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The Unmet Educational Agenda in Integrated Care

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Abstract One of the reasons integrated care has not become a dominant service delivery model is the unmet training agenda. This article argues that the typical mental health professional is not trained to adequately address the challenges of integrated care. To insure competency both a macro and clinical training agenda are needed. At the macro-level, mental health professionals need to understand healthcare economics and basic business principles as any integrated care service delivery system is embedded and driven by economic forces. Integrated care practitioners also need some basic business skills to understand these forces and to create and manage a financially viable system, given the future flux of the system. Traditional mental health professionals also do not have the clinical skills to implement integrated care. Integrated care is not simply placing a traditionally trained mental health professional and letting them practice specialty mental health in a medical setting. Thus, the special skills needed in integrated care are enumerated and discussed. Finally, a new degree program is described as it is time given the huge need and advantages of integrated care to develop specialty training in integrated care.

Keywords Integrated care · Education · Psychology

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Introduction

Integrated care has received a lot of attention over the last few decades but it has failed to become a dominant service delivery paradigm. This may be due to several reasons, e.g., generally slow dissemination of research and innovation; perverse financial incentives (see Cummings, O'Donohue, & Cummings, in press), and some key gaps in the research base. However, another reason may be the unmet training and educational agenda in integrated care (O'Donohue, 2008). Graduates from typical professional programs including clinical psychology, social work, psychiatric nursing, medical school, public health, and business rarely learn much about integrated care and even more rarely are systematically trained in the core competencies related to integrated care. This educational deficit can result in both a lack of appreciation for integrated care among key decision makers as well as a lack of competent professionals to implement an integrated care system. Thus, the educational agenda needs to be prioritized to combat the perfect storm of a lack of understanding of integrated care from the top, and a lack of skilled professionals from the bottom.

The Macro-educational Agenda

We have argued (Cummings & O'Donohue, 2008) that too many behavioral health professionals are, to put in bluntly, economic and business illiterates. Simply put: as President Clinton used to say, "it is the economy, stupid", and mental health care professionals need to come to grips with this. We suggest that this needs to be systematically corrected in professional curricula in our field. If mental health professionals are to understand the financial forces that

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have a huge impact on health care delivery, if they are to understand all the implications of health care reform proposals (e.g., universal healthcare) which will impact the future of healthcare, and if they are to be able to respond to these forces in a pro-active and constructive manner (e.g., see opportunities), then we recommend that two courses be added to the admittedly already dense professional curricula: one in health care economics; and one in basic business principles. The goal of these two courses is to make the professionals literate in economic and business principles and are admittedly no substitute for a degree in economics or business.

A good course in healthcare economics will cover topics such as:

- Basic economic principles, role of healthcare in national output
- Understanding market forces in healthcare; the role of prices
- Insurance, risk management, and how insurance affects demand curves
- Productivity
- Quality
- The hospital and pharmaceutical industries
- Cost control measures, including managed care
- Role of government in providing health insurance (e.g., Medicaid, Medicare, military)
- Externalities
- Regulation
- Trends in healthcare economics (e.g., technology, aging, lifestyle)
- Health policy, including universal healthcare

We believe this type of course is necessary for healthcare professionals to understand and intelligently respond to healthcare trends affecting them. We need to replace a victim mentality that financial forces are contriving to injure us (sometimes promoted by our professional organizations) with a proactive, reasoned approach based on an understanding of basic healthcare economics and business. This is especially important for leadership and managers. Thus, we believe that when professionals better understand healthcare economics, they will better appreciate the need for innovations like integrated care, a demand side response (by creating healthier patients) to the health care crisis (5% of GDP in 1960 growing to 16% in 2008), instead of managed care's traditional supply side response (e.g., denying MRIs).

A good course in basic business principles would cover topics such as:

- Writing a business plan
- Entrepreneurship
- Venture capital and investment
- Management principles
- Marketing
- Basic accounting
- Business strategy
- Managing quality improvement
- Human resources
- Business law and governmental regulation
- Information technology
- Business in the public sector

This course would allow professionals to both create and manage a successful integrated care delivery system. All too often integrated care can fail because it is not run as a sound business. To succeed integrated care needs to hire the right people (HR), manage these people well (management principles), have quality improvement as an essential component (QI), run on a reasonable budget and meet financial objectives (accounting), be marketed to internal and external customers (marketing), obey relevant laws and regulation (business law), have a sophisticated information technology system for management information (IT), and have a strategy for survival, maintenance and/or growth in the modern competitive environment (business strategy). We need to realize that there is a body of knowledge around these areas and appreciate this enough to learn its basics, instead of trying to "wing it". Poor management often based on "trial and error" or "on the job training" is the Achilles heel of modern behavioral healthcare and we need to take systematic steps to remedy the problem.

There is considerable flexibility in both these curricula, however the point is illiteracy or "learning on the job" (if such learning even occurs), greatly hampers the efficiency, quality, and productivity of our services.

The Clinical Curriculum

The macro-educational curriculum sets the context for the clinical curriculum. It is also important to realize that integrated care is not simply placing a conventionally trained specialty mental health professional in a medical setting. The medical setting requires skill sets that the conventionally trained mental health professional does not have. Thus, the typical graduate of a mental health program is not ready to function well in an integrated care delivery system. Examples of these core skills for integrated care include:

1. Medical literacy
2. Consultation liaison skills with medical problems as well as behavioral health problems
3. Population screening
4. Population management strategies
5. Chronic disease management

6. Working in a medical team
7. Working within the fast paced, action oriented ecology of primary care
8. Behavioral medicine skills such as treatment adherence and chronic disease management
9. Case management skills
10. Educating the medical staff about integrated care
11. Stepped care approaches to problems (e.g., self management, bibliotherapy, e-health)
12. Brief, evidenced based interventions
13. Group interventions

This specialized skill set thus requires specialized hiring and specialized training.

Objective Hiring Process

It would be useful to construct clinical and team scenarios that arise in integrated care and have a job candidate role play their responses. One would also need a valid rating system to score these. The second author had such a system in his American Biodyne. He reasoned that one cannot tell how good a clinician actually is by his vita and a typical job interview. One can put symptoms of psychiatric conditions in these scenarios (e.g., depression, personality disorders) and see if the clinician detects these and makes the right diagnosis. One can then ask for case formulations and brief treatment plans to assess whether they can translate assessment information into an evidenced based action plan that is properly nuanced. One can include scenarios similar to the hallway handoff where a physician is asking a focused referral question and see if the job candidate focuses on this and addresses it in a satisfactory manner. One can also then state that this is the first treatment session for an individual with depressive symptoms and then let the job candidate take over the role-play. It would be interesting and important to develop a core set of these clinical scenarios (e.g., treatment compliance, chronic pain, lifestyle change) and see exactly where the job candidate is. It would also be interesting to see how the candidate can handle the meta-issues that come up in therapy (e.g., therapy interfering behaviors, lack of motivation, ambivalence, very late or missing appointments, relapse) to see the candidate's skills in handling these kinds of important clinical problems.

Clinical Training in Integrated Care

We will discuss three major ways to gain training. The first method is mainly relevant for graduate students or more precisely applicants choosing a graduate program. The remainder of the article will assume that one has hired a conventionally trained mental health professional. They know specialty care practice but they do not know integrated care. How do they learn these skills at the post-graduate level?

Pre-graduate Training

As mentioned previously there are some doctoral programs that have formal integrated care training. An example is the curriculum taught at the University of Nevada, Reno's doctoral program in Clinical Psychology developed by two of the authors of this manuscript, Nicholas Cummings and William O'Donohue. It consists of 8 courses (6 didactic courses; and 2 practica) that students take in addition to their normal course work. It is designed to produce competent clinicians as well as leaders (e.g., administrators, entrepreneurs, researchers) in integrated care. See Table 1 for a more detailed description.

Post Graduate Training

There are a variety of options, each with its own set of advantages and disadvantages, to succeed as a mental health professional in an integrated care environment.

One method is to hire consultants who will come to your organization and train. Obviously this is not very efficient for one practitioner but can be cost efficient for multiple clinicians. Consultant costs are usually a few thousand dollars a day plus expenses. Two major consultants offering this training are CareIntegra (www.CareIntegra.com; the authors are principals in this company); and Mountainview Consulting (Patty Robinson and Kirk Strosahl, www.behavioral-health-integration.com). Training is often a week or two initially. It is very important that this initial training be augmented with a tail that includes case consultation and problem solving during implementation. Clinicians can drift back to conventional specialty care and the trainer can help identify this early and solve problems. In addition there are usually problems commonly encountered during implementation (e.g., low initial referrals) for which the trainer can also provide invaluable help. Without this supportive, timely problem solving and monitoring the integrated care system can fail or become needlessly controversial.

Table 2 provides an example of a two week training that occurred in a very successful integrated care project in military treatment facilities. This project achieved high patient satisfaction, provider satisfaction, clinical outcomes, improvements in functioning, and evidence of increased physician efficiency.

Table 1 Integrated care curriculum at University of Nevada, Reno

Course title	Content
Introduction to Health Care Delivery, Managed Care	A general survey of the healthcare crisis, responses to this such as managed care, epidemiology, medical economics, quality improvement, clinical outcomes, disease management, and consultation liaison services. This course is designed to give the student both the context that integrated care occurs in and a synoptic view of integrated care
Economics of Health Care and Health Policy	This course is taught by a healthcare economist and introduces the student to the history of healthcare economics, the economic dimensions of the current healthcare crises, an understanding of insurance, incentives and perverse incentives in healthcare, advantages and disadvantages of schemes like universal healthcare and other major economic tools and analysis of healthcare
Business Basics	This course is usually taught by a MBA and designed to allow the student to be business literate. Topics covered were discussed in this paper earlier
Psychopharmacology	This course is the conventional psychopharmacology course taught in most programs
Psychotherapy and Supervision in Organized Systems of Care	This course covers evidence based assessments and interventions used in integrated care including motivational interviewing, chronic pain management, treatment adherence, disease management, smoking cessation, diet and exercise, relapse prevention and stepped care interventions for depression, anxiety and other commonly occurring mental disorders
Medical Psychology	This course is designed to make the student medically literate. It is a brief course on common medical illnesses encountered in primary care (e.g., diabetes, COPD, asthma, coronary heart disease, Alzheimer's disease, cancers etc.), usually organized around organ systems. The course emphasizes the pathophysiology, common medical treatments, and common psychological problems and treatments
Behavioral Medicine	This is a traditional behavioral medicine course focusing on the assessment and treatment of chronic pain, pre-surgery interventions, etc
Organized Systems of Care Practicum/ Externship (2 semesters)	One of these practica is clinical and the other is business/administrative

Table 2 Two-week training agenda

Day 1	General Introduction: Goals of the Project, Background, What is Integrated Care? Basic Principles, Population Management, Ecology of Primary Care, Teamwork, and Medical Literacy
Day 2	Medical Psychology: Becoming Medically Literate
Day 3	Practicing in a Primary Care Team: Population Management, Epidemiology, Chronic Diseases, Stepped Care, Consultation Liaison Services in Primary Care, Depression, Pain, Anxiety, Diabetes, Lifestyle, Treatment Adherence, Groups, Managing Referrals
Day 4	Practicing in a Primary Care Team (continued)
Day 5	Psychopharmacology
Day 6	Biodyne Model
Day 7	Quality Improvement and General Discussion
Day 8	Clinical Role Plays (entire group): Depression, PTSD, Panic, Marital Problems, Obesity, Treatment Compliance, ADHD, Difficult Patient, Diabetes Group
Day 9	Clinical Role Plays (continued) and Practica
Day 10	Clinical Role Plays and Practica (continued)

The following required readings were used in the training

- Focused Psychotherapy: A Casebook of Brief, Intermittent Psychotherapy Throughout the Life Cycle (Cummings, N. & Sayama, M. (1995) New York: Taylor & Francis).
- Integrated behavioral healthcare: A Guide for effective intervention (O'Donohue et al., 2005) New York: Prometheus Books.
- Evidenced Based Practice Guidelines (Fisher & O'Donohue, 2006).
- Primary Care Consultation (James & Folen, 2005).

This training was then augmented by, as needed, telephonic case consultation, bi-weekly group meetings, and bi-monthly clinic visits looking at key parameters (e.g., schedules being filled, percentage of physicians making referrals, note review, satisfaction rating reviews). In addition, clinicians would indicate gaps in their training (e.g., protocols not covered) and were supported then by being given these protocols and materials.

A second way to gain integrated care skills are various post-doctoral training programs, some offering certificates. A list of these is available at: http://www.integratedprimarycare.com/training%20programs.htm. An example of an innovative certificate program is one recently developed and implemented by Alexander Blount at the Department of Family Medicine and Community Health and the University of Massachusetts Medical School. The cost currently is $1,600 per student and they offer several

distance learning sites. The downside of these programs is they do require multiple trips to a few distance learning sites (mainly east of the Mississippi) and the associated expenses in addition to the tuition. In addition it takes 6 months to complete the course as each workshop is offered on one Friday per month. However, the topics they cover are relevant to integrated care. Please refer to Addressing the Workforce Crisis in Integrated Primary Care (Blount & Miller, in press) in this special issue dedicated to integrated care for more details of this type of training.

Key Readings in Integrated Care as a Key Part of Training

Although one cannot learn to be a good clinician simply by reading, reading is essential to becoming a good clinician. Very useful books in integrated care that should be part of any clinician's library include:

Cummings, N., & Sayama, M. (Eds.). (1995). *Focused psychotherapy: A casebook of brief intermittent psychotherapy throughout the life cycle*. New York: Taylor & Francis.

Cummings, N., Cummings, J., & Johnston, J. (Eds.). (1997). *Behavioral health in primary care: A guide for clinical integration*. New York: Psychosocial Press.

Cummings, N., Duckworth, M., O'Donohue, W., & Ferguson, K. (Eds.). (2004). *Substance abuse in primary care*. Reno, NV: Context Press.

Cummings, N. A., & O'Donohue, W. T. (2008). *Eleven blunders that cripple psychotherapy in America: A remedial unblundering*. New York: Routledge (Taylor and Francis Group).

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Cummings, N. A., O'Donohue, W., & Ferguson, K. (Eds.). (2002). *The impact of medical cost offset on practice and research: Making it work for you.* Reno, NV: Context Press.

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Fisher, J. E., & O'Donohue, W. (Eds.). (2006). *Practitioners' guide to evidence-based psychotherapy*. New York: Kluwer Academic/Plenum Publishers.

Haas, L. J. (2004) *Primary care psychology*. Oxford: Oxford University Press.

James, L., & Folen, R. (2005). *The primary care consultant*. Washington, D.C.: APA Books.

James, L., & O'Donohue, W. (in press). *The primary care toolbox*. New York: Sage.

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O'Donohue, W., & Levensky, E. (Eds.). (2006). *Treatment adherence: A practitioner's guide*. Thousand Oaks: Sage Publications, Inc.

O'Donohue, W., Moore, B., & Scott, B. (Eds.). (2007). *Handbook of pediatric and adolescent obesity treatment*. New York: Routledge.

Robinson, P., & Reiter, J. (2006). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.

O'Donohue, W. T., Cummings, N. A., Cucciare, M., Cummings, J., & Runyan, C. N. (2006). *Integrated behavioral healthcare: A guide to effective intervention*. New York: Prometheus Books.

The Future: A New Model for Training BCPs

A Paradigm Shift

The pioneer doctoral programs in training psychologists to practice as behavioral care providers (BCPs) have demonstrated the limitations posed by the inflexibility and often irrelevancy of the Ph.D. and Psy.D. programs as currently constituted in our graduate psychology departments. The problem stems from the determination to graduate psychologists who are scientist/professionals, resulting too often in second rate scientists and unskilled practitioners. All other health professions have solved this problem in their mission to train skilled professionals who are intelligent consumers of science, something psychology has not yet figured out.

Examples of irrelevance include three courses in statistics dictated by the APA approvals process where only one would be sufficient. Every time a well-meaning APA task force adds another course in diversity or cultural sensitivity nothing is subtracted, rendering the doctoral program in psychology longer and longer. Courses in outmoded non-evidence based psychological tests

(e.g., Rorschach) are still mandated in most programs. Too many departments are identified with conflicting "schools" of psychology; what Cummings (see Cummings & O'Donohue, 2008, p. 303) has often referred to as "psycho-religions" (e.g., Skinnerian, radical behaviorism, gestalt, cognitive behaviorism, and yes, some still as psychodynamic and even psychoanalytic). It is not unusual for programs to spend more time indoctrinating the student in the psycho-religion than sharpening clinical skills, possibly because too often the faculty doing the training are not all that skilled themselves. Finally, because of the shortage of available internships to meet the demand of hordes of graduates, there is a movement afoot to eliminate the internship, thus removing the last vestige of intensive hands-on clinical training.

Our patients very frequently have co-morbidities interacting with their psychological issues, yet most psychotherapists lack even a rudimentary knowledge of neurology, clinical medicine, medical psychology, and even the healthcare lingo necessary to navigate the health system. The specialty of health psychology addresses these issues to some extent, but it does not train its students to be primary care behavioral providers. The primary care psychologist is a rare breed, trained mostly in-service.

A New Degree

The lessons of the last several years indicate that primary BCPs are best trained in the health science divisions of universities rather than in psychology departments. Thus, a major state university is in the process of implementing such a program to begin accepting students for the fall of 2009. The degree will be both responsive and innovative, and called the *doctor of behavioral health* (*D.Bh.* or *D.B.H.* as yet to be decided).

The Curriculum

The psychology aspect of the curriculum is streamlined according to the paradigm shift:

- One (rather than three) graduate courses in statistics
- A two-semester course in the scientific method as it applies to behavioral research
- A course in psychodiagnostics and psychopathology
- A course in evidence-based psychological testing
- A survey course on personality theories and an overview of clinical psychology
- Eliminated: a dissertation. Substituted: a professional project.

The courses added are:

- Survey of basic sciences (chemistry and biochemistry, basic physics, anatomy and physiology). Students with an undergraduate background in basic sciences are exempt from this requirement
- Physiological psychology
- Clinical medicine
- Neuroanatomy and neurology
- Anatomy
- Medical psychology
- Psychopharmacology
- Two courses in psychotherapy and behavioral care interventions.

Breadth course:

- The economics and business of healthcare and designing and implementing healthcare delivery systems.

Hands-on experience:

- A major thrust of the program is its experiential feature, according the student ongoing exposure to a functioning medical setting. At the appropriate juncture the student will be immersed in an integrated behavioral/primary care setting.

Faculty

The program will rely heavily on "clinical" (adjunct; part time) faculty teaching one or two courses in their area of expertise. It is imperative that these faculty members are making their living (i.e., actually doing) what they are teaching. Much of the problem in traditional psychology programs is the teaching of hands-on clinical work by "armchair" clinicians who rarely if ever see a patient.

Moving in Unison

It is often jokingly said by psychology graduate students that the cardinal training they receive is how to live with ambiguity. It is not uncommon for a three or four year program to drift to six or seven, and even more years. The ABD (all but dissertation) is far from being a rare phenomenon. In this new program the students all move in unison from semester to semester just as is the manner of all other healthcare educational programs. The length of the program is, four years, two for advanced students who already possess a masters degree.

A Program to Upgrade Masters Level Providers

There has been a dramatic proliferation of masters level psychotherapists of several disciplines (e.g., counselors, MFTs, social workers), resulting not only in a glut of sub-doctoral practitioners, but also in a fractionation that often erupts into internecine warfare. As psychology moves further into mainstream healthcare delivery, there is a

growing sense of unifying what is now scattered in versions of "mental health," as well as a recognition that upgrading sub-doctoral practice is required to more appropriately function in this changing role.

This growing sense or realization is common in sub-doctoral providers after they have struggled for seven to ten years in an overcrowded field. The need to upgrade and become more employable becomes acute, and they look around for how they might do this. They usually become discouraged, finding nothing. The D.B.H. (or D.Bh.) program has designed a two-year sequence in which masters level providers can enter the program and graduate with the doctorate in two years.

Online and Distance Learning

From the outset the program will take advantage of distance learning, with the ability to tap nationally respected experts for various courses. It plans also to develop an online program in integrated behavioral/primary care for those already possessing the Ph.D. or Psy.D. who want to be trained as BCPs. A number of courses that would be required are already available on DVDs.

Summary and Conclusions

Probably the most frequent mistake and the mistake most responsible for failures of integrated care delivery systems is to fail to realize that there is a training agenda. This article began with outlining the reasons for this training agenda: (1) there is a healthcare economic and business case that needs to be understood—this provides some of the need for integrated care and (2) in a nutshell—integrated care is not simply placing a specialty care clinician in a medical setting. There is a much needed research agenda in hiring which the authors have outlined. Finally, the authors discussed pre-doctoral and post-doctoral training opportunities, providing resources in graduate programs, consultants, certificate programs, and key readings.

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