

Training Psychiatrists for Integrated Behavioral Health Care

A Report by the American Psychiatric Association Council on Medical Education and Lifelong Learning 2014

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EXECUTIVE SUMMARY

Integrated behavioral health care has been defined as “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population” (Peek, et al, 2013). Integrated care improves access, outcomes and quality, and represents a decisive new direction for the transformed American health care system with its focus on assessment and treatment of mental illness and enhancement of wellness.

Most medical education regarding mental illness takes place in traditional psychiatric settings, such as hospitals, community mental health centers and clinics, and is based on traditional psychiatrist roles. As the care system shifts from the current norm toward integrated models of care, there is a need across the medical education continuum – undergraduate, graduate and continuing medical education – for programmatic change to teach and lead about integrated care practice.

Integrated care requires new skills and responsibilities for psychiatrists, as well as other health professionals. This report champions education about integrated care and (i) reviews the literature to define these skills and responsibilities, (ii) scans the undergraduate, graduate medical education, and continuing medical education environment to examine the extent and methods used to educate trainees about this model, (iii) discusses challenges and solutions to promoting training in integrated care techniques, and (iv) makes recommendations to educational programs and the American Psychiatric Association (APA). The report represents the work of the Council on Medical Education and Lifelong Learning of the APA, and the individuals with primary responsibility for each section are designated.

INTRODUCTION (ART WALASZEK, M.D.)

Pursuit of the triple aim of America’s health care system – quality, access and cost – challenges our current models of care and points the way toward integrated behavioral care. Although the majority of behavioral health care in the United States takes place in primary care, characterized as the “de facto mental health system” (Kessler and Stafford 2008), concerns have been raised about the quality of the care provided (Raney, et al, 2013). For example, the rates of appropriate identification and diagnosis of patients with depression are low; for those patients diagnosed with depression, treatment is often not evidence-based, especially with regard to duration and intensity of treatment.

But, quality is not the only problem. The financial cost of inadequately treated mental illness is staggering and the additional healthcare cost of patients with behavioral comorbidities in 2012 was estimated at \$293 billion (Melek, 2014). Patients with mental illness are overrepresented in populations at risk of hospitalization (Katon and Unutzer, 2013).

Finally, access to mental health services is often poor (Cunningham, 2009), and likely to get worse as many Americans get health insurance through the Affordable Care Act prior to changes in the mental health care system that could increase access. The total number of psychiatrists is unlikely to increase, at least in the short term, since limited funds are available to create new psychiatry residency training slots. New models that extend psychiatric expertise to larger populations of patients are necessary.

These gaps in the healthcare system lead to new opportunities for psychiatrists to help improve the mental health care of patients in primary care. Indeed, the APA Board of Trustees’ Work Group on Health Care Reform has recommended that psychiatrists “must play a major role in formulating integrated care solutions by defining their role and benefit to patients” (APA, 2014a).

The integrated care model “may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization (Peek 2013).”

Integrated care comprises a number of different approaches, including co-location, collaborative care, improved primary care for patients with severe mental illness (Raney, et al, 2013), and telepsychiatry. Co-location refers to the physical presence of psychiatric treatment in primary care and/or other medical/surgical outpatient settings. The collaborative care model (CCM) is a population-based approach in which psychiatrists work with primary care providers and behavioral health care managers to manage the behavioral health of a defined population of patients. This includes the use of objective rating scales, regularly scheduled caseload-focused review with the psychiatrist, adjustment of care based on rating scale results and evidence-based treatment algorithms to reach desired outcomes (treatment to target), and care management, including use of evidence-based brief interventions. Improved primary care may involve provision of primary care services in the behavioral health setting (also referred to as reverse co-location). Finally, telemedicine facilitates psychiatric consultation or collaborative care with medical colleagues in settings with workforce shortages or geographic dispersion.

Of the approaches to integrated care, the strongest database exists for the collaborative care model (CCM), especially for depression. For example, a recent meta-analysis of 57 treatment trials found that CCM consistently improves depression, mental quality of life, physical quality of life, and social role functioning (Woltmann, et al, 2012). A Cochrane review of 79 randomized controlled trials found CCM to be effective in improving depression and anxiety, increasing patient satisfaction, and in providing enduring benefits (Archer, 2012). Most studies of CCM have shown net decreased health care costs (Melek, et al, 2014). Recent clinical trials have found that collaborative care in the setting of multiple medical and psychiatric co-morbidities (e.g., diabetes, heart disease and depression) is effective at improving a wide range of medical outcomes (Katon, et al 2010).

As these new care delivery models emerge, psychiatrists' roles will likely change. They will need to collaborate effectively, communicate with other physicians and health care providers, leverage their knowledge across teams, apply their consultative skills, utilize screening tools, and embrace information technology. The continuum of psychiatry education, including undergraduate and graduate medical education, as well as continuing medical education, must take on the challenge of preparing current and future psychiatrists, and their primary care colleagues, including physician assistants and nurse practitioners, to deliver this sort of patient-centered, team-based, measurement-based and population-oriented care.

A variety of excellent resources are already available to meet this challenge. This report aims to augment these resources by providing an analysis of how the field is responding this need and reflect on the lessons learned so far in order to help psychiatry educational programs further develop their teaching and training.

This report champions education about integrated care and (i) reviews the literature to define these skills and responsibilities, (ii) scans the undergraduate, graduate medical education, and continuing medical education environment to examine the extent and methods used to educate trainees about this model, (iii) discusses challenges and solutions to promoting training in integrated care techniques, and (iv) makes recommendations to educational programs and the American Psychiatric Association (APA). The report represents the work of the Council on Medical Education and Lifelong Learning of the APA, and the individuals with primary responsibility for each section are designated.

UNDERGRADUATE MEDICAL EDUCATION (BENOIT DUBÉ, M.D.; MARCY VERDUIN, M.D.)

Crucial issues at the center of discussions about undergraduate medical education include the length of medical school (Emanuel EJ, Fuchs VR, 2012) and the impact of the cost of training and resulting medical student debt on the health care workforce (Greysen SR, 2011, Steinbrook R, 2008). The Affordable Care Act and its mandate for integrated care has added another important and timely issue for educators to consider (Croft B, Parish SL, 2013). Although residency training is more proximate to clinical psychiatry practice, and has been a focus of interest for integrated care experts for some time (Cowley, et al, 2014), clerkship directors and medical school faculty clearly recognize the need to shape student perceptions of the field of psychiatry, expose students to a variety of models of care, and teach future physicians of all specialties to facilitate behavioral health care.

Integrated Care in Undergraduate Medical Education

In August, 2014, all members of the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) were invited to complete a short survey on training and education about integration of physical and behavioral health at their respective institutions (see Dubé B, Verduin M, 2014 for detailed information about the survey). There were several important findings from the survey. First, behavioral health topics are most commonly taught during Introduction to Doctoring, Neurology and Reproduction courses (Figure 1) and they are taught primarily by the psychiatry faculty (Table 1).

Second, during non-psychiatry clinical rotations, behavioral health topics are most frequently taught during the Family Medicine clerkship and, conversely, least commonly during the Surgery clerkship (Figure 2). Because these rotations are sponsored by other departments, the teaching faculty are much less likely to be psychiatrists (Table 2).

Figure 1. Pre-clinical course offering behavioral health content

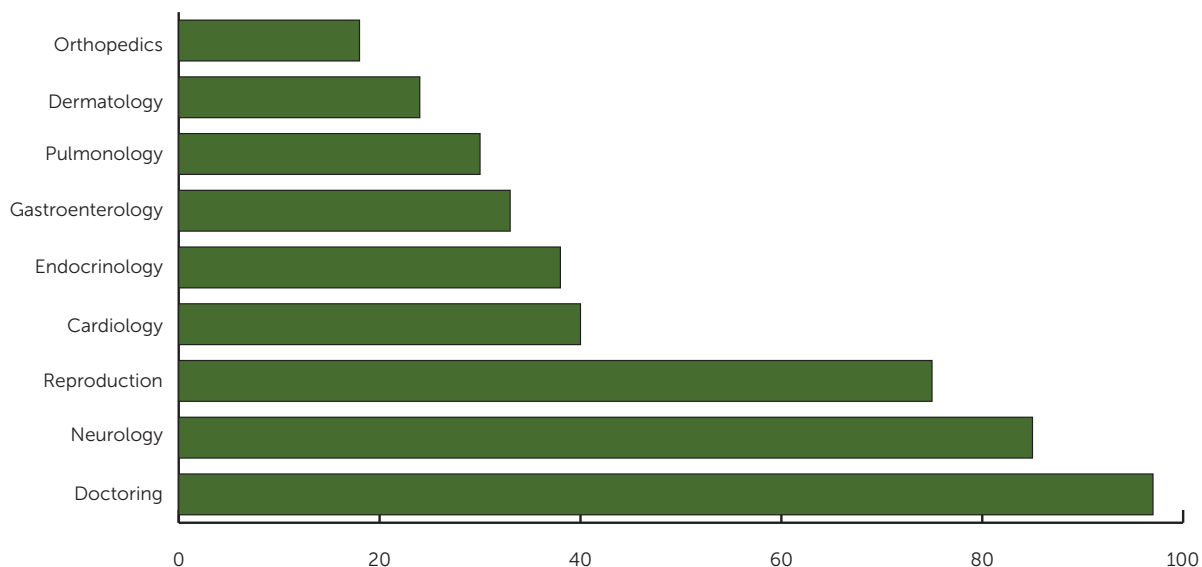


Table 1: Specialty of Faculty Teaching About Behavioral Health Topics

Who Teaches Behavioral Health Topics?	Psychiatry Faculty (%)	Non-Psychiatry Faculty (%)
Doctoring	70	30
Neurology	55	45
Reproduction	50	50
Cardiology	10	90
Endocrinology	13	87
Gastroenterology	15	85
Pulmonology	15	85
Dermatology	0	100
Orthopedics	0	100

Figure 2: Clinical Rotation (Excluding Psychiatry) Offering Behavioral Health Content

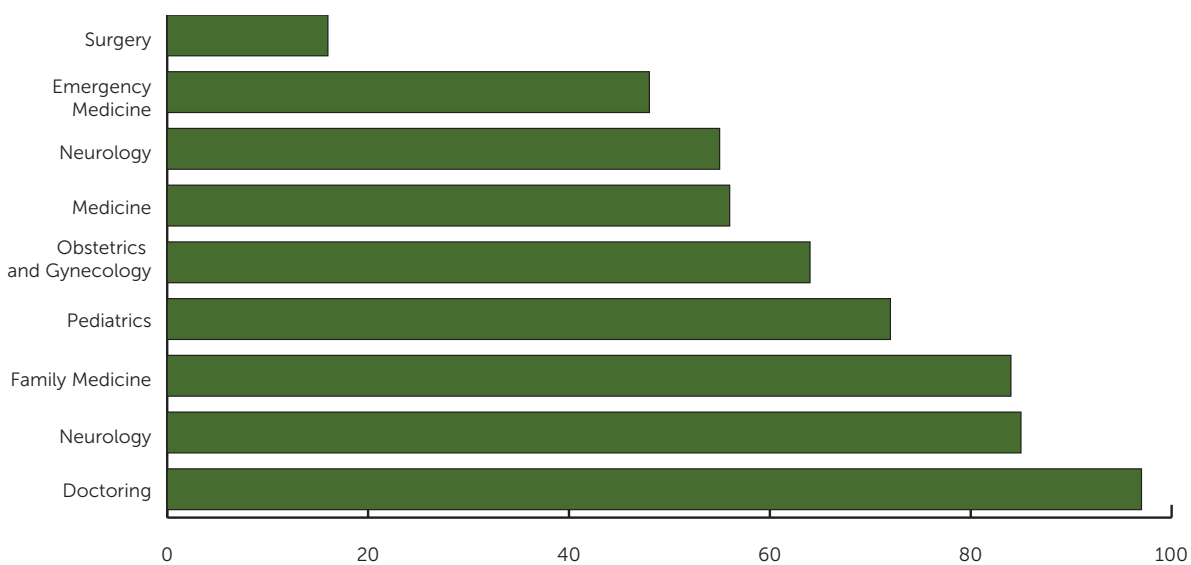


Table 2: Specialty of Faculty Teaching About Behavioral Health Topics on Clinical Rotations

Who Teaches Behavioral Health Topics?	Psychiatry Faculty (%)	Non-Psychiatry Faculty (%)
Family Medicine	33	67
Pediatrics	25	75
Obstetrics and Gynecology	44	56
Medicine	27	73
Neurology	27	73
Emergency Medicine	23	77
Surgery	33	67

Table 3: Integrated Care Clinical Rotations

Integrated Care Clinical Setting	Psychiatry Clerkship			Psychiatry Elective		
	Yes (mandatory)	Yes (optional)	No	Yes (mandatory)	Yes (optional)	No
Traditional psychiatric consultation in a primary care setting	12%	44%	44%	2%	37%	61%
Traditional psychiatric consultations in a non-primary care medical or surgical outpatient setting	15	35	50	3	28	69
Collaborative care with primary care providers	10	30	60	3	30	67
Collaborative care with other medical colleagues	0	13	87	0	15	85

Table 4: Integrated Care Rotation Venues

	VA ¹	FQHC ²	Primary Care Clinic ³	Medical Surgical Outpatient Clinic ⁴	Other ⁵
Traditional psychiatric consultation in a primary care setting	26%	30%	35%	4%	5%
Traditional psychiatric consultations in a non-primary care medical or surgical outpatient setting	18	29	0	35	18
Collaborative care with primary care providers	14	29	36	14	7
Collaborative care with other medical colleagues	20	0	20	0	60

1 Veterans Administration Medical Centers

2 Federally Qualified Health Centers

3 Non-VA, non-Federally Qualified Health Centers

4 Non-VA, non-Federally Qualified Health Centers' medical surgical clinics that are not primary care

5 Includes correctional facilities and juvenile detention centers

Third, integrated care settings are not commonly among the training sites in the Psychiatry clerkship. They are typically optional experiences and usually involve traditional psychiatric consultations in primary care settings. They are also rarely offered as elective rotations (Table 3).

Finally, there are a wide variety of settings for integrated care rotations (Table 4). The VA System, Federally Qualified Healthcare Centers (FQHCs), and other types of primary clinics were the main venues for these rotations. Telemedicine experiences take place in the VA system and in other unique venues.

These survey data do not allow us to fully appreciate ongoing current efforts. To do so, we would need to query undergraduate curriculum deans. There are some interesting new models of integrated care education for medical students. For example, the University of California at Davis offers a combined medicine/psychiatry elective for their senior students. During a 4-week period, medical students work in a county clinic alongside dual-boarded psychiatry and internal medicine/family medicine faculty to provide medical care for indigent and uninsured patients as well as primary care for psychiatric patients. While innovative and forward thinking, the paucity of dual-boarded physicians makes this scenario elusive for most medical schools. For most undergraduate educators today, psychiatry is primarily taught in the acute inpatient setting and offers some students the opportunity to join the consultation-liaison team in the hospital.

Some medical school such as Commonwealth University, Dalhousie University in Nova Scotia, Georgia Health Sciences University and University of California at San Francisco offer longitudinal integrated clerkships. These experiences are structured to ensure continuity with the primary preceptor, clinical micro-system, and panel of patients in each clerkship over an extended period of time. They stand in contrast to the traditional block clerkships that occur as one specialty at a time for four to eight weeks and are primarily inpatient-based. Although students rotate through the usual services in this educational model, they follow their patients through the care system and have the opportunity for a bird's-eye view of the degree to which the care is integrated or not. This offers an invaluable learning opportunity in understanding "patient-centered-ness," but does not provide exposure to an effectively functioning integrated care system.

Undergraduate Medical Education Conclusions

Exposure to integrated care for medical students is just the beginning. There are many exciting opportunities for modeling inter-specialty collaboration (discussed more fully in section below), developing team participation skills, and incorporating a population-based framework for understanding illness and care. As the health care system changes to reflect these new values, and clinical services are increasingly organized along these lines, the clinical educational opportunities for medical students will surely improve.

It will be important for undergraduate medical educators to adequately address population-based medicine, behavioral

health, and include frequent case material that emphasizes co-morbidity and the opportunities and challenges in collaborating across specialties and professions. Exposure to these new skills for psychiatrists will hopefully respond to medical student concerns about the future of psychiatry and the role of psychiatrists in a transformed health care system and create excitement and recruitment potential. Specific suggestions follow in the Recommendations section below.

GRADUATE MEDICAL EDUCATION (DEBORAH COWLEY, M.D., CLAUDIA REARDON M.D.)

Educational experiences in integrated care for psychiatry residents have been implemented and described in published reports since the 1990s (Kates, 2000; Cowley, et al, 2000; Yudkowsky, 2000; Dobscha and Ganzini, 2001). The number of residency programs offering such experiences has increased in recent years for several reasons.

In this section, we review the results of recent surveys providing information about what residency programs are doing now to teach psychiatry residents about integrated care (Reardon, et al, 2014, 10-12, Burkey, et al, 2014, Annamalai, et al, 2014), types of rotations and didactics offered, clinical settings and supervision, and challenges involved in establishing and maintaining such educational experiences. In addition, we describe best practices and resources that can help in the development of future rotations and didactics, as well as administrative, leadership, and funding issues involved, issues of evaluation, and milestones that can be met through integrated care education.

Core Competencies, Milestones, and Evaluations

There are several skills that psychiatry residents and fellows must learn to work effectively in integrated care settings. These have been articulated in terms of core competencies (Cowley, et al, 2014) and, more recently, Psychiatry Milestones (e.g. Reardon, et al, 2014, AADRPT, 2014, Barkil-Oteo and Huang, 2014). These include providing "curbside" consultation (patients are not evaluated in person or by video), engaging ambivalent patients in mental health treatment and use of brief interventions such as motivational interviewing, problem solving therapy, behavioral activation, and cognitive-behavioral therapy, all of which have proven efficacy in primary care settings (Bell and Zurilla, 2009, Roy-Burne, et al, 2010, Barsky, et al, 2013, Gros and Haren, 2011, Wissow, et al, 2008, Noordman, et al, 2012). In providing primary care to psychiatric patients, lifestyle interventions such as smoking cessation, weight management, and chronic disease management for conditions such as diabetes are important (Annamalai, et al, 2014). Retention of skills in the recognition and treatment of common medical conditions for psychiatrists treating the seriously mentally ill (SMI) population is also an important emerging competency.

Residents must learn to work within the "culture" of primary care. Several authors (Cowley, et al, 2014; Yudkowsky, 2000; Schuyler and Davis, 1999; Brown and Zinberg, 1992)

have written about the different “cultures” of psychiatry and primary care. Psychiatric outpatient practice emphasizes regular, scheduled appointments of carefully defined length, clear boundaries, and maintaining the frame of the treatment. Primary care settings are generally more fast-paced, with brief appointments, flexible boundaries, frequent interruptions, and double-booking, adding on, and “squeezing in” additional patient appointments. It is very important for psychiatry residents to learn how to navigate these different “cultures,” setting clear expectations for clinic staff and providers while also being responsive. Primary care providers also appreciate prompt, succinct notes and clear recommendations. Residents working in population-based care also need to develop skills in supervising non-psychiatric mental health providers (care managers often trained in social work), assessing their knowledge and skills, and providing guidance and consultation about patients the resident has not personally seen.

It is interesting that the ACGME does not require education of psychiatry residents in preventive and primary medical care beyond the PGY1 year. A recent, small survey suggests that psychiatry residency programs generally do not provide rotations or didactics in this area beyond the PGY1 year, and that residency directors would anticipate resistance from faculty and residents to implementing further training in general medicine (Annamalai, et al, 2014).

Integrated care rotations and curricula provide the opportunity to assess many of the new Psychiatry Milestones. While the milestones most commonly linked with integrated care have been those included in subcompetencies SBP4 (Consultation to non-psychiatric medical providers and non-medical systems) and ICS1 (Relationship development and conflict management with patients, families, colleagues, and members of the health care team), there are several level 3, 4, and 5 milestones across multiple competency domains that are

particularly well assessed through these experiences, depending on the type of integrated care rotation (for examples, see Table 5). Although level 1-2 milestones can also be assessed, most integrated care rotations occur later in residency, when the focus is on achieving higher-level milestones.

Evaluation methods for trainees and faculty are primarily traditional written evaluations, like those used for other residency rotations and didactics. Some of the curricula mentioned above, and some rotations described in the AADPRT compendium, include other evaluation methods such as pre- and post- knowledge tests, self-assessments, 360-degree evaluations by other team members and patients, observed interviews by attendings, patient outcomes, or video simulations to test competencies in telemental health and interventions such as motivational interviewing.

Few studies have evaluated longer-term outcomes of integrated care experiences for psychiatry residents or fellows, such as effects on their career choices and future clinical practice, patient care and outcomes, or attitudes toward psychiatry and patients with mental health problems among primary care providers and staff. Patients at the Portland VA who received both primary medical and psychiatric care from a single Oregon Health Sciences University psychiatry resident reported a high level of satisfaction with their care and showed no differences from matched controls on psychiatric symptom burden, active medical problems, or preventive health screenings over the course of a year (Snyder, et al, 2008). Psychiatry residents completing this elective rotation endorsed greater preparation to address their patients’ medical problems and comfort in making medical referrals, but no greater likelihood of performing medical evaluations or providing medical care after graduation (Dobscha, et al, 2005). Residents working in the Yale Psychiatry Primary Care program were more aware of medical comorbidities of their patients and the importance

Table 5: Examples of Advanced Psychiatry Milestones That Can Be Assessed in Integrated Care Rotations

Milestone	Description
PC3/4.1	Devises individualized treatment plan for complex presentations
PC3/4.2	Integrates multiple modalities and providers in comprehensive approach
PC3/5.1	Supervises treatment planning of other learners and multidisciplinary providers
MK2/4.3	Shows knowledge sufficient to identify and treat a wide range of psychiatric conditions in patients with medical disorders
MK2/4.4	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
PBLI3/4.1	Gives formal didactic presentation to groups (e.g. grand rounds, case conference, journal club)
SBP4/3.3	Discusses methods for integrating mental health and medical care in treatment planning
SBP4/4.1	Provides integrated care for psychiatric patients through collaboration with other physicians
ICS1/4.1	Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care
ICS1/4.2	Leads a multidisciplinary care team
ICS2/4.1	Demonstrates effective verbal communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent
ICS2/4.2	Demonstrates written communication with patients, families, colleagues, and other health care providers that is appropriate, efficient, concise, and pertinent

of collaboration with primary care providers, but were no more likely than their peers to choose to provide medical care for their psychiatric patients or to incorporate primary care practices into patient care (Rohrbaugh, et al, 2009).

Surveys Regarding Current Graduate Medical Education in Integrated Care

In May and June, 2014, the American Association of Directors of Psychiatric Residency Training (AADPRT) Integrated Care Task Force conducted a survey on integrated care education (described in detail in Reardon, et al, 2014). Of respondents, 78% of general psychiatry and 72% of Child and Adolescent Psychiatry (CAP) program directors stated that they offered one or more integrated care rotations. Of these, 65% of general psychiatry rotations and 40% of CAP rotations were elective. Most were offered in the senior years of training.

The most common type of integrated care rotation was psychiatric consultation within a primary care clinic, while the least common was provision of both primary care and psychiatric care by psychiatry residents. Ninety-five percent of program directors reported supervisors for at least some of their rotations were psychiatrists, with 18% having some rotations supervised by dually-trained physicians, 18% by psychologists or social workers, and 16% by primary care physicians. Most supervisors were on site at the same time as the resident. In general psychiatry residency programs, rotations were most commonly offered in VA settings, followed by other primary care clinics, while the most common sites for CAP rotations were Federally Qualified Health Centers. Forty-three percent of programs also offered didactics about integrated care.

Using the most conservative estimate, and assuming that none of the non-respondents offer integrated care experiences, these results indicate that at least 20% of general psychiatry and 23% of CAP programs nationally are offering at least one integrated care rotation.

A separate survey by the American Academy of Child and Adolescent Psychiatry (AACAP), was sent to CAP program directors in June 2013. Forty-three percent of eligible participants responded and 98% of these had an affiliated pediatrics residency program in their institution (Burkey, et al, 2014). Eighty-eight percent of respondents reported that their fellows regularly participated in teaching, clinical care,

and/or consultation in a primary care pediatric setting. Forty-four percent reported that fellows performed indirect consultation (i.e. without seeing the patient), 31% reported direct consultation by fellows, and 13% indicated that fellows regularly provided ongoing psychiatric care in a primary care setting. Thirty-seven percent of programs required at least one integrated care rotation. In 63% of programs, fellows taught pediatric residents and 77% provided didactics about integrated care for CAP fellows. Seventy-seven percent disagreed or strongly disagreed that CAP programs are already preparing fellows for changes in health care delivery and 62% reported plans to increase fellows' exposure to integrated care within the next three years. Major barriers were competing clinical demands for fellows and lack of sustainable funding for fellows and faculty to provide indirect consultation to primary care providers.

These results confirm a pattern of increasing interest in, recognition of the importance of, and provision of educational experiences in integrated care for psychiatry trainees, as well as reiterating common concerns about financial sustainability of these health care delivery and educational models.

Integrated Care Education Best Practices

The AADPRT website (www.aadprt.org) Virtual Training Office (accessible to AADPRT members) provides several general collections of best practices and examples related to integrated care education (AADPRT, 2014). These include a list of general and child and adolescent psychiatry residency programs that offer integrated care rotations and curricula, together with information about rotation structure, supervision, challenges, and evaluation; Frequently Asked Questions (FAQs); and a collection of detailed curriculum materials from several residency programs, including rotation and curriculum goals and objectives, rotation descriptions, slide sets, bibliographies, training manuals, and evaluation forms. These materials are intended to help program directors wishing to implement integrated care rotations and/or curricula. Access to these materials requires an AADPRT login and password.

Below, we discuss some best practices in integrated care education for psychiatry residents and fellows, derived from these AADPRT resources, other online resources, and the published literature.

Table 6: Potential Integrated Care Experiences and Timing During Psychiatry Training

Integrated Care Experience	Timing During Residency
Outpatient primary care, or other primary care rotation focusing on medical problems commonly seen in psychiatric patients	PGY1 (part of four-month primary care requirement)
Co-located psychiatric consultation	PGY3/PGY4 (preventive and/or primary medical care of psychiatric outpatients, or part of community psychiatry rotation)
Collaborative Care/Population-Based Care	PGY4 (prior experience in co-located care ideal)
Telemental Health	PGY3/PGY4
Integrated Care Didactics	PGY2/PGY3/PGY4

Rotations and Clinical Experiences

The AADPRT compendium of integrated care experiences includes 33 separate clinical experiences submitted by 25 different programs. Consistent with the AADPRT survey results described above, rotations are primarily co-located psychiatric consultation within primary care settings for senior psychiatry residents. Three are specifically designed for child and adolescent psychiatry fellows and four mention inclusion of psychosomatic medicine fellows in addition to general psychiatry residents. A minority of these programs report offering rotations providing co-located psychiatric consultation in other medical/surgical settings (e.g. oncology, neurology, pain, infectious disease, HIV, cardiology, high-risk obstetrics clinics), population-based collaborative care, telepsychiatry consultation, or primary care medicine delivery by psychiatry residents. Most rotations are half a day to one day per week for one to twelve months.

Several of these rotations feature noteworthy best practices. For example, the University of Washington's Idaho Advanced Clinician Track focuses on working closely with family medicine residents and requires that PGY3 and PGY4 psychiatry residents rotate in the Family Medicine Residency of Idaho Clinic for at least one day per week for two years. This experience includes supervision in health psychology and lifestyle interventions such as smoking cessation and weight loss, as well as a very well-received "PGY4 attending room consultation" component, in which PGY4s are available in the clinic's provider room for curbside consultation and to see patients jointly with family medicine residents. The University of California San Diego (UCSD), Oregon Health and Sciences University (OHSU), and Emory programs offer rotations in which psychiatry residents provide both psychiatric and primary medical care for patients. At Emory, this experience is based in a community psychiatry rotation, emphasizes medical care of seriously and chronically mentally ill individuals, and may involve doing a project (e.g. leading a smoking cessation group, developing lectures or curricula about diagnosis and/or treatment of common medical conditions).

In general, this compendium provides a wide variety of examples of rotations of varying type and duration. For a summary of possible integrated care rotations at different PG years of a general psychiatry residency program, please see Table 6. Of note, optimal timing during residency may vary, depending on the order of rotations and clinical experiences within a particular residency program. However, upper-level residents, or those with experience in outpatient and consultation-liaison psychiatry, are generally better prepared for integrated care rotations.

Didactics, Supervision, and Mentoring

The AADPRT resources include a number of approaches to integrated care didactics, including detailed curricula from several residency programs. A basic curriculum regarding collaborative care, consisting of two 60-minute sessions, has been developed at Yale (Barkil-Oteo and Huang, 2014)

and is particularly useful for programs unable to provide clinical experiences in this area. The curriculum includes goals and objectives, milestones assessed, a detailed faculty guide and slides for each session, pre- and post-tests, case examples, and references.

Included among the AADPRT resources are training manuals and curricula from Boston University and Loyola University that describe their clinical rotations, with Boston University materials including milestones-based objectives. The Yale Telemental Health training materials describe the telemental health rotation and competencies, and include evaluation forms and references.

An AADPRT Model Curriculum focusing on collaborative care is also publicly available on the website for the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) website (Ratzliff and Basinski, 2014). This curriculum is used as part of a PGY4 elective collaborative care rotation and provides background readings, didactic sessions with slides, faculty guides, and discussion points. Elements of this curriculum can be used for didactic sessions in programs without integrated care clinical experiences or with clinical rotations that do not include a population-based care component, to teach basic knowledge and skills in collaborative care.

Other approaches to didactic teaching already in place in programs with integrated care rotations include lunchtime, pre-clinic, or post-clinic teaching sessions, case conferences, and/or journal clubs focusing on topics in mental health and primary care medicine. These teaching sessions frequently involve trainees from different disciplines (e.g. psychiatry residents and fellows, residents from primary care or other specialties, trainees from other mental health fields). Some programs have psychiatry and primary care residents teach each other. Other teaching methods include sessions about integrated care within core residency didactics, online modules, and the Loyola University Integrated Care Grand Rounds.

Most supervision in integrated care rotations is provided by psychiatry faculty members, most of whom are physically present in the clinic with the resident. An early study of co-located rotations showed that resident satisfaction was greater when there was a faculty psychiatrist supervisor who had already been working within the clinic as a consultant, and who could provide not only clinical case supervision, but also guidance regarding the administrative, practice style, and interpersonal challenges involved in working as a psychiatrist in primary care settings (Cowley, et al, 2000). Residents providing primary medical care, telemental health services, and population-based collaborative care require a high level of supervision by faculty members with expertise in these areas.

Administration, Funding, and Leadership

In the AADPRT survey (Reardon, et al, 2014), respondents were queried about funding for faculty supervision time, with multiple responses regarding funding sources allowed. Fifty-two percent reported funding by psychiatry departments, 43% by billing revenues generated in the integrated care

clinic, 22% by the primary care or other department, and 17% by grants. Several programs included in the AADPRT compendium of example programs and rotations reported a transition of funding from initial grants to intermediate sources of funding through their own or other departments, with an ultimate goal of sustainability through clinical or other billing. Common sources of funding for rotations were the VA and FQHCs. One population-based collaborative care service and rotation was funded by a state contract.

Administration and leadership of integrated care rotations for residents most commonly lies with the residency program director and faculty members supervising the rotation. However, multiple programs commented on the importance of enthusiasm at the level of the other department, leaders and staff of the particular clinic, psychiatry department leadership, the institution, and the Graduate Medical Education (GME) Office, both for integrated clinical services in general and for including psychiatry trainees.

Challenges

Multiple challenges to the success of integrated care education have been mentioned in the literature and in the surveys described above (Kates, 2000; Cowley, et al, 2014; Yudkowsky, 2000; Dobscha and Ganzini, 2001; Cowley, et al, 2014; Reardon, et al, 2014; Burke, et al, 2014; Annamalai, et al, 2014). Chief among these have been sustainable financial support, especially for indirect consultation not involving direct face-to-face patient interactions; finding time in the psychiatry residency curriculum; acceptance of this care model by primary care providers, staff, and psychiatry faculty and trainees; availability of qualified psychiatry faculty supervisors; and finding office space within busy primary care settings.

Funding for faculty supervision time has been a major issue, given the patient case mix, no show rate, and poor reimbursement for mental health services in many of these settings. With parity of mental health care reimbursement and the requirements for mental health services within patient-centered medical homes and ACOs, reimbursement for faculty time through billings or by the institution may improve. It is particularly important that psychiatrists working in integrated care be reimbursed for the indirect consultation involved in collaborative care and for telemental health services. The demonstrated cost-effectiveness of collaborative care (Katon and Unutzer, 2011; Katon, et al, 2005) will help to argue for such support at a health system level.

Currently, the ACGME does not require experience in integrated care for psychiatry residents or fellows. It may be difficult to incorporate a new rotation into the residency or fellowship curriculum without such a requirement, given competing demands for trainee time and clinical experiences. Interestingly, the Canadian Psychiatric Association and the College of Family Physicians of Canada have a longstanding partnership in support of collaborative mental health care (Kates, et al, 2011). The Royal College of Physicians and Surgeons of Canada now requires that psychiatry residents

spend a minimum of eight weeks in collaborative projects, ideally in primary care.

Many AADPRT members who reported implementing integrated care rotations discussed barriers related to acceptance of integrated mental health care by providers and staff. These included initial lack of enthusiasm for having psychiatrists and/or psychiatry residents in their clinic, a wish to just refer patients to psychiatry and have the psychiatrist assume care of the patient rather than managing mental health problems collaboratively, and issues of lack of office space and differences in scheduling. Some programs reported resistance from psychiatry residents, who preferred ongoing treatment of patients in their outpatient clinic practice to a consultative model. It may be difficult to find qualified and interested psychiatry faculty members to supervise rotations.

Rotations teaching residents to provide preventive and primary care to psychiatric patients are even more difficult to implement, given the need for both psychiatry and primary care faculty supervisors or dually-trained faculty and the fact that most psychiatrists, including faculty attendings, do not view medical care of their patients as part of their practice. Although it appears clear that psychiatry residents should be educated to ensure adequate medical screening and care of their patients, it is far from clear how such education should be delivered and what the expectations of psychiatrists should be. One study showed enhanced medical care and outcomes of chronically mentally ill patients with the incorporation of nurse care managers to facilitate referrals to primary care, provide health education, and coach patients in communication with primary care providers (Druss, et al, 2010). In models like this, psychiatrists would not need to deliver primary medical care, but would still need to recognize and screen for medical conditions requiring referral.

Graduate Medical Education Conclusions

Significant numbers of general psychiatry and child and adolescent psychiatry residency programs are now offering rotations and/or didactics in integrated care. Rotations primarily involve co-located psychiatric consultation in primary care clinics, but in some cases include consultation in other medical/surgical clinics, population-based collaborative care, telemental health consultation, or delivering primary medical care for psychiatric patients. The VA and Federally Qualified Health Centers often have integrated mental health services amenable to psychiatry residency training. Most rotations are for senior residents or fellows who already have familiarity with and skills in both outpatient and consultation-liaison psychiatry. Multidisciplinary didactics, case conferences, and journal clubs can provide teaching about and modeling of a collaborative, integrated approach and give residents opportunities to teach trainees in other fields. There are also curricula about integrated care that can be used by programs unable to offer integrated care rotations. Integrated care didactics and clinical experiences can be used to assess and meet multiple Psychiatry milestones.

Challenges to integrated care education include finding sustainable funding for faculty supervision time, competing demands for resident time since integrated care education is not required by the ACGME, the need for acceptance of novel care delivery models by faculty and trainees in both psychiatry and primary care, finding qualified psychiatry faculty supervisors, and logistical issues such as office space.

CONTINUING MEDICAL EDUCATION (KRISTIN MOELLER, MARK RAPOPORT, M.D., MELINDA YOUNG, M.D.)

There is a continuing medical education learning gap for psychiatrists, and physicians in general, about collaborative practice, consultation/integrated models of care, and types of team-based care. Up until very recently, solo practice was the primary practice model emphasized in many residency training programs. Thus, neither experienced practitioners nor newly trained psychiatrists are familiar with the new models for health care delivery and/or reimbursement. The learning gap includes both an understanding of the evolving models of care and the skills and tools necessary to be successful in the new clinical settings associated with collaborative practice.

Current State of CME on Integrated Care

There have been a number of important recent developments that have moved the current state of CME forward. The SAMHSA-HRSA Center for Integrated Health Solutions contracted for a set of integrated care and workforce core competencies that would reinforce or enhance the basic competencies of each discipline. The Core Competencies for Integrated Behavioral Health and Primary Care (http://www.integration.samhsa.gov/workforce/Integration_Compencies_Final.pdf) is a useful launching point for determining what psychiatrists need to know now and will need to know in the future when integrated care systems become more established. The recommended competencies include: interpersonal communication, collaboration, and teamwork, screening and assessment, care planning, and care coordination, intervention, cultural competence and adaptation, systems-oriented practice, practice-based learning and quality improvement and informatics.

The APA has taken a lead in developing CME on Integrated Care. A recent issue of *FOCUS: Journal of Lifelong Learning in Psychiatry* was on Psychosomatic Medicine and Integrated Care in Fall, 2013, with Deane L. Wolcott, M.D. as the Guest Editor. The APA Department of Healthcare Financing developed the Healthcare Financing Seminar on Healthcare Reform and Integrated Care in Fall, 2013. This training program brought representatives of District Branches up-to-date on this topic with the goal of stimulating District Branches to present the seminar curriculum to their members at local meetings. Primary Care Updates for Psychiatrists, a course chaired by Lori Raney, M.D., with presentations by dual-boarded med-psych physicians was presented at APA meetings and then

produced as an Online Course in November 2013. The topics included: Basic Preventive Medicine; Diabetes; High Blood Pressure; Dyslipidemias; Smoking Cessation.

The APA presidents and the Scientific Program Committees of APA meetings have made integrated care a focus. The integrated care tracks at recent Annual Meetings and Institute on Psychiatric Services meetings have included sessions on clinical information, as well as information about collaboration models, systems, and patient risk.

The APA has studied other continuing medical education providers and has determined that CME providers with a large multispecialty audience such as Medscape are in a strong position to offer multidisciplinary and multispecialty continuing education since their learner group is not specific to a specialty. For example, the *Journal of Clinical Psychiatry* publishes a Primary Care Companion for CNS Disorders, a web-based, peer-reviewed, abstracted publication for primary care physicians and other health care professionals.

Although the audience for most continuing medical education programs of American Psychiatric Association is primarily psychiatrists, the Division of Education has begun to make a concerted effort to disseminate its educational products to other fields in order to further the integration of psychiatric knowledge into other specialties. One innovation is that the DSM-5 online course provides credit to most mental health disciplines. Earlier this year, APA worked with the American Association of Physician Assistants (AAPA) to add AAPA credit to physician assistants for APA's Maintenance of Certification (MOC) programs, FOCUS, and APA Performance in Practice Modules.

Challenges

There are some significant challenges in developing CME materials on integrated care. First, there are regional differences in the rate that integrated care models are being introduced. Because the penetration of these care models is limited at present, and focused in a few regions and settings, there is limited motivation and interest among practicing psychiatrists. Second, since integrated care is relatively new, many different models of integrated care are being promulgated. There is substantial convergence in the work of the leaders of the field, but the terminology, best practices and evidence are still emerging.

Third, there is a lack of alignment between MOC requirements, Joint Commission requirements, and what psychiatrists actually need to learn and incorporate into their practices to prepare for the transitions in healthcare. Both the ABPN, through measures of Performance in Practice, and The Joint Commission, through Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), require the assessment and documentation of psychiatrists practice, but at this time the two processes are not synchronized. Thus, the clinician must engage in two separate practice reviews in order to fulfill these related but not identical requirements. Unfortunately, neither of these processes is currently designed to help psychiatrists assess

the skills they need to develop to be successful leaders in integrated medicine. There is an opportunity to create a better coordination between Performance in Practice assessments, OPPE and FPPE in order to better meet the need of busy clinicians.

Finally, the electronic medical record may represent an obstacle to the development of integrated care because many psychiatrists still employ paper charts, and many electronic medical record systems either do not contain a module for psychiatry or have a poorly developed one.

Recommended Content of CME Programs on Integrated Care

Raney L, et al (2013) recommended the following essential components for CME Programs on integrated care:

- Understanding of new models of care and encouragement for additional training.
- Updating the knowledge base and skill set in the treatment of common medical conditions to enhance work in collaborative settings.
- Learning how to use rating scales to track progress and adjust treatment when goals are not being met.
- Focus on leadership skills and team building to prepare for new psychiatric roles.

Conclusions:

Psychiatrists recognize the need to learn about integrated care and want the field to develop “user friendly” MOC and Lifelong Learning products to educate them about this new area. APA has taken the lead in this area and developed many valuable programs. There are a number of barriers to the creation and implementation of these products aside from the usual challenges faced by the busy practitioner of time and cost. These include the rapid evolution of the field, the lack of alignment among the various accrediting agencies to which practitioners are subject, and the inadequate integration of psychiatric modules into electronic medical record systems.

INTER-SPECIALTY AND INTER-PROFESSIONAL EDUCATION AND TRAINING (JUSTIN KUTTNER M.D., KRISTIN KROEGER)

Educational Collaboration with Other Specialties

Primary care doctors have risen to the challenge of treating behavioral health problems and this trend has accelerated because more Americans are seeking care following the passage of the ACA and there is a marked shortage of psychiatrists. But, few feel they have adequate clinical training or knowledge about mental health care, including an understanding of the system of care. Collaborative practice models have arisen to meet these needs, but education of psychiatrists about collaborative practice is done almost entirely by psychiatrists and there has been little involvement of primary care physicians, or their organizations, in the process.

These realities presented a clear opportunity for APA to be a leader in establishing cross-educational opportunities for

psychiatrists and primary care physicians during residency and throughout their careers. In June 2014, APA convened a meeting with the American Academy of Family Practice (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and the American Academy of Obstetrics and Gynecology (ACOG) to begin discussions about what these organizations are doing to educate their members about mental health treatment and integrated care models, and consider how APA and these organizations can collaborate on joint education activities.

It became clear at the meeting that all of the national organizations recognized the importance of residency education about mental health care. But, it was also clear that there was little collaboration across organizations in developing educational interventions. They affirmed the need for clinical rotations for their residents in both inpatient and outpatient psychiatric centers and continued exposure to psychiatric diagnosis and management through resident continuity clinics. Some are providing CME activities. AAFP offers a course on behavioral interventions for office-based care along with other educational modules on mental health issues in primary care and family practice. AAP created curricula on behavioral health for training directors and has worked with the American Academy of Child and Adolescent Psychiatry (AACAP) on a number of advocacy initiatives; this has led to the development of a course on psychopharmacology for primary care doctors that is presented at both at AACAP and AAP annual meetings.

The American Academy of Pediatrics has a toolkit for pediatricians on mental health problems along with other materials. The American College of Obstetricians and Gynecologists (ACOG) has materials on 180 topics in mental healthcare for their physicians. Some specialties have developed integrated care programs for specific disorders, such as COPD, or depression and diabetes.

APA's education products in this area include packaging online programs for primary care physicians from presentations at the Institute on Psychiatric Services and planning a pre-annual meeting event for primary care physicians. Neither of these activities has been substantially successful in reaching the appropriate audience. However, the Performance in Practice tools on substance use disorder, depression, and suicide and an eFOCUS program on Understanding the Evidence: Off Label Use of Atypical Antipsychotics are APA products that would be useful for primary care physicians, but these are not currently marketed to them.

The major lesson learned from the meeting of primary care specialty organizations was the importance of working hand-in-hand with other organizations to develop educational content. Materials that are authored in collaboration with primary care physicians, rather than repackaged and marketed to them, may be more effective. APA may have an important coordinating role in developing these educational initiatives. Presentations at each other's annual meetings, focusing on multiple areas such as psychopharmacology,

diagnosis of specific disorders, management of mental health issues within a practice and when to refer, and service delivery and collaborative care models, would be a good start. For training directors, joint presentations at each other's training directors meetings, and shared and co-authored curricula would be desirable. Although there is an uneasiness and sometimes confusion among each organization's members about recertification demands, there might also be an opportunity for coordination between specialty boards for approved maintenance of certification products to ensure this is a part of primary care physicians' life-long learning.

Inter-Professional Education

Government, accrediting organizations, and health care delivery systems have placed increasing emphasis on developing curricula to change the way health professionals are educated and trained. Nurses, physicians, psychologists, social workers, other behavioral health clinicians, physical therapists, and speech therapists must learn together if they are to understand each other and work together in a meaningful way. As our health system transitions from a subdivided, fee-for-service system arranged around medical specialties to a more integrated, value-based, and patient-centered system oriented around a patient's specific disease process, increased coordination of care and inter-professional collaboration will be critical to both improving the quality of care and decreasing the cost of managing a population of patients.

To meet this need for coordination and collaboration within our health care system, inter-professional education is seen as one of the critical workforce solutions. If these future health care professionals do not learn together, how will they be able to work together? According to the World Health Organization (WHO, 1988), inter-professional education occurs when students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Inter-professional education is a necessary step in preparing a "collaborative practice-ready" health workforce that is better prepared to respond to local health needs. The Institute of Medicine (IOM, 2003) declared that "health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team." The IOM, as well as many other organizations, have stated that patients receive safer and higher quality care when health care professionals work effectively in a team, communicate productively, and understand each other's roles. While an abundance of evidence exists supporting the need for inter-professional education in health professions schools, it is unfortunately not the norm in most health profession educational programs.

The Liaison Committee on Medical Education (LCME) has finalized standard ED-19-A which states that "The core curriculum of a medical education program prepares medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the

other health professions" (LCME, 2014). It is not enough to think about collaboration and integration within the "house of medicine," but medical students must also be exposed to the other traditionally silo-ed professions such as nursing, respiratory therapy, and occupational therapy amongst many others. The LCME's primary rationale, like that of the WHO and IOM, is ensuring improved patient outcomes, enhanced safety and quality of care.

Psychiatry may be in a natural position to become a leader in inter-professional education within medical schools. Students rotating on an inpatient unit or in an intensive, wrap-around outpatient program are directly exposed to the range of mental health professionals required for the optimal care of a sick individual. For example, case managers are uniquely positioned to teach medical students about the important social determinants of mental health and they can offer insights on how psychosocial interventions can help address these key factors.

Conclusions

Inter-specialty and Inter-professional collaboration will need to be a priority across the continuum of medical education. The integrated care model rests on collaboration among healthcare professionals, cross-fertilization of medical knowledge across specialties, shared technology platforms and new approaches to collecting empirical data. Education about collaboration and collaboration in education will surely improve these essential components of care and specific recommendations about this are found below.

CONCLUSIONS AND RECOMMENDATIONS (RICHARD F. SUMMERS, M.D., JOHN Q. YOUNG, M.D., SANDRA SEXSON, M.D.)

We strongly recommend educating psychiatrists about integrated behavioral health care and responding to the need to train a generation of physicians who can take on clinical and advocacy roles in integrated care. Further, we conclude that all components of the psychiatric education continuum will need to examine their current practices and consider how to incorporate integrated care models and techniques into didactic and clinical training in order to meet this need. We anticipate building excitement and enthusiasm around these new models and developing psychiatrists who are both competent and confident in the provision of these new models of care. We recognize that our conclusions and specific recommendations reflect the view from 2014, and know that we will learn much from greater experience with integrated care models and educating students and practitioners for these roles. These recommendations will surely need to be updated with that additional experience.

The impetus for system change provided by the Affordable Care Act and the impressive data supporting the improvement in cost effectiveness, quality of care and the increased access provided by integrated behavioral health care (especially the collaborative practice model) make this a propitious time for

psychiatry to assert its importance in the health care system. To do so, we will need well-trained psychiatrists who are conversant in working in integrated care settings to advocate for well-designed care systems and then staff them when they are created. In most healthcare systems, we are struggling with the “chicken and egg” problem of waiting for reimbursement reform while wishing to create integrated care systems to address current needs and be ready to take advantage of changes in financing when they do take place.

Before discussing specific recommendations for UME, GME, and CME programs, we will first describe four tensions that must be addressed by educational programs: psychiatric basics versus the new model, culture versus techniques, early versus late, and didactics versus experiential. Each educational program and each institution will surely find their own local responses and solutions to these tensions.

First, there is a tension between the “nuts and bolts” psychiatric skills involved in all direct patient care, including rapport-building, diagnostic interviewing, treatment planning and implementation of biopsychosocial treatments, and the population-based care skills of screening, health maintenance, interdisciplinary collaboration with each clinician providing care “at the top of his/her license,” and consultation with and without direct patient contact. No matter how pervasive the development of collaborative practice models, psychiatrists will need substantial experience in direct patient care with longitudinal follow-up, using a wide variety of treatment modalities, including general psychosocial management, psychopharmacology, and psychotherapy.

Medical students will need to learn the fundamental skills of psychiatric care along with their application in integrated care systems. Residents must hone their ability to provide the nuanced diagnostic assessment and multi-modality treatment that some complex patients require. Continuing medical education will be required to help practitioners learn new knowledge about illnesses and their treatment, and refresh their basic medical skills. We expect that integrated care practice will grow substantially, but there will likely continue to be specialty psychiatric clinics, single modality care settings, and private practice care. We must make sure that psychiatrists learn the essential knowledge and skills of our specialty, both broadly and deeply, at the same time that they learn how to deploy those skills in evolving new care settings.

Second, integrated care is both a care model and a set of specific techniques. The attitudes and culture of integrated care involve collaboration, shared responsibility, and more flexible roles for psychiatrists. Education about integrated care must reflect this. Immersion in settings with clinicians who live and breathe these values and have this vision of healthcare is essential. At the same time, the specific techniques of integrated care, including screening tools, decision support software, registries, and educational interventions for patients and other clinicians, are required to make this model work. On each level of the educational continuum, attention will be required to both the model and the tools.

Third, there is a tension between early and late educational attention to integrated care. Medical education is necessarily developmental, and early introduction to ideas leads to increased interest and salience, but simpler ideas and skills are the building blocks for more complex ones. While early introduction to integrated models for medical students will bring early attention to the importance of collaboration, interdisciplinary communication, population-based thinking, and new important roles for psychiatrists, students must understand psychiatric illness and treatment in order to appreciate the problems the system is designed to treat. Residents will be more respected, and will function with greater confidence in collaborative and interdisciplinary roles when they have the knowledge and confidence about psychiatry to bring to their work. If exposure to integrated care is too late, the “cake is already baked” and trainees are less open, but if it is too early there may be a loss of attention to direct care skills.

Finally, learning about integrated care requires both didactic attention and clinical experience. It is important to understand the evidence supporting the approach, the rationale for the model, and learn about the essential techniques. Of course, actual clinical experience is critical to learning about how integrated actually works. Because it is efficient and fast-paced, the opportunities for real time teaching will have to be planned for and protected. Trainees will need exposure to the ideas and immersion in the integrated care system to fully develop their skills.

Recommendations

We recommend the following steps, taking into account the four tensions we have just described, for educational programs and for the American Psychiatric Association.

Undergraduate, Graduate and Continuing Medical Education programs should:

- 1) Develop new learning experiences across the medical education continuum that promote the development of knowledge, skills and attitudes necessary to advocate for and provide integrated behavioral healthcare.
- 2) Make use of the existing resources in this area (referenced throughout this document) to develop new curricula and rotations organized around the specific care settings available, and study the effectiveness of these educational interventions with the goal of improving pedagogy about integrated care.
- 3) Emphasize inter-specialty and inter-professional education to help trainees and practitioners develop the attitudes and skills necessary for collaborative practice.

Undergraduate Medical Education programs should:

- 1) Promote a view of medical care, including integrated behavioral health care, as a collaborative, inter-specialty and inter-disciplinary enterprise through the creation of didactic content and early pre-clinical exposure to role models and care systems.

- 2) Develop early clinical exposure to primary care settings with effective integrated behavioral health to the extent it exists in the available clinical learning settings.
- 3) Develop clinical case material and simulation experiences that emphasize medical-psychiatric co-morbidity.
- 4) Engage medical students in a range of activities designed to improve inter-professional and inter-disciplinary communication, beginning in the pre-clinical years, to promote the development of interpersonal and teamwork skills. This should include didactics that emphasize cross-system understanding of pathology, interdisciplinary collaboration and collaborative service delivery.
- 5) Develop integrated care clinical experiences as part of the Psychiatry Clerkship, when possible, utilizing effective teaching sites where residents, fellows, and attending psychiatrists experienced in integrated care are working.
- 6) Share experiences about the use of already developed educational resources to promote best use of existing materials, and develop new educational materials for medical students about integrated behavioral health care.
- 7) Support innovation in rotation design, especially in settings offering integrated behavioral health, and study the educational outcomes of these experiences. Programs should consider the potential for longitudinal educational experiences, which by their nature involve interdisciplinary and inter-specialty collaborative experiences.
- 8) Include the psychiatrist's role in integrated behavioral health care in discussions about physician career choice in recruitment activities.

Graduate Medical Education programs should:

- 1) Develop a comprehensive four-year developmental sequence of educational experiences to prepare residents to provide psychiatric care in integrated settings.
- 2) Create a didactic experience in integrated care, probably in PGY3 or PGY4 year of residency. A minimal educational experience for a residency would probably be a didactic experience in the later years of the residency.
- 3) Engage residents in a range of activities designed to improve inter-professional and inter-disciplinary communication, including didactics that emphasize cross-system understanding of pathology, shared clinical case conferences and Grand Rounds, and collaborative service delivery.
- 4) Provide clinical experience in recognition of and management of common medical conditions, metabolic side effects of psychopharmacologic treatments, causes of early mortality in patients with psychiatric illness, motivational interviewing, and lifestyle interventions such as smoking cessation, and techniques for psychiatrists to ensure adequate primary medical care for their patients.
- 5) Identify and develop faculty members with interest and experience in integrated behavioral health care to teach

didactics, supervise residents, and advocate for collaborative practice in the institution.

- 6) Focus the majority of clinical experiences regarding integrated care later in the residency when trainees have developed core psychiatric skills.
- 7) Plan clinical experiences for residents and fellows that arise organically out of existing integrated care settings, rather than attempting to graft rotations for trainees onto clinical services that are functioning without behavioral health input. Co-location, improved primary care and telemedicine settings may be more available in some institutions currently, while collaborative practice models are less prevalent but expanding. Programs should look to the VA Health Care System, Federally Qualified Healthcare Centers and primary care settings for current clinical learning opportunities and anticipate that more rotation sites will likely develop with further health care system change.
- 8) Use existing online AADPRT resources on integrated to develop curricula and clinical experiences.

Continuing Medical Education programs should (specific recommendations for the APA regarding CME are in the next section):

- 1) Develop tools that help practitioners assess whether they have the knowledge to be successful in the new health care environment.
- 2) Focus on the components of integrated care that are knowledge and skills-based, such as supporting evidence base, screening tools, and registry technology.
- 3) Develop materials across the range of integrated behavioral healthcare including providing consultation in the primary care setting and addressing the health status of the SMI population.

The American Psychiatric Association should:

- 1) Continue to champion the integrated care model through advocacy for reimbursement reform to facilitate population-based care, educational outreach efforts, and development of systematic outcome data collection.
- 2) Pursue partnerships with other specialty professional associations, including the American Psychological Association, to advocate for reimbursement reform to support integrated care.
- 3) Serve a catalyzing role in promoting communication and collaboration among primary care specialty organizations and continue to promote inter-specialty educational planning meetings. This includes supporting cross-presentation at national meetings and training director collaborations across specialties.
- 4) Serve a catalyzing role in promoting communication and collaboration among mental health professional organizations to promote inter-professional education.

- 5) Continue collaboration among Councils working to promote integrated behavioral health care, including the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing.
- 6) Develop and publicize new CME materials about integrated care on an ongoing basis, and:
 - a. Include materials about caring for the health status of the SMI population.
 - b. Focus on the components of integrated care that are knowledge and skills-based, such as the supporting evidence base, screening tools, and registry technology.
 - c. Include an advocacy focus to support practitioners working in systems that may be considering evolution of service delivery toward this model.
 - d. Create tools that can help practitioners assess whether they have the knowledge to be successful in the new health care environment.
- 7) Update the APA website and provide ample resource materials regarding integrated care, including educational resources and career planning information.
- 8) Encourage American Psychiatric Publishing to continue to find authors and develop publications on the topic of integrated care.
- 9) Continue and expand the Integrated and Collaborative Care Track at all APA meetings and insure that a range of topics are covered to provide regular presentations on new research in integrated care.
- 10) Provide training about integrated care to members through the District Branches.
- 11) Support flexibility in timing of the four-month primary care requirement in residency to allow for rotations past PGY1 year to count toward the requirement.
- 12) Advocate for increased inclusion of integrated care skills in the Psychiatry Milestones at the next opportunity for revision.
- 12) Consider the feasibility of collaborating with representatives from the ABPN and The Joint Commission to determine the potential for reconciliation of expectations about the monitoring of psychiatric practice when psychiatrists are part of integrated care systems.
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