authors (HH) and a CHA behavioral care manager filmed what such an interaction may look like in order to illustrate the essential elements of the case review (e.g. prioritizing cases for discussion, using validated instruments such as the PHQ-9 or AUDIT, and providing education for the primary care team) (19).

Core topics on both the practice of integrated and collaborative care and clinical approaches are also necessary to complement the clinical experience. In 2013, we incorporated a monthly Integrated Care seminar for consultation-liaison fellows, PGY3s, and psychology fellows. This multidisciplinary seminar is based on readings covering key integrated care topics intended to stimulate conversation, especially across disciplines (see Table 1 for the 2016 academic year reading list). During these lively discussions, the trainee moderator and faculty encourage the group to draw from their clinical experiences and think about how concepts of integrated care may affect the way they approach their patients' care. The readings aim to cover the different dimensions of integrated care such as substance use disorders, bipolar disorder management in primary care settings, and behavioral health homes. A comprehensive list of integrated care articles has been compiled by the Research and Evidence-based Practice Committee of the Academy of Psychosomatic Medicine. These papers can be referred to for more reading options for journal club (20).

Barriers to implementation of integrated care experience

Several barriers exist in the creation of an integrated care experience for psychiatry residents. One barrier to the development of integrated care training models is the maintenance of silos in residency education among psychiatry, internal medicine, and family medicine programs. Differing ACGME learning objectives can present a challenge in aligning integrated care curricula and clinical experiences. Within psychiatry residencies, time allotted to integrated care curricula must be allotted out of one of the traditional "buckets" of training time (inpatient, outpatient, consultation-liaison, etc.) which necessarily leads to a reduction of time spent in the traditional aspects of training in one of these experiences. In addition, a practical limitation is the lack of space (e.g. exam or consultation rooms) for co-located mental health clinicians in many primary care clinics. Although collaborative care model comprise mostly indirect patient care via case reviews between the

consult psychiatrist and behavioral care manager, most clinical experiences will start off with integrated or co-located care. Thus, it is important to have support from leadership in the organization, medical directors of primary care clinics, and specialty departments (medicine, family medicine, psychiatry) in order to commit resources of time and space for the practice of integrated care.

Conclusion

In summary, collaborative care has a strong evidence base and has the potential to improve access to quality mental health care, while controlling costs. This guide describes a template for psychiatry residencies designing curricula that prepares psychiatry residents to practice skills in integrated care along the spectrum from co-located to collaborative care.

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This paper is dedicated to Wayne Katon, MD (1950–2015).

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Table 1

Integrated care seminar topics (for 2016–2017 academic year at Cambridge Health Alliance)

Topics	Articles
Seminar Overview	Katon (2012). Collaborative Depression Care Models (21)
Depression and Chronic Medical Illness	Katon (2011). Epidemiology and treatment of depression in patients with chronic medical illness (22)
Medical Care for those with SMI	Chwastiak (2013). Preventive counseling for chronic disease: missed opportunities in a community health center (23)
Substance Abuse: Screening, Brief Intervention & Referral to Tx (SBIRT)	Chan (2013). Substance screening and referral for substance abuse treatment in an integrated mental health care program (24)
Suicidality in Primary Care	Bauer et al (2012). Characteristics, management, and depression outcomes of primary care patients who endorse thoughts of death or suicide on the PHQ-9 (25)
Cultural Issues in Collaborative Care	Yeung et al (2010). Culturally Sensitive Collaborative Treatment for Depressed Chinese Americans in Primary Care (26)
Behavioral Health Homes	Viron (2014). Behavioral Health Homes: An opportunity to address healthcare inequities in people with serious mental illness (27)
Telepsychiatry	Shore (2013). Telepsychiatry: Videoconferencing in the Delivery of Psychiatric Care (28)
Global mental health	Scazufca (2015). Identification and treatment of depression of older adults in primary care: findings from the Sao Paulo Ageing and Health Study (29)
Child/Adolescent Mental Health in Primary Care	Kolko (2014). Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial (30)
Bipolar Disorder in Primary Care	Cerimele (2013). The presentation, recognition, and management of bipolar depression in primary care (31)
Insomnia	Schuman (2012). Integrating sleep management into clinical practice (32)