Communiqué

Striving to Increase Telemental Health Services in VISN 16: An Overview of the South Central MIRECC/VISN 16 Mental Health Product Line Telepsychotherapy Pilot Project

By Geri Adler, Ph.D., Danielle Nadorff, Ph.D., & Michael Kauth, Ph.D.

The availability of mental health services in rural areas is of particular importance to the Department of Veterans Affairs (VA). Forty-one percent of all Veterans live in rural areas, whose residents tend to be poorer, older, less educated, and to have poorer health status than their urban counterparts. (Department of Veterans Affairs Veterans Health Administration 2011; National Rural Health Association 2012) Improving rural mental health is complicated by a lack of access and resources to care, as mental health providers are disproportionately located in urban centers (Thomas, et al., 2009).

The VA offers mental health care to rural Veterans through community-based outpatient clinics (CBOCs). The South Central (VISN 16) Network has 57 CBOCs spread throughout an 8-state area. Yet, despite the presence of these CBOCs, many Veterans in rural communities find it difficult to secure mental health care, particularly specialty services.

One solution to this problem is the use of telemental health technology whereby services are delivered to Veterans at remote sites through videoconferencing equipment. Research has shown telemental health to provide effective treatment and to bridge the mental health services gap for rural residents with limited access to care (Richardson et al., 2009). However, there are several barriers to its implementation, including therapist reluctance to embrace services not provided face-to-face, perceived patient discomfort, safety and privacy concerns, and difficulties with the technology (Barak et al., 2008; Bee et al., 2008; Smith & Allison, 1998; Tuerk et al., 2010).

In late 2010, the South Central MIRECC initiated a collaborative pilot project with the VISN 16 Mental Health Product Line to increase telepsychotherapy services to VISN 16. Three medical centers volunteered to participate in the project and 12 therapists were identified to provide services to 6 CBOCs. The project employed a FOCUS-PDSA model, a quality improvement framework used by many healthcare organizations, to plan the intervention and evaluation. The project's goal was to increase the amount of telepsychotherapy services provided at VISN 16 CBOCs. Telepsychotherapy was defined as any psychosocial therapeutic intervention, although formal psychotherapy of any kind was a priority. The project's objectives were to establish active telepsychotherapy programs at participating medical centers/ CBOCs and to identify barriers and facilitators to the implementation process.

Participants and Procedure

Twelve therapists participated in the pilot project. Eight (67%) were female and four (33%) were male. Their mean age was 44.6 years (+ 10.7). Seven participants were psychologists (58%), three were social workers (25%), and two (17%) were from other backgrounds (counselor, vocational specialist). On average, therapists had been working as mental health clinicians for over eight years, with more than six of those years for the VA.

Therapists were required to complete mandatory telemental health training and were provided an additional 1-hour training from an experienced telepsychotherapist to increase their comfort with practical elements of conducting telemental health. Participating medical centers were provided two Polycom systems for video teleconferencing. South Central MIRECC staff communicated with therapists at least once per month and with clinical leaders every other month about their progress in setting up and delivering telepsychotherapy. In addition, therapists completed surveys at four intervals: pre-training, immediately post-training, at six months, and at the project's conclusion. Therapists were asked to identify barriers and facilitators to providing telepsychotherapy and about their knowledge, confidence and motivation to conduct telemental health.

Results

Barriers and Facilitators

Despite training efforts and regular contact by South Central MIRECC staff, only two clinicians were offering telepsychotherapy one year later. Multiple organizational and individual barriers were encountered at all sites, slowing implementation. A variety of constraints were noted, including poor staff communication, patient recruitment problems, staff changes, lost equipment, lost work orders, and difficulties setting up and supporting new clinics. The establishment of organizational practices and therapist enthusiasm helped facilitate the process. (See Figure 1.)

While the two adopters of telemental health had more positive views of telehealth at the beginning of the project and did not have worries about staffing (a unique concern of the non-adopters), both adopters and non-adopters increased their knowledge of telemental health procedures after training. At the six-month follow-up, those clinicians who began practicing telemental health were reporting

Figure 1. Barriers and Facilitators of the Telepsychotherapy Pilot Project
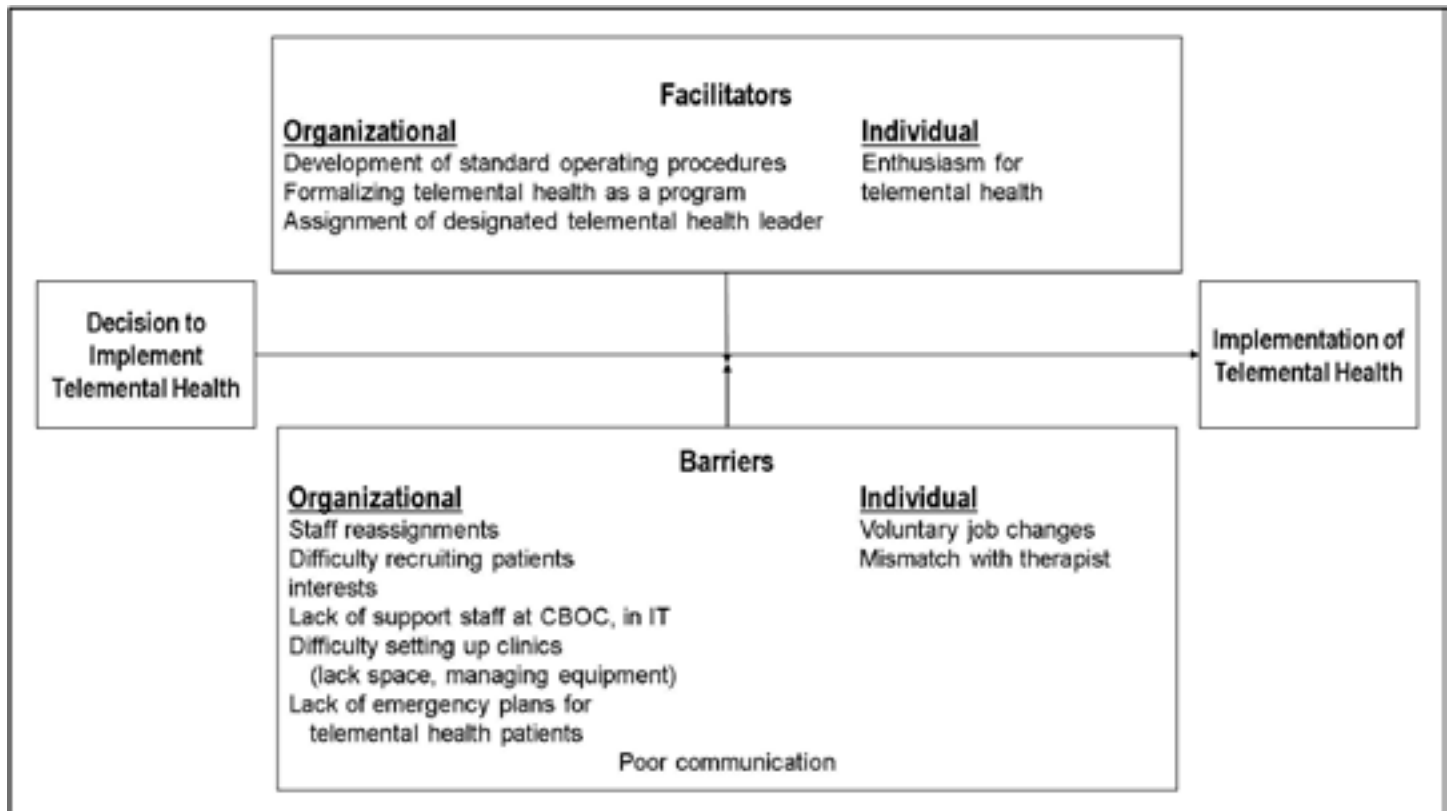
"excellent" knowledge of telemental health procedures, while most providers in the group of non-adopters reported a "good" knowledge of telemental health. Similarly, at the six-month follow-up, those who began getting hands-on experience conducting telemental health reported their confidence as "excellent," while the non-adopters remained at "good."

Therapist Motivation, Confidence and Knowledge of Telemental Health

Therapists were also asked about their perceived knowledge, motivation, and confidence toward telemental health. We found that early adopters in this small group were more motivated than non-adopters to begin telemental health and that the very act of simply providing telepsychotherapy coincided with a rise in reported knowledge and confidence levels.

Conclusion

The goal of this project was to increase the amount of telepsychotherapy services provided in VISN 16. Despite training and regular follow-up efforts, only two clinicians provided telemental health by project's end. Therapists and clinical leaders identified several organizational and individual barriers to the implementation process. Therapists who provided telepsychotherapy reported increases in motivation, knowledge, and confidence.

This project provided information about factors that helped and hindered the adoption of telemental health in VISN 16. For future efforts, we recommend formalized decision-making with clinical leaders regarding goals of the project, better matching of therapist fit with telemental health, and assessment of CBOC readiness for telemental health. We also suggest identifying more therapists at each site and increased frequency of communication with clinical leaders.

Since this pilot project ended, the South Central MIRECC has begun another telemental health initiative in partnership with the VISN 16 Mental Health Product Line. This new project, supported by VA Central Office funding, is to establish evidence-based telemental health services for PTSD at seven medical centers and is ongoing. While a number of barriers to implementation still exist, this project has moved faster and has already been more successful than the previous pilot study. The difference may be due in part to a number of changes in telemental health processes in VISN 16. A significant change has been the establishment of Telehealth Clinical Technicians, who are assigned to each Medical Center and CBOC. Telehealth Clinical Technicians perform many functions to support the telehealth program, including maintaining equipment and escorting patients into the rooms. In addition, Facility Telehealth Coordinators lead telehealth committee meetings and coordinate schedules, among other tasks. In a future Communiqué issue, we will describe how telemental health is expanding across the network. ♦

References

Department of Veterans Affairs Veterans Health Administration. (2011). "2010 Survey of Veteran Enrollees' Health and Reliance Upon VA." Retrieved July 24, 2012, from http://www.va.gov/HEALTHPOLICYPLANNING/Soe2010/SoE_2010_Final.pdf.

National Rural Health Association. (2012). "What's Different About Rural Health Care?" Retrieved July 31, 2012, from http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care.

Barak, A. Boniel-Nissim, M., & Suler, J. (2008). Fostering empowerment in online support groups. Computers in Human Behavior, 24, 1867-1883.

Bee, P. E., Bower, P., Lovell, K., Gilbody, S., Richards, D., Gask, L., & Roach, R. (2008). Psychotherapy mediated by remote communication technologies: A meta-analytic review. BMC Psychiatry, 8, 60.

Richardson, L. K., Frush, B. C., Grubaugh, A. L., Egede, L., & Elhai, J. D. (2009). Current directions in videoconferencing tele-mental health research. Clinical Psychology, 16(3), 323-338.

Smith, H. A. & Allison, R. A. (1998). Telemental health: Delivering mental health care at a distance. U.S. Department of Health and Human Services. Retrieved from http://nebhands.nebraska.edu/files/telemental%20health%20systems.pdf

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. Psychiatric Services, 60.

Tuerk, P. W., Yoder, M., Ruggiero, K. J., Gros, D. F. & Acierno, R. (2010). A pilot study of prolonged exposure therapy for posttraumatic stress disorder delivered via telehealth technology. Journal of Traumatic Stress, 23, 116-123.

SC MIRECC Clinical Education Products

The SC MIRECC supports the development of clinical education products . These products are available to mental health providers and consumers via download or by request at no charge. Download the complete catalog at http://www.mirecc.va.gov/VISN16/clinicalEducationProducts.asp.
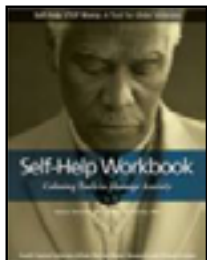
Self Help STOP Worry Manuals: A Tool for Older Veterans

This clinician guide and self-help workbook provide a user-friendly, guided cognitive behavioral treatment of generalized anxiety disorder for Veterans 60 years of age or older who experience high levels of worry and anxiety. The self-help workbook contains practice exercises and forms to monitor progress. The workbook also includes a CD with instructions for diaphragmatic breathing and progressive muscle relaxation. The workbook may be used independently or as a component of formal treatment.

Clinicians: http://www.mirecc.va.gov/VISN16/docs/STOP_Worry_Clinican_Workbook.pdf

Self -Help: http://www.mirecc.va.gov/VISN16/docs/STOP_Worry_Self-Help_Workbook.pdf.

The Reaching out to Educate and Assist Caring, Healthy Families (REACH) Program: Manual for Multifamily Psychoeducational Groups for PTSD

The Oklahoma City VA Medical Center's Family Mental Health Program modified William McFarlane's multifamily group model, an evidence-based model of family psychoeducation, for a VA setting and for Veterans living with PTSD and their family members. Phase I of the three-phase REACH Program includes four single-family sessions focused on rapport building and goal setting. Phase II consists of six weekly sessions for cohorts of 4-6 Veterans and their families focused on problem-solving, psychoeducation about symptom management, communication, managing symptoms of depression, stress management, and anger/conflict resolution. In Phase III, Veterans/families attend six monthly multi-family groups to support maintenance of gains.

Providers: http://www.mirecc.va.gov/MIRECC/VISN16/docs/REACH_Provider_Manual.pdf

Students: http://www.mirecc.va.gov/MIRECC/VISN16/docs/REACH_Student_Workbook.pdf

VISN 6 and 16 mental health providers are invited to attend the next SC MIRECC CBOC Mental Health Rounds titled "Engaging Families in Recovery: Practical Tips" on Wednesday, September 12, 2012 at 8:00-9:00 a.m. (CST). This LiveMeeting session will be presented by Leigh Ann Johnson, MSW.

Call 1-800-767-1750 and use access code-26461# to participate. For registration information and links to the LiveMeeting, email Ashley.McDaniel@va.gov.

RECENT SC MIRECC PUBLICATIONS

BRIEF COGNITIVE BEHAVIORAL THERAPY IN PRIMARY CARE: A HYBRID TYPE 2 PATIENT-RANDOMIZED EFFECTIVENESS IMPLEMENTATION DESIGN

Cully JA, Armento ME, Mott J, Nadorff MR, **Naik AD**, **Stanley MA, Sorocco KH, Kunik ME, Petersen NJ,** and **Kauth MR**

Despite the availability of evidence-based psychotherapies for depression and anxiety, they are underused in non-mental health specialty settings, such as primary care. Hybrid effectiveness-implementation designs have the potential to evaluate clinical and implementation outcomes of evidence-based psychotherapies to improve their translation into routine clinical care practices. This protocol article discusses the study methodology and implementation strategies employed in an ongoing, hybrid, type 2 randomized controlled trial with two primary aims: (1) to determine whether a brief, manualized cognitive behavioral therapy administered by VA Primary Care Mental Health Integration program clinicians is effective in treating depression and anxiety in a sample of medically ill (chronic cardiopulmonary diseases) primary care patients and (2) to examine the acceptability, feasibility, and preliminary outcomes of a focused implementation strategy on improving adoption and fidelity of brief cognitive behavioral therapy at two Primary Care-Mental Health Integration clinics.

The study uses a hybrid type 2 effectiveness/implementation design to simultaneously test clinical effectiveness and to collect pilot data on a multifaceted implementation strategy that includes an online training program, audit and feedback of session content, and internal and external facilitation. Additionally, the study engages the participation of an advisory council consisting of stakeholders from Primary Care-Mental Health Integration, as well as regional and national mental health leaders within the VA. It targets recruitment of 320 participants randomized to brief cognitive behavioral therapy (n = 200) or usual care (n = 120). Both effectiveness and implementation outcomes are being assessed using mixed methods, including quantitative evaluation (e.g., intent-to-treat analyses across multiple time points) and qualitative methods (e.g., focus interviews and surveys from patients and providers). Patient-effectiveness outcomes include measures of depression, anxiety, and physical health functioning using blinded independent evaluators. Implementation outcomes include patient engagement and adherence and clinician brief cognitive behavioral therapy adoption and fidelity. Hybrid designs are needed to advance clinical effectiveness and implementation knowledge to improve healthcare practices. The current article describes the rationale and challenges associated with the use of a hybrid design for the study of brief cognitive behavioral therapy in primary care. Although trade-offs exist between scientific control and external validity, hybrid designs are part of an emerging approach that has the potential to rapidly advance both science and practice.

Featured VISN 16 Publication

Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Report Addressing Serious Gaps in U.S. Mental Health Training

Schmitz WM Jr., Allen MH, Feldman, BN, Gutin NJ, Jan DR, Kleespies PM, Quinnett P and Simpson S.

Suicide and Life-Threatening Behavior, 43(3).

PROVIDER, VETERAN, AND FAMILY PERSPECTIVES ON FAMILY EDUCATION IN VETERANS AFFAIRS COMMUNITY-BASED OUTPATIENT FACILITIES

Sherman MD and Fischer EP

The VA healthcare system is dedicated to providing high-quality mental health services to all Veterans, including the nearly 40% of enrolled Veterans living in rural areas. Family education programs regarding mental illness and posttraumatic stress disorder, mandated for delivery in all VA medical centers and some community-based outpatient clinics (CBOCs), have been developed and provided primarily in large, urban medical centers. This qualitative investigation involved interviews with CBOC providers and Veterans and families who live in rural areas and/or seek care in CBOCs to ascertain their perceptions of the benefits, feasibility, structural and cultural barriers, and logistical preferences regarding family education. The perspectives and concerns that emerged in these interviews were combined with expert knowledge to identify the resources and considerations a VAMC would want to address when

translating and implementing similar programming into CBOCs. Although institutional, logistic, and attitudinal challenges were described, all three stakeholder groups endorsed the need for family education, did not see the barriers as insurmountable, and provided creative solutions. Administrators and CBOC clinicians may benefit by anticipating and problem solving around the key issues raised when developing family programming.

these guidelines when writing articles about team-based learning implementations should help standardize descriptive information in the medical and health sciences education literature about the essential aspects of team-based learning activities and allow authors and reviewers to successfully replicate team-based learning implementations and draw meaningful conclusions about observed outcomes. ♦

PERSPECTIVE: GUIDELINES FOR REPORTING TEAM-BASED LEARNING ACTIVITIES IN THE MEDICAL AND HEALTH SCIENCES EDUCATION LITERATURE

Haidet P, Levine RE, Parmelee DX, Crow S, Kennedy F, **Kelly PA**, Perkowski L, Michaelsen L, and Richards BF.

Medical and health sciences educators are increasingly employing team-based learning in their teaching activities. Team-based learning is a comprehensive strategy for developing and using self-managed learning teams that has created a fertile area for medical education scholarship. However, because this method can be implemented in a variety of ways, published reports about team-based learning may be difficult to understand, critique, replicate, or compare unless authors fully describe their interventions. The authors of this article offer a conceptual model and propose a set of guidelines for standardizing the way that the results of team-based learning implementations are reported and critiqued. They identify and articulate the seven core design elements that underlie the team-based learning method and relate them to educational principles that maximize student engagement and learning within teams. The guidelines underscore important principles relevant to many forms of small-group learning. The authors suggest that following

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century