Integration of Physical and Mental Health Care in Ohio Graduate Medical Education: A Follow-Up Study

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Morbidity and Mortality in People with Serious Mental Illness

What Should be Done?
Recommendations & Solutions

NASMHPD Medical Director’s Council

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National Level
- Designate SPMI an at-risk population and establish national priority to co-ordinate MH and general healthcare
- Establish national surveillance of SMI population health status
- Share information about physical health risks widely with the healthcare community, consumers, and families

State Level
- Designate SMI as at risk, health disparities population
- Establish coordination as a state priority
- Education and advocacy: policy makers, funders, providers, individuals, families, communities
- Policy changes for BH provider systems to screen, assess, and treat general health issues.

Local Provider Systems and Clinicians
- Provide quality medical care and mental health care
- Adopt care coordination models
- Support consumer wellness and empowerment
What About training?

People are talking but actual Workforce education and experience lag behind

- **Combined Family Medicine/Psychiatry**
  - 30% of graduates worked in programs designed for combined trained physicians.
  - 11% of graduates participated in fully integrated practice.
  - Graduates spent 70% of their time practicing psychiatry and 16% practicing family medicine.

  Warner et al, Acad Psychiatry 31:297-303, August 2007

- **The Future?** If population-based care, surveillance, health disparities designation, consumer demand, guidelines and standards of care become accepted &/or required, measurement based care and treatment to goals, payment structures, record keeping barriers, and the cultures of care, etc. become altered...practice and training will change
Also there is not one clear model

Patient Centered Medical Homes for Integrating Care

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Transforming Mental Health Care and Education

- “...the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years.”
  - *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, 2001

- Every system is perfectly aligned to accomplish the outcomes it achieves
  - *Quality Improvement Principle*

- “You can’t do just one thing!”
  - *Personal communication, Michael Hogan, PhD, Chair of the President’s New Freedom Commission on Mental Health, “Achieving the Promise: Transforming Mental Health Care in America”, 2003*
Feedback from Residency Programs:

1. Changing training requirements is impractical
2. Need increased collaboration, information sharing, & interdisciplinary practice
3. Barriers reimbursement, policies, data, investment in community mental health, stigma
What has changed since the survey?

- **Affordable Care Act**
  - Expands coverage and paves the ways for innovative care delivery models that include integration

- **Medicaid Health Home Option**
  - Provides a model and funding stream to facilitate integration and coordination of care for individuals with SPMI

- **SAMHSA Primary Behavioral Healthcare Integration (PBHCI) Program**
  - Launched in 2009, supported practice transformation in over community behavioral health settings nationwide

- **Efforts underway to update GME to address chronic disease treatment and prevention, integration across disciplines, in community settings (e.g., IOM recommendations)**
Widespread recognition of the need for skill sets for integration

- Accrediting bodies developed requirements for integrated care recognition (person centered, coordinated, multidisciplinary team-based)
- Annapolis Coalition - Core Competencies for Integrated Care (Hoge et al., 2014)
- Multidisciplinary Culture and Enhanced Primary Care Skills (Raney, 2014)
Developments within Ohio

- Ohio Health Homes and SAMHSA PBHCI implementation
  - Psychiatrists within these models work with a multidisciplinary team
- Funding for integrated training through MEDTAPP Healthcare Access Initiative
- State budget proposal – Medicaid Behavioral Health benefits will be shifted to managed care organizations (MCOs)
  - On July 1, 2016, MCOs can set standards for payment, scope, and duration of psychiatry services
  - Access and quality may be impacted; Incentives to shift services to the lowest cost providers
  - Increases pressure for psychiatrists to define role and value when supply in pipeline is limited
  - Potential to support integration through care management provided by MCOs
Medicaid mental health service changes:
  ○ July 2015, "un-bundle" Medicaid Health Home, and CPST services to fund a new array of services including assertive community treatment (ACT), home based services for children (IHBT), and others
  ○ Unknowns:
    • Future of Medicaid Health Home service
    • Role for psychiatry in new service array
    • How MCOs will cover these services
Possibility of tuition caps reducing funds available to medical schools, increasing pressure to finance residency programs
Reduction of funding for state's Mental Health/AOD agency (OMAS)
Question of the Day

- Has graduate psychiatry and nursing education and nursing education made significant progress in preparing the workforce to provide integrated care?

- Yes
- No
- Maybe
The 2006 survey was updated with general topics consisting of:

1. General perspective on the role of integration in training;
2. Past, present, and future integration efforts at each program;
3. Interdisciplinary collaboration efforts;
4. Supports and policy changes necessary to advance integration efforts in the future

9 Ohio’s graduate training directors participated in 60-90 minute interview using standardized questionnaire

Data from each program was assessed for trends, successes/failures, approaches, and models, common themes, as well as notable novel approaches
Results
1) Deciphering the Role of Trainees and Mental Health Providers
Assess and Refer

“Our job is] purely to assess and refer, not to treat” and we “need to be actively engaged and involved in [comorbid management] … by screening and follow-up.”

- Most programs felt bound by ACGME and LACE requirements
  - Anything beyond the medicine months in the first year of training would detract from core psychiatric competencies
- Physical healthcare knowledge is aimed at appropriate referral:
  - 6 out of 9 programs reported that it is not the responsibility of trainees to learn to independently manage comorbidities such as DM, COPD, or HTN.
  - Only 2 programs expected trainees to solely manage basic medical problems of their patients

Workforce Implication:
- Current training is well-suited for models wherein psychiatrists act as outpatient-consultants on interdisciplinary teams, such as in PCP-centered approach of the IMPACT trial
- But, not as well suited for CMHCs, where “there is a growing call for psychiatrists to be responsible for and prepared to assume greater medical oversight of the general medical care of their patients, particularly individuals with serious mental illnesses” (Raney 1077)
How do trainees function in integrated clinics?

- Although psychiatrists, APNs, and NPs are able to adjust to the roles required of the different models at various sites, how these models are implemented into training is not clear:
  - Residents express “frustration about not understanding their role in the system … [and] how residents were utilized.”
  - Some NP trainees had difficulty practicing therapy and physical assessments because busy offices “just wanted cheap psychiatrists”
  - Some residents were told at select Internal Medicine integrated clinics “why should I waste my time training a psychiatry resident.”
  - “Trainees were frustrated by expectations at sites … there were lots of situations where [psychiatry residents] were expected as consultants to become primary caretakers for [SMI patients].”
  - One strategy to improve: “sen[d] out preceptor packets to clinics, clearly stating goals on a provided face sheet” and administrators visit each site to ensure these are truly being met.
Outpatient Consultants

“Trainees were frustrated by expectations at sites … there were lots of situations where [psychiatry residents] were expected as consultants to become primary caretakers for [SMI patients].”

- Big Question: How to establish the psychiatric outpatient consultants role? To what do psychiatrists assume ownership of SPMI patients rather than providing consultation that extends psychiatric expertise?

  "In the IMPACT approach … a consultant psychiatrist is available to the team for caseload review, ‘curbside’ consultation, and education—and, less frequently, for direct evaluations. Working behind the scenes, the psychiatrist provides continuous input to the team in the primary care clinic, allowing extension of psychiatrists’ expertise to a larger population of patients than is possible in one-to-one evaluations. Patients who are not responding to treatment at one level can be “stepped” to higher levels of care via this consultation model.” (Raney 1077)

- While this theoretical definition of the outpatient psychiatrist allows for stepped care, respondents report tendency for PCPs to skip these steps and seek to relinquish care of individuals with SPMI which undermines the consultant model.
Leadership structure

It remains essential that “[t]eam members must be clear on their roles in caring for consumers” and that the most effective teams are those with the designated “presence of a team champion.” (SAMHSA Behavioral Health Homes Core Clinical Features 16)

- Role confusion stemmed from lack of standardized leadership structure in integrated clinics
- Graduate nursing programs suggested that APNs are poised to be team leaders due to “background in management, conflict resolution, being case managers, and being able to coordinate chaos.”
  - All 3 APN programs provided formalized training in team leadership
- 5 of 6 medical residency programs endorsed physician leadership role due to “depth of medical background knowledge … and because [physicians] are best able to assess acuity.”
  - 1 program recommended that leadership be “formed organically.” Physicians are the ones who “drive the culture [of integration], but there are no fixed roles” upfront
  - None of the medical residency programs had formal training to lead integrated teams, until the fellowship level if at all.
2) How do you teach integration?

“Medical educators report that GME curriculums lack sufficient emphasis on care coordination, team-based care, costs of care, health information technology, cultural competence, and quality improvement” (IOM report, S-4)
“IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. “

IV.A.5.b).(4) the diagnosis and treatment of neurologic disorders commonly encountered in psychiatric practice, such as neoplasm, dementia, headaches, traumatic brain injury, infectious diseases, movement disorders, multiple sclerosis, seizure disorders, stroke, intractable pain, and other related disorders;

IV.A.5.b).(12) Axis III conditions that can affect evaluation and care of patients (e.g., CNS lesions, HIV/AIDS, and other medical conditions)

IV.A.5.f) Systems-based Practice  Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality;
Didactics

- 7 of 9 programs have interdisciplinary lectures, especially in the form of FM/IM/EM instructors teaching mental health trainees about basic knowledge of comorbidities.

- 3 of 9 programs had inter-professional lecture series or conferences between physicians, nurses, pharmacists, social workers, and others, but many of these petered out (small size, coordinating schedules across disciplines) or were not as cordial as intended:
  - “We tried getting [APN] students to fellows’ seminars, but it did not work, because the physicians would not bridge the gap.”

- Only 1 categorical program teaches integrated models formally with theoretical underpinning (history, policy, various models of delivery), while 1 graduate nursing and 1 residency program use University of Washington’s web based integrated training module (IMPACT trial).
Clinical Placement

- All but 1 program had integrated clinical sites for trainees to rotate through
  - One program lacked rotation due to recent departure of psychiatry attending in these sites and unfilled vacancies

- All program identified challenges finding preceptors for integrated clinic sites

- 7 of 9 programs require trainees to spend time in an integrated clinical setting, and the other 2 offer electives
  - Of the 7 programs, 5 offer multiple types of integrated clinical experiences (from CMHC to FQHC, IM/FM/neuro/peds run clinics)
Clinical Placement

- Majority of training focusing on primary care is provided during the first year and never revisited
- Clinical integration exposure does not occur until the 3rd year and 4th year elective

- “Residents ought to have a PCP-based integrated clinic throughout residency for continuity.”
- “Residents need to be trained in a culture where integration is second nature, instead of training in an environment that is consult-heavy.”
- “Without experience with integration, [trainees] form their identity with a certain viewpoint of psychiatry, and it is better to have a unified approach.”
● In both 2006 and now, programs identified challenges finding common space to deliver co-location models.
● Furthermore, having common space did not guarantee integration; co-location does not ensure greater communication.
● Several residencies rotate at the VA where models of co-location received positive feedback from patients, as it helped reduce patient stigma when they did not have to go to the office of a separate mental health professional.
● 1 residency reported success using a “bullpen structure,” where “faculty is centralized and all teams work from a common room.”
  ○ “Allows conversations to flow naturally between teams.”
  ○ “Direct access to family medicine and psychiatry residents.”
  ○ “Increased teaching between disciplines and professions”
3) Standards of Measurement
3 programs regularly surveyed trainees regarding experience in integrated clinics

4 programs regularly surveyed patients regarding integrated care experience
  - Results mostly positive: patients liked the convenience of “one-stop-shopping”
  - Patients at one site reported “confusion” about the team structure and hierarchy/variety of providers

Only 1 program has outcomes-based measures for their integrated training sites:
  - changes in health status, healthcare utilization, ED visits, and cost per patient
Both in 2006 and now, all programs expressed interest in a shared database or organized resource for gathering evidence-based training practices and sharing strategies/challenges to help programs improve integrated care training.

Despite universal interest, no one has spearheaded this effort.
Panel Discussion

BARBARA DREW, PhD, PMHCNS-BC
Kent State University College of Nursing

ROBERT RONIS, MD
UH Case Medical Center
### Core Competencies of Integrated Care

*Hoge, Morris, et al., 2014*

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<td>Interpersonal Communication</td>
<td>establish rapport quickly and to communicate effectively with consumers of healthcare, their family members and other providers.</td>
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<tr>
<td>Collaboration and Teamwork</td>
<td>function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.</td>
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<td>Screening and Assessment</td>
<td>conduct brief, evidence-based and developmentally appropriate screening and more detailed assessments when indicated.</td>
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<tr>
<td>Care Planning and Coordination</td>
<td>create &amp; implement integrated care plan, access to array of linked services, exchange of information with consumers, family, and providers.</td>
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<tr>
<td>Intervention</td>
<td>provide a range of services</td>
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<td>Cultural Competence and Adaptation</td>
<td>provide services that are relevant to the culture of the consumer and their family.</td>
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<td>System Oriented Practice</td>
<td>function effectively within the organizational and financial structures of the local system of healthcare.</td>
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<td>Practice-based Learning and QI</td>
<td>assess and continually improve the services delivered as an individual provider and as an interprofessional team.</td>
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<td>Informatics</td>
<td>use information technology to support and improve integrated healthcare.</td>
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What deficiencies do Ohio training programs have when evaluating them against the Core Competencies of Integrated Care?
Where do we train residents?

How should leadership be defined in training environments?
Future Suggestions from Michael Yao’s 2007 Survey

- Maximizing access to primary care and mental health care for SPMI
  - Explore novel financial models to prioritize integration
  - Use financial incentives to promote co-location
  - Implement stepped care models for mental health care for PCPs as well as for medical co-morbid management in CMHC
  - Establish loan forgiveness programs for primary care residents who will serve SPMI population
  - Expansion of telemedicine to underserved areas

- Systemic Support for Integration
  - Support joint conferences, interdisciplinary didactics
  - Meeting of mental health leaders to advocate state legislature changes to support integration
  - Use state resources for mental health initiatives (screening, surveys, PSAs)

- Increased use of evidence-based medicine
  - Establish research consortium for EBM regarding integration
  - Encourage researchers to devote more funds to evaluating different integration models
  - Establish online resource for up-to-date EBM and best practices
  - Conduct more patient satisfaction surveys regarding integration
4) Are We Catering to Our Clientele?

“[There is] a mismatch between the health needs of the population and specialty make-up of the physician workforce” (IOM Report, S-1)
Can we just wait around for ACGME to change?

“[T]he current GME program does not … train physicians to practice in the community-based settings where most Americans seek care. Perhaps most critically, it lacks the oversight and infrastructure to track outcomes, reward performance, and respond nimbly to emerging challenges” (IOM report, ix)

- Nursing programs reported attempt toward integration through LACE with “across the lifespan” approach to promote training in medication management, therapy, and physical assessment.

- ACGME preparing to re-structure, yet most programs focused on integrated care within current ACGME guidelines
  - 1 program expressed desire to participate in shaping new ACGME guidelines to establish core competencies in integrated care

- We need to ensure that ACGME is in place to produce professionals that meet the demands of our clients
- If ACGME continues to support psychiatrist role as that of outpatient consultant, will SPMI fall through the cracks?
  - How will we address workforce shortage given current pressure for psychiatrists to become sole managers of SPMI care?
What can we do with ACGME requirements to incorporate more integrated care?
Summary of Findings from 2006 Survey:

1) *Role of psychiatry and psychiatric APNs in providing basic health care to SMI*:
   - Scope of training should focus on recognizing and referring medical conditions
   - High satisfaction with the current level of general medical training
   - Increasing requirements would impact the quality of core specialty skills training
   - BH/PH integration requires system-level changes

2) *Past, current, and future BH/PH efforts with identification of barriers*:
   - Didactics focus on differential diagnosis and referral, management of medication related adverse effects; required medicine and neurology rotations during PGY1
   - Residencies encourage electives rotations with BH/PH overlap, provide some interdisciplinary research opportunities and community consultation experience, though focus of effort varies with program
   - Barriers include limited funding, poor reimbursement, lack of faculty and departmental support
   - Future plans include expansion of community liaison role, starting interdisciplinary clinic sites, developing evidence-based BH/PH practice guidelines among others
Changes Since 2006?

Integration of BH and PH in Ohio Residency and Training

Michael Yao, 2006,
Ohio Department of Mental Health

3) *Past, current, future collaborative efforts, with identification of barriers:*
   - Efforts ranged from informal relationships between psychiatry and area primary care at WSU, support of CCOEs at several institutions, demonstration projects such as OSU Collaborative and NEOUCOM co-location of FQHC office in CMHC
   - Nursing programs have implemented placement opportunities with psychiatrist preceptors, primary care sites, and schools with varying success
   - Barriers include limited funding, faculty availability, administrative coordination
   - Future plans include expansion of OSU Collaborative to include all psychiatric nursing and more psychiatry residents, co-locating FQHC primary care services within community mental healthcare sites at NEOUCOM

4) *Types of supports necessary to develop and sustain integration of BH/PH:*
   - All programs identified resource needs: e.g. faculty support, bridging costs for residents, reimbursing area primary care providers
   - Technical and administrative supports reflected site-specific needs: telemedicine technology, electronic documentation, on-line evidence-based practice curriculum, support for FQHC scope of change and long-term work visa applications
   - Policy supports include BH/PH screening and interdisciplinary networking at the local level, state policy to change reimbursement schemes and reward collaboration, and national policy to increase mental health research and educational funding
Where do we go from here?

What are our next steps?
Bibliography

- Accreditation Council for Graduate Medical Education. (2007). ACGME Program Requirements for Graduate Medical Education in Psychiatry.


