Achieving the Promise: National Dissemination and Implementation of Evidence-Based Psychotherapies in the U.S. Department of Veterans Affairs Health Care System

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• Over the past 40+ years, specific psychotherapeutic interventions have been developed and validated for various MH conditions
  – Evidence-based psychotherapies (EBPs) are psychotherapies that have been shown to be efficacious in randomized controlled trials and typically involve active change components and strategies

• For some conditions (e.g., PTSD, other anxiety disorders, insomnia) EBPs have been shown to be more effective and have more enduring effects than medications (e.g., Butler et al., 2006; Institute of Medicine, 2007)

• Specific EBPs are highly recommended in clinical practice guidelines and are recognized in some contexts as first-line treatments (e.g., National Institute for Clinical Excellence, 2005; National Institutes of Health, 2005; U.S. Department of Veterans Affairs/U.S. Department of Defense, 2010)
National Dissemination of Evidence-Based Psychotherapies in the VA Health Care System

- National initiative to disseminate and implement 16 evidence-based psychotherapies in the VA health care system
- Largest dissemination of EBPs in the United States
• Earlier approaches to the dissemination of EBPs and other services (Mittman, 2012):
  1. Generally relied on *unidimensional* approaches
     • Focus on individual clinicians, neglect of larger systems, the overall organization, and patients
  2. Often involve *passive* methods of information exchange
     • Dissemination of CPS, clinical reminder systems, and practice toolkits
• National, multi-level model, based on D&I science
  (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Tabak, Khoong, Chambers, & Brownson, 2012)
  – Barriers and facilitators
  – Emerging multi-component D&I models
<table>
<thead>
<tr>
<th>Level</th>
<th>Focus</th>
<th>Selected Strategies</th>
</tr>
</thead>
</table>
| **Policy** | National requirements for EBP availability| • Uniform MH Services Handbook (VHA Handbook 1160.01)  
• VHA Mental Health Initiative Operating Plan |
| **Provider** | Staff training and support                 | • Competency-based staff training programs  
• Longer-term consultation support  
  • Local peer consultation and communities of practice |
| **Local Systems** | Local clinical infrastructures and buy-in | • Infrastructure requirements (e.g., scheduling grid)  
• Adaptations to culture of care  
• Local champions (Local EBP Coordinators)  
• Pre-implementation readiness |
| **Patient** | Clinical implementation strategies         | • Promoting patient awareness and generating demand  
• Informed choice and shared decisionmaking  
• Motivational enhancement  
• Assessing and enhancing the therapeutic relationship  
• Case conceptualization and goals-based approach to treatment |
| **Accountability** | Monitoring and evaluating implementation and impact | • Surveys of EBP delivery  
• Computerized EBP documentation templates  
• EBP training program evaluation  
  • Therapist and patient-level outcomes |

National Competency-Based EBP Training Programs

• PTSD
  – Cognitive Processing Therapy
  – Prolonged Exposure Therapy

• Depression
  – Cognitive Behavioral Therapy
  – Acceptance and Commitment Therapy
  – Interpersonal Psychotherapy

• Serious Mental Illness
  – Social Skills Training
  – Behavioral Family Therapy
  – Multifamily Group Therapy

• Relationship Distress
  – Integrated Behavioral Couple Therapy

• Insomnia
  – Cognitive Behavioral Therapy

• Chronic Pain
  – Cognitive Behavioral Therapy

• Motivation/Adherence
  – Motivational Interviewing

• Substance Use Disorders
  – Motivational Enhancement Therapy
  – Behavioral Couples Therapy
  – Contingency Management
  – Cognitive Behavioral Therapy

⇒ 8,000+ mental health staff have received training in one or more EBPs
• Promoting the “pull” as well as “push” in EBP dissemination!
Key Questions . . .

• Can busy clinicians be trained to deliver EBPs with competency and fidelity?

• How effective are EBPs outside of the laboratory context with real-world patients with often very complex health care needs?
• Overall medium to large increases in therapist competencies and large improvements among patients (e.g., Eftekhar et al., 2013; Karlin et al., 2012; Karlin, Trockel, et al., 2013; Karlin, Walser, et al., 2013; Stewart, Karlin, et al., in press; Stewart, Raffa, et al., 2014; Trockel, Karlin, Taylor, & Manber, 2014; Trockel, Karlin, Taylor, Brown, & Manber, 2015).
Training Outcomes

• ~80-90%+ clinicians successfully completed EBP training and competency-based requirements
<table>
<thead>
<tr>
<th>Therapy</th>
<th>Clinically Significant Reduction in Primary Symptoms</th>
<th>Improvements Quality of Life</th>
<th>Improvement in Therapeutic Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT for Depression</td>
<td>■</td>
<td>■</td>
<td>■</td>
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<tr>
<td>IPT for Depression</td>
<td>■</td>
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<tr>
<td>ACT for Depression</td>
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<tr>
<td>CBT for Insomnia</td>
<td>■</td>
<td>■</td>
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</tr>
<tr>
<td></td>
<td>Also: Depression Suicidal Ideation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged Exposure for PTSD</td>
<td>■</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CPT for PTSD</td>
<td>■</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
VA CBT for Depression Training Program
Patient Outcomes: Beck Depression Inventory-II (BDI-II)

Intent-to-Treat Analysis: n=356
(Mixed Effects Model Using, Initial, Middle, and Later Phase Data)

<table>
<thead>
<tr>
<th>BDI-II scores</th>
<th>Initial mean</th>
<th>Later phase mean</th>
<th>Change</th>
<th>Regression Standard Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28.1</td>
<td>16.9</td>
<td>-11.2</td>
<td>6.2</td>
</tr>
</tbody>
</table>

VA CBT for Insomnia Training Program
Patient Outcomes:
Insomnia Severity Index (ISI)
Intent-to-Treat Analysis (Mixed Effects Model): n=182

<table>
<thead>
<tr>
<th>ISI scores</th>
<th>Initial mean</th>
<th>Later phase mean</th>
<th>Change</th>
<th>Regression Standard Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>20.9</td>
<td>10.3</td>
<td>-10.6</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Impact on Costs and Utilization
Impact on Costs and Utilization

- VA researchers have demonstrated significant cost and service offset associated with receiving EBPs for PTSD (Myers et al., 2013; Tuerk et al., 2013)
  - ~30% reduction in mental health service utilization
  - ~40% reduction in health care costs

A Few Lessons Learned . . .

- Large scale D&I (of complex treatments) is hard work, but achievable!

- Active, theoretically-based, and empirically-informed approaches are essential to real-world implementation
  - Multidimensional approach
  - Top-down and bottom-up processes

- Don’t forget the consumers/patients!
  - Promote the “pull” as well as “push” in implementation
  - Pre-therapy processes to prepare and engage patients

- Importance of pre-implementation readiness
Panel Discussion: Guiding Questions

1. Specific barriers or needs to delivering evidence-based psychosocial interventions in your system or organization

2. Specific implementation elements or processes in your system or organization that have worked well — or how such could work well

3. Efforts underway for promoting implementation and delivery of evidence-based psychosocial treatments — or what steps you and other stakeholders might take to adopt quality improvement systems at multiple levels