Training for integrated care with older adults: Real world implementation and the path forward
Training for integrated care with older adults: Real world implementation and the path forward

Presenters:

- Jennifer A. Moye, PhD, Chair  
  VA Boston Healthcare System, Brockton, MA
- Patricia A. Areán, PhD  
  UCSF, San Francisco, CA
- Erin E. Emery, PhD  
  Rush University, Chicago, IL
- Brian D. Carpenter, PhD  
  Washington University, St. Louis, MO
- Richard A. Zweig, PhD  
  Ferkauf Graduate School of Yeshiva University, Bronx, NY
- Antonette M. Zeiss, PhD, Discussant  
  VA Central Office, Washington, DC
Integrated health care is especially important for older adults:

- Up to two thirds of older adults with a mental health problem do not receive the services they need.

- Preventive and early identification strategies for geriatric mental health disorders are lacking, with a low rate of referral to mental health care by general practitioners and a mismatch between services offered and those preferred by older adults (e.g., psychotherapy).

- Older adults have complex interacting medical needs and prefer to receive mental health care within integrated care settings.
Training for integrated care with older adults: Real world implementation and the path forward

• How do we prepare psychologists to implement integrated care, particularly with older adults?
• What are the practice competencies for integrated care psychology and how do these compare to geropsychology?
• How does integrated care in primary care settings compare to that in specialized medical settings, such as rehabilitation, long term care, and community-based service sites?

This symposium offers the perspective of leaders in integrated care research and training discussing real-life challenges for implementation and dissemination at the graduate school, externship, internship, fellowship, and post-licensure levels.
Co-Teaching Interprofessional Care in Graduate School

Brian D. Carpenter, Ph.D.
Associate Professor

Washington University in St. Louis
Objectives

1) Review a curricular model for introducing graduate students to disciplinary perspectives and interdisciplinary teamwork

2) Recount administrative and logistical challenges in course implementation

3) Summarize indicators of student development

4) Discuss future adjustments
Origins of our course

• Growing interest in interprofessional care
  • WHO Framework for Action on Interprofessional Education and Collaborative Practice (2010)
  • Interprofessional Education Coalition Core Competencies for Interprofessional Collaboration (2011)

• Provost’s Cross-School Interdisciplinary Teaching Grants
InterD 5001: Geriatric Interdisciplinary Teams

Course Description:

Interdisciplinary collaboration is a foundation of geriatric care, yet students are often trained with little exposure to the theories, methods, and practice techniques of disciplines complementary to their own. The purpose of this course is to bring together students across schools and disciplines who are training to work with older adults. Students will learn about 1) the theories and methods typical of each discipline, and 2) features of effective interdisciplinary teamwork that is essential in high-quality geriatric care.

Course Organizers:

Brian Carpenter (Psychology), Nancy-Morrow Howell (Social Work), Susy Stark (Occupational Therapy)
Course development process

- Teaching grant received: May 2011
- Course development started: June
- Advisory Board meeting: July
- Teaching Assistants identified: August
- Course started: January 2012
- Course concluded: May
- Evaluations reviewed and modifications initiated: June

- Evaluations reviewed and modifications initiated: June
Principles guiding course development

• Provide baseline education about aging that students complete before semester
• Include guest lecturers from different disciplines
• Focus on aging issues relevant to discipline
• Interweave interdisciplinary team dynamics & communication
• Emphasize case-based learning
• Focus on understanding and appreciating other disciplines (i.e., how to practice with other disciplines, not how to practice within other disciplines)
Structure of each class

• 5:30 - 5:40 Dinner
• 5:40 - 7:00 Disciplinary lecture
• 7:00 - 7:15 Snacks
• 7:15 – 7:45 Discussion based on student reflection papers
• 7:45 - 8:30 Case discussion or research presentation
Disciplinary lectures

- History of profession
- Training and licensure requirements
- Major theories/evidence-based practice
- Reimbursement
- Future trends in the profession

- Psychology
- Social Work
- Occupational Therapy
- Physical Therapy
- Speech and Language Pathology

- Chaplaincy
- Nursing
- Medicine
- Pharmacy
Team functioning & communication

- Didactic readings
- Hartford GITT video cases
- National League of Nursing written case studies
- Western Health Sciences written case studies
- University of Missouri – Columbia Virtual Health Care Team written case studies
- Experiential exercises
Site visits to observe teams in action

• Inpatient rehabilitation hospital, long-term dementia care residence, community-based outpatient screening and referral clinic, outpatient multi-service clinic (PACE)
• Attended two interdisciplinary team meetings
• Recorded observations of team features and team process
• Delivered in-class, interdisciplinary group report on shared observations and evaluations
Enrollment challenges

- Physical Therapy daytime class schedule
- Medicine rotations only 7 weeks long
- Pharmacy and Nursing students not affiliated with our university
- Confusion about tuition

Who enrolled (n = 20):
- OT – 4
- Psychology – 5
- Public Health – 3
- Social Work – 7
- Medicine – 1
- Nursing – 0
- PT – 0
- Pharmacy – 0
- Chaplaincy – 0
Logistical challenges

- Scheduling a class time
- Different spring breaks
- Location – parking permits? rotate? classroom?
- Dinner
- Academic culture differs across schools
  - expectations about availability of syllabi and reading lists
  - sanctity of reading period
Change in attitudes/beliefs

<table>
<thead>
<tr>
<th>Score</th>
<th>Pre-Semester</th>
<th>Post-Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>80</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>70</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>60</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>50</td>
<td>40</td>
<td>50</td>
</tr>
</tbody>
</table>

* $t = -4.77(19), p < .001$
** $t = -9.99(19), p < .001$
Change in attitudes/beliefs

**Attitude Toward Older Adults**

- **Score**
  - Pre-Semester: 140
  - Post-Semester: 180

- **Significance:** * \( t = -3.80(19), p < .01 \)
Attitudes toward working with teams

Score

Pre-Semester Post-Semester

Attitude toward other disciplines

Providing care for elderly

Practicing in team environment

* $t = -5.14(18), p < .001$

** $t = -2.80(18), p < .05$

*** $t = -5.50(18), p < .001$
Future plans

Career will emphasize geriatrics
Teams influence career choice
Team work contribute to team training success
Seek addtl gero training

Pre-Semester vs Post-Semester

Score

* p < .05
“I have to admit that as I learned about various disciplines, I had to actively prevent myself from becoming defensive of [my profession] and our expertise and skeptical of other professions purported competencies.

I was initially resentful at the idea of other disciplines conducting brief [versions of assessments I was trained to conduct]. I now acknowledge the global benefits of various professionals having [that skill]…

Had I not been given interdisciplinary training exposure, my openness to other disciplines would still be limited.”
How will they practice

“XYZ program was a good example of cultural silos—the group thought they were acting as a team when they were really functioning as autonomous units managed by a staff person.

There was a total lack of common understanding and communication—each professional documented their results and it was only viewed by 1 staff member. What could have been great interdisciplinary care turned out to be very similar to the traditional model.”
Reflecting on reimbursement for geriatrics:

“Professionals would hesitate to choose geriatrics and/or gerontology if their effort to care for older clients (patients) is not well compensated in the system or valued in society, and this will eventually lead to the shortage of geriatric professionals. ..Therefore, it is important and necessary to either improve the existing reimbursement policy or introduce a brand-new policy to support geriatric professionals and their interdisciplinary teams better than now.”
Future development

• More disciplines represented in student body
• More contemporary scholarly resources
• Consulting national experts
• More sophisticated and longitudinal student outcome assessment
• Faculty sustainability issues
• Budgetary sustainability issues
Co-Teaching Interprofessional Care in Graduate School

Brian D. Carpenter, Ph.D.
Associate Professor
bcarpenter@wustl.edu
Internship and Fellowship Training in Integrated Care: Lessons from training programs in primary care and rehabilitation

Erin E. Emery, PhD
Geriatric & Rehabilitation Psychology
Rush University Medical Center
Overview

- Geropsychology Competencies
- Training at intern and fellow levels
- Issues in Interprofessional teams
- Training in Rehabilitation Teams
- Training in Primary Care/ BRIGHTEN Teams
Competency Assessment

• Pikes Peak Competence Tool
  – Online administration available:
    http://gerocentral.org/competencies/competencies-tool-online/
  – Integrated care reflected throughout; “team” mentioned 20+ times

• Setting-specific competencies

Karel, Emery, Molinari, & CoPGTP Task Force on the Assessment of Geropsychology Competencies, 2010
Training at the Intern Level

- Interdisciplinary team training is recommended for geropsychology interns¹
- First exposure to significant work with older adults for many
- First exposure to team dynamics
- Confidence and voice

¹Hinrichsen, Zeiss, Karel & Molinari, 2010
Training at the Fellow Level

- Interdisciplinary team training is required for geropsychology fellows
- Observe supervisors negotiating team dynamics, conflict, and power struggles
- Functioning autonomously in teams
- Confidence and voice

Hinrichsen, Zeiss, Karel & Molinari, 2010; Karel & Stead, 2011
Rehab

- Assessment and brief treatment
- Highly medically and psychologically complex inpatients
- Short hospital stay
- Trainees are full members of the team
  - Multidisciplinary team meetings
  - Family meetings with the team
  - Challenging team members to consider alternate perspectives
Primary Care: BRIGHTEN

- BRIGHTEN: Bridging Resources of an Interdisciplinary Geriatric Health Team via Electronic Networking
- Screening, Assessment and Treatment
- Minority older adults with depression and cardiometabolic syndrome
- Co-location hybrid
Trainees

• Learning:
  – What you know and what you don’t know
  – Players in the system and dynamics among them
  – Stimulus value as psychology and as trainee
  – How to interact and advocate effectively
    • Observe supervisors and other team members
    • Ask questions
    • Try things out
Supervisors

- Model effective interactions
- Help trainees use what they know
- Provide information to team members about psychology and trainees
- Balance helping trainees to understand team dynamics with personal feelings about team members
- Provide opportunities in group supervision to practice skills
To ensure funding for interprofessional team activities, advocacy to provide a reasonable level for the Relative Value Units (RVUs) for team meetings and consultation should be established. CPT codes exist for these activities exist, but with zero (0) RVUs, so that such essential activities are not reimbursable.
Discussant Comments – Symposium At APA on Integrated Health Care

- No one likely can work at all of these levels, but I challenge each of you to consider how you can best support change in your settings – through utilization of the excellent training suggestions made by the panelist presenters and through advocacy efforts you are willing to make.
Thank you!

Erin E. Emery, PhD
Geriatric & Rehabilitation Psychology
Rush University Medical Center
Integrated Care in the Primary Care Setting

Patricia Areán, Ph.D.
Professor, UCSF
Integrated Care in the Primary Care Setting

Patricia Areán, Ph.D.
Professor, UCSF
Integrated Care in the Primary Care Setting

Agenda

• Brief background on effectiveness of primary care integration;

• Importance of leadership to support integration;

• Training psychologists in culture of primary care/brief treatment;

• Preparing psychology for integrated care.
• Affordable Care Act will increase access to mental health services;
• Integration of mental health into primary care will be supported under ACA;
• Several models exist to support integration;
Integrated Care Model Common Features

- Patient Activation;
- Education of primary care providers;
- Care manager;
- Mental health expert;
- Panel management;
- Brief, first line treatment in primary care;
- Team approach to managing care.
What makes integration work?

- Transformational and Transactional Leadership (Aarons et al, 2006);
- Access to experts in the model (Mancini, 2009);
- Efficient training models;
- Including Human Resources in planning to sustain practice;
- Hiring to the skill set needed.
Skills needed by leaders/experts

• Strategic thinking: seeing the Big Picture;
• Collaboration;
• Self Reflection/Emotional Intelligence;
• Making values visible and viral;
• Ability to prevent, and management, conflict;
• Problem solving skills;
• Ability to coach, educate, motivate and delegate.  -Geisler, 2013.
Skills needed by Care Managers

- Working in fast pace settings;
- Brief – very brief – treatment;
- Communication skills (patients and docs);
- Redirection and containment skills;
- Use of assessment to inform practice (panel management);
- Knowing when and willingness to refer patients.
Successful Model for training

• Design training to competencies needed;
• Demonstration of skills;
• Opportunities to practice skills prior to utilization;
• Review samples of actual cases;
• Technical assistance while trainee employs new skills.
PST training example

• One day workshop, brief overview of skill with live demonstrations with experts, then role-play practice with feedback;
• Two months of weekly role play in PST skills;
• Review of at least 3 audio sessions.
Data on effectiveness

Traditional Model (n=46)
• Cohort size = 3;
• Time to certification = 10 months;
• 50% dropped out of training prior to certification;
• 20% say they use PST in practice.

Standardize Patient Model (n=96)
• Cohort size = 8;
• Time to certification = 2.3 months;
• 10% dropped out prior to certification;
• 15% needed additional remediation;
• 70% say use PST in practice.
Future Directions

• Prepare psychologists for integrated care *early!*
• Use of simulated cases to effectively and efficiently train skills;
• Need to support retraining programs for psychologists who will be faced with changes.
• Work closely with general internal medicine.
Thank you!

pata@lppl.ucsf.edu

pstnetwork.ucsf.edu
Integrated Care Geropsychology Training: A Need to Integrate the Integrators?

Richard Zweig, Ph.D.
Director, Ferkauf Older Adult Program
Associate Professor of Psychology, Ferkauf Graduate School of Psychology
Assistant Professor of Psychiatry, Albert Einstein College of Medicine
Yeshiva University

Michele J. Karel, Ph.D.
Psychogeriatrics Coordinator, Mental Health Services, VA Central Office
Associate Professor, Department of Psychiatry, Harvard Medical School

Chapters:
• The broken healthcare system for older adults
• A basic model of integrated, interdisciplinary healthcare
• Knowledge and skills that psychologists contribute to integrated healthcare
• Principles of integrated healthcare
• Interdisciplinary collaboration in diverse sites of care
• The older consumer’s perspective on health care
• Recommendations for future APA action


• #1: Support the development of psychology graduate curricula on integrated healthcare for older adults

• #2: Promote clinical training opportunities in integrated healthcare settings

• #3: Support the development of education and training opportunities in integrated healthcare for students and healthcare professionals across disciplines

• #4: Collaborate with interdisciplinary colleagues to provide educational opportunities on the need and value of integrated care

• #5: Offer CE education programming on the roles of psychologists in initiating and facilitating the development of and participating as members of members of integrated healthcare teams
Have We Made Progress in Education and Training as outlined in the Blueprint for Change?

Note: APA efforts to delineate professional competencies for integrated care:

• Competencies for professional psychology practice: http://www.apa.org/ed/graduate/competency.aspx


#1: Support the development of psychology graduate curricula on integrated healthcare for older adults


• Pike’s Peak Training model and competencies (Knight et al., 2009) and related geropsychology competency assessment tool at:
  (2) On-line version at GeroCentral: http://www.gerocentral.org/copgtp/ppcat.php
#2: Promote clinical training opportunities in integrated healthcare settings:


- CoPGTP, APA Div. 12-2 listings of programs that provide substantive geropsychology training ([www.copgtp.org](http://www.copgtp.org); [http://www.geropsychology.org/home/geropsychology-training-resources](http://www.geropsychology.org/home/geropsychology-training-resources))
Blueprint for Change: Education and Training Recommendations

#2: Promote clinical training opportunities in integrated healthcare settings, cont.

- Report of APA Primary Care Training Task Force (2011)

- Includes survey of (N=230) doctoral, internship, and postdoctoral education and training programs in professional psychology
  - About half offered education and training in primary care
  - High degree of variability in types of training experiences across programs
  - Most common model is “integrative” or “collaborative”
  - Population served: 61-73% serve older adults

- Barriers to education and training integrated healthcare in primary care:
  - Availability of settings for training
  - Lack of faculty availability and expertise in primary care settings
  - Financial support
  - Institutional barriers
#2: Promote clinical training opportunities in integrated healthcare settings, cont.

• Among doctoral programs (N=36) that have chosen to list themselves as providing training opportunities in primary care psychology (www.apa.org/ed/graduate) there is considerable diversity:
  • Population served: 61% list “geriatrics”
  • Funding: 25% provide a stipend to trainees
  • Training/ Care Model:
    • “Integrated Care” (61%)
    • “Collaborative Care” (14%)
    • “Co-located Care” (6%)
#3: Support the development of education and training opportunities in integrated healthcare for students and healthcare professionals across disciplines

Multiple recent, interdisciplinary efforts:

• Core Competencies for Interprofessional Collaborative Practice
  http://www.aacn.nche.edu/education-resources/ipecreport.pdf

• Interprofessional Professionalism Collaborative
  http://interprofessionalprofessionalism.weebly.com/index.html

• Partnership for Health in Aging Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree

• Partnership for Health in Aging Position Statement on Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Healthcare for Older Adults
A Case Example:
Yeshiva University’s Practicum in Primary Care Geropsychology
Cross-disciplinary training objectives and activities:
• Training in diagnostic evaluation / treatment planning, consultation re culturally diverse primary care elderly/ adults
• Training in evidence-based psychotherapy approaches for primary care setting
• Pairing of psychology trainees with medical residents to provide integrated MH services
• Supervision/didactics: interdisciplinary & separate
Challenges Faced and Strategies Employed by Yeshiva University’s Practicum in Primary Care Geropsychology

Clinical service limitations in primary care:
- Modify treatment models, establish reasonable service goals
- On-site services coordination by psychology and medicine faculty
- Build a culture of interdisciplinary training and service provision

Complexities of interdisciplinary training in primary care:
- Address role conflict/ambiguity in trainee didactic sessions
- Model collaborative rather than hierarchical professional roles
- Interdisciplinary faculty meetings to address differing methods

CONCLUSION: Challenging but possible to support the development of education and training opportunities in integrated healthcare for students and healthcare professionals across disciplines
#4: Collaborate with interdisciplinary colleagues to provide educational opportunities on the need and value of integrated care

Examples


• Patient Centered Primary Care Collaborative: Behavioral health interest group, with practice and training resources http://www.pcpcc.org/behavioral-health
#4: Collaborate with interdisciplinary colleagues to provide educational opportunities on the need and value of integrated care

**Examples**
- Veterans Health Administration (VHA), Primary Care-Mental Health Integration
    - 1. Building a Strong Foundation
    - 2. Depression and Anxiety Management
    - 3. Alcohol Misuse
    - 4. Referral Management
    - 5. Clinician Resources
    - 6. Patient Resources
- VHA Home Based Primary Care Mental Health Initiative
  - Psychologist or Psychiatrist integrated into every HBPC team (serving mostly older Veterans)
  - Training efforts: Developing webcourse series re: integrated model of MH care in HBPC, monthly conference calls for CE, monthly case discussion calls
#5: Offer CE programming on the roles of psychologists in initiating and facilitating the development of and participating as members of members of integrated healthcare teams:

Questions:

• How to help post-licensure psychologists learn attitude, knowledge, and skills competencies for interprofessional practice WITHIN the context of developing competencies in delivering integrated care to older adults?
• Can CE programming be developed to facilitate psychologists’ learning from other disciplines, and training other disciplines?
• Might APA, CoPGTP work together to address the challenge of the learning needs and training strategies for post-licensure psychologists and develop CE in collaboration with other professions?
How might CoPGTP, APA, and Others Help to Integrate the Integrators?

• How to ensure that training efforts for integrated care practice include attention to needs of older adults, AND that geropsychology training efforts address integrated care practice?

Some initiatives to consider/discuss:
• Identify and disseminate effective models of integrated care training (across settings, populations, training strategies)
• Develop mechanisms for programs to pool resources such as training materials (e.g. syllabi; clinical forms; screening tools) WITHIN psychology
• Explore mechanisms for interprofessional training: sharing resources ACROSS disciplines, models for cross-disciplinary training experiences
• Continue to advocate for geropsychology training infusion within integrated care programs, and integrated care infusion within geropsychology programs to “integrate the integrators”
Summary

• Significant progress has been made to address APA 2008 Blueprint for Change Education and Training recommendations, both within Psychology and through interprofessional efforts.
• Many resources currently exist to help guide training efforts for integrated care geropsychology training.
• We have work to do to “integrate the integrators” and ensure that health care professionals are trained to meet the behavioral and mental health care needs of older adults in integrated care settings.
Contact Information:

Richard A. Zweig, Ph.D.
Email: Richard.Zweig@einstein.yu.edu

Michele J. Karel, Ph.D.
Email: Michele.Karel@va.gov
Discussant Remarks

Antonette Zeiss, PhD
VA Central Office, Washington, DC
Rather than comment specifically on each presentation, I want to layout some broad themes that were especially interesting to me throughout these very strong presentations.

These themes will emphasize that this is a time of great progress in the development of well-coordinated, integrated, interprofessional care, but there are great challenges, especially related to the mismatch between traditional discipline-specific training and the emergence of integrated care models.
Discussant Remarks

Changes in the health care system are broadly underway

• Care has shifted to a model called alternatively interdisciplinary (most common term in US) and interprofessional (most common term internationally and emerging rapidly in US).

• This model emphasizes integrated care, with an expectation of multiple professions working in close collaboration to provide holistic, integrated care for the population served.

• Geropsychology was a leader in the transition to this care model, along with pediatric psychology, but this is now becoming the model broadly, as was evident in the presentations today:
  – Primary care
  – Rehabilitation services
  – Specialty care: e.g., pain, oncology, rheumatology
The presentations show that this approach works, both to generate enhanced health outcomes and to reduce overall costs of care. These data will strongly support the continued expansion of areas of care organized in an integrated, interprofessional way.
Challenge: our system for training professionals at the graduate level was set up to accomplish different goals and is not currently able to prepare students fully for providing care in an integrated health care system. This is true for all professions, but we can focus on psychology.
Discussant Remarks

• What current training does well:
  – Imparts extensive training in a specialized body of knowledge
  – Implicitly and explicitly trains the expectations for the culture of care – who does what, pace of care, relationship of provider to care recipient, etc.
  • In psychology, it also explicitly trains that the goal of training is to become a “licensed independent provider.” This does not capture the collaborative approach to integrated care. It is appropriate when used to acknowledge that psychologists are not supervised by other disciplines, but it does not convey a commitment to integrated care.
  – Supports identification with one’s own profession: “I am proud to be a psychologist” (or whatever discipline. That is good, but can lead to turf issues on teams, expectations of hierarchical relationships, etc. if it becomes distorted to “My profession is better than other professions.”
Because of the way training currently is done, the talks today have been about “patches” to an inadequate training system. They are fabulous patches and I endorse their broad use by those in the audience. Right now, developing such approaches to provide the training that our graduate systems fail to provide is essential.

But how can we support more profound changes?
Discussant Remarks

• What can we do about this as psychologists? “Leap frog model” – do what you can, the progress that leads to will open new opportunities and then new actions will be possible.

• Add training components in whatever training setting you work in – use what you heard today
  – Teach students that these are essential for what students will face in the workplace – they must know how to be interprofessional team members.

• Focus on policy for training and for other health care policy that supports integrated care
Discussant Remarks

In APA

1) the changes in governance structure might allow APA to be more collaborative with other organizations, leading to opportunities for mutual development of interprofessional training opportunities and competencies, and

2) the Guidelines and Principles for obtaining accreditation of professional psychology training programs are in the process of change, and several groups are advocating to include specific requirements for interprofessional training in them.
The Affordable Care Act seems to be headed toward creating integrated care health programs; support for this would be valuable.

To ensure funding for interprofessional team activities, advocacy to provide a reasonable level for the Relative Value Units (RVUs) for team meetings and consultation should be established. CPT codes exist for these activities exist, but with zero (0) RVUs, so that such essential activities are not reimbursable.
Discussant Comments

No one likely can work at all of these levels, but I challenge each of you to consider how you can best support change in your settings – through utilization of the excellent training suggestions made by the panelist presenters and through advocacy efforts you are willing to make.
Thank you!

Antonette Zeiss, PhD
VA Central Office, Washington, DC