Interprofessional Mental Health Services in VA Primary Care and Home Based Primary Care Programs: Competency Development for Psychologists

Michele J. Karel, PhD
Lisa Kearney, PhD, ABPP
Antonette Zeiss, PhD

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Mental Health in the Patient Aligned Care Team (PACT): Guiding Discussion Points

• How can we help transform traditional primary care to an integrated, interprofessional system of care delivery?
• What lessons learned are present from VA’s implementation of interprofessional mental health care delivery within the context of the patient centered medical home? What were the greatest challenges to overcome?
• How can we take these lessons to continue to implement a long term vision for full implementation of interprofessional care?
• How can psychologists develop competencies to meet needs of older adults in primary care setting?
In 2007, MH in PACT began as a joint effort between PC and MH (Zeiss & Karlin, 2008; Post and van Stone, 2008)

The Uniform Mental Health Services Handbook (VHA, 2008) then mandated the following year the following:

- Co-located, collaborative care, AND
- Care management (Behavioral Health Laboratory (BHL), the Translating Initiatives for Depression into Effective Solutions (TIDES) model)

Since 2010, VA is implementing its patient-centered medical home model, known as the Patient Aligned Care Team (PACT).
Developing a full continuum of care to meet the unique needs of each individual Veteran

**Primary Care**
- Screening for mental health conditions
- Initiation of pharmacological treatment for mild to moderate mood symptoms
- Co-management of Veteran care with PC-MHI and specialty MH providers
- Health Behavior and Prevention
- Emphasis on wellness

**PC-MHI**
- Behavioral Health Interdisciplinary Program (BHIP)

**BHIP**
- Discipline-specific PACT includes Integrated Care for physical and mental health in one setting
- Evaluation and treatment for mild to moderate mental health conditions (depression, substance misuse, anxiety, PTSD)
  - Follow-up evaluation for positive MH screens
  - Behavioral health interventions for chronic disease
    - Care management
    - Referral management

**Secondary and Tertiary Care:**
- Outpatient Care for treatment resistant, severe or complex illnesses
- PTSD specialty treatment; Substance dependence treatment
  - Treatment of serious mental illness (including MHICM)
  - Full spectrum of psychosocial rehabilitation and recovery services
    - Inpatient mental health care
    - Residential treatment
    - Supported and therapeutic employment
    - Homeless programs
    - Behavioral Health Interdisciplinary Program (BHIP)

**Specialty MH**
- Emphasis on wellness

**Specialty MH**
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**Developing a full continuum of care to meet the unique needs of each individual Veteran**
Primary care clinics are NOT machines that can be fixed or changed by replacing parts or adding additional resources but are complex adaptive systems with a relationship infrastructure among members of the team that is critically important in any change or transformation effort that is undertaken (Leykum, 2007).

Rogers’ Diffusion of Innovation

**Natural barriers exist to implementation (e.g., space issues, staffing concerns, etc) – how do we positively move forward despite these normal challenges?**

(Rogers, 1962)
MH in PACT: Competency Development and Preparation for Roles

- A different type of competency is required for service within integrated PC settings (Kaslow, et al., 2013; McDaniel et al., 2014) - science, systems, professionalism, relationships, application, and education
- Modeling, mentoring, and training in roles is needed, yet frequently may not be readily available
- Challenges faced in national implementation related to competency assessment and development
- Initially training focused on in national conferences primarily with MH providers
- Need to develop de-centralized training opportunities which can be experienced virtually
MH in PACT: Training Needs

• Need for training of PC providers, not just MH providers, and training those with different years of experience in VA (cross training strategies needed)

• Transformation to 30 minute brief appointments and functional assessments

• Training in brief EBPs appropriate for PC setting (e.g., PST, CBT, MI)

• Business operations (e.g., marketing, template creation, program development skills and program evaluation, collaboration with leadership across multiple partnerships, business plan creation, program sustainment)

• Focus on care management and same day access implementation

• Implementation in smaller clinics compared to large medical centers
MH in PACT: Resources/Training Tools

- Primary Care-Mental Health Integration (PC-MHI) Program Office
- PC-MHI SharePoint and Newsletter Resources [https://vaww.portal.va.gov/sites/pcmhihub/PCMHI/Pages/default.aspx](https://vaww.portal.va.gov/sites/pcmhihub/PCMHI/Pages/default.aspx)
- VeHU Presentations (e.g., 30 minute appointment)
- Functional Tool
- Office of Mental Health Operations Facilitation – intensive consultation services for those needing greater assistance
MH in PACT: Addressing Needs of Older Veterans

- Training is needed in a variety of areas for MH providers in PC
  - dementia management
  - evaluation of cognitive impairment (no current mandated screening- dementia warning signs approach)
  - Driving ability assessment
  - Capacity assessment –independent living, medical decision making
  - Caregiver stress/resources

- Little training to date has focused on older Veterans treatment in MH in PACT
- Currently national training needs assessment is underway
- What don’t we know that we need to know?
A Note about Integrating Technology into Clinical Care: Everyday Practice in VA

• Electronic health record
  – Facilitates interprofessional care: sharing of progress notes, discharge summaries, etc.
  – Psychologists reference medication lists, lab results, imaging results
  – Veterans may also access records

• Telehealth technology for monitoring chronic conditions
  – E.g., HTN, heart failure, diabetes, COPD, depression, weight management

• Clinical Video Telehealth → Increasing access to care
  – Including psychotherapy via video to community clinic or home
Mental Health in Home Based Primary Care: Guiding Discussion Points

• How do we conceptualize model of integrated, interprofessional mental health care in specialized geriatric care settings?
• What does VHA experience in the Home Based Primary Care Mental Health Initiative teach us about care model and training needs?
Integration of Mental Health Care in Geriatrics and Extended Care Programs

• Increasing access to mental health services for older adults
  – Older adults/Veterans with lower utilization of specialty mental health services
  – Many older Veterans unable to access clinic-based services
  – Behavioral /mental health care: part of holistic team care!

• Transforming mental health care for older Veterans in VHA: Integrate MH Providers on teams in:
  – Home Based Primary Care
  – Community Living Centers
  – Hospice and Palliative Care
  – Also, Spinal Cord Injury and Rehabilitation Centers for the Blind

VHA Home Based Primary Care: An Illustration

- Comprehensive, longitudinal primary care
- Delivered in the home
- By an interprofessional team
  - Nurse, Physician, Social Worker, Rehabilitation Therapist, Dietitian, Pharmacist, Psychologist/Psychiatrist
- Targets patients with complex, chronic, disabling disease
- When routine clinic-based care is not effective
  
  *For those “too sick to go to clinic”*
  
  From Cooper & Edes, 2012

- HBPC serves primarily older Veterans; in 2013:
  - 85% of were aged 65 or over
  - 65% were aged 75 or over
Mental Health Issues in Home Based Primary Care (HBPC)

- High rates of mental illness
  - Most prevalent are: major depression or dysthymia, anxiety disorder, PTSD, substance use disorder, and psychotic disorders including schizophrenia
- High rates of dementia, and related behavioral problems
- Behavioral health challenges
  - Coping with disability, insomnia, chronic pain, adherence
- Mental health problems complicate adjustment to medical illness
- Caregiver strain
  - ~2/3 of Veterans with identified caregivers; ~20% of caregivers report high level of caregiving strain
Home Based Primary Care Mental Health Initiative

- VA HBPC Mental Health Initiative, 2007:
  - Every interprofessional HBPC team required to have at least one full-time psychologist or psychiatrist

- Position description duties include providing/promoting:
  - Screening, assessment, diagnosis, treatment of mental disorders
  - Assessment of cognitive deficits, and decision making and functional capacities
  - Prevention services
  - Services for family caregivers, and couples/families
  - Behavioral medicine interventions
  - Communication/interaction among team members
  - Supervision/training
Building Blocks for an Integrated Care Model in HBPC

- Interprofessional Care
- Collaborative Care
- Patient-Centered Care
- Care Management
- Stepped Care

Evidence-Based Psychological and Psychopharm Assessment and Intervention
2010 Survey of HBPC MH Providers (N=132)
% Respondents Interested in Further Training in Various Topics

- Behavioral interventions for dementia
- Capacity assessment
- Dementia evaluation
- Family caregiver interventions
- Grief and loss
- Motivational interviewing
- Team mental health training
- EBP for depression
- EBP for PTSD
- Team functioning
- Stress/coping for healthcare providers

Y-axis: 0 20 40 60 80 100
X-axis: Various Topics
Competency Development Needs: Primary Care and/or Geropsychology

• Interprofessional team functioning
  – Defining appropriate role(s) for/with the team; addressing team conflict and/or functioning challenges; consulting with and supporting staff (and setting limits as needed)

• Practice management
  – Meeting needs of population with limited resources; helping the team help patients; determining appropriate “dose” of mh care
  – Care management, stepped care approaches
  – Issues of workload capture, CPT coding

• Negotiating ethical/legal issues re: capacity, independent living, involvement of APS

• Cognitive and capacity evaluations; dementia evaluation
Competency Development Needs (cont)

- Evidence-based interventions applicable to population
- Adapting interventions for medically frail population, with high rates of cognitive impairment
- Behavioral/caregiver interventions re: dementia
- Program evaluation – making the case for needed resources
- Supervision/training in the integrated, home care environment
Program Resources

- Monthly expert talks, for CE/CME
  - Exposure to knowledge and resources
- Monthly case discussion call
- Webcourse series, for CE/CME
  - Model for integrated care; integrated MH assessment; integrated MH intervention
- SharePoint: clinical and administrative resources
- Active listserv for community information sharing
- PST in HBPC pilot training program: EBP adapted for HBPC
- Peer Mentor Program
Discussion Points

• “On-the-job” professional development
  – Self-evaluation of competencies and training needs – do folks know what they do and don’t know?
  – Opportunities for supervision/consultation/mentoring for new skill development can be hard to come by
  – Training opportunities?

• Being the “lone ranger” psychologist on a team
  – Can feel professionally isolating
  – No direct role models or immediate peer for consultation
  – Professional communities of support?
Discussion Points

• Emotional component of working in team settings
  – Different opinions/perspectives, can feel as if others are critical
  – Team/patient/family disagreement on values/goals of care, expand with increasing case complexity
  – Gaining confidence in one’s roles and one’s voice on the team
  – Opportunities for growth and support?

• Issues of ageism, respect for older adults
  – Stereotypes may influence communication, clinical judgment
  – Increasing self-awareness re: attitudes
  – Challenges for training re: “attitudes” without direct observation