Preparing the Workforce for Primary Care Behavioral Health: Training and Workforce Challenges

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Your Prior Training in Integrated Primary Care

- How many of you had the following types of training in IPC?
  - Reading materials
  - Workshop training
  - Graduate course
  - Practicum in IPC
  - Internship in IPC
  - Residency in IPC
  - Competency-based training where you had to demonstrate the skills of IPC
- How many of you had these types of training prior to starting work in a job in IPC?

Your Prior Training in Integrated Primary Care

- Many people, however, experience the plop and drop method of training
- This is NOT effective.
- Personal account anyone?

Need for Specific Training

- Most mental health providers do not have background or specific training to practice in integrated settings (Serrano et al., 2018).
- Simply hiring and placing mental health providers with no specific background in PC into these settings may lead to the development of traditional MH settings in primary care, rather than truly integrated care practice
- Integrated primary care requires adjustment of mental health providers to work in fast-paced, team-based care settings requiring the development of new skills to promote successful collaboration and same-day access to services, a hallmark of integrated care models (Dollar et al., 2018).

Dollar, K. M., Kearney, L. K., Pomerantz, A. S., & Wray, L. O. (2018). Achieving same-day access in integrated primary care. *Families, Systems, & Health*, *36*(1), 32-44. doi:10.1037/fsh0000327
Serrano, N., Cos, T. A., Daub, S., & Levkovich, N. (2017). Using standardized patients as a means of training and evaluating behavioral health consultants in primary care. *Families, Systems, & Health*, *35*(2), 174-183. doi:10.1037/fsh0000272

Why is Unique Training in Integrated Primary Care Needed? Is it Really That Different from Mental Health?

Table modified from Rowan & Runyan, 2005 and USAF PCBH Practice Manual.

	IPC	Mental Health Specialty
Location	PC Clinic	A different floor, building, site
Population	Full population in primary care	Most with moderate to severe MH concerns
Inter-Provider Communication	Collaborative , ongoing, & consultative Using PCP method of choice	Consult reports CPRS Notes
Service Delivery Structure	20-30 minute appointments Limited number (mean: 2-3)	50-90 minute psychotherapy sessions; 14 weeks or more
Approach	Problem-focused Solution Oriented	Varies by therapy Diagnosis focused
Treatment Plan Leader	PCP continues to lead	MH Provider is lead
Primary Focus	Support overall health of Veteran/Population Focus on function	Cure or ameliorate MH symptoms
Termination and Follow-Up	Responsibility remains with PACT/PCMH	MH Provider remains person to contact if needed
IPC PRACTICE IS REALLY DIFFERENT FROM WHAT WE HAVE ALL BEEN TRAINED TO DO!		

Rowan, A. B., & Runyan, C. N. (2005). A primer on the consultation model of primary care behavioral health integration. In L. C. James & R.A. Folen (Eds.), The Primary Care Consultant: the Next Frontier for Psychologists in Hospitals and Clinics, p. 9-27. American Psychological Association. Washington, DC.
Primary Behavioral Health Care Services Practice Manual 2.0, U.S. Air Force Medical Operations Agency, 2002.

Creating a Training Program to Meet Your Workforce Needs

- Training models for PCBH are still in the earliest stages of development (Serrano et al., 2018)
- Not yet conclusively determined the specific forms of training which will produce a well-rounded PCBH clinician (Dobmeyer et al., 2016)
- We do know from other clinical training that educational materials and non-hands on workshops have been shown to have minimal impact on provider behavior or patient outcomes (e.g., Farmer et al., 2009; Giguere et al., 2012; Rakovshik & McManus, 2010).

Farmer, R. F., & Chapman, A. L. (Eds.). (2008). Changing behavior by building skills. *Behavioral interventions in cognitive behavior therapy: Practical guidance for putting theory into action* (pp. 177–201). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11664-007
Giguère, A., Légaré, F., Grimshaw, J., Turcotte, S., Fiander, M., Grudniewicz, A., . . . Gagnon, M. P. (2012). Printed educational materials:Effects on professional practice and healthcare outcomes. *The Cochrane Database of Systematic Reviews, 10,* CD004398. http://dx.doi.org/10 .1002/14651858.CD004398.pub3
Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review, 30,* 496–516. http://dx.doi.org/10.1016/j.cpr.2010.03.004

Competency Attainment, Not Passive Education is Required

- Several organizations have developed specific IPC competencies for practice
  - Substance Abuse and Mental Health Services Administration (SAMHSA – Hoge et al., 2014),
  - American Psychological Association (McDaniel et al., 2014),
  - Colorado State (Miller et al., 2016) and
- Insufficient to simply attend a workshop training and be able to adapt these skills from practice
- Clinical providers must demonstrate the desired competencies in order to ensure that clinic practices change to promote truly integrated care.

Hoge M.A., Morris J.A., Laraia M., Pomerantz A., & Farley, T. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care*. Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions.
McDaniel, S. H., Grus, C., Cubic, B., Hunter, C., Kearney, L. K.,. Schuman, C., … Johnson, S., B. (2014). Competencies for psychology practice in primary care. *American Psychologist, 69* (4), 409-429
Miller, B.F., Gilchrist, E. C., Ross, K. M., Wong, S. L., Blount, A., & Peek, C. J. (2016) Core Competencies for Behavioral Health Providers
Working in Primary Care. Prepared from the Colorado Consensus Conference. Retrieved from: http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf

SAMHSA (Hoge et al., 2014)

Note: These competencies include the whole care team, including PCPs!

[1]Hoge M.A., Morris J.A., Laraia M., Pomerantz A., & Farley, T. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care*. Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions.

American Psychological Association (McDaniel et al., 2014)

Science
- Science Related to the Biopsychosocial Approach
- Research/Evaluation

Systems
- Leadership/Administration
- Interdisciplinary Systems
- Advocacy

Professionalism
- Professional Values and Attitudes
- Diversity
- Ethics in Primary Care
- Reflective Practice/Self-assessment/Self-care

Relationships
- Interprofessionalism
- Building and Sustaining Relationships in Primary Care

Application
- Practice Management
- Assessment
- Intervention
- Clinical Consultation

Education
- Teaching
- Supervision

McDaniel, S. H., Grus, C., Cubic, B., Hunter, C., Kearney, L. K.,. Schuman, C., … Johnson, S., B. (2014). Competencies for psychology practice in primary care. *American Psychologist*, *69* (4), 409-429

Colorado (Miller et al., 2016)

I. Identification and Assessment

II. Engagement and Activation

III. Care Planning

IV. Team Functioning

V. Communication

VI. Population-based

VII. Whole-Person Care

VIII. Cultural Competence

[1]Benjamin F. Miller, PsyD, Emma C. Gilchrist, MPH, Kaile M. Ross, MA, Shale L. Wong, MD, MSPH, Alexander Blount, EdD, C.J. Peek, PhD. Core Competencies for Behavioral Health Providers Working in Primary Care. Prepared from the Colorado Consensus Conference. February 2016.

Step 0: Hire Well

- Completion of discipline specific graduate training in integrated care, including practicum experiences
  - E.g. The American Psychological Association's Directory of Doctoral Training Programs with Training Opportunities in Primary Care Psychology is a list of **internship**, **postdoctoral**, and **doctoral training** programs that offer training in primary care psychology.
- Review for completion of certification programs in integrated care
  - VA or DoD certification in primary care behavioral health
  - **The Behavioral Health and Integration Training Institute** is a 40-hour continuing education training offered in a one-week format, targeted to current mental and behavioral health professionals interested in furthering their skill and knowledge base on integration and behavioral health. Participants are eligible to receive continuing education credits through Radford University.
  - **A Certificate Program in Primary Care Behavioral Health** from the Department of Family Medicine and Community Health at the University of Massachusetts Medical School offers licensed mental health professionals certification to work as primary care behavioral health providers.
  - **The Certificate in Integrated Behavioral Health and Primary Care** from the University of Michigan - School of Social Work is designed for direct clinical practitioners -- social workers, nurses, care managers, psychologists, and physicians -- who deliver or plan to deliver integrated health services and who serve populations often presenting with complex needs in physical health, mental health, and substance use.
  - The University of Washington - AIMS Center provides an **online training for psychiatrists working in primary care**. The training provides an introduction to practice in an integrated care team. This online training consists of five modules that describe the basic structure of an integrated care program for behavioral health in a primary care setting and provides information on the process of development and implementation of an integrated care team.
  - University of Maryland School of Medicine's **Behavioral Health Integration in Pediatric Primary Care** supports the efforts primary care providers (PCPs), including pediatricians, family physicians, nurse practitioners, and physician assistants, in assessing and managing mental health concerns in their patients from infancy through the transition to young adulthood.
  - The **Certificate Program in Integrated Primary Care (CPIPC)**, offered by Fairleigh Dickinson University, reviews key principles of integrated primary care. Major program topics include basic concepts in integrated primary care, attributes of the care provider, practice standards, assessment, and program development.

Step 0: Hire Well - Discussion

- How do you interview to assess for competency in integrated primary care?
- What types of questions do you ask?
- Who is on your interview panel?
- What do you look for in CVs/Resumes for prior training?

Step 1: Assess the Baseline Competency of Your Providers (Self Report)
Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ)

- Validated self-report measure of integrated care provider fidelity to the PCBH Model (new version includes CoCM fidelity)
- Uses a 5-point, Likert-type response scale ranging from "never" to "always."
- Includes essential items, which measure behaviors that are highly consistent with the PCBH model,
- Includes prohibited items, which measure behaviors that are inconsistent with the PCBH model.
- Can be used as a self assessment to evaluate usual clinical practices across four domains of practice:
  - Clinical Scope and Interventions;
  - Practice and Session Management;
  - Referral Management and Care Continuity;
  - Consultation, Collaboration, and Interprofessional Communication.

The PPAQ self-report form can be downloaded here:

Beehler, G. P., Funderburk, J. S., Possemato, K., & Vair, C. (2013). Developing a measure of provider adherence to improve the implementation of behavioral health services in primary care: A Delphi study. Implementation Science, 8, 19.
Beehler, G. P., Funderburk, J. S., Possemato, K., & Dollar, K. (2013). Psychometric assessment of the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ). Translational Behavioral Medicine, 3, 379-391.
Beehler, G. P., Funderburk, J. S., King, P., Wade, M., & Possemato, K. (2015). Using the Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ) to identify practice patterns. Translational Behavioral Medicine, 5, 384-392
Beehler, G. P., & Lilienthal, K. R. (2017). Provider perceptions of an integrated primary care quality improvement strategy: The PPAQ Toolkit. Psychological Services, 14, 50-56.

Sample Items:
Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ)

Question	Never	Rarely	Sometimes	Often	Always
During clinical encounters with patients, I see patients for 30 minutes or less.	1	2	3	4	5
I manage patients reporting mild to moderate symptoms in primary care and I refer those with more severe symptoms to specialty mental health services when possible.	1	2	3	4	5
During patient appointments, I discuss barriers to implementing a plan or adhering to treatment recommendations.	1	2	3	4	5
I accept referrals for patients with common mental health problems (i.e., depression, anxiety, etc.).	1	2	3	4	5
During clinical encounters with a patient, I implement behavioral and/or cognitive interventions.	1	2	3	4	5
In introducing my role in the clinic to patients, I explain that what I want to get an idea of what is and is not working for the patient and then together develop a plan to help them manage their concerns.	1	2	3	4	5
During clinical encounters with patients, I triage patients to determine if they can be treated in primary care or should be referred to a specialty mental health or a community agency.	1	2	3	4	5

Toolkit for Self-Guided Education
Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ)

- Includes self-report form, interpretation guidelines, suggestions for how to engage in quality improvement, and links to resources
- Excel-based PPAQ toolkit automatically scores the PPAQ items and includes interpretation guides as well as suggestions for how to apply the results of the self-assessment to improve integrated care practice. There are three versions of the toolkit available: one for VA-based integrated care providers; one for integrated care providers practicing in non-VA settings; and the latest version applicable to both VA and non-VA providers which will compare PPAQ scores at two time points (e.g., baseline and follow-up).
  - **PPAQ Toolkit for VA providers:**
  - **PPAQ Toolkit for non-VA providers:**
  - **PPAQ Toolkit for baseline and follow-up assessment (for both VA and non-VA providers):**
-

All PPAQ products are free to use for personal reference, training, or quality improvement activities. Please contact us at (gregory.beehler@va.gov) to discuss options if you would like to use the PPAQ in research.

Step 2: Assess Clinic Provider Behavior Through Administrative Measures

Measure	Description
30 Minute Appointment Fidelity	Percentage of appointments conducted in 30 Minutes
Return to Clinic Rate	Average number of sessions per patient (<4-6 desired)
Same Day Access	Percentage of first appointments with an integrated care provider seen the same day as the primary care clinic appointment
Open access rate	Percentage of overall utilization of open access scheduling slots
Specialty MH Referral	Percentage of patients referred to SMH

Kearney, L. K., Smith, C. S., & Pomerantz, A. (2015) Capturing psychologists' work in integrated care: measuring and documenting administrative outcomes. *Journal of Clinical Psychology in Medical Settings, 22* (4), 232-242.

Step 3: Assess Provider Competency Through Role Play and Observation

- Utilize standardized assessment rating scales by trainers to assess ability to complete functional assessments, follow-up interventions, and behavior in clinic
  - DoD rating scale
  - VA rating scale
  - Behavioral Health Consultant Outcome Rating Scale (Serrano et al., 2017)
- May wish to use standardized patient cases or simulated patients prior to clinic observations (e.g., Serrano et al., 2017)
- Consider video recordings and feedback of patient interactions (Serrano et al., 2017)
- Include your primary care team in role plays

Serrano, N., Cos, T.A., Daub, S., & Levkovich, N. (2017). Using standardized patients as a means of training and evaluating behavioral health consultants in primary care. *Families, Systems, & Health*, *35*(2), 174-183. doi:10.1037/fsh0000272

Step 4: Create a Method for Ongoing Assessment of Fidelity

- Consider implementation of ongoing peer review for fidelity (sample from DoD here)
- Create methods for electronic health record data extraction to assess for 30 minute, RTC, and same day access fidelity
- Implement a minimum of biannual feedback processes based on self report assessments and observational data in clinic

Assessing Current and Ongoing Fidelity of Providers

How do you currently assess competency of new providers in IPC?

How do you review ongoing maintenance of fidelity in your providers?

Are there particular administrative dashboards and observational techniques you utilize?

VA's Integrated Primary Care Training Model

Lessons Learned and Challenges Overcome

KEY CONTRIBUTORS TO VA'S TRAINING PROGRAM

- Jessica Ackermann
- Peggy Arnott
- Joel Baskin
- Peggy Bramlet
- Kathy Dollar*
- Pat Dumas
- Brad Felker
- Joe Grasso
- David Hunsinger
- Karey Johnson

- Elyse Kaplan
- Lisa Kearney*
- Johanna Klaus
- Andy Pomerantz*
- Elizabeth Scheu
- Beret Skroch
- Katharine Vantreese
- Tanya Workman
- Laura Wray*
- Erin Zerth

Key Program Evaluation Colleagues
- Greg Beehler
- Wade Goldstein
- Laurie Brockmann
- Leigha Destefano

VA's Model: Primary Care-Mental Health Integration (PCMHI)

- Care Management (CM)
  - Also called "collaborative care" outside VA
  - Takes targeted approach, includes care manager and a consulting MH provider supporting PCP guideline supported care
  - Strong evidence base
- Co-located Collaborative Care (CCC)
  - Also called primary care behavioral health or integrated primary care outside VA
  - Embeds licensed independent practitioners in the PC clinic where they work collaboratively with the PC team to serve all patients with MH concerns
  - Evidence base not strong

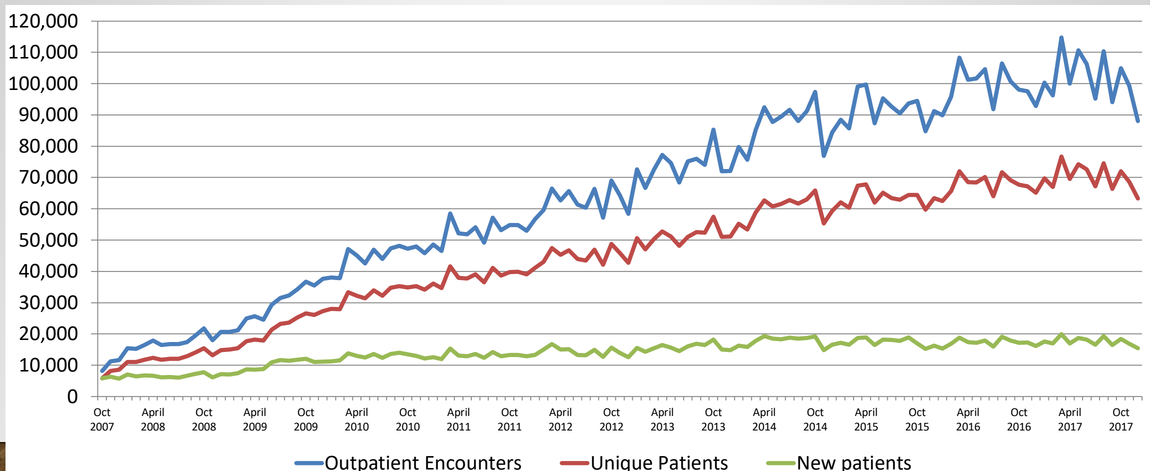
According to VA: PCMHI =
Care management (CM) + Co-located Collaborative Care (CCC)

VA's Model: Primary Care-Mental Health Integration (PCMHI): Implementation Successes

- Since 2008, PCMHI has been mandated to be present in large outpatient clinics, serving over 5000 patients, and in all hospitals (Kearney et al., 2014).
- VA has one of the largest integrated primary care systems across the nation with over 350 sites of care and over 1600 PCMHI team members.

Kearney, L. K., Post, E. P., Pomerantz, A. S., & Zeiss, A. (2014). Transforming primary care: Applying the interprofessional Patient Aligned Care Team in the Department of Veterans Affairs. *American Psychologist, 69* (4), 399-408.

VA's Model: PCMHI Implementation Successes Encounters and Patients Served (data provided by Dr. John McCarthy)



VA's Model: Primary Care-Mental Health Integration (PCMHI): Implementation Successes

Data provided by Dr. John McCarthy, Director - PCMHI Evaluation Office

Calendar Year	Unique Patients who Received PC-MHI Encounters	Primary Care (PACT) Patients	Prevalence of Receipt of PC-MHI
2013	240,462	4,027,424	**6.0%**
2014	277,579	4,026,609	**6.9%**
2015	295,972	4,076,079	**7.3%**
2016	315,527	4,074,926	**7.7%**
2017	332,327	4,109,536	**8.1%**

PCMHI Training Challenges

- 2007-2011 VA provided national trainings for facilities in PCMHI during initial program rollouts (Kearney et al., 2011)
  - Provided foundational knowledge in the delivery of PCMHI essential for practice in these settings,
  - Did not provide a systematic, competency based approach allowing for skill practice and assessment of clinician competency.
- In 2012, travel restrictions limited access to national trainings and VA moved to regional trainings, when requested by local facilities.
- Increasing numbers of providers hired in PCMHI settings, particularly with MH expansion funds and the hiring initiative in 2012.

Kearney, L. K., Post, E. Zeiss, A., Goldstein, M., & Dundon, M. (2011). The role of mental and behavioral health in the application of the patient-centered medical home in the Department of Veterans Affairs. *Translational Behavioral Medicine: Practice, Policy and Research, 1 (4),* 624-628.

PCMHI Training Challenges

- No required trainings or assessment of competency to practice prior to initiating of PCMHI services by newly hired personnel.
- Many providers reported experiencing a "plop and drop" approach
- Multitude of national resources available (e.g., community of practice calls, the PCMHI Foundation Manual, SharePoint resources, and policy guidance) but lacked the hands on training necessary to develop these skills
- Little opportunity for training of Primary Care with Mental Health Providers.

Kearney, L. K., Post, E. Zeiss, A., Goldstein, M., & Dundon, M. (2011). The role of mental and behavioral health in the application of the patient-centered medical home in the Department of Veterans Affairs. *Translational Behavioral Medicine: Practice, Policy and Research, 1 (4),* 624-628.

Plop and Drop Techniques of IPC Training are Ineffective

- Same day access to PCMHI was at 33.7% (Goal: 75%).
- PCMHI penetration (reach of services) was at 7.37% (Goal: >10%).
- In FY12-15 VA Central Office site visits found PCMHI fidelity to be one of the top concerns across all areas of mental health

Launching of PCMHI Competency Training Program as Part of My VA Access Strategic Plan

- Training of 1600+ PCMHI team members by December 2018 in SAHMSA based model
- Reflect VA's blended and regional models of decentralized Evidence-Based Psychotherapy (EBP) training, providing a platform and network for quick dissemination of emerging evidence-based practices
- Training of Regional Trainers, Facility Trainers, and then local PCMHI team members in model developed by CIH in collaboration with Dr. Andy Pomerantz and Field Based SMEs
- Use of hands-on training to increase fidelity, as educational materials and non-hands on workshops have minimal impact on provider behavior or patient outcomes (e.g., Giguere et al., 2012; Rakovshik & McManus, 2010)

Giguère, A., Légaré, F., Grimshaw, J., Turcotte, S., Fiander, M., Grudniewicz, A., . . . Gagnon, M. P. (2012). Printed educational materials:Effects on professional practice and healthcare outcomes. *The Cochrane Database of Systematic Reviews, 10,* CD004398. http://dx.doi.org/10 .1002/14651858.CD004398.pub3

Rakovshik, S. G., & McManus, F. (2010). Establishing evidence-based training in cognitive behavioral therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review, 30,* 496–516. http://dx.doi.org/10.1016/j.cpr.2010.03.004

Competency Training Rollout

Phase I

Conducted virtually

Baseline assessment of competency, review of written materials, and online trainings (all on Pulse Site)

Must be completed to attend in-person Phase II training

Phase I Pre work

Phase II

2.5 day in-person training with on **hands-on role playing and demonstration** of all CCC and CM skills

At conclusion of passing of competency assessment, participants receive certification in CCC and/or CM (trainers must complete both)

Agenda

Phase III

Virtual follow-up at 3/6 months with SME

Ongoing fidelity will be reviewed through self-report measures and national data*

Booster training provided until fidelity is obtained.

Invitation for Inclusion of PC in Phase II (5 sessions dedicated to joint training and role play)

Fidelity Rating Tools: Self Report, Demonstration Ratings , and Administrative Data

- The Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ – Beehler et al., 2013, 2015) – self report
- Fidelity Rating Scales for Role Plays
- VA PCMHI Core Competency Tool
- Administrative Data

Standardized Case Role Plays

On the last day, of training, complete two role plays in your area of practice (e.g., CCC initial and follow-up or CM initial and follow-up)

- Co-located Collaborative Care (CCC) Functional Assessment
- CCC Follow-Up
- Care Management (CM) Initial Assessment
- CM Follow-Up

All role plays are on standardized cases. Basic information at the start of each role play is provided:

- Basic demographics
- Presenting problem and reason for referral/warm handoff
- Medications/relevant medical diagnoses
- Brief military history
- Results of self report instruments
- Clinical reminder data

Use of Training Tools for Demonstrations

- Functional Assessment Training Tool
- Follow-up Appointment Training Tool

Fidelity Rating Scales for Role Plays

- Four scales to assess adherence during role play for care management and co-located collaborative care initial and follow-up
- Critical elements are denoted for all areas for passing
- Timing is also denoted for various elements
- Behavioral anchors are denoted for each element
- Need to show at least "average performance" on all categories with most all elements exhibited and no critical items missing

Fidelity Rating Scales for Role Plays: Sample Items

Observed Element (Note: * items denote critical items - if these not present, participant will be rated as a 1 in the overall category)	Time Allotment	Time Allotment Met	Element present	Overall Rating of Category
Assess: Identifies and/or clarifies the presenting problem*	**10-60 seconds**			
Assess: Evaluates how presenting problem impacts patient's functioning (home, social, work, recreational, and spiritual)	**12-15 minutes (items from here to summary)**			
Assess: Asks about duration, frequency, and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem				
Assess: Appropriately assesses and manages risk of harm to self/others*				
Assess: Uses/references assessment measures appropriate to primary care (e.g., PHQ9, GAD-7, PCL)*				

VA PCMHI Core Competency Tool

- Reviews behavioral anchors for all SAMHSA competencies demonstrated at in person training
- Based on fidelity rating scales and role plays
- Rating is yes/no for presence of noted demonstrated behaviors

VA PCMHI Core Competency Tool

SAMHSA Competency III: Screening and Assessment						
Element (CCC/CM/Both)	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors and Data Sources	Skill Rating			Comments
			Pass	Fail	Not Observed	
1.Introductory Script for CCC (CCC)	1a. Accurately describes per standardized script: i) Who they are and their role in the clinic ii) How long the appointment will be, iii) What will happen during the appointment, iv) What types of follow-up might occur, v) That the appointment note will go in medical record, vi) That the PCP will get feedback, vii) Any reporting obligations.					
	1b. Delivers the script in 2 minutes or less.					
	1c. If interrupted by the patient during the introductory script, the PCMHI provider answers questions and appropriately redirects to complete the introductory script					

Sample Feedback Form

Name: Facility Lead Trainer VISN/Facility: (1V02) (528) Albany
Dates of Phase II Training: 9/21/2017

COMPETENCY RATING				
Competency Role Play Rating		Baseline	3-Month	6-Month
		Q3 2017	Q1 2018	FY__Q__
	Overall Rating	Pass	Pass/Pass	(Pass/Fail)
ADMINISTRATIVE DATA[1]				
Average Rate of Revisits for Patients (Target: <4-6 visits)	Provider			
	Facility Trainer Average			
Percentage of PCMHI Mental Health Visits Coded < 30 mins. (Target: > 75%)	Provider			
	Facility Trainer Average			
PRIMARY CARE BEHAVIORAL HEALTH PROVIDER ADHERENCE QUESTIONNAIRE (PPAQ) – BY DOMAIN [2]				
PPAQ – Co-located Collaborative Care (CCC) Clinical Scope and Interventions	Provider			
	Facility Trainer Average			
PPAQ - CCC Practice and Session Management	Provider			
	Facility Trainer Average			
PPAQ – CCC Referral Management and Care Continuity	Provider			
	Facility Trainer Average			
PPAQ – CCC Consultation, Collaboration, and Interprofessional Communication	Provider			
	Facility Trainer Average			

Sample Feedback Form

PPAQ - Care Management: Patient Identification	Provider			
	Facility Trainer Average			
PPAQ - Care Management: Patient Education, Self-Management Support, Psychological Intervention	Provider			
	Facility Trainer Average			
PPAQ - Care Management: Supervision and Care Coordination	Provider			
	Facility Trainer Average			
PPAQ - Care Management: Measurement-Based Care and Protocol Adherence	Provider			
	Facility Trainer Average			
PPAQ - Care Management: Panel Management	Provider			
	Facility Trainer Average			
PPAQ – Total Score	Provider			
	Facility Trainer Average			

Facility Trainer Average is the average for the group of all PCMHI Facility Lead Trainers nationally (N=XXX)
1. Administrative data definitions and sources can be found here
2. PPAQ - Higher Scores=Higher Fidelity; More information about the PPAQ can be found here
3. PPAQ – note that CCC providers would not be expected to have high fidelity ratings for Care Management (CM) Domains if they are not generally conducting CM. Likewise, CM providers would not be expected to have high fidelity rating for CCC Domains.

STRENGTHS:

AREAS FOR IMPROVEMENT:

SUGGESTED RESOURCES:

VISN PCMHI LEAD TRAINING EVALUATION DATA HIGHLIGHTS (JUNE 2017, N = 30)

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Participant Satisfaction standard Questions)	**Agree n, (%)**	**Strongly Agree n, (%)**
I will be able to apply the knowledge and skills learned to improve my job performance.	1, (3.3)	29, (96.7)
I would recommend this training course to others.	2, (6.7)	28, (93.3)
The content of the learning activity was current.	2, (6.7)	28, (93.3)
The scope of the learning activity was appropriate to my professional needs.	3, (10.0)	27, (90.0)

Participant Comment: *"As a result of this training, I will change my practice to be more in line with the national model. I will teach my team about the specifics of this model and I will change the requirements of our training program to include these principles."*

LOCAL PCMHI EVALUATION DATA HIGHLIGHTS TO DATE (APRIL 2018, N = 487)

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Participant Satisfaction Standard Questions)	**Agree n, (%)**	**Strongly Agree n, (%)**
I will be able to apply the knowledge and skills learned to improve my job performance.	189, (39.3)	255, (53.0)
I would recommend this training course to others.	177, (36.5)	237, (48.9)
The content of the learning activity was current.	204, (42.2)	259, (53.5)
The scope of the learning activity was appropriate to my professional needs.	189, (39.0)	255, (52.6)

Participant Comment Regarding How They Will Apply The Training: "Implementing more successful warm hand-offs, framing mental health services in a non-stigmatizing manner, collaborating with mental health providers to optimize patient health and well-being within a primary care setting."

VISN TRAINER OUTCOME DATA

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	Baseline	**3 month**	**6 months**	***p***
PPAQ Total	208.6 (16.3)	215.9 (13.6)	215.5 (15.8)	<.001 *
PPAQ CM Total	206.1 (19.0)	217.9 (22.5)	222.3 (17.8)	.001 *
30 Minute Ratio	51.4% (28.3)	64.4% (25.4)	63.8% (27.8)	.002*

Note: Significant PPAQ -2 subscales include Practice and Session Management; Patient Education, Self-Management Support, and Psychological Intervention; Measurement Based Care and Protocol Adherence. Repeated Measures ANOVA utilized for statistical analyses.

FACILITY TRAINER OUTCOME DATA

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	Baseline	3 month	6 months	*p*
PPAQ Total	197.7 (17.7)	207.7 (14.2)	In progress	<.001*
PPAQ CM Total	198.8 (24.4)	210.1 (22.9)	In progress	<.001*
30 Minute Ratio	50.7% (25.5)	61.4% (25.4)	63.8% (25.6)	<.001*

Note: Significant PPAQ-2 subscale changes noted for all but 1 subscale at 3 months. Paired t-tests and Repeated Measures ANOVA utilized for analyses.

LOCAL FRONT LINE STAFF OUTCOME DATA

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	Baseline	3 month	*p*
PPAQ Total	186.1 (30.2)	196.3 (28.5)	<.001*
PPAQ CM Total	190.5 (38.1)	202.1 (35.1)	<.001*
30 Minute Ratio	54.0% (30.7)	74.0% (28.1)	<.001*

Note: Significant PPAQ-2 subscale changes noted for all but 2 subscales at 3 months. Paired t-tests utilized for statistical analyses.

LOCAL CLINIC OUTCOME DATA (FOR 18 SITES WITH ALL TRAINED)

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	Baseline	**3 month**	***p***
Same Day	50.0%(15.8)	55.3%(12.3)	.039*
30 Minute Ratio	52.5% (22.3)	65.8%(18.9)	<.001*
Penetration Rate	6.9%(2.1)	7.0%(1.6)	.652

Note: Paired t-tests utilized for statistical analyses. Penetration rate requires further time to show change due to rolling quarter data and partnership with PC.

Bringing It Home

Next Steps in Training Your Own Workforce

Your Next Steps

- What training tools might you wish to develop or apply in your own setting?
- What are actionable next steps you would like to take when you return to your clinic to improve fidelity of yourself or the team you oversee?

ADDITIONAL WEBSITE RESOURCES

- ***The Academy: Integrating Behavioral Health and Primary Care*** http://integrationacademy.ahrq.gov/
- ***AHRQ Integration Playbook*** https://integrationacademy.ahrq.gov/playbook/about-playbook?utm_source=WESTAT&utm_medium=&utm_term=&utm_content=24&utm_campaign=AHRQ_IAPB_2016
- ***VA Center for Integrated Healthcare (CIH)*** http://www.mirecc.va.gov/cih-visn2/
- ***Advancing Integrated Mental Health Solutions (AIMS)*** https://aims.uw.edu/
- ***Collaborative Family Healthcare Association*** http://www.cfha.net/
- ***Dr. Kirk Strosahl's Mountainview Consulting Group*** http://www.mtnviewconsulting.com/
- ***SAMHSA-HRSA Center for Integrated Health Solutions*** http://www.integration.samhsa.gov/
- ***Society for Health Psychology*** https://societyforhealthpsychology.org/training/integrated-primary-care-psychology/

TEXTBOOKS

- Behavioral Consultation and Primary care: A guide to integrating services (2nd ed.). Robinson, P. J., & Reiter, J. T. (2015). New York, NY: Springer.
- Integrated Behavioral Health in Primary Care: Step-by-step guidance for assessment and intervention. Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2016). Washington, DC: American Psychological Association.
- Real Behavior Change in Primary Care: Improving patient outcomes & increasing job satisfaction. Robinson, P. J., Gould, D. A., & Strosahl, K. D. (2010). Oakland, CA: New Harbinger.
- Behavioral integrative care: Treatments that work in the primary care setting. W. O'Donohoe, M. Byrd, N. Cummings, D. Henderson (2005). New York: Brunner-Routledge.
- Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration. Gatchel, R. J. & Oordt, M. S. (2003). Washington, DC; American Psychological Association.
- Integrated Care: Creating Effective Mental and Primary Health Care Teams (1st ed.). Ratzliff, A., Unutzer, J., Katon, W. & Stephens, K. A. (2016). Hoboken, NJ: Wiley.