Academic Psychiatry (2024) 48:405–406
https://doi.org/10.1007/s40596-024-01978-8

LETTER TO THE EDITOR

Integrating Integrated Care into Psychiatry Training: A Win–Win for Programs and Trainees

Nina Camille Burruss[1] · Ramanpreet Toor[2] · Nathaniel A. Sowa[3] · Winston Li[3]

Received: 13 March 2024 / Accepted: 24 April 2024 / Published online: 9 May 2024

To the Editor:
In the United States (US), millions of adults live with a mental illness [1]. For those with mental health diagnoses, rates of comorbid disease are high, life expectancy is shorter, and overall cost to the healthcare system is increased compared to those without mental illness [2]. Although the need for mental health care is great, the ability to access such care remains challenging. Given these difficulties, many Americans turn to their primary care providers (PCPs) for evaluation and treatment of mental health concerns. While PCPs are well-trained to handle a variety of mental health concerns, it is important that they can access psychiatric specialists when needed. To address the burden of mental illness and limited subspecialty resources available, various mental health integrated care models have been implemented in primary care settings [3].

Integrated care models vary widely in their application and generally exist on a continuum of integration. To better classify integrated care models, the Substance Abuse and Mental Health Services Administration Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions has described six levels of care collaboration ranging from minimal collaboration to full collaboration in a merged practice [3]. One of the most integrated models, the Collaborative Care Management (CoCM) model, has been shown to improve patient outcomes, increase patient and provider satisfaction, decrease stigma, and lower costs [1].

Given their benefits and complexities, it is important that future psychiatrists gain exposure and education early in training to integrated care models so that they can be effective participants in integrated care delivery. To support this training, an increasing number of psychiatric residency programs are incorporating integrated care education into curricula [4]. This affords residents the opportunity to become proficient in the application of integrated care systems, and allows early exposure to population health interventions and ways to address shortcomings of the health care system on a broader scale.

To better understand the current landscape of integrated care education available to psychiatry residents in the US, the authors conducted a small survey among individuals who attended the 2019 American Psychiatric Association's (APA) Collaborative Care Model Residency Education Conference ($n = 19$). The study was deemed to be non-human subjects research by the Institutional Review Board. Results demonstrated that most programs surveyed have both integrated care (84%) and collaborative care (79%) experiences available to residents. Many barriers to implementing and sustaining collaborative care education were named by survey respondents. These included competing clinical demands (34% for implementation and 32% for sustainability), financial barriers (14%, 9%), lack of faculty experience (20%, 6%), and lack of interest from departmental leadership (20%, 3%).

To ensure future psychiatrists are well-trained to practice independently in the community, the Accreditation Council for Graduate Medical Education (ACGME) presents target milestones for resident performance throughout their educational program [5]. They require that residents demonstrate clinical competency across several domains. Among these domains, numerous sub-competencies are related to the work of integrated care. Despite this connection, integrated care is not explicitly mandated as a requirement in residency training, creating variability in exposure and training among residents. We propose that integrated care curricula may provide a unique space for residents to gain training in integrated care models, as well as meet ACGME requirements that are difficult to complete within current inpatient

✉ Nina Camille Burruss
nburrus1@jh.edu

1 The Johns Hopkins Hospital, Baltimore, MD, USA

2 University of Washington, Seattle, WA, USA

3 University of North Carolina School of Medicine, Chapel Hill, NC, USA

or outpatient curricular models. Programs may utilize primary integrated care clinics to meet such requirements, or there may be creative ways of implementing certain key elements of integrated care into current rotations based in outpatient clinics, inpatient psychiatry units, or inpatient consultation-liaison (CL) services. Brief examples for how some key elements of integrated care could be incorporated into pre-existing clinical experiences are included below.

In the outpatient setting, lectures may incorporate discussions about care delivery, including if a patient needs ongoing treatment from a psychiatrist or if they may be appropriately transitioned to their primary care provider. For patients being managed by both primary care and psychiatric providers within the same health system, psychiatric trainees may practice writing primary care–focused encounter notes. Patient registries and utilization of psychiatric screening tools could ensure a systems-based approach and allow for focused, quantitative monitoring of outcomes.

Within inpatient settings, discussions of outpatient treatment options after discharge as a multidisciplinary team would allow residents to gain a better understanding of which patients may benefit from existing integrated care models. For patients who may have been involved in integrated care models prior to admission, liaising with outpatient providers would allow residents a deeper understanding of clinic practices, strengths, and possibly limitations.

On CL rotations, didactic series could provide substantial training on proactive psychiatry consultation models, which take a population health approach to screening for behavioral health disorders for all patients hospitalized for medical and/or surgical care. CL rotations can also emphasize an understanding of integrated care resources available in their communities, allowing consultants to better assist primary teams with the establishment of post-discharge psychiatric follow-up.

Despite the impact of integrated care models on population health outcomes, there continue to be numerous barriers to implementing and sustaining integrated care clinics and educational experiences for residents. The positive outcomes of integrated care as well as ongoing recommendations from APA and ACGME for psychiatric residents to have substantial training in integrated care practice raise the question: should integrated care education be required for general psychiatry residents? Requiring these rotations not only would ensure quality medical care for psychiatric patients with comorbid medical conditions but also would support ongoing changes in psychiatric care delivery that prioritizes comprehensive treatment of psychiatric and medical conditions. While integrated care clinics would not replace current outpatient clinics or community mental health centers, they would improve community access to mental health providers through the creation of an additional clinical resource. The need for psychiatrists trained in integrated care will continue to grow, and it is important that residencies support trainees in gaining this skillset for their future careers and communities.

Declarations

Disclosures On behalf of all the authors, the corresponding author states that there is no conflict of interest to disclose.

References

1. American Psychiatric Association. Learn about the collaborative care model. 2020. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn. Accessed 30 May 2023.
2. Simon G, Ormel J, VonKorff M, Barlow W. Health care costs associated with depressive and anxiety disorders in primary care. Am J Psychiatry. 1995;152:352–7.
3. Heath B, Wise Romero P, Reynolds K. A standard framework for levels of integrated healthcare. Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions; 2013.
4. Cowley D, Dunaway K, Forstein M, Frosch E, Han J, Joseph R, et al. Teaching psychiatry residents to work at the interface of mental health and primary care. Acad Psychiatry. 2014;38:398–404.
5. The Accreditation Council for Graduate Medical Education. Psychiatry milestones. 2020. https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf. Accessed 11 March 2024.