Psychiatric Residency Training, Managed Care, and Contemporary Clinical Practice

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Managed care has transformed the health care environment that residents encounter on completion of their training. Unfortunately, residency education has not kept pace with changes in the field, leaving graduates inadequately prepared. The authors identify necessary changes in the residency training tasks of instilling values, imparting required knowledge, building core skills, selecting appropriate training sites, and offering a diversity of instructors and supervisors. They also discuss the obstacles that have impeded the evolution of academic clinical services and clinical training. They suggest strategies of change that may lead to more relevant educational programs that provide residents with a balanced perspective on the strengths and weaknesses of both traditional and contemporary approaches to delivering care. (*Psychiatric Services* 51:1001–1005, 2000)

The delivery of mental health and substance abuse services has changed dramatically over the past 15 years. Driven by payer concerns about escalating costs, managed care has overturned traditional assumptions and practice patterns (1). Longer-term, intensive treatments are being replaced by brief, focused interventions, particularly for patients who do not suffer from the most severe forms of mental illness. Acutely ill patients increasingly are diverted from hospitalization or moved rapidly from inpatient to ambulatory care.

The current backlash against managed care leaves its future uncertain. However, psychiatric practice has been radically changed, and a return to traditional assumptions and practice patterns is unlikely to occur. As educators, we are left with the pressing question of whether we are adequately preparing psychiatric residents for the realities of practice and the environment of care that they will encounter on completion of their training.

Unfortunately, it is quite common in all areas of medicine for professional training to lag behind changes in service delivery (2). In a recent survey, a sample of residents drawn from all specialties reported significant deficiencies in their knowledge of managed care and their preparedness to practice in a managed health care environment (3). It has been estimated that physicians require up to two years of experience after residency to become adequately skilled at functioning in a managed care environment (4). The lag between changes in practice and changes in training characterizes the current state of affairs for psychiatry no less than for the rest of medicine.

Current approaches to residency training

Although a few departments have restructured their residency programs to address current practice realities, the modal approach to training in psychiatry can be described as follows. Didactic material related to health care economics and managed care is limited to a handful of lectures scattered throughout the residency experience. Residents receive some early exposure, without much preparation, to the most intrusive aspect of managed care, which is the utilization management of inpatient services. Residents tend to gain minimal experience with the modalities favored by managed care, such as brief treatment, intensive outpatient care, and ambulatory detoxification. Because managed care organizations exclude trainees from their panels, many residents do not have the opportunity to work in outpatient settings where the care is managed and time-sensitive treatment approaches predominate.

Of considerable concern is that residents' supervisors often present only negative views of managed care rather than a balanced discussion of the strengths and weaknesses of both managed care and traditional approaches to treatment. There appear

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to be few faculty role models who have embraced the changing assumptions about practice patterns and who are demonstrating adaptive and satisfying approaches to working in the current health care environment.

The result is that many residents leave training largely unprepared for the realities and demands of the health care marketplace, encountering what Gabbard (5) has referred to as "the big chill." Citing the gulf between current approaches to training and practice realities, Yager and colleagues (6) have gone so far as to accuse academic psychiatry of "pedagogic malfeasance." Given the complex nature of academic settings, keeping pace with changes in the field has been a daunting challenge for most departments, including our own.

New directions for residency training

Although training programs seem to have made little accommodation to recent changes in the field, the need to make the clinical aspects of residency education more relevant has not gone unnoticed (7). Many professionals have offered recommendations on residency training (5–17). To further develop this work, we have integrated their suggestions and combined them with our own experience (18) to outline new directions for residency education in relation to managed care and contemporary clinical practice. This effort is similar to other recent initiatives to define the training objectives, content, and teaching strategies for specific areas of psychiatric residency education such as psychotherapy (19), psychopharmacology (20), community psychiatry (21), consultation-liaison psychiatry (22), and child psychiatry (23).

Defining the training objective

In reshaping residency training, the objective should not be simply to teach about managed care. Both traditional and contemporary approaches to behavioral health care must be taught so that a balance of perspectives is maintained in the educational process. With respect to teaching about contemporary approaches, managed care is just one aspect of sweeping changes in the field emphasizing increased efficiency, cost control, accountability, evidence-based practice, and outcomes.

This is a subtle but critical point. Teaching only about managed care oversimplifies the complex forces that have led to the current health care climate. It leads to a naive vilification of managed care companies and omits potentially stimulating discussion with students about issues central to the field, such as practice standards, quality management, treatment effectiveness, health care rationing, and cost-benefit issues in service delivery.

The goal should be for residents to understand the inherent dilemmas in meeting the health care needs of individuals and populations and to develop the capacity to critically evaluate proposed solutions to these dilemmas. They will then be prepared to make their own decision about whether to collaborate with or advocate against managed care and other aspects of health care reform.

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Instilling values

In turbulent times, values can help ground a resident and provide a reference point for evaluating changes in the field. Traditional values in psychiatry emphasize the needs of individual patients, quality of care, and professional independence in clinical judgments. The values promulgated through managed care both qualify and add to these traditional values by emphasizing the cost-effective use of scarce resources, attention to the treatment needs of populations, and adherence by professionals to practice standards.

Residency education should include an expanded dialogue about these traditional and emerging values. Faculty behavior will heavily influence residents' adoption of specific values. With that in mind, probably the most important value for faculty to espouse and model is what Ross (13) identified as academic integrity—a questioning attitude with frank acknowledgment of what we do and do not know about behavioral disorders and their treatment.

Imparting knowledge

To be adequately prepared for contemporary practice, residents must acquire a broad range of information, much of which is contained in traditional training programs. Drawing on the recommendations of other professionals cited above and our own training initiatives, we recommend certain changes in this knowledge base.

The recommendations address two areas. The first is new topics, those that traditionally have not been covered in residency programs but have become relevant as a result of changes in the field over the past decade. They include health care regulation and reform; the economics of behavioral health care; managed care and related organizational structures such as health maintenance organizations, preferred provider organizations, physician hospital organizations, and individual practice associations; medical necessity, level-of-care criteria, and the utilization management process; practice standards and guidelines; quality management; the interface between psychiatry and general medicine; and consumerism in psychiatric practice.

The second set of recommendations focuses on topics that traditionally have been addressed in residency programs but must have their content significantly modified and updated to remain current with changes in the

field. They include the continuum of care, treatment planning, legal and ethical issues, documentation requirements, professional roles and career options, and approaches to interdisciplinary relationships.

Building skills

There exists a growing consensus about the skills or competencies that residents should possess to practice effectively in a managed care environment. These skills either supplement or refine essential skills currently being taught in residency programs. Schreter (15) organized these skills into three categories. The first category, clinical skills, includes efficient multiaxial assessment and differential diagnosis; goal-focused and problem-oriented treatment planning; and facility with a broad repertoire of clinical interventions including psychopharmacology, crisis intervention, brief treatments, group and family interventions, alternatives to inpatient care, and the treatment of substance abuse.

The second category, clinical management skills, focuses on competencies related to managing care. They include assessing medical necessity and determining an appropriate level of care; evidence-based selection of treatments; care coordination and the case management of "high utilizers"; and analyzing and managing the ethical dilemmas created by managed care.

The third category is administrative skills. The recommended competencies include navigating the interface with managed care organizations; creating focused documentation of care that complies with all requirements; achieving proficiency with credentialing and billing procedures; and learning to advocate for patients' rights with treatment systems and managed care organizations.

Selecting training sites and structures

The sites of training heavily influence the educational experience. Despite considerable concern about the traditional emphasis on inpatient units as a setting for residency training (14), inpatient rotations remain prominent in many programs.

Brief lengths of stay, the limited depth of interaction with patients, and the intrusiveness of managed care all contribute to residents' disillusionment with inpatient rotations. Further, training directors have noted that the first residency rotation has disproportionate influence on residents' attitudes and treatment approaches. Yet we often persist in assigning residents exclusively to inpatient experiences at the beginning of their training, missing the opportunity to balance such assignments with other rotations (9).

Optimally, the sites and program structures used for training should exemplify for residents the principles and practices reviewed in the didactic portions of the training. For example, placing residents on continuous treatment teams early in the residency brings to life the concepts of a continuum of services and continuity of care. These program structures require residents to serve as principal caregivers across a range of modalities, giving them firsthand experience with the process of managing care by continually matching patient need to treatment intensity. Such teams have seen widest use in public-sector settings such as community mental health centers (14) and in the Veterans Affairs system (24). They have also been used successfully in academic clinical settings such as in the Dartmouth program (25).

Specific settings afford exposure to treatment approaches that are increasingly relevant in a managed care environment. Intensive outpatient, partial hospital, and crisis respite rotations expose residents to alternatives to inpatient care. Similarly, rotations in dual diagnosis and addiction programs strengthen residents' ability to address both psychiatric and substance abuse treatment needs, a skill increasingly in demand in the health care marketplace.

Rotation through an outpatient setting where care is managed by internal or external reviewers builds residents' skills in brief treatment. There is evidence to suggest that once exposed, a significant percentage of residents choose to work in such a setting (26). Primary care settings also have been suggested as venues in which to educate residents about the interface between general medicine and psychiatry.

Senior residents and fellows have some selected opportunities to rotate through managed behavioral health care organizations. These rotations afford firsthand experience with the clinical, ethical, and legal issues involved in managing care. Such rotations are typically of most interest to residents who wish to pursue careers in administrative psychiatry.

Selecting teachers and supervisors

Finding faculty qualified and interested in teaching about managed care and contemporary clinical practice is a challenge. A common short-term strategy involves hiring part-time faculty or drawing on voluntary clinical faculty to manage and provide this portion of the curriculum. A more permanent solution is to recruit new full-time faculty members with interests and expertise in these areas. Clinical educator tracks have been developed in medical schools across the country in response to the need for faculty who specialize in clinical care and the clinical education of residents. Promotional criteria for these faculty members place greater emphasis on clinical and educational accomplishments and less emphasis on traditional requirements for research productivity.

As a related challenge, current supervisory pools tend to be composed of full-time faculty and voluntary clinical faculty members, many of whom have little interest in or tolerance for managed care. Often missing in the supervisory process is dialogue about the weaknesses of traditional approaches to treatment and the enormous challenge of caring for individuals and populations in a cost-conscious manner. Didactic instruction and clinical training experiences can be undermined if most supervisors view such instruction and experiences as misguided and convey that attitude to their students.

A simple strategy for solving this supervisory dilemma is to add to the full-time and adjunct faculty supervisors who possess skills and attitudes that will help residents understand, critically evaluate, and adapt to the

current health care environment. The objective should not be to replace, but rather to balance, traditional approaches and thereby diversify the supervisory experience.

Modeling and mentoring are best accomplished when a resident and an attending physician work as a pair, and all patients are seen by the resident and the attending either simultaneously or sequentially. This practice has been less common in psychiatry than in other specialties. However, it is increasing, partly in response to the requirements of payers. This model has been implemented in several ambulatory sites, such as the University of Louisville's public-sector clinic (14). That department found that pairing attendings and residents enhanced the quality of supervision, increased revenue and compliance with regulatory requirements, and did not impede resident-patient relationships.

Discussion

Over the past decade, some very talented individuals have tackled the issue of what we must do to ensure that residents are provided with the necessary skills to thrive after completing their training. The truly puzzling question is not what academic psychiatry should do but rather why it has taken so few steps in these directions (27). In a series of case studies of academic psychiatry and managed care, Meyer (25) identified only one department that, in his view, had transformed its clinical, training, and research programs broadly and quickly enough to respond adequately to changes in the health care environment.

Numerous causes for the slow process of change have been suggested. On the surface, it appears that many psychiatrists in academic medical centers continue to question the permanence of changes in the field. Perhaps encouraged by the recent backlash against managed care, many hope that the field will revert to traditional assumptions and practices. Alternatively, Sabin (28) has suggested that the absence of a timely response to changes is due to the "moral myopia" of academic psychiatry. He defines this myopia as difficulty in attending to the needs of populations while simultaneously maintaining the traditional and very important emphasis on the needs of individuals.

Monica Oss, the editor of *Open Minds,* has suggested that many provider organizations change only when forced to do so (personal communication, May 1998), leading to the hypothesis that academic psychiatry and academic psychiatrists may have been somewhat isolated from the contingencies of the marketplace. Although few academic departments have escaped the economic pressures of managed care, many have been somewhat protected by their host universities or medical centers, which have absorbed department operating losses (29). Similarly, the principle of academic freedom and the practice of granting tenure have isolated some faculty members from the need to respond to market changes in a timely fashion.

The question of how change is initiated and accomplished is as elusive for academic organizations as it is for the individuals we treat.

Another dynamic that has impeded change in some departments is an underlying ambivalence about the clinical mission. Traditionally, clinical care has been one aspect of the tripartite mission of academic psychiatry and of unquestioned value given its ability to generate substantial cross-subsidies for the other missions of teaching and research. Since it can no longer generate such significant subsidies, some departments have an unresolved ambivalence, whether explicit or implicit, about the importance of a continued clinical mission. Particularly in research-oriented departments, this dynamic has lessened faculty motivation to respond to changes in the market and to modify their approaches to clinical care and clinical teaching.

The solutions proposed for moving academic psychiatry forward are complex. Levinson (30), a noted organizational consultant, has suggested that in times of change organizations and the individuals within them must grieve and accept their losses before they can effectively move forward. For most departments, reassessing and reaffirming a commitment to the clinical mission for reasons other than subsidizing research and teaching also seem essential. Recruiting new faculty and retraining selected faculty can reshape and balance perspectives within a department. Introducing contingencies that reward successful clinical endeavors is perhaps the most rapid way in which to change faculty behavior. Lastly, some departments have chosen to accept contracts to manage mental health and substance abuse care (31). This strategy undoubtedly broadens departmental perspectives on clinical care from the individual patient to the population level.

In the end, the question of how change is initiated and accomplished is as elusive for academic organizations as it is for the individuals we treat. Emotions, beliefs, and behaviors collide repeatedly with the changing environment until motivation for individual or organizational change develops. New behaviors then slowly emerge. Highly relevant and applicable to this process for academic psychiatry is the literature on changing individual behavior (32–34), physician behavior (35,36), and organizations as a whole (37–39).

Conclusions

Although managed care as we know it may die at the hands of legislators and the courts, the practice of psychiatry has been dramatically altered. Academic psychiatry must respond to the changes in the field. On the educational front, it must meet its obligation to prepare residents by providing the knowledge and skills they will require to thrive professionally after completing their training.

Academic organizations are complex systems. Changing one aspect, such as the educational program, will undoubtedly have some unintended or unwanted effects on other aspects of the academic enterprise. Nonetheless, the educational mission carries with it the responsibility to educate residents about current practice patterns and marketplace realities.

The recommendations outlined above suggest directions for increasing the relevance of the psychiatric residency. The next steps involve accelerating the pace with which such ideas are incorporated into department curricula and developing model curricula to further inform efforts to update education programs. ♦

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