Original title: *An Intervention to Adopt Telepsychotherapy in Rural VA Clinics*

New title: Barriers to Adopting Telepsychotherapy in Rural VA Clinics

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Background

About 20% of Americans live in rural areas

Rural populations are poorer, older, whiter, and less educated

Ricketts TC, III, KD Johnson-Webb, and RK Randolph. Populations and places in rural America. In *Rural Health in the United States.* 1999.

Baugher E and L Lamison-White. *Poverty in the United States: 1995*. U.S. Depart. Commerce, Bureau of the Census. 1996.

Norton CH and MA McManus. *Health Serv Res*. 1989;23(6): 725-56.

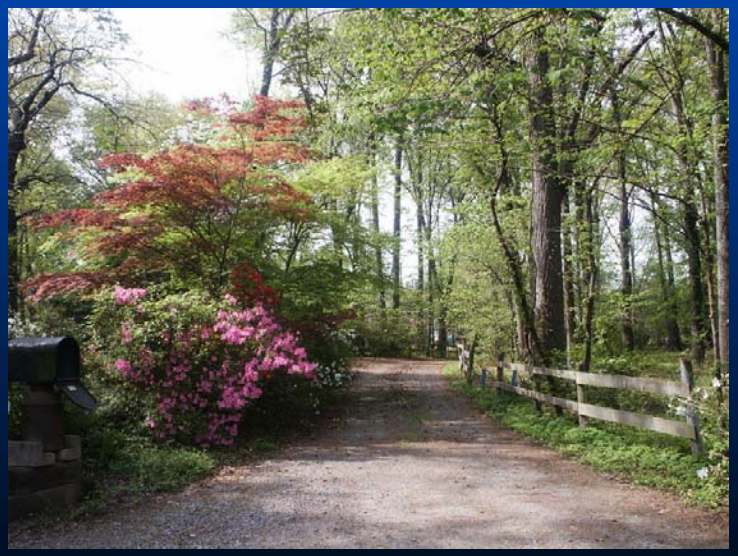
US Depart. Agriculture, Economic Research Service. *Economic Information Bulletin* 2008;40.

Background

There are no differences in mental illness prevalence across rural and non-rural areas

Number of challenges in providing mental health services in rural areas

•Fewer MH providers in rural areas; services are further away

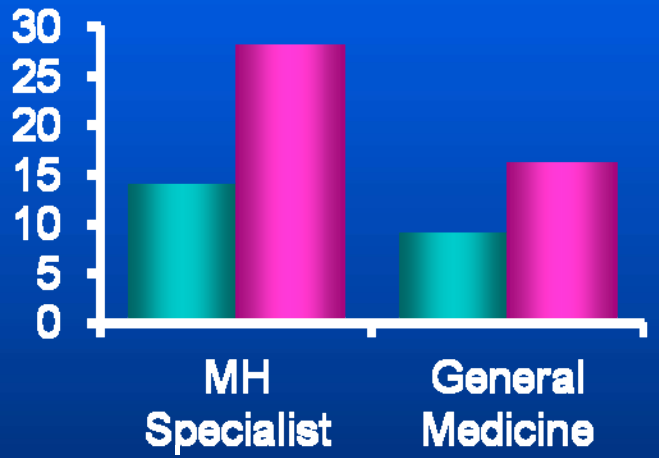


Background

Availability of
Providers per 1000 Pop.

APN= Advanced Practice Nurse
LPC= Licensed Professional Counselor

Accessibility in
Travel Time (minutes)



MH= Mental Health

Ellis A, et al. *Psychiatr Serv* 2009;60:1315–1322

Background

Rural Americans with a mental illness are less likely to receive any (formal or informal) mental health treatment

- More likely to receive help from informal providers, such as clergy
- They are less likely to receive specialty MH care; more likely to receive care in Primary Care
- More likely to receive pharmacotherapy only; less likely to receive psychotherapy

Wang PS, et al. *Arch Gen Psychiatry* 2005;62:629-640
Fortney J, Harman J, Xu S. The Association Between Rural Residence and the Use, Type, and Quality of Depression Care, working paper
Fortney J. Rost K. and Zhang M. *Medical Care* 1999;37(9):884-893.

Background

VA's response has been to open hundreds Community Based Outpatient Clinics (CBOCs)

- *VA Uniform Mental Health Services Handbook* requires comparable treatment services at CBOCs as medical centers; provide evidence-based MH treatments, like CBT, as first-line treatment

  - *Still problems with access; CBOCs may still be far; some have 1-2 MH providers*
  - *Few CBOC MH clinicians trained in evidence-based MH treatments*
  - *When trained, evidence-based MH treatments, not always delivered with fidelity*

Background

Distance psychotherapy (telemental health) is one solution

- Not new; used with hard-to-reach rural, remote populations for years
- Telepsychotherapy as effective as face-to-face treatment
- Barriers include therapists' discomfort, perceived patient discomfort, safety concerns, unfamiliar with the equipment, equipment inaccessible

Barak A, L Hen, M Boniel-Nissim, and N Shapira. 2008. *J Tech Human Services* 2008;26:2/4, 109-160.

Bee PE, et al. *BMC Psychiatry* 2008;8:60 doi: 10.1186/1471-244X-8-60

Smith HA and RA Allison. *Telemental health: Delivering mental health care at a distance. A summary report.* 1998. U.S. Depart. Health & Human Services, SAMHSA.

Teal C. 2009. *Executive summary: CBOC partnership for improving rural mental health care*. South Central MIRECC.

Tuerk PW, et al. *J Traumatic Stress* 2010;23:1, 116-123.

Background

VA health care system organized by 20 Networks or VISNs (Veterans Integrated Service Networks)

South Central VA Network is large and rural

- 10 medical centers and 53 CBOCs
- Treat 80,000 Veterans annually for MH problems
  - ✓ Half of Veterans receive care in CBOCs

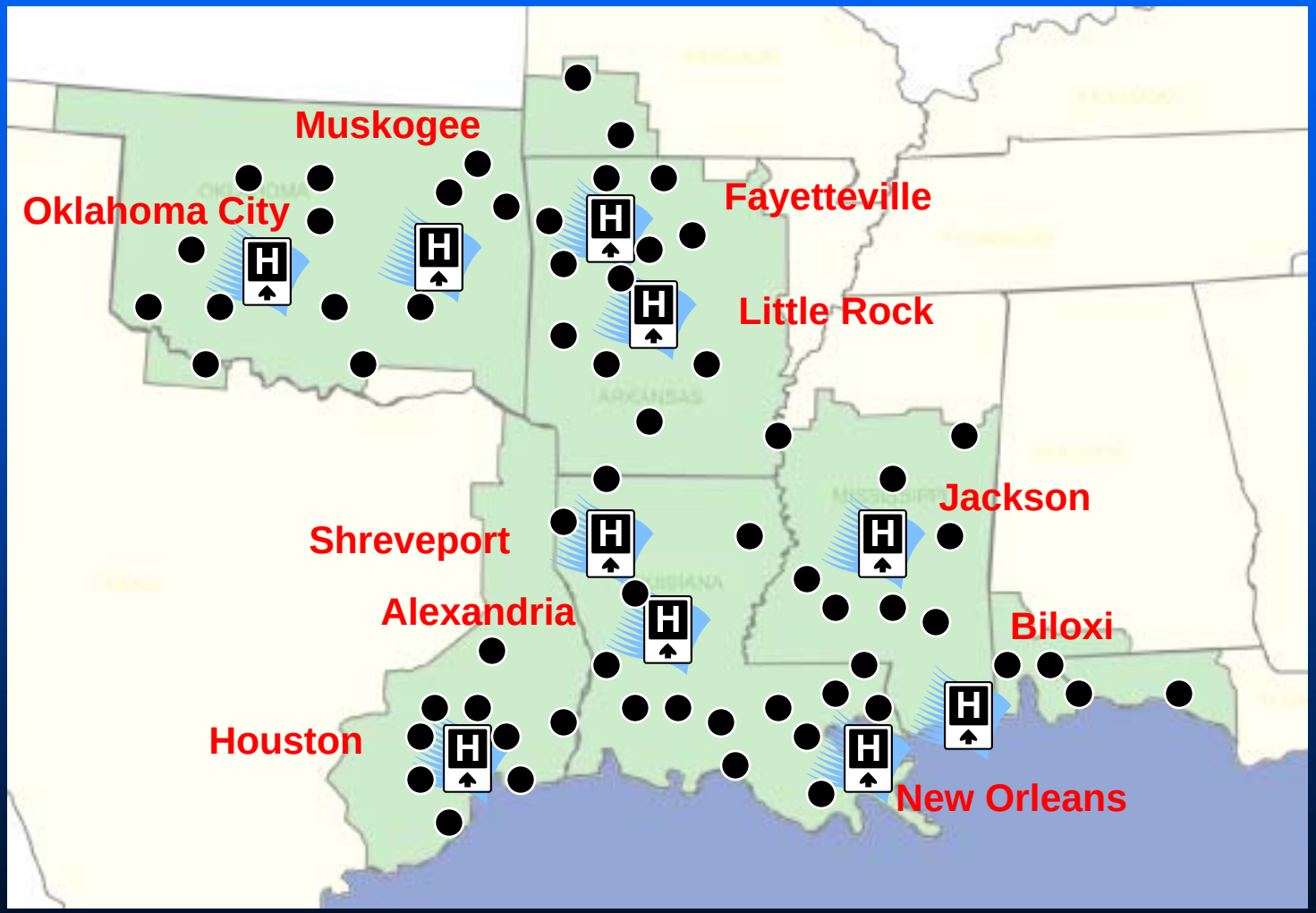
South Central Network has high % of veterans returning from Iraq / Afghanistan

1:5 returning veterans have a mental health diagnosis

Hoge, Auchterlonie, and Milliken. *JAMA* 2006;295:9, 1023-1032.

South Central VA Network 16

= VA medical centers, ● = VA community clinics



Background

South Central Network MH requests help to increase telepsychotherapy services

TeleMH for psychiatric assessment, medication monitoring is common in the Network

TeleMH for psychotherapy / psychosocial interventions is rare. Three therapists providing telepsychotherapy in the Network in late 2010

Background

VA South Central Mental Illness Research, Education, and Clinical Center (SC MIRECC), *improve access to evidence-based treatments for rural and other underserved populations*.

Education efforts to improve knowledge, skills, and practice changes. Partner with the Network and facility MH clinical care services to address mutual goals.

Background

Based on authors' previous experience (Kauth, Sullivan, Blevins, Cully, Landes, Said & Teasdale, 2010; Sullivan, Blevins & Kauth, 2008), we employed blend of FOCUS-PDSA and PARiHS framework as conceptual approach.

F – find a process to improve
O – organize a team
C – clarify current knowledge of the process
U – understand the causes of process variation
S – select the process improvement

P – plan a practice change
D – conduct (do) the change on a small scale
S – study the effect of the intervention
A – act on the results

JCAHC, 1993

Background

Promoting Action on Research Implementation in Health Services (PARiHS) framework

Successful implementation is a function of –

1. The nature and type of evidence
2. The qualities of the context
3. The nature of facilitation to support adoption

Kitson et al., 2008; Rycroft-Malone et al., 2002

Method

Team:

Implementation experts, teleMH clinicians, evaluators, clinical leaders

Goal:

Increase the amount of telepsychotherapy services provided in the Network. Establish sustainable telepsychotherapy services to CBOCs at 3 medical centers

Outcomes:

1.Active telepsychotherapy program at each medical center

2.Number of therapists delivering any telepsychotherapy / telepsychosocial services at each medical center

3.Number of CBOCs served by each medical center

4.Number of hours of telepsychotherapy / telepsychosocial services delivered

5.Type and frequency of evidence-based psychotherapies delivered

Method

Formative and summative evaluation:

Baseline survey of therapists' attitudes and motivation; training evaluation; barriers and facilitators to telepsychotherapy at CBOCs; amount of contact with therapists, leaders, and clinics; six-month assessment of outcomes.

Implementation strategy:

Engage local clinical leaders, reduce therapists' discomfort and increase motivation, and identify and reduce system barriers as soon as possible.

Training:

Required VA TeleHealth training + *one hour live video meeting with experienced telepsychotherapist* to increase comfort

Method

Feedback to key participants

- Contact with teleMH team leader: 1-2x per month
- Contact with clinical leader: every 2 months
- Contact with therapists monthly or more

Purchase 2 polycoms per medical center for therapists

Provided basic info about clinic set-up

Strongly encouraged therapists to visit each CBOC

Method

Sample:
Three volunteer medical centers:
2 medium sized facilities (Site A & B)
1 large facility (Site C)

- 12 therapists to provide services to 6 CBOCs

Therapists Characteristics (N=12)

Age	44.6	(10.7)	29-62
Female	8	(67%)	
Discipline			
Psychologist	7	(58%)	
Social worker	3	(25%)	
Other	2	(17%)	
Years as MH clinician	8.2	(8.6)	0-22
Years as VA clinician	6.2	(6.0)	

Therapists Characteristics (N=12)

Self-rating (excellent=1, poor=5)

Knowledge about teleMH	3.4 (1 – 4)
Confidence	3.1 (1 – 4)
Motivation	2.3 (2 – 5)

Expectations about telepsychotherapy (not at all concerned =1, extremely concerned =7)

System will be difficult to use	2.9 (1 – 5)
Anxiety about using teleMH	2.9 (1 – 5)
Good use of therapist's time	5.0 (2 – 7)
Unable to provide same quality of treatment by teleMH	4.0 (3 – 7)

Therapist Characteristics (N=12)

Expectations about telepsychotherapy (not at all concerned=1, extremely concerned=7)

Personal comfort with teleMH as a way to deliver care	4.3 (1 – 7)
Veterans will like teleMH	3.8 (1 – 6)
Frequent equipment malfunctions	2.9 (1 – 5)
Tech help will be readily available	4.6 (2 – 7)
Able to establish rapport	5.1 (2 – 6)
Therapist's job will be more difficult	2.3 (1 – 5)

Training Evaluation (N=10)

Ratings regarding training (excellent=1, poor=5)

Overall rating	1.9 (1 – 3)
Content of training	1.8 (1 – 3)
Practicality of training	1.6 (1 – 3)

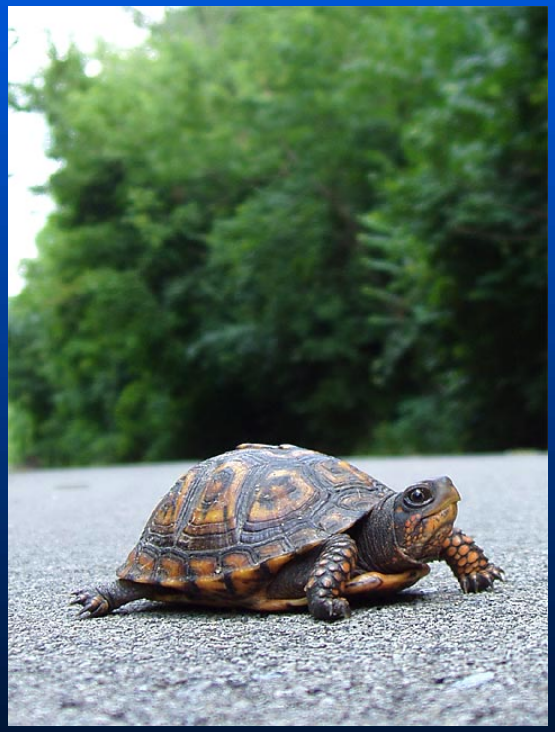
Self-rating after training (excellent=1, poor=5)

	pre	post
Knowledge about telepsychotherapy	3.4	2.8 (1 – 4)
Confidence	3.1	2.8 (1 – 4)
Motivation	2.3	2.3 (1 – 4)

After training, my motivation to conduct telepsychotherapy increased
yes = 10 (100%)

Expect to offer telepsychotherapy in the next 2 months yes = 9 (90%)

Then Things Happened…..
S l o w l y



Site A (medium med center + CBOCs)

Barriers

- *Videoconf. equipment in 2 occupied CBOC offices; needs to move*
- *CBOCs need onsite clerical support to meet patient*
- *CBOCs need notification of TeleMH patients*
- *1 therapist takes a different job after 3 months*
- *1 therapist assigned different duties after 6 months*
- *Protracted conflict between Psychiatry and Psychology over where to install polycoms*
- *IT refuses to install polycoms because they didn't buy them*
- *Difficulty recruiting patients at CBOCs*
- *Chief of Staff assigns TeleMH personnel to other clinical programs*

Facilitators

- *4 therapists added to the project at 3 months*
- *1-2 enthusiastic therapists*
- *Site views services as a Program*
- *Site develops own Standard Operating Procedures*

Site B (medium med center + CBOCs)

Barriers

- *Videoconf. equipment in 2 occupied CBOC offices; needs to move*
- *Videoconf. equipment located in non-sound proof CBOC office*
- *CBOCs need onsite clerical support to meet patient*
- *CBOCs need notification of TeleMH patients*
- *1 therapist planned to provide services through a research protocol but dropped out when funding fell through*
- *Therapists slow to visit community clinics*
- *Protracted problems establishing the clinics, requiring multiple requests*
- *1 therapist took a different job after 7 months*

Facilitators

- *1 enthusiastic therapist*

Site C (large med center + CBOCs)

Barriers

- *Videoconf. equipment in occupied CBOC office; needs to move*
- *Videoconf. equipment in non-sound proof CBOC office; move*
- *1 CBOC questions need for telepsychotherapy*
- *1 CBOC has no formal emergency plan*
- *Polycoms are lost at medical center; sit in basement without a barcode for months*
- *Indecision at med center about location of polycoms; lack of space*
- *1 therapist not credentialed since start of project (10 months and counting)*
- *1 therapist works for Primary Care; struggle over duties; therapist moves to another clinic*
- *1 therapist covers for retired staff for 4 months*
- *Protracted difficulty setting up clinics*

Facilitators

- *Assignment of a teleMH team leader to oversee the program*

Summary of Barriers

Multiple, unanticipated barriers at all sites slowed implementation to a glacial pace

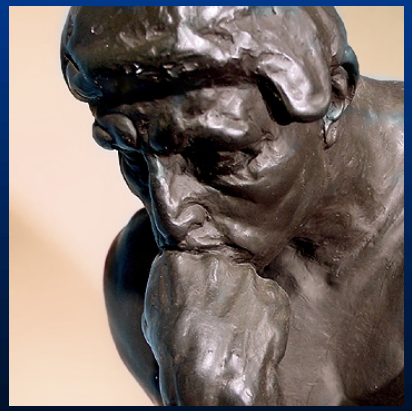
Obstacles –

- Organizational: *setting up clinics, lack of office/clinic space, managing polycoms, credentialing*
- Administrative: *poor communication from leaders to staff and from medical center to community clinics; reassignment of staff*
- Individual: *mismatch in therapist interests; therapists change jobs*

Potential Solutions to Barriers

In hindsight, we would have –

1. Formalized decision-making with clinical leaders regarding which therapists & CBOCs, why, and how
2. Selected more therapists per site to account for attrition
3. Increased the frequency of communication with clinical leaders
4. Planned for longer implementation timeline; lowered our expectations



Next Steps

Just completed follow up assessment 8 months post-training

Preliminary data shows that 2/11 therapists (two medical centers) are providing some telepsychotherapy services - 1 providing individual psychotherapy, 1 conducting a psychotherapy group

All therapists endorsed multiple barriers to providing services

Thank you

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