The Continuum of Care for PTSD

Kelly Phipps Maieritsch, PhD
National Center for PTSD-Executive Division
Edward Hines Jr VA Hospital
ACKNOWLEDGEMENTS

• OMHSP Continuum of Care Workgroup (75+)
• Dr. Tracey Smith, Dr. Jennifer Burden, Dr. Elissa McCarthy, Dr. Cindy Yamokoski, Dr. Pearl McGee-Vincent
• NCPTSD Consultation and Mentor Staff
OBJECTIVES

• Continuum of Care Background and Principles
• PTSD Specialty Care Continuum of Care
• Emerging Trends
• **Stepped Care Model** (Bower & Gilbody, 2005; Ahmedani & Vannoy, 2014; Richards, 2014)
  - Mange limited health care resources including demand for specialty mental health services
  - Improve reach and availability of services
  - “Step up” and “Step down” processes

• **Key Elements**
  - Least restrictive care available
  - Self-correcting (i.e., movement to different steps)
  - Treatments of differing intensity
• Assumptions of Stepped Care

  – Equivalence
    • Minimal interventions equivalent benefit for a proportion of patients

  – Efficiency
    • Utilizing lower levels of care allows for efficient use of other higher healthcare resources

  – Acceptability
    • To both patients and providers
• **United Kingdom: Improving Access to Psychological Therapies (IAPT)**
  
  - Implementing National Institute for Health and Clinical Excellent (NICE) guidelines within health care system (Clark, 2011)
  
  - Key Principles: Access, Stepped Care/Guideline concordant, employment, weekly outcome informed discussions
  
  - Recovery rate 51% and 66.3% show reliable improvement (Clark, 2018)

• **Veterans Health Administration Model of Mental Health** (Report from the Office of Mental Health & Suicide Prevention)
  
  - Based on interrelated evidence-informed principles and incorporates existing mental health initiatives
CONTINUUM OF CARE

- Inpatient
- Residential
- Specialty Mental Health
- General Mental Health
- Primary Care MH Integration (PCMHI) in PACT
- Self-directed care

Self-directed care
Peer Support
Community partners
CONTINUUM OF CARE BACKGROUND & PRINCIPLES

- Least Restrictive Care
- Measurement-Based Care
- Shared Decision Making
- Recovery-Oriented Mental Health Care
- Suicide Prevention
- Medical Necessity
- Team-Based Care
- Practicing at the Top of One’s License
- Flexible Service Delivery Methods
- Reduction of Redundancy/De-implementation
- VA partners and Non-VA Community Resources
• Provision of a PTSD continuum of care implies matching the unique needs of a Veteran with the level of care required at the time, as well as ongoing evaluation of whether the Veteran should receive a greater or lesser level of care.

• All VHA points of service must provide EBP services for the treatment of PTSD, specifically CPT or PE, in person or via Telemental health by trained clinicians.
### PTSD Continuum of Care

<table>
<thead>
<tr>
<th>Self-Directed Care</th>
<th>Peer Support</th>
<th>Primary Care MH Integration</th>
<th>General Mental Health/BHIP</th>
<th>PTSD Specialty Outpatient</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PTSD Treatment Decision Aid</td>
<td>➢ Outreach</td>
<td>- Brief assessment and screening</td>
<td>- General Skills</td>
<td>-EBPS for PTSD</td>
<td>-Structured environment of care to deliver EBPs for PTSD for:</td>
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<tr>
<td>• About Face</td>
<td>➢ -Mentoring</td>
<td>- Motivational enhancement</td>
<td>- Maintenance of goals after intensive tx</td>
<td>-Time-limited skills-based interventions for severe sxs</td>
<td>Risk of relapse</td>
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<tr>
<td>• Whiteboard</td>
<td>-Goal setting</td>
<td>- PTSD education</td>
<td>- Management of comorbid diagnosis</td>
<td>-Medication</td>
<td>Attempted or difficulty w/ lower level of care</td>
</tr>
<tr>
<td>• PTSD Coach &amp; other mobile apps</td>
<td>-Support groups</td>
<td>- Brief protocols for PTSD</td>
<td>- EPBs for PTSD (availability permitting)</td>
<td>-Medication</td>
<td>Coping skills required to complete EBP</td>
</tr>
<tr>
<td>• Beating the Blues internet intervention</td>
<td>-After-care groups</td>
<td>- Skills building</td>
<td>- Skills &amp; education groups</td>
<td>-Case Management</td>
<td>-Medication</td>
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<tr>
<td></td>
<td></td>
<td>- Referral management</td>
<td>- Medication</td>
<td></td>
<td>-Case Management</td>
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</tbody>
</table>

#### Residential
- Structured environment of care to deliver EBPs for PTSD for:
  - Risk of relapse
  - Attempted or difficulty w/ lower level of care
  - Coping skills required to complete EBP
  - Medication
  - Case Management
• Self-directed care would include participation in any services, interventions, or activities that are primarily driven by patient preference (i.e., time, locations, duration, or level of participation)

• Include but not limited to:
  – Educational materials, videos, mobile apps, websites
**Levels of Support for Veterans’ Use of Mobile Mental Health Apps**

**Self-Directed Care**

**Providing Information**
- Give informational handout, e.g.:
  - Flyer about self-care apps
  - Flyer about specific app
  - Instructions on how to download

**Examples of when to provide info:**
- One-time visit/infrequent visits (primary care, inpatient, rural settings)
- Subclinical issues/psychotherapy with a provider not indicated
- Before/after an episode of care

*Clinical or non-clinical staff can provide information about apps for self-care*

**Supplement to Treatment**
- With Veteran’s buy-in and access to needed equipment, provider introduces tool(s) that:
  - Facilitate treatment (e.g., skills practice, psychoeducation, self-monitoring) for:
    - Primary focus of treatment
    - Supplemental issues (e.g., anger management)

**Supplement to Treatment**
- Use all features of app or select specific tools or features
- Care provided is mostly the same as without app
- Provider works within scope of practice and knowledge (e.g., is trained in CBT skills in apps)
- Provider integrates app in ways that fit with the treatment being provided (e.g., assigning homework with app)

**Specialty Mental Health**

**Treatment Companion**
- For Veterans participating in an evidence-based treatment (e.g., CBT-I, PE, CPT, STAIR, ACT):
  - The app is presented as an option (for homework completion, skills practice, self-assessment, etc.)
  - Alternatives (e.g., paper worksheets, tape recorder) also presented

*EBT is delivered per protocol*

*Following an episode of care, apps may be recommended for ongoing self-management and self-monitoring of symptoms*
• Domiciliary PTSD (DOM PTSD)

  – Residential care to Veterans with PTSD including Military Sexual Trauma in 24/7 structured and supportive environment

  – Strong emphasis on provision of EBPs with inclusion of additional psychosocial and medical services addressing co-occurring needs

  – Need: Severity of illness, high-relapse potential, exacerbation of co-occurring disorders, and absence of safe, supportive recovery environment
Veteran must:

- Be assessed as not meeting criteria for *acute psychiatric or medical admission*.
- Have tried a less restrictive treatment alternative, or one was unavailable.
- Be assessed as not a significant risk of harm to self and others.
- Be lacking a stable lifestyle or living arrangement that is conducive to recovery.
- Be capable of self-preservation and basic self-care.
- Have identified treatment and rehabilitation needs, which can be met by the program.

Veterans cannot be denied admission based *solely* on:

- Length of current abstinence from alcohol or non-prescribed controlled substances
- Number of previous treatment episodes
- Time interval since last residential admission
- Use of prescribed control substances
- Legal history

*Screening process must consider each of these and determine if program can meet the Veterans needs while maintaining safety, security and integrity.*
RESIDENTIAL STEPPED CARE CONSIDERATIONS

• Safety prior to Residential Treatment
  – Collaboration and contact prior to admission – required weekly
  – Help patients follow through with preadmission plans re: safety behaviors

• Safety following discharge from Residential Treatment
  – The safety plan has been updated. Is everyone on the same page? Are there new resources to add?
  – Collaborative mobilization of Veteran’s social support system
  – Minimum of 2 encounters following discharge (4 for some Veterans) with expectation for first encounter within 7 days
- MHRRTP Program Locator
PTSD Consultation Program

• Dr. Elissa McCarthy is a consultant specializing in questions related to assessment and treatment, including: Cognitive Processing Therapy, Prolonged Exposure, Cognitive Behavioral Therapy for Insomnia, and residential treatment programs.
• She is a clinical psychologist with experience in training other clinicians in evidence-based therapy.
• She has experience working in a VA residential treatment program for PTSD and continues to deliver evidence-based psychotherapies through the VA Connecticut Healthcare System.

Elissa McCarthy, PhD
Consultant
• PTSD Clinical Team (PCT) and PTSD Specialists
  – Provide resource of expertise for entire facility
  – Knowledgeable of assessment and diagnosis of PTSD and military culture
  – Scope and flow of services is often determined by local continuum of care resources
Patient Flow in PTSD Clinical Teams FY’17

- Treat all with PTSD; Stay as long as Veteran wants: 50%
- Treat only those wanting EBP, Stay in program after EBP: 10%
- Treat only those wanting EBP, transition to other clinics: 20%
- Other: 20%

N=129; Source: NEPEC FY’17 Annual Review for Specialized PTSD Programs
• **Context Matters...** (Sayer et al., 2017)
  
  – Promoting Effective, Routine, and Sustained Implementation of Stress Treatments (PERSIST)
  
  – Identify organizational and team factors that promote high levels of reach of EBPs for PTSD to patients seen on outpatient PTSD teams
  
  – 9 sites, 10 PTSD teams
  
  • High (38.6%-58.9%)
  
  • Medium (28.8%-31.7%)
  
  • Low (14.0-17.7%)
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<tr>
<th>Domains</th>
<th>High Reach Teams</th>
<th>Low Reach Teams</th>
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<tbody>
<tr>
<td><strong>Clinic Mission or Purpose</strong></td>
<td>Time-limited specialty clinics. Primary purpose was delivering CPT and PE in weekly sessions.</td>
<td>General mental health clinics for patients with PTSD. Provided all types of mental health care for as long as patients needed &amp; wanted it.</td>
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<td><strong>Team Engagement in EBP Delivery</strong></td>
<td>Team leaders were experts in and champions of EBPs. They built staff commitment to the clinic’s EBP mission.</td>
<td>Team leaders saw EBPs as only one of many valuable treatment options. There was variability in staff commitment to EBPs.</td>
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<tr>
<td><strong>Clinic Operations/Procedures</strong></td>
<td>High reach teams developed procedures to facilitate EBP delivery.</td>
<td>Low reach teams grafted EBPs on existing clinic procedures.</td>
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<td><strong>Staff Perceptions of CPT and PE</strong></td>
<td>CPT and PE seen as helping most patients, more effective than other treatments, and benefitting clinic.</td>
<td>CPT and PE seen as beneficial for some but not most patients. Perceived benefit for clinic was variable.</td>
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<td><strong>Broader Practice Environment</strong></td>
<td>Support from facility and MH leadership enabled focus on EBPs, including ability to refer patients out of clinic.</td>
<td>Facility did not support specialized EBP mission; team expected to provide a broad range of services as long as patients need and want them.</td>
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We are in this together!

- Care coordination agreements/MOU
  - Who is most appropriate?
  - Scope of services available
  - Expectations regarding treatment episodes and discharge

- Multiple data sources for shared-decision making and transition planning
  - MBC, Patient/Provider, program-level resources

- Leadership Support for CoC
• Brief Prolonged Exposure for PTSD to Primary Care (Cigrang et al. 2017)
  – PE-PC: Treatment delivered in 4 thirty-minute sessions
  – VA PCMHI Training Plan Underway
  – 1 in 5 patients with PTSD will only see PCP for treatment – refuse MH referral
• Massed EBPs for PTSD: Intensive Treatment Care Models (Foa et al., 2018; Hendriks et al., 2017; Ehlers et al., 2014)
  – PE and Cognitive Therapy
  – Condensed time period
    • Intensive treatment provided in less than 2 weeks
  – Similar to greater sessions/hour than standard
    • Massed PE=10 sessions; iPE=12 sessions; CT=14 sessions
  – Completion rates...
    • 86%; 95%; 97%
EMERGING TRENDS: EXPANDING THE CONTINUUM

  - 4 Academic Medical Centers
    - Emory Healthcare- Veterans Program
    - Rush University Medical Center-Road Home
    - Massachusetts General Hospital-Home Base
    - University of California (UCLA) Operation Mend
  - 2 to 3 week programs: PE and CPT
  - Includes: family support, wellness, case management
  - VA MOU to ensure collaboration and post treatment coordination;
    - AMC Case Manager ↔ VA Liaison ↔ VA Case Manager
  - Completion rate: 93.5% (n=572)
  - Effectiveness: Cohen’s d=1.07 (n=428)
• Cleveland VAMC Intensive Program
  – Two week program
    • Daily individual PE
    • Check in groups +mindfulness
    • Group in-vivo exposure
    • Yoga twice weekly
  – Four week program
    • 3 times weekly individual CPT or PE
    • Attend groups with 2 week cohort
  – Additional treatment options via substance use program
• Provision of a PTSD continuum of care implies matching the unique needs of a Veteran with the level of care required at the time, as well as ongoing evaluation of whether the Veteran should receive a greater or lesser level of care.

• Successful implementation of the stepped care model relies on integration of the key principles