Teaching the Existing Workforce: A Community Based Collaborative Care Program

Jennifer M Erickson, DO, Diane Powers, MBA, MA, Betsy Payn, MA, Deborah Bowen, PhD, Ramanpreet Toor, MD, Anna Ratzliff, MD, PhD

Department of Psychiatry & Behavioral Sciences

BACKGROUND

The number of US psychiatrists, when adjusted for population size, has decreased almost 10% from 2003 to 2013. 60% of the psychiatrist practicing today are 55 or older. This psychiatrist growing shortage likely contributes to the lack of access to mental health care in the US. Approaches such as collaborative care where a psychiatrist leverages their expertise as part of team to serve a population of primary care patients, have been found to double the effectiveness of depression treatment and represent an important strategy to address this shortage. However, few opportunities exist to assist mid-career psychiatric specialists in repurposing their skills for primary care integration. The Community-Based Primary Care Collaborative Care Fellowship was created for psychiatric providers to train in these innovative approaches while continuing full-time employment. This poster describes the evaluation of the program according to the RE-AIM framework.

REACH

Reach is defined roughly as the proportion of the target population that participates in an intervention. For this intervention, the target population are psychiatric providers in Washington State, including MELODA and ARNPs. Training providers impacts patient outcomes as well, and so patient numbers are also included in our estimate of reach for this intervention.

So far across 2 cohorts we have trained 30 clinicians working at 36 different clinics that serve a total of 149,768 patients per year around the state of Washington.

EFFECTICITY/EFFECTIVENESS

As the name suggests, efficacy looks at how effective the program was at achieving its aims. One of the aims of this program was to increase competency in delivering and supporting other providers in their clinics in a variety of Brief Behavioral Interventions.

The two tables describe the results of two competency questions measured before the cohort began training and at the end of their final quarter (quarter 4) of training.

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<thead>
<tr>
<th></th>
<th>Pre-Assessment</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td><strong>Number of Clinicians Recruited and Engaged</strong></td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td><strong>Number of Clinicians with Provider Entering Program</strong></td>
<td>36</td>
<td>36</td>
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<tr>
<td><strong>Number of Trainee’s Patients that had a Scale entered in the last week</strong></td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td><strong>Number of Clinicians recruited and engaged</strong></td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td><strong>Number of clinicians serving patients per year at the trainee’s clinic site</strong></td>
<td>149,768</td>
<td>149,768</td>
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REFERRENCES


IMPLEMENTATION

Implementation is defined as the extent the intervention is implemented as intended in the real-world. One measure of this comes from the 4-person training sessions as the question “what do you plan to change in your practice”. The majority indicated that they had plans to change their practice, with the most common responses below:

- Including a sleep interview with patients
- Using more DBT and distress tolerance
- Focusing on their leadership role
- Applying SMART goals for themselves and their clinics

MAINTENANCE

Maintenance is defined as the extent the program is sustained over time. Since this program is still in its infancy, we are just beginning to collect data on Cohort 1 after their fellowship ended. We plan on asking questions related to their:

- Continued practice of CoCM activities
- Adaptations in program; elements retained
- Use of CoCM in non-depression settings
- Fidelity to CoCM program post training

In addition we plan to qualitatively assess their comfort in providing their interventions in their clinics.