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New Ideas

Meeting of the Minds: A Novel Longitudinal Ambulatory Mental Health Rotation for Internal Medicine Residents

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Setting and Problem

Primary care physicians often are the first providers to encounter patients with undiagnosed or undertreated psychiatric illness, but they are rarely trained to competently evaluate and treat these patients. In addition, mental health resources are difficult for patients to access. Providing internal medicine (IM) residents with education and training in ambulatory mental health will better equip them with the competencies to address the needs of this complex patient population.

Intervention

We adopted a "2 + 4" immersion schedule for our primary care IM residency at Cambridge Health Alliance to provide more meaningful ambulatory training experiences. Residents rotate for 2 weeks in the ambulatory setting, alternating with 4 weeks in other inpatient settings and electives for all 3 years of training. This structure emphasizes longitudinal relationships with patients, a meaningful participation in our transformation to a patient-centered medical home and our focus on teamwork and community health.

Residents participate in a primary care continuity clinic at 1 of 3 busy, urban community health centers affiliated with our institution. Psychiatric comorbidity is common in our patient population. In an integrated model of care, staff psychiatrists, psychologists, and counselors work with primary care providers at each site to care for patients with comorbid psychiatric illness and addictions.

We developed a novel longitudinal mental health rotation for our first-year primary care residents which addresses the gap in mental health knowledge and skills for primary care IM residents. We worked closely with psychiatry leaders to align faculty resources and goals for the rotation. This work was facilitated by an existing structure of psychiatry providers who already practiced in the ambulatory sites where IM residents see their patients. Core goals and objectives for the rotation were developed collaboratively by IM and psychiatry faculty.

Outcomes to Date

For a full year, first-year residents work with a staff psychiatrist once a week at the resident's continuity clinic site. During this 4-hour session, IM residents participate in the care of patients referred to a consult liaison psychiatrist, and comanage each patient with the consultant. Time is set aside for case-based teaching that builds longitudinally throughout the year. The rotation enables trainees to refer their own patients to sessions with the psychiatrist. Importantly, IM residents are present for the mental health evaluation and contribute the medical perspective, as diagnostic and treatment strategies for each patient are evolving. Rather than seeing patients once in an acute phase of mental illness, as is the case in inpatient psychiatry rotations for IM residents, this

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rotation allows residents to longitudinally observe treatment, patient response, and the course of illness. The longitudinal nature of the rotation makes it a more meaningful experience for trainees who aim to practice primary care.

Our second cohort of 8 first-year primary care residents is currently participating in this mental health rotation. Residents who completed the first rotation of this type evaluated its overall quality as excellent (mean score 5.17 on a 6-point Likert scale), and believed the rotation was of high educational value and utility.

The supervised rotation provides a robust educational experience for residents, facilitates integrated care for patients, and promotes ongoing primary care-mental health collaboration.

Conclusions

We found our program's immersion schedule provides a facilitating framework for innovative, longitudinal care experiences with patients and for more meaningful educational engagement in outpatient medicine. We expect it also will reinforce resident development of humanistic practice toward patients with psychiatric comorbidity.

Plans are underway to document the program's effectiveness and to demonstrate feasibility for adoption by other residency programs.

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New Ideas

Defense of the Measures: A Tool for Engaging Integrated Care Teams in Outcomes Measurement

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Setting and Problem

Government agencies, insurance companies, health systems, and accreditors have developed numerous outcome measures that providers should consider and achieve. However, effective outcomes measurement faces barriers in teaching settings. In ambulatory practice, measurement tends to emphasize individual physician performance. This is problematic in ambulatory training practices, as residents are frequently absent for significant periods of time. In addition, measures selected are often chosen from outside the practice, and buy-in can suffer. This environment can lead to trainees and allied health providers accepting measures without critically analyzing what should be measured and why.

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Intervention

University of Cincinnati internal medicine residents rotate through a yearlong ambulatory long block, occurring from months 17 to 29 of residency. The practice is divided into 6 mini-teams with 4 residents, and 1 nurse per team. Other team members include pharmacists, educators, administrators, a social worker, and a nurse practitioner. The team meets weekly to review care delivery, including performance measures. Before the start of the long block, residents are assigned a single outcome measure and asked to perform a literature-based review of the measure, termed the Defense of the Measures (DOM). Measures assessed may include items currently being followed in the practice, or new measures the group deems worthy of review (TABLE). During long block orientation, residents present their review to the entire team, including nurses and allied health professionals. The review uses the PICOT question format (Population, Intervention, Comparison, Outcome, Time) to present evidence for or against a given measure, and