**BRIEF REPORT**

# Integrated Care: Should It Count as Community Psychiatry Training for Psychiatry Residents?

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## Abstract

Psychiatry residents are required to be exposed to community psychiatry. Historically, this occurred in public hospitals or assertive community treatment (ACT) teams. A new model of psychiatric care delivery, integrated care, has become prevalent. While integrated care shares some features with traditional community psychiatry rotations, no research exists to demonstrate if integrated care rotations can accomplish the aims of traditional rotations. This pilot study compared learning outcomes in ACT team rotations versus integrated care rotations. Pre- and post-rotation surveys were disseminated to third-year psychiatry residents (N = 8) who were randomized to complete a rotation with an ACT team or an integrated care team. By rotation end, many in both settings changed how conservative they were in treatment philosophies, but this did not result in a difference between groups. Residents in both groups were satisfied with their rotations. Training in integrated care may be a reasonable alternative to traditional community psychiatry rotations.

**Keywords** Community psychiatry · Integrated care · Assertive community treatment · Psychiatry residents

## Introduction

The Accreditation Council for Graduate Medical Education (ACGME) requires that psychiatry residents be exposed to community psychiatry in an experience that "must provide residents with a cohort of persistently and chronically-ill patients in the public sector, such as in community mental health centers, public hospitals and agencies, and other community-based settings. This experience must include learning about, and using community resources and services in planning patient care, as well as consulting and working collaboratively with case managers, crisis teams, and other mental health professionals" (Accreditation Council for Graduate Medical Education 2017). Further, the ACGME states "residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system" (Accreditation Council for Graduate Medical Education 2017).

Historically, community psychiatry training has been provided to psychiatry residents in the form of public hospitals or assertive community treatment (ACT) teams, both of which provide exposure to important types of psychiatric practice. However, many residency programs do not have access to ACT teams or to state hospitals. Moreover, there is an increasing shortage of psychiatrists, meaning that we need to look at ways to increase capacity to care for large numbers of patients efficiently, while maintaining high quality of care.

In addition to the ACGME's psychiatry-specific requirements, programs are now expected to provide opportunities for residents to meet ACGME Milestones particular to the specialty. For psychiatry, these include the systems-based practice level 4 milestone of "provides integrated care for psychiatric patients though collaboration with other physicians" (Accreditation Council for Graduate Medical Education 2015).

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One such way to comprehensively address all of these issues, while also meeting the ACGME requirements for community psychiatry training, may be through participation in integrated care teams. In the integrated care approach, mental health professionals provide psychiatric consultation to other medical providers, often within a primary care setting. ACGME guidelines for exposure to patients with persistent, chronic mental illness would potentially be met if these teams were housed in community health centers that care for underserved populations. Indeed, many integrated care training sites for psychiatry residents are federally qualified health centers (FQHCs) (Reardon et al. 2015). Moreover, this model of care provides an important venue for interprofessional training, especially among members of psychiatry, family medicine, internal medicine, and pediatrics teams. Such training is becoming more important with evolution of the medical home and quality initiatives related to communication.

There have been recent reports in the literature of curricula to train psychiatry residents in the integrated care model (Reardon et al. 2015). However, there have been no such reports comparing "traditional" community psychiatry rotations with integrated care rotations. Even if integrated care rotations meet many ACGME requirements, it is desirable to establish that they also meet many of the aims of traditional community psychiatry experiences, if they are to be considered as replacements for more traditional rotations in some residency programs. Attitudinal aims of community psychiatry rotations may be more important than knowledge- and skill-based ones (Brown et al. 1993; Factor et al. 1988). These attitudinal aims include: increasing comfort with management of severely psychiatrically ill patients in the community as opposed to in long-term institutions; satisfaction with opportunities for work in interdisciplinary teams; maintenance of hope for severely ill psychiatric patients; and satisfaction with the level of care that can be provided in community settings (Brown et al. 1993; Factor et al. 1988).

This report compares an integrated care rotation with a traditional community psychiatry rotation with respect to the attitudinal aims discussed above, and it may serve as a pilot proposal on which future, larger studies can build.

## Methods

Pre- and post-rotation surveys were disseminated to postgraduate year (PGY)-3 residents (N = 8) randomly assigned in a 1:1 ratio to complete a three-month long community psychiatry rotation, one-half day per week, at one of two sites: a "traditional" community psychiatry site, i.e., an ACT team at the Veterans Affairs Hospital, or an urban FQHC as part of an integrated care team. The model of consulting psychiatry in an integrated care setting at this FQHC has been previously described (Zeidler Schreiter et al. 2013; Zeidler Schreiter 2014; HipXChange toolkit 2014).

Survey instructions included a fictional case of a patient with severe and persistent mental illness, with six related questions asking the resident to estimate level of safety risk, functional status, intensity of long-term psychiatric care needed, and treatment recommendations given certain levels of psychiatric decompensation. Each of the six questions had between four and six possible responses. The levels of intensity of care were described as based on the American Association of Community Psychiatrists' (AACP) designations (LOCUS Level of Care 2009). All questions were developed with the consultation of two longstanding community psychiatrists who are AACP members and were involved as psychiatrists in the initial development of the world's first ACT program. No assessment instruments to collect the data we desired were available in the literature, and thus we developed our own in this way. The survey was piloted and feedback obtained from three community psychiatrists and three psychiatry residents who were not involved in this study. In "scoring" this survey, the goal was to establish a mechanism that would categorize residents as choosing more "conservative"/"risk-averse" responses versus the opposite. Accordingly, the least conservative responses were given a score of 1, most conservative responses a score of 4, 5, 6 and intermediate responses intermediate scores. For example, in a given scenario, a resident choosing to manage a patient in an ACT program would be regarded as less conservative (score = 4) in their approach than a resident choosing to manage that patient via secure care in a long-term, locked environment (score = 6). There were not any single correct answers to the questions, but they allowed general attitudinal tendencies to be assessed. Total pre- and post-rotation *conservativeness-of-care scores* were then calculated for each resident with a possible range of 6–30, where higher scores indicate an overall more conservative approach to treatment.

Survey instruments also asked five questions to assess the residents' pre-rotation *anticipated* satisfaction with teamwork and with the approach to patient care at the assigned setting, and post-rotation *actual* satisfaction with teamwork and the approach to patient care at that setting. The most positive responses were assigned a score of 5, and the least positive responses a score of 1, with intermediate responses receiving intermediate scores. For example, residents were asked on a scale of 1–5 how challenging they anticipated finding it, or did find it, to maintain hope and optimism for their patients at their given site, with 1 = extremely challenging and 5 = not at all challenging. Total pre- and post-rotation *satisfaction scores* were then calculated for each resident with a possible range of 5–25, where higher scores indicate overall more positive anticipated or actual satisfaction with teamwork and patient care at the site.

Survey data were analyzed using R version 3.2.3 (R Development Core Team 2008). Descriptive statistics for total conservativeness-of-care and satisfaction scores and individual questions were calculated at both time points and for pre-post differences. Pre-post change in the full n = 8 cohort was assessed with paired t-tests; differences in scores and/or pre-post changes between rotations were assessed with two-sample t-tests.

The University of Wisconsin Health Sciences Institutional Review Board granted exemption for this study. The authors report no known conflicts of interest. All authors certify responsibility for the manuscript.

## Results

One hundred percent (N = 8) of residents participated. By the end of their rotations, many individual residents in both settings changed how conservative they were in estimating level of safety risk, functional status, intensity of long-term psychiatric care needed, and treatment recommendations given certain levels of psychiatric decompensation described in survey patient vignettes, with changes in conservativeness-of-care scores ranging from − 5 to + 6, compared to a baseline score range of 16–26. However, there was no consistent shift towards more or less conservativeness of care in the residents as a whole (n = 8, p = 0.96) and no evidence of a difference by rotation type (p = 0.39). Residents in both settings ended up significantly more satisfied with teamwork and with the approach to patient care at their assigned settings than they anticipated they would be prior to the rotation, with a mean change in anticipated to actual satisfaction score of + 3.5 (95% CI [+ 0.2, + 6.8], p = 0.04). There was no evidence of a difference in change in satisfaction by rotation type (p = 0.41). Residents in both groups expressed overall satisfaction with their rotations. In particular, when asked to provide an "overall rating of the rotation" on a five-point Likert scale (1 = poor, 5 = excellent), all residents gave scores of 4 or 5 (mean = 4.4) except for one resident randomized to the traditional rotation who provided a lower score.

## Discussion

A rotation intended to meet the ACGME requirement for psychiatric residency training in community psychiatry as conducted in an integrated care setting may be no different in accomplishing many of the attitudinal aims of more traditional community psychiatry rotations. Some may argue that patients in an integrated care setting in a federally qualified health center would have less severe psychopathology than those whose mental health care is managed by an ACT team.

While it is likely to be true that all patients seen by an ACT team have significant psychopathology, often in the form of psychotic illness, patients in FQHCs may have high risk in other ways, for example, socioeconomic and level of social support. In particular, patients in ACT teams may be more likely to at least have some insurance, compared to the many uninsured patients seen at FQHCs.

One of the changes that may be seen within residents as they spend time within an ACT team is increased comfort with managing psychiatric risk in the community versus hospital setting. This is an important attribute to develop. One way this may be developed in an integrated care setting is that residents must develop comfort with turning some important aspects of management over to other members of the treatment team. For example, in many integrated care models, the psychiatrist makes treatment recommendations but never actually writes prescriptions, instead entrusting that to the primary care providers. The primary care provider is also then responsible for ongoing management of the patient including needed laboratory monitoring, refills, and medication adjustments as appropriate, taking into consideration recommendations provided by the psychiatrist.

Almost 20 years ago, one literature report from prominent community psychiatrists looked at a new (at the time) model of training residents in community psychiatry by having them work in an ACT team for the homeless population, versus their traditional community psychiatry model of inpatient work with the seriously mentally ill. Their rationale was that financial and policy shifts away from extended hospital treatment were providing new opportunities for moving training to the "front lines" of the community. The authors commented that "recent and ongoing economic and health care delivery trends provide opportunities to enrich the education and clinical experiences of psychiatry residents through 'front line' work with disaffiliated and difficult-to-reach populations of the mentally ill" (Cohen et al. 1998). The paper deemed their particular ACT experience a new and successful model of training psychiatry residents in community psychiatry. It notably pointed out that "Although there are a number of academic training programs in community psychiatry around the country, the most successful are informed by and fit well into their environment's service needs" (Cohen et al. 1998). We see this as a call to more closely examine what now are even newer models of community psychiatry, especially those that seem to fit an area's particular service needs at the current time. We hope this paper may serve as a first step in that evaluation.

A strength of this pilot study is that residents were randomly assigned to their rotation venues. A common theme in education research that looks at new curricula is that residents choose the new option over the standard option, thereby contributing to selection bias. This is true in the literature that exists on community psychiatry curricula

(Randall et al. 2011). Weaknesses include the small sample size, limited duration of the rotations studied, single institution utilized in this pilot study, and inability to assess all of the previously described attitudinal aims of traditional community psychiatry rotations (especially maintenance of hope for severely ill psychiatric patients) with the measures used in this study. The sample size limits conclusions that can be drawn, but hopefully sets up important educational research questions to be studied in larger trials.

In conclusion, training in integrated care may be a reasonable option for providing required community psychiatry exposure for psychiatry residents. It is not that one should necessarily replace the other, as the experiences may complement each other (Battaglia et al. 2015) and thus expand the options available to psychiatry training programs to meet the needs of their residents.

## Compliance with Ethical Standards

**Conflicts of interest** The authors declare that they have no conflict of interest.

**Ethical Approval** The University of Wisconsin Health Sciences Institutional Review Board granted exemption for this study. All participants consented to participation. The authors report no known conflicts of interest. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

## References

Accreditation Council for Graduate Medical Education. (2015). The Psychiatry Milestone Project. Retrieved from http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf.

Accreditation Council for Graduate Medical Education. (2017). ACGME program requirements for graduate medical education in psychiatry. Retrieved from https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf.

Battaglia, J., Walaszek, A., & Reardon, C. (2015). The program of assertive community treatment and the university of wisconsin psychiatry residency. In L. W. Roberts, D. Reicherter, S. Adelsheim, et al. (Eds.), *Partnerships for mental health: Narratives of community and academic collaboration* (pp. 89–100). New York: Springer.

Brown, D. B., Goldman, C. R., Thompson, K. S., et al. (1993). Training residents for community psychiatric practice: Guidelines for curriculum development. *Community Mental Health Journal, 29*(3), 271–283.

Cohen, N. L., McQuistion, H., Albert, G., et al. (1998). Training in community psychiatry: New opportunities. *Psychiatric Quarterly, 69*(2), 107–116.

Factor, R. M., Stein, L. I., & Diamond, R. J. (1988). A model community psychiatry curriculum for psychiatric residents. *Community Mental Health Journal, 24*(4), 310–327.

HipXChange toolkit. Access community health centers (Access) integrated primary care consulting psychiatry toolkit. (2014). Retrieved from http://www.hipxchange.org/Access.

LOCUS level of care itilization system for psychiatric and addictive services (Adult Version 2010). (2009). Retrieved March 20, 2009, from http://providersearch.mhnet.com/Portals/0/LOCUS.pdf.

Randall, M., Romero-Gonzalez, M., Gonzalez, G., et al. (2011). Competency of psychiatric residents in the treatment of people with severe mental illness before and after a community psychiatry rotation. *Academic Psychiatry, 35*(1), 15–20.

RDevelopment Core Team. (2008). R: A language and environment for statistical computing. (2008). R Foundation for Statistical Computing, Vienna, Austria. ISBN 3-900051-07-0. Retrieved from http://www.r-project.org.

Reardon, C. L., Bentman, A., Cowley, D. S., et al. (2015). General and child and adolescent psychiatry resident training in integrated care: a survey of program directors. *Academic Psychiatry, 39*(4), 442–447.

Zeidler Schreiter, E. A. (2014). Consulting psychiatry. In Serrano, N., (Ed.), *The implementers guide to primary care behavioral health*. Access Community Health Centers. Retrieved from http://itunes.apple.com/us/book/implemnters-guide-toprimary/id833906873.

Zeidler Schreiter, E. A., Pandhi, N., Fondow, M. D. M., et al. (2013). Consulting psychiatry within an integrated primary care model. *Journal of Health Care for the Poor and Underserved, 24,* 1522–1530.