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Teaching Collaborative Care in Primary Care Settings for Psychiatry Residents

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Background: *Job descriptions for psychiatrists will change significantly over the next decade, as psychiatrists will be called on to work as caseload consultants to the primary care team.* **Objective:** *The purpose of this pilot study was to examine the effects of an American Association of Directors of Psychiatric Residency Training–approved collaborative care curriculum on caseload consulting skills among psychiatry residents.* **Methods:** *In 2014, 46 psychiatry residents (5 postgraduate year 1s, 10 postgraduate year 2s, 22 postgraduate year 3s, and 9 postgraduate year 4s) from 5 academic psychiatry residency programs in the New England area were given the 2-hour pilot collaborative care curriculum. Participants were asked to complete an anonymous survey at both the beginning and the end of the workshop to rate their comfort level in aspects of collaborative care psychiatry (7 items from SBP4 psychiatry milestones) based on a Likert scale (1—not at all, 2—slightly, 3—moderately, and 4—extremely). Paired t-test was used to examine the difference between pretest and posttest results of residents participating in the workshop.* **Results:** *The pretest mean score for the group was 2.9 (standard deviation = 0.44), whereas the posttest mean was 3.51 (standard deviation = 0.42), $p < 0.0001$. Only 15% ($n = 7$) of residents reported having some form of primary care or ambulatory specialty care consultation experience while in training.* **Conclusion:** *This brief collaborative care curriculum significantly improved resident confidence in milestone criteria related to population health and case-based consultations.*

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INTRODUCTION

The goal of providing access to high-quality care at a low cost requires a fundamental change in the way health care services are organized and delivered.[1] It is recognized that co-morbid behavioral health conditions such as depression contribute to increased disease burden and health care costs.[2] Given that more patients with behavioral health needs receive their care in primary care settings than in specialty psychiatric settings,[3] psychiatrists have an opportunity to work in primary care settings to help provide needed high-quality and low-cost care on a population level.[4]

Many approaches to integrating behavioral health care have been developed, but the strongest evidence currently exists for collaborative care.[5] This approach is different from the traditional consultation models found on consultation-liaison/psychosomatic medicine services because it is population-based and delivered in primary care settings. Collaborative care interventions are based on group information: systematic screening, active case identification, and patient registries. Direct patient care is delivered by a primary care provider and a behavioral care manager, using evidence-based algorithms. Weekly systematic case

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reviews by a psychiatric consultant and the care manager are provided for patients who do not improve on specified behavioral health outcomes (e.g., on the Patient Health Questionnaire-9).

As noted in a recent American Psychiatric Association report, the continuum of medical education must prepare physicians "to deliver this sort of patient-centered, team-based, measurement-based, and population-oriented care."[6] However, most psychiatry training programs do not have curricula teaching skills in collaborative care.[7–9] The experience at many programs with an "integrated care" option is typically either through a hospital-based consultation-liaison service or a psychiatric practice that is co-located with a primary care clinic. We believe that these settings do not allow psychiatric trainees to learn to approach care from a population health perspective or to incorporate measurement-based evaluations. To meet this educational need, we have developed a 2-hour curriculum that teaches these essential skills to trainees. For residency programs that do not have clinical settings to support collaborative care, this brief module can be used to provide an appreciation of population health with a focus on key integrated care skill sets, such as using validated instruments (e.g., Patient Health Questionnaire-9), provision of stepped care, and being a caseload consultant. The purpose of this article is to describe the results of the pilot curriculum in increasing competency among psychiatry residents in key areas of collaborative care.

METHODS

This American Association of Directors of Psychiatric Residency Training–approved model curriculum (and currently under peer review at MedEdPORTAL) was developed by the authors to teach principles of collaborative care while addressing several Accreditation Council for Graduate Medical Education Psychiatry milestones (SBP4). The learning objectives are described in Table 1. The curriculum contains a facilitator guide, suggested readings and videos to review before the session, 2 modules (60 minutes each) to explain the main concepts, and interactive clinical cases through which the residents learn to think and act like a psychiatric consultant in a primary care setting. Through the case simulations, they are encouraged to use the advantages of the collaborative care model while learning to recognize the limitations of practicing in such a setting. During the session, residents practice administering validated clinical instruments such as the Patient Health Questionnaire-9 for depressive disorders, Generalized Anxiety Disorder Questionnaire for anxiety disorders, and Composite International Diagnostic Interview for bipolar disorder.[10–12]

In 2014, one of the authors (H.H.) delivered this curriculum to 5 adult psychiatry residency programs in the New England area. Resident participants were asked to fill out an anonymous survey at the beginning and end of the workshop to rate their comfort level by applying the following aspects of collaborative care psychiatry: (1) Describes the difference between consultant and primary treatment provider, (2) describes differences in providing consultation for the system or team vs the individual patients, (3) provides consultations to other medical services, (4) clarifies the consult question, (5) assists primary treatment care team in identifying unrecognized clinical care issues, (6) discusses methods for integrating mental health and

TABLE 1. Learning Objectives for Collaborative Care Curriculum

Knowledge	Understand the case for collaborative care
	Understand the model of collaborative care and be familiar with the growing evidence base
Skills	Conceptually understand and be ready to use a population health perspective and validated scales in caring for patients
	Use screeners effectively to aid in diagnostic evaluation
	Recognize the basic elements and principles of collaborative care
	Perform psychiatric consultation
	Demonstrate increased comfort in communications with both care managers and primary care providers
Attitudes	Examine their own experiences and opinions of existing outpatient mental health systems while considering collaborative care psychiatry's potential for delivering more integrated and population-based care
	Be open to making a diagnosis in the absence of a direct assessment
	Integrate the patient's own and other providers' perspectives into a common understanding of the patient's problems and presentation