Enhancing Continuity of Care
Residency Training in an Integrated Inpatient–Partial Hospital Program

Edward Kim, M.D.
Irina Efremova, M.D.
Pradeep Arora, M.D.

This paper describes a teaching/service model that integrates inpatient, partial hospital, and intensive outpatient treatment. In this model, individual multidisciplinary treatment teams retain responsibility for a patient’s care for any or all of three levels of intensity of services accessed during an episode of illness. This teaching/service model allows residents to follow patients for an average of 2.5 weeks across an entire acute episode of care compared with the 7.3 days of the average inpatient stay at the inpatient facility. The opportunity to continue treatment in step-down settings over longer periods of time allows residents and medical students to develop a fuller understanding of their patients. The authors believe that this continuum-care service model more efficiently trains residents in multiple aspects of psychiatric practice and provides patients with better care than the traditional inpatient-care service model. (Acad Psychiatry 2002; 26:4–8)

Between 1988 and 1994, the average length of stay in general hospital psychiatric units decreased by more than 25%, from 12.6 to 9.4 days (1). The increased turnover of patients and shortened episodes of inpatient care raise concerns regarding the quality of the educational experience offered to residents on acute inpatient units. This trend has changed the experience of acute inpatient psychiatry to emphasize brief stabilization goals. As a result, residents may become demoralized by the “assembly line” nature of rapid treatment units and may learn little about the continuum of care available in contemporary behavioral health delivery systems. The shortening of treatment episodes may reduce opportunities for residents to perform more than a cursory assessment of patients and to observe the results of their interventions.

The influence of managed care pressures on academic psychiatry in general, and on psychiatric residency training in particular, has raised concerns regarding the future of psychiatric education (2,3). The demand for greater efficiency in service delivery, with associated reductions in staffing and increased case loads, presents challenges to the professional development and skill acquisition of residents rotating through inpatient services. Core educational objectives on inpatient psychiatric rotations include acquisition of clinical skills, development of a requisite knowledge base, and professional growth (4). Psychiatry residents must familiarize themselves with a modified set of treatment models and clinical skills different from those taught on inpatient units prior to the 1990s (5). Their professional identity must
evolve beyond the individual therapist-physician model to one that promotes team leadership and multidisciplinary interdependence.

Houghtalen and colleagues (5,6) have described a short-term treatment unit in Rochester, NY, integrating inpatient and partial hospital programs at a university hospital as a means of providing continuity of residents’ treatment experience with patients. This service uses screening criteria to select patients at intake for “factors predicting effective brief admissions.” Benefits of this integrated experience include the opportunity to monitor patients as they improve clinically and to observe their responses to changes in levels of care. However, these efforts to provide residents with the experience of treating patients in a variety of settings, from an inpatient facility to ambulatory care, are challenged by the requirement of the Accreditation Council for Graduate Medical Education (ACGME) for training experiences in particular modalities that are traditionally offered in discrete blocks of time (3). The ACGME requires that residents spend 9 to 18 months rotating through general adult inpatient units. Partial hospital programs are not credited toward this requirement “unless the rotation . . . is comparable in breadth, depth and experience to training on general inpatients units” (7).

The clinical teaching/service model at the University of Medicine and Dentistry of New Jersey–University Behavioral HealthCare (UMDNJ-UBHC) integrates an acute inpatient unit with a 5-day-a-week partial hospital (comparable in breadth, depth, and experience to training on general inpatients units) and an intensive outpatient program. In this teaching/service model, each multidisciplinary treatment team treats patients on all three levels of care. Unlike the service described by Houghtalen et al., our service does not select patients on the basis of any screening criteria.

DESCRIPTION OF TEACHING/SERVICE MODEL

UMDNJ-UBHC is an academically affiliated community mental health center with multiple sites throughout central and northern New Jersey. UBHC provides a broad range of services including inpatient, case management, and traditional outpatient treatment for mentally ill and dually diagnosed patients (mentally ill with substance abuse). In addition to serving a public patient population, UMDNJ-UBHC services a commercial capitated behavioral health contract covering approximately 300,000 lives in central and northern New Jersey. The organization also services noncapitated contracts with other commercial third-party payers. Approximately 40% of registered patients are Medicare or Medicaid beneficiaries, 40% have commercial insurance, and the remaining 20% are medically indigent.

Located adjacent to the Robert Wood Johnson Medical School campus, the Acute Adult Service of UMDNJ-UBHC is the primary teaching service for the UMDNJ-Robert Wood Johnson Medical School psychiatric residency and a major teaching affiliate for the third-year psychiatry clerkship for medical students. It consists of a 24-bed locked voluntary inpatient unit physically contiguous to a 30-patient partial hospital unit that operates 6 hours a day 5 days a week. The partial hospital unit includes an intensive outpatient program, which is a 3-hour component of the partial hospital. Patients are admitted to any level of care in the Acute Adult Service by direct admission from outpatient providers or through a 24-hour on-site psychiatric emergency service. Residents and medical students are exposed to a broad spectrum of psychiatric disorders, as indicated in Table 1. More than half of the patients treated have comorbid substance abuse disorders. Inpatients and partial hospital patients attend separate programming in their respective units, although program staff is shared between the units. This segregated programming permits staff to focus on the goals and needs of each patient population. Inpatient programming emphasizes discharge planning and preparation for return to the ambulatory setting and its attendant stressors. To this end, groups and activities focus on improving reality testing, impulse control, and self-care. The partial hospital emphasizes more longitudinal goals and patients’ ability to cope with environmental and relationship stressors in their home environment. A substance abuse recovery group is operating as part of the partial hospital. Inpatients who are sufficiently motivated and clinically stable to be allowed off the inpatient unit can also attend this group. This linkage enables patients to begin working on recovery as soon as clinically appropriate. This treatment model emphasizes a functional stabilization approach intended to progressively increase patient self-