Residency/Workforce Training
A Model for Integrating Education into Co-Location

Karen Blackman, MD
Maureen Moloney, LMSW, ACSW
Amy Odom, DO
Julie Phillips, MD, MPH
Amy Romain LMSW, ACSW
George Smith, MD
Objectives

• Describe gaps in primary care and psychiatry in our community

• Understand how residency requirements and workforce needs create opportunities to collaborate and address the gaps in care of underserved

• Understand a model for integrating education into colocation
Agenda

• Needs
  – Primary Care Gap, Mental Health Care Gap and Educational Gap

• Project to address those needs

• Future Directions

• Discussion
Medical Care

Psychiatric Care

Patients with Mental Illness
Patients with Mental Illness

MEDICAL GAP

CMH

PSYCH RESIDENCY

PRIVATE PSYCHIATRIST

ED

PRIVATE PRIMARY CARE

PSYCHIATRIC GAP

ICHDP CLINIC

FM RESIDENCY
Primary Care Gap
Health Issues for Persons with Mental Illness

• Compared to the general population, persons with major mental illness typically lose more than 25 years of normal life span from preventable conditions  (Parks, 2006)
Health Issues for Persons with Mental Illness

• Access to health care is limited due to:
  – Limited income
  – Overuse of emergency and specialty care
  – Complications of mental illness
  – Significantly lower rated of primary care
  – Significantly lower rates of routine testing
  – Very poor dental care
  – Little integration of primary care and psychiatry

(Parks, 2008)
The Psychiatry Gap
The Need

• Mental disorders are the leading source of disability in the U.S.
• 1:4 adults suffer from a diagnosable mental disorder in a given year
• Less than 1/3 of them receive treatment!
Shortage of Psychiatrists

• Nearly 55% of psychiatrists are over age 55 or older
• Declining number of psychiatry training programs and psychiatry graduates over past decade
• Percentage of psychiatrists providing care to Medicaid patients is declining
• Limited availability of mental health services for patients with low incomes
Additional Access Barriers

• Stigma
• Insurance/Cost
• Transportation
• Appointment scheduling
• Office policies

The one medical specialty where the sicker you are, the less likely you are to see a specialist (except if sick enough to be at CMH)
Mental Health in Primary Care

- 70% of all primary care visits are driven by psychological factors
- 80% of patients with depression initially present with a physical symptom
- At least 50% of all mental healthcare provided by PCPs
  - 41% of antidepressants are prescribed by PCPs

Surveys show < 20% receive AHRQ recommended guidelines for “minimally adequate treatment”
Standing in the Gap: Family Medicine

+ Biopsychosocial approach
+ Continuity
+ Trust
+ Easier Access
+ Collaboration

- Knowledge/skills
- Time demands
- Resources/support
- Reimbursement
Educational Needs

Create opportunity to address both psychiatry and primary care gaps
Common Training Requirements

• FM and Psychiatry training programs share common curriculum
  -- Community medicine
  -- Human behavior and mental health
  -- Communications skills
  -- Systems-based practice

• Community medicine and systems-based practice components challenging to meet

• Urgency to adequately meet increased by new FM program requirements (2014) emphasizing linkage of community medicine/community mental health
• American Psychiatric Association had as their primary initiative in 2011-2012 the promotion of integrated care (primary care and psychiatry)

• FM and Psychiatry training programs (ideally working together) positioned to create/join community collaboratives designed to bridge identified psychiatry, primary care, and educational gaps
Preparing a Workforce for 2014

• Mismatch exists now regarding ability to address psychiatry needs of primary care patients and primary care of psychiatry patients
• As in geriatrics, primary care forced to provide complex mental health services, often in isolation
• Even more patients will be seeking care due to 2014 Affordable Care Act triggers
• Dwindling number of primary care and psychiatry trainees and training opportunities
  – Medical school class sizes increasing
  – Federal GME infrastructure and funding remains threatened
  – Medical students continue to prioritize more “attractive” specialties/subspecialties

• Need to strategize ways to leverage available primary care and psychiatry caregivers to spread skills and talents of both further
• Need to promote educational training models emphasizing collaborative, integrated, team care in order to demonstrate “doability” to learners

• Collaborative learning begets a collaborative workforce
The Project
Purpose: Address the Gaps

- To provide primary care for patients with severe and persistent psychiatric illness at CMH
- To provide psychiatry care for SFMRP FHC patients (Mason and Central) who don’t have access to psychiatry
- To educate family medicine residents, psychiatry residents and associated residency faculty about interprofessional teamwork for shared patients
Lansing Community BIRCH Project

Building Interprofessional Relationships for Community Health
CMHA of CEI Counties

- Serving Clinton, Eaton and Ingham Counties
- In FY 2011/2012, served 10634 consumers
- Of the 10634 consumers served in FY2011/2012, 5143 were served by Adult Mental Health Services (AMHS), the department serving persons with serious mental illnesses
CMHA of CEI Counties

• Commitment to improving the lives of consumers, including their health outcomes
• Commitment to provision of services through interdisciplinary teams
• Dedication to training for Psychiatric Residents, MSW interns, Nursing students and other professional disciplines
• Commitment to hiring persons with lived experience as treatment team members
CMHA Initiative with the ICHD

• In 2009, on a contract with the Ingham County Health Department, AMHS began providing mental health services in three ICHD FQHC sites

• Three Mental Health Therapists provide over 2000 units of service annually to over 600 patients in these three sites

• Four hours of weekly consultative psychiatry services are provided in the Adult Health Clinic of the ICHD; added November 2011
Addressing the Medical Gap
Consensus was that while working to gain approval for an FQHC look-alike at CMHA, the ICHD Mobile Medical Vehicle (MMV) would begin seeing patients at the CMHA main location for two half days a month.

Primary care would be provided by Sparrow Family Medicine Residents; Clinic staff (MMV) by ICHD and Psychiatric RN staff by CMHA.

In June 2012, the first clinic was held!
BIRCH Project
Building Interprofessional Relationships for Community Health

• Clinics are going very well!
• Through September 2012, 8 clinics were held
• During the 8 clinics, 23 patients were seen for initial visits
• Seven patients have been seen for follow up visits (two for more than one follow up)
• 6 no-shows
• Overall success: Of the 38 appointments scheduled, 32 appointments were kept for an 84.2% show rate!
FM Residency Experience

Primary Care Clinic at CMH
Residency Workforce

• Faculty: Julie Phillips, MD, MPH and Cheryl Doane, DO
• Residents: 2\textsuperscript{nd} and 3\textsuperscript{rd} year family medicine residents
• Cover consecutive clinics
• Cover ½ day twice a month
Positive Attributes

• Patients are clinically interesting and in clear need of basic primary care
• Residents exposed to a pt population that is more mentally ill and socially disadvantaged than usual patients
• Residents experience high level of staff support from nurse/social worker/MA
• Residents not doing mental health care
Challenges

• Lack of continuity between resident and patient
• Limited supplies and physical space limits scope of services and feels constraining
• Building family medicine faculty support (“we already see enough mentally ill patients”)
• New and different EMR
FM Residency “Rules”

• Residents need to have faculty oversight (4:1 ratio max)
• For graduation residents must meet minimum number of patients seen in their office setting
• Emphasis on continuity
  → BIRCH Clinic does not replace residents primary continuity clinic but is in addition to it
Resident Feedback

• “The problems we faced were those of homelessness and poverty... this is a field we should all have some experience in. It can be frustrating at times... but this will help us learn how to practice with limited resources.”
  - 3rd year Family Medicine resident

• “The staff who has worked with [the patients] before was so invaluable and helpful in knowing where resources are located and their sheer presence placed the patient at ease. I think this population often does not trust a lot of people, especially in healthcare, but having the staff present... made them very comfortable and more trusting of us.”
  - 2nd year Family Medicine resident
Resident Feedback

• They (the patient population) are like any other patient, sometimes it's hard to make them focus on the problem at hand because they have been through so much but they are cooperative ... But most of them were very appreciative of what we were doing.

  3rd year FM Resident

• I think what I gained from it is seeing pure untreated disease in a very unique population, starting from the ground up which we don't often do.

  2nd year FM Resident
Addressing the Psychiatry Gap
Current Psychiatry Resident Training

• See patients with severe and persistent mental illnesses at CMH
• See outpatients who are functioning well enough to come to the MSU Psychiatry Clinic
• Sessions tend to be dyadic and fairly long
  – Medication checks approx. 20-30 minutes
  – Initial evaluations commonly 1 hour or longer
• PASCA is outreach to primary care
Current Family Medicine Resident Training

• See many outpatients at the Sparrow Family Medicine Residency Health Centers with significant psychiatric illness
  – Depression, Anxiety, PTSD, Bipolar, and more
  – Many do not have access to psychiatry
  – Clinic payors = 35% Medicaid
  – Create longer more difficult visits in PCP office

• Our solution up till now, training FM docs in psychiatric interventions
Our Ideas

• Establish Psychiatry in Primary Care Clinic
  – Place to both serve and train psychiatry residents

• Promote short term interventions so that co-located psychiatrists can see more patients

• Train psychiatrists to do curbside consults, chart reviews, and work with care-manager so as dyadic care is not always necessary

• Spark psychiatry interest in this work
Partners in Addressing the Psychiatry Gap
MSU Psychiatry & Sparrow/MSU FMRP

1. MSU Psychiatry Residency
   – Provide psychiatry workforce for the clinic
   – Entertain changing the concept of psychiatry intervention
     • Short term stabilization (as done in PASCA)
     • Working in medical settings
     • Interventions without patient visits (in progress)
Residency Workforce

- Faculty: Karen Blackman, MD
- Residents: 2\textsuperscript{nd} and 3\textsuperscript{rd} year psychiatry residents
- Provide care ½ day per week
- Available by phone or email between patient visits (by family medicine physicians)
Partners in Addressing the Psychiatry Gap
MSU Psych & Sparrow FMRP

2. Sparrow/MSU Family Medicine Residency Program
   – Provides space (standard or slightly larger exam rooms with lots of chairs)
   – Refers psychiatrically needy patients
   – Bills for visits
   – Co-management
   – Makes time in day to collaborate (in progress)
Structure
Psychiatry in Primary Care Clinic

• Every Thursday morning
• 2 new psychiatry evaluations and one recheck visit
• Alternate between 2 Family Health Center sites (rural/urban)
• Psychiatry attending sees all patients with psychiatry resident
• 2 month resident commitment
Structure
Psychiatry in Primary Care Clinic

• Tools used to assess patients
  – PHQ-9, GAD-7, other PCP-friendly tools

• Collaboration strategies
  – Curbside and chart reviews
  – Algorithmic EMR notes
  – In progress: Huddle/face to face collaboration
Positive Attributes

• Patients with psychiatry problems are getting care at a place where they are comfortable receiving care
• Psych residents are seeing a population they don’t otherwise see
• Psych residents are getting an understanding for the problems and practice of the primary care physician
• Moments of collaboration have been dynamic and lively
Challenges

• Confidentiality/EMR issues
• Finding time for collaboration
• Building value in psychiatry culture for this endeavor - sustainability
• The complex social and economic problems of these gap patients
  – Less agency to create and sustain change
  – No caremanager currently (or only a nurse without interest in psychosocial)
  – Produces caregiver anxiety, even in psychiatrists
Psychiatry Resident Experience

N-1.5
Resident Feedback
2nd year Psychiatry Resident

“I have never seen a patient this sick, in an outpatient setting, before”

“We are seeing patients in the gap...who wouldn’t make it to the psychiatry clinic”

“Highlights were those collaborative moments”

“It has been awesome...given me ideas of how to have integrated care so psychs can practice full patient medicine”
Resident Feedback
2\textsuperscript{nd} year Psychiatry Resident

• “Feels inefficient: Want to see the most patients and use the time well to help as much with consultation as we can”

• “No shows; no back up plan”

• “No formal time for curbside consults”
Future Directions
Future Directions

• Formalizing a time for FM and Psych Resident Collaboration at the Psych in Primary Care Clinic

• Caremanagers (RN/MSW)
  ✓ Important link in collaboration between psychiatry and primary care team
  ✓ Connection with community resources
  ✓ Mental health care management

• Psychotherapy services within the FHC’s

• Training social workers in the FHC’s
Future Directions (cont.)

- Increase collaboration between psychiatry and primary care providers at all sites
- BIRCH Center → FQHC Look-Alike
- More collaborative didactics for the 2 residency programs
- Sustainability
  - Identify champions
  - Institutionalize programs
Searching for Partnerships

• Psychiatry Residency Training Programs (6)
• Family Medicine Residency Training Programs (21)
• Other Opportunities?
Discussion