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

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VA Center for Integrated Healthcare
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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).

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

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

IPC PRACTICE IS REALLY DIFFERENT FROM WHAT WE HAVE ALL BEEN TRAINED TO DO!

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

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).
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.

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

SAMHSA (Hoge et al., 2014)

1. Interpersonal Communication
2. Collaboration and Teamwork
3. Screening and Assessment
4. Care Planning and Care Coordination
5. Intervention
6. Cultural Competence and Adaptation
7. Systems Oriented Practice
8. Practice-based Learning & Quality Improvement
9. Informatics

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

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

### 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 (CIPPC)*, 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.

### 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:

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**Sample Items:**

**Primary Care Behavioral Health Provider Adherence Questionnaire (PPAQ)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>During clinical encounters with patients, I see patients for 30 minutes or less.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>During patient appointments, I discuss barriers to implementing a plan or adhering to treatment recommendations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I accept referrals for patients with common mental health problems (i.e., depression, anxiety, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>During clinical encounters with a patient, I implement behavioral and/or cognitive interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**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**

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

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


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.


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

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

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

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.

PCMH Training Challenges

- No required trainings or assessment of competency to practice prior to initiating of PCMH 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 PCMH 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.


Plop and Drop Techniques of IPC Training are Ineffective

- Same day access to PCMH was at 33.7% (Goal: 75%).
- PCMH penetration (reach of services) was at 7.37% (Goal: >10%).
- In FY12-15 VA Central Office site visits found PCMH 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)

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 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

<table>
<thead>
<tr>
<th>Observed Element</th>
<th>Time Allotment</th>
<th>Time Allotment Met</th>
<th>Element present</th>
<th>Overall Rating of Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess:</strong> Identifies and/or clarifies the presenting problem*</td>
<td>10-60 seconds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assess:</strong> Evaluates how presenting problem impacts patient’s functioning (home, social, work, recreational, and spiritual)</td>
<td>12-15 minutes (items from here to summary)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assess:</strong> Asks about duration, frequency, and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assess:</strong> Appropriately assesses and manages risk of harm to self/others*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assess:</strong> Uses/references assessment measures appropriate to primary care (e.g., PHQ9, GAD-7, PCL)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### 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**

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

### Sample Feedback Form

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

#### COMPETENCY RATING

<table>
<thead>
<tr>
<th>Competency Role Play Rating</th>
<th>Baseline</th>
<th>3-Month</th>
<th>6-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Rating</td>
<td>FY 2017</td>
<td>FY 2018</td>
<td>FY <em>Q</em></td>
</tr>
<tr>
<td>Pass/Bond/Pass</td>
<td>Pass</td>
<td>Pass/Pass</td>
<td>Pass/Fail</td>
</tr>
</tbody>
</table>

#### ADMINISTRATIVE DATA

<table>
<thead>
<tr>
<th>Average Rate of Revisits for Patients (Target: &lt; 6 visits)</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of PCMHI Mental Health Visits Coded &lt; 30 min. (Target: &gt; 75%)</td>
<td>Provider</td>
</tr>
</tbody>
</table>

#### PRIMARY CARE BEHAVIORAL HEALTH PROVIDER ADHERENCE QUESTIONNAIRE (PQAQ) – BY DOMAIN

<table>
<thead>
<tr>
<th>PQAQ – Co-located Collaborative Care (CCC)</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQAQ – CCC Practice and Session Management</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PQAQ – CCC Referral Management and Care Continuity</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PQAQ – CCC Consultation, Collaboration, and Interprofessional Communication</td>
<td>Facility Trainer Average</td>
</tr>
</tbody>
</table>
Sample Feedback Form

<table>
<thead>
<tr>
<th>PPAQ - Care Management: Patient Identification</th>
<th>Provider</th>
<th>Facility Trainer Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAQ - Care Management: Patient Education, Self-Management Support, Psychological Intervention</td>
<td>Provider</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PPAQ - Care Management: Supervision and Care Coordination</td>
<td>Provider</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PPAQ - Care Management: Measurement-Based Care and Protocol Adherence</td>
<td>Provider</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PPAQ - Care Management: Panel Management</td>
<td>Provider</td>
<td>Facility Trainer Average</td>
</tr>
<tr>
<td>PPAQ - Total Score</td>
<td>Provider</td>
<td>Facility Trainer Average</td>
</tr>
</tbody>
</table>

Facility Trainer Average is the average for the group of all PCMHI Facility Lead Trainers nationally (N=XXX)

1. Administrative definitions and sources can be found here.
2. PPAQ - Higher scores = higher fidelity; more information about the PPAQ can be found here.
3. PCMHI – 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:

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

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

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)**

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

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

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 month</th>
<th>6 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAQ Total</td>
<td>208.6 (16.3)</td>
<td>215.9 (13.6)</td>
<td>215.5 (15.8)</td>
<td>&lt;.001 *</td>
</tr>
<tr>
<td>PPAQ CM Total</td>
<td>206.1 (19.0)</td>
<td>217.9 (22.5)</td>
<td>222.3 (17.8)</td>
<td>.001 *</td>
</tr>
<tr>
<td>30 Minute Ratio</td>
<td>51.4% (28.3)</td>
<td>64.4% (25.4)</td>
<td>63.8% (27.8)</td>
<td>.002*</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 month</th>
<th>6 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAQ Total</td>
<td>197.7 (17.7)</td>
<td>207.7 (14.2)</td>
<td>In progress</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>PPAQ CM Total</td>
<td>198.8 (24.4)</td>
<td>210.1 (22.9)</td>
<td>In progress</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>30 Minute Ratio</td>
<td>50.7% (25.5)</td>
<td>61.4% (25.4)</td>
<td>63.8% (25.6)</td>
<td>&lt;.001*</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 month</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAQ Total</td>
<td>186.1 (30.2)</td>
<td>196.3 (28.5)</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>PPAQ CM Total</td>
<td>190.5 (38.1)</td>
<td>202.1 (35.1)</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>30 Minute Ratio</td>
<td>54.0% (30.7)</td>
<td>74.0% (28.1)</td>
<td>&lt;.001*</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 month</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Day</td>
<td>50.0% (15.8)</td>
<td>55.3% (12.3)</td>
<td>.039*</td>
</tr>
<tr>
<td>30 Minute Ratio</td>
<td>52.5% (22.3)</td>
<td>65.8% (18.9)</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Penetration Rate</td>
<td>6.9% (2.1)</td>
<td>7.0% (1.6)</td>
<td>.652</td>
</tr>
</tbody>
</table>

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/
• 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


