Navigating the Bumps in the Road: Strategies for National Implementation of Primary Care-Mental Health Integration

May 21, 2014

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Objectives

- Identify the current status of primary care-mental health integration within the VA
- Articulate the place of primary care-mental health integration within the full continuum of care
- Articulate the contextual and evidence barriers that exist in implementation of primary care-mental health integration and options for addressing them
Current Status of PC-MHI Implementation

Lisa K. Kearney, Ph.D., ABPP
Senior Consultant for Technical Assistance
Office of Mental Health Operations, VA Central Office
Rogers’ Diffusion of Innovation

Where are we for PCMHI implementation??

(Rogers, 1962)
UMHSH PC-MHI Requirements

• VA medical centers, very large CBOCs, and large CBOCs must have:
  • Co-located, collaborative care, **AND**
  • Care management (Behavioral Health Laboratory (BHL), the Translating Initiatives for Depression into Effective Solutions (TIDES) model, or other model approved by MHS)

• VAMCs and very large CBOCs must have this on a full-time basis

• Large CBOCs’ hours and days of availability of integrated care services can vary depending upon the clinical needs of the patient population
2013 PACT PC-MHI Survey

National Evaluation Survey
Fielded October 29, 2013
Sample (N = 349 divisions)
100% Response Rate

All VAMC divisions provide PC services

All Very Large CBOCs provide PC services
10,000+ uniques

All Large CBOCs provide PC services
between 5,000-10,000 uniques

VAMC sites
N=166
48%

Large CBOC sites
N=127
36%

Very Large CBOC sites
N=56
16%
Preliminary FY13 PCMHI Survey Findings

- Data is collected annually by the PC-MHI Evaluation Office
- FY13 PC-MHI Survey reported results from 349 VA Medical Centers and CBOCs serving >5000 patients

<table>
<thead>
<tr>
<th>Component</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-located, Collaborative Care</td>
<td>82.5%</td>
</tr>
<tr>
<td>Care Management</td>
<td>58.5%</td>
</tr>
<tr>
<td>Both Co-located, Collaborative Care AND Care Management</td>
<td>54.7%</td>
</tr>
</tbody>
</table>

*Special thanks to Dr. John McCarthy and Dr. Laurie Brockmann for data on this slide and following slides
Where are we at?

- 52% (73/140) met or exceeded the 6% benchmark for engagement of primary care Veterans in PC-MHI (pact15, January 2014 data)
- 18% (25/140) did not meet the floor of 4%
What’s it all about, Andy?

Andrew S. Pomerantz, MD
National Mental Health Director, Integrated Services
Mental Health Services, VA Central Office
The Past
(still the present in most places)

- Patient identified as having trouble
- PCP thinks Veteran needs mental health care
- Sends Consult
- Veteran gets appointment mailed (usually)
  - Veteran shows up at appointed time (aim for 14 days)
  - Veteran does not show up (30-40% likelihood)
- If A:
  - Veteran never comes back a second time (most common) – either Veteran choice or we think it was an unnecessary referral
  - Veteran keeps coming back, sometimes never stops coming back
- Either way:
  - PCP wonders what ever happened
End Result

- Enormous amount of clinician time wasted on patients who do not show up or do not engage
  - 1 no show means 2 people did not get care
  - 1 who does not engage means 3 did not get care

- Waiting time increases as system fills up

- Population needs are not met and everyone is mad at us
The Present
(in some places)

• PCP identifies need for treatment
  • Discusses with PCMHI to determine best course of action
  • Warm handoff to PCMHI
  • Requests phone assessment to gather info, triage to appropriate level of MH care
• Veteran receives treatment in PACT, led by PCMHI or PCP
• PCMHI manages referral to BHIP or specialty care for those who can’t be managed in PACT
  • When episode of illness, resolved care returns to PCP
  • If required, may be followed in MH long term
(VA published literature to date)

Present - past =

- Reduced no-show rates
- Increased engagement if referred on to MH specialty
- Increased identification AND treatment in the population
- Increased guideline-concordant care after positive screens
- Improved clinical outcome in Alcohol dependence
- Improved antidepressant use by PCPs
- Reduced waiting times

- And hopefully more to come
PCMHI requires a change in thinking from the standard:

• The patient does not really know what is wrong. He/she presents with an idea of what it is but if we spend enough time we will find out what it really is

• TO:
Rethinking the paradigm: Primary, Secondary and Tertiary Levels of Need

Triangle represents the prevalence of clinical severity
• 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

• 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

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 psychiatric care
    - Residential treatment
    - Supported and therapeutic employment
    - Homeless programs
    - Behavioral Health Interdisciplinary Program (BHIP)
Pop Quiz

• A cat named Adam created kittens with a cat named Eve. They were born in the oven. Do you call them:

A. Muffins
B. Adams ribs
C. Snakes
D. Kittens
BHIP in PACT?

- Co-location is necessary but not sufficient for integrated care
- Co-locating BHIP or any MH service in PACT is a great thing
- But you still need PCMHI for stepped care
4 systems, past to future
(without the coffee stains)
## Levels of Care for Mental Health

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACT (includes PC-MHI Providers)</td>
<td>General Mental Health Team-based Care: Behavioral Health Interdisciplinary Program (BHIP)</td>
<td>Specialty Outpatient Programs</td>
<td>Residential Rehabilitation &amp; Treatment Programs (RRTPs)</td>
<td>Inpatient Services</td>
</tr>
</tbody>
</table>
So Why Don’t We Just “Do It”? 

JoAnn Kirchner, MD 
Director, Mental Health QUERI
EBPs are Challenging to Implement

- Top down initiatives are not sufficient
- Readiness to participate differs across facilities
- Requires the participation of multiple stakeholder groups
- Limited availability of providers to participate in implementation activities
- Education alone is rarely sufficient
EBPs are Challenging to Implement

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Medical Center ACOS:

“Sometimes…you’ve got to tell me three times to do it because if you tell me three times, it was really important. If you tell me once and I never hear from you again, then it probably wasn’t important and was a passing fad and I’ll kind of wait”
Recommendations from the PCMH COVES Study
Recommendations from the PCMH COVES Study

Essential to involve local site participants in implementation efforts to assure buy-in and customization
Medical Center Chief:

“Different sites are going to have different kinds of primary care providers, they’re going to have different resources….They’re going to have different patient populations…so I don’t think one size will fit all…..There may be pitfalls that those who design the program from afar are unaware of …that are happening at the front line level and so if you don’t get the input locally, you might be lucky and everything will go fine but you also may be unwittingly setting yourself up for disaster”
Recommendations from the COVES Study

- Preparatory work, prior to implementation, is crucial for program success
- Need to develop and recommend a structured sequence for rolling out new programs or practices
- When scaling up implementation of evidence-based practices, there is the need for the allocation of additional organizational resources that directly support the implementation process
Adoption of a program
Adoption of a program

Organizational Context
Adoption of a program

Organizational Context

- Participatory climate
- Innovativeness
- Readiness
- Effective leadership
- Adequate resources
- Evaluation
Adoption of a program

Organizational Context

Beliefs about Evidence for the programs
Adoption of a program

Organizational Context

Beliefs about Evidence for the programs

Evidence

• Perception of evidence
• Relative advantage compared to existing practice
• Clinical experience
Adoption of a program

Organizational Context

Beliefs about Evidence for the programs
Adoption of a program

Organizational Context

Beliefs about Evidence for the programs
The PARiHS Diagnostic and Evaluative Grid

F1

F2

F3

Ideal situation for implementation of PC-MHI

CONTEXT (Weak)  EVIDENCE (Weak)  CONTEXT (Strong)  EVIDENCE (Strong)
Facilitation

• Process of helping site level personnel to implement and sustain a new program or practice
Facilitation of program implementation

Organizational Context

Beliefs about Evidence for the program

Adoption of a program

Facilitation
- Applies multiple strategies
- Flexibility
- Interpersonal skills
- External and internal facilitators
Facilitation of program implementation

Organizational Context

Beliefs about Evidence for the program

Adoption of a program
Facilitation of program implementation

Organizational Context

Beliefs about Evidence for the program

Adoption of a program
“So, how do I get one of those?”

Dean Krahn, MD
HSR&D Conference, 2007
“So, how do I get one of those?”

Dean Krahn, MD
HSR&D Conference, 2007

Funny you would ask, Dean........
Office of Mental Health Operations
PC-MHI Facilitation Program

- Uses an external facilitator
- Piloted in 2012-2013
- 4 sites participated thus far
- 7 facilitation visits “in the works” for 2014
- Facilitators include 4 field based SMEs

Spread to implementing evidence based psychotherapies in 2013
OMHO Facilitation Site
Percent PC-MHI Penetration

FY09  FY10  FY11  FY12  FY13  FY14
# A Different Approach to Practice

<table>
<thead>
<tr>
<th>Location</th>
<th>PC Clinic</th>
<th>A different floor, building, campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Most are healthy</td>
<td>Most have MH Dx</td>
</tr>
<tr>
<td>Inter-Provider Communication</td>
<td>Collaborative, consultative, continuing using PCP method of choice</td>
<td>Consult reports CPRS Notes</td>
</tr>
<tr>
<td>Service Delivery Structure</td>
<td>20-30 minute appointments Limited number (mean: 2-3)</td>
<td>50-90 minute psychotherapy sessions 14 week course</td>
</tr>
<tr>
<td>Approach</td>
<td>Problem-focused</td>
<td>Varies by therapy</td>
</tr>
<tr>
<td></td>
<td>Solution Oriented</td>
<td>Diagnosis focused</td>
</tr>
<tr>
<td></td>
<td>Patient Centered</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Leader</td>
<td>PCP continues to lead</td>
<td>MHP is lead</td>
</tr>
<tr>
<td>Primary Focus</td>
<td>Support overall health Of Veteran/Population Focus on function</td>
<td>Cure or ameliorate MH symptoms</td>
</tr>
</tbody>
</table>
A Different Approach to Practice

Population-Based, Stepped Care

- Support PACT MH Screening
- Support Patient Self-Management
- Provide Brief MH Interventions
- Support MH Treatment Provide by PCP
- Triage and Crisis Management
- Engagement in Treatment
- MH Subject Matter Expert in PACT
# The Role of the PC-MHI Clinician

<table>
<thead>
<tr>
<th>Goals</th>
<th>Primary Care – Mental Health</th>
<th>Mental Health Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performs appropriate clinical assessments</td>
<td>• Delivers primary MH treatment to resolve condition</td>
<td>• Delivers primary MH treatment to resolve condition</td>
</tr>
<tr>
<td>• Supports PCP decision-making</td>
<td>• Phone contact to PCP</td>
<td>• Phone contact to PCP</td>
</tr>
<tr>
<td>• Builds on PCP interventions</td>
<td>• Teaches Pt core self-management skills</td>
<td>• Teaches Pt core self-management skills</td>
</tr>
<tr>
<td>• Teaches PCP and PACT core MH skills</td>
<td>• Improves PCP-Pt working relationship</td>
<td>• Improves PCP-Pt working relationship</td>
</tr>
<tr>
<td>• Education Pts in self-management skills</td>
<td>• Manages chronic Pts with PCP as primary provider</td>
<td>• Manages more serious MH disorders over times as the primary provider</td>
</tr>
<tr>
<td>• Improves PCP-Pt working relationship</td>
<td>• Assists with team building</td>
<td></td>
</tr>
<tr>
<td>• Manages chronic Pts with PCP as primary provider</td>
<td></td>
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| Intervention Methods                                                  | Informal, revolves around PCP                                                                | Formal, requires intake assessment, treatment plan                                       |
|                                                                      | • Targeted txs, less intensity, longer between session interval                              | • Higher intensity, more concentrated care                                                |
|                                                                      | • Relationship generally is not primary focus                                               | • Relationship built to last Visits unrelated to PC                                       |
|                                                                      | • Visits time with PCP visits                                                               | • Long term follow-up encouraged                                                         |
|                                                                      | • Long term follow-up is rare, reserved for high risk cases or to bridge to MHS             |                                                                                        |

| Termination and Follow-Up                                             | Responsibility returned to PCP                                                              | Therapist remains person to contact if needed                                            |
|                                                                      | • PCP gives relapse prevention or maintenance treatment                                     | Therapist provides relapse prevention or maintenance                                     |
Training New Clinicians

- Didactics
- Memorization of Scripts
- Self-Assessment Using Behavioral Markers
- Observation of Skilled Clinician
- Practice and Feedback
- Practice with Intermittent Observation using Behavioral Makers
### Training Core Competency Tool

Use a rating scale of 1 = low skills to 5 = high skills to assess current level of skill development for all attributes within each dimension. Check in the column corresponding to the rating that best describes the trainee’s current skill level. Competency Tool: BHC mentor rates the BHC trainee based on their observations for each dimension (verbal feedback is also strongly recommended). A rating of 3 or higher is considered satisfactory for training.

| Dimension               | Element                          | Attribute                                                                 | Skill Rating
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. Clinical Practice</td>
<td>1. Role definition</td>
<td>Says introductory script smoothly, conveys the BHC role to all new patients, and answers patient’s questions</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Practice Knowledge and</td>
<td>2. Problem identification</td>
<td>Identifies and defines the presenting problem with the patient within the first half of the initial 30-minute appointment</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>3. Assessment</td>
<td>Focuses on current problem, functional impact, and environmental factors contributing to/maintaining the problem; uses tools appropriate for primary care</td>
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<tr>
<td></td>
<td>4. Problem focus</td>
<td>Explores whether additional problems exist, without excessive probing</td>
<td></td>
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<tr>
<td></td>
<td>5. Population-based care</td>
<td>Provides care along a continuum from primary prevention to tertiary care; develops pathways to routinely involve BHC in care of chronic conditions; understands the difference between population-based and case-focused approach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Biopsychosocial approach</td>
<td>Understands relationship of medical and psychological aspects of health</td>
<td></td>
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<tr>
<td></td>
<td>7. Use of empirically-supported</td>
<td>Utilizes evidence-based recommendations/interventions suitable for primary care for patients and PCMs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interventions</td>
<td></td>
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PPAQ

- The Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ) is a self-report measure of PCMH provider fidelity
  - The PPAQ aims to improve provider knowledge of practice behaviors that may enhance their ability to provide high quality PCMH care to Veterans and their families
- The PPAQ was developed to represent the following Co-located Collaborative Care practice domains:
  - Clinical scope and interventions
  - Practice and session management
  - Referral management and care continuity
  - Consultation, collaboration, and inter-professional communication
- The PPAQ may be used alone by individual PCMH providers or as part of program development activities (e.g., facilitation)
- The PPAQ takes about 10-15 minutes to complete and is available by request from the author (gregory.beehler@va.gov)
  - The PPAQ will soon be made available for web-based administration via the CIH website

How to Assess Clinician Competencies

Example Performance Plan Components

• **Clinical Practice Skills**
  Applies principals of population-based care as measured by number of patient contacts per month, number of 30 min appointments, number of encounters per patient and range of interventions provided

• **Documentation Skills**
  • Writes clear, concise notes with explicit impression, recommendations and plan for PCP use and adds PCP as co-signer

❖ **Consultation/Team Skills**
  Uses warm-hand off strategy with PCPs
  Attends PACT meetings and daily huddles
Competencies vs. Personalities

- Competencies
  - Abilities or Skills
- Personality
  - Flexible/Adaptable
  - Open-Minded
  - Reliable/Team Player
  - “Can Do” Attitude
  - Patient-Centered
  - Enthusiastic and Persistent
  - Good Communication Skills
What is in the Toolbox?

• Advanced Access Strategies
  • Brief, Efficient Appointments
  • Team Approach to Availability

• Understands and Can Effectively Access All SMH programs/resources

• Access and Use of Program Data

• Clearly defined role
  • Sees patients fitting into program standards and refers others on
  • Ensures referred patients get into SMH
What is in the Toolbox?

- Patient-Centered, Functionally Oriented Care
- Motivational Interviewing
- Brief Interventions for Common MH Conditions
  - PST
  - Relaxation
  - Behavioral Activation
  - Brief Intervention for SUD
It’s Not Just the PC-MHI Clinicians …

- Primary Care Providers and PACT Members
- Specialty Mental Health
- Mental Health and Facility Leaders
- Patients
Resources

• Mental and Behavioral Health in PACT Education and Training Workgroup

• Mental and Behavioral Health in PACT Listserv
  • Contact to Join: laura.wray@va.gov or johnpatrickmarr@va.gov

Resources

• VA Center for Integrated Healthcare
  • Website: 
    http://www.mentalhealth.va.gov/coe/cih-visn2/
    • Policies/Procedures
    • Practice Management
    • Patient Education
    • Clinician Education

• SharePoint:
  https://vaww.visn2.portal.va.gov/sites/natl/cih/Shared%20Documents/Forms/AllItems.aspx

• VeHU Presentation on the 30-Minute Appointment:
  http://www.myvehucampus.com/desktop/#loc=contentid4691
• Primary Care Mental Health Integration Program Office
  • Website:
  • SharePoint:
    https://vaww.portal.va.gov/sites/pcmhihub/PCMHl/Pages/default.aspx
  • PC-MHI Dashboard:
    %2fPC%2fPCMM%2fPC-MH+Integration%2fMainMenu
  • PC-MHI Functional Tool:
    https://vaww.portal.va.gov/sites/pcmhihub/PCMHl/Document%20Reposi
tory%201/Forms/Functional%20Tool.aspx
Resources

- Behavioral Health Lab

- TIDES

- Patient Aligned Care Team
  - SharePoint: http://vaww.infoshare.va.gov/sites/primarycare/mh/pcmhin/default.aspx
Helpful Data Resources

- **PCMHI Penetration Rate** (pact15) - PACT Dashboard at [http://go.va.gov/xhh6](http://go.va.gov/xhh6)


Discussion