

Program Profile

Interprofessional Education in Patient Aligned Care Team Primary Care-Mental Health Integration

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Interprofessional education is an effective approach for preparing health care providers for team-based practice.

Over the past 10 years, the VHA has been a national leader in primary care-mental health integration (PC-MHI) within patient aligned care teams (PACTs).^{1,2} Studies of the PC-MHI collaborative care model consistently have shown increased access to MH services, higher levels of MH treatment engagement, improved MH treatment outcomes, and high patient and provider satisfaction.³⁻⁷ Primary care-mental health integration relies heavily on interprofessional team-based practice with providers from diverse educational and clinical backgrounds who work together to deliver integrated mental and behavioral health services within PACTs. This model requires a unique blending of professional cultures and com-

munication and practice styles.

To sustain PC-MHI in PACT, health care professionals (HCPs) must be well trained to work effectively in interprofessional teams. Across health care organizations, training in collaborative interprofessional team-based practice has been identified as an important and challenging task.⁸⁻¹¹

Integrating educational experiences among different HCP learners is an approach to developing competency in interprofessional collaboration early in training. The World Health Organization defined *interprofessional education* (IPE) as occurring “when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.”⁹ Fundamental to this definition is the belief that interaction among learners from different disciplines during their training develops competency in subsequent effective collaborative practice. Studies of IPE in MH professional training have found that prelicensure IPE contributes to increased knowledge of roles and responsibilities of differ-

ent disciplines, improved interprofessional communication and attitudes, and increased willingness to work in teams.¹²⁻¹⁷

Interprofessional education is a valuable training model, but developing interprofessional learning experiences in a system of diverse and often siloed training programs is difficult. More information about design and implementation of IPE training experiences is needed, particularly in outpatient settings in which integration of traditionally separate discipline-specific care is central to the health care mission. The VA PACT PC-MHI is a strong team-based care model that represents a unique opportunity for training across disciplines in interprofessional collaborative care.

To find innovative approaches to meeting the need for IPE in PACT PC-MHI, the authors developed a new IPE program in PC-MHI at the William S. Middleton Memorial Veterans Hospital (WSMMVH) in Madison, Wisconsin. This article reviews the development, implementation, and first-year evaluation of the training program and discusses the

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challenges and the IPE areas in need of improvement in PACT PC-MHI.

METHODS

In 2012, the VHA launched phase 1 of the Mental Health Education Expansion Initiative (MHEEI), a collaboration of the Office of Academic Affiliations (OAA), VHA Mental Health Services (VHA-MHS), and the Office of Mental Health Operations (OMHO).¹⁸ The MHEEI was intended to “increase expertise in critical areas of need, expand the recruitment pipeline of well-trained, highly qualified health care providers in behavioral and mental health disciplines, and promote the utilization of interprofessional team-based care.”¹⁸ In response, WSMNVH organized a planning committee and submitted a funding request through the section of MHEEI called PACT With Integrated Behavioral Health Providers. The planning committee included training program directors and staff from psychiatry, pharmacy, social work, psychology, and primary care. The authors received funding for trainees in psychiatry (postgraduate year 4 [PGY-4]), pharmacy/MH residency (PGY-2), pharmacy/ambulatory care (PGY-1), and social work (interns).

Curriculum Development

The planning committee met regularly for 6 months to develop the organization, learning objectives, educational strategies, and implementation plan for the IPE program. The program was organized as a 4- to 12-month clinical rotation with the PC-MHI team in PACT, combined with 12 months of protected weekly IPE time (Table 1).

Learning Objectives

To better understand the educational needs and foci for learning objec-

Table 1. Clinical Rotation in PACT PC-MHI

Disciplines	Trainees, n	Clinical Rotation
Psychiatry resident (PGY-4)	2	1 d/wk for 12 m
Psychiatry resident (PGY-2)	8	0.5 d/wk for 3 m
Social work (intern)	2	1.5 d/wk for 8 m
Pharmacy/mental health resident (PGY-2)	3	4 d/wk for 4 m
Pharmacy/ambulatory care resident (PGY-1)	7	1 d/wk for 12 m

Abbreviations: PACT, patient-aligned care team; PC-MHI, primary care–mental health integration; PGY, postgraduate year.

tives, the interprofessional planning committee reviewed guidelines on training in integrated care and collaborative team-based practice.^{2,9,10,19-21} These guidelines were compared with existing training opportunities for each discipline to identify training gaps and needs.

Learning objectives were organized into 3 domains: patient-centered PC-MHI, collaborative team-based practice, and population health and program improvement. Table 2 outlines the shared learning objectives linked to each domain that were common to the psychiatry, pharmacy, and social work disciplines. Although many of the learning objectives were shared among all disciplines, each trainee also had discipline-specific clinical activities and learning objectives. Psychiatry and pharmacy residents focused on primary care psychiatric medication consultation and care management for antidepressant medication starts. Social work interns focused on psychosocial and functional assessment and brief problem-focused psychotherapies. Learning objectives were met through direct veteran care in the primary care clinic as part of the PACT PC-MHI team and through interprofessional learning activities

during protected weekly education time.

IMPLEMENTATION

Critical stakeholders in implementing the IPE program involved themselves early and throughout the planning process. Stakeholders included VAMC leadership, primary care and MH service line chiefs and clinic managers, training program directors, and PACT staff. Planning committee members gave presentations on the IPE program at MH service line and PACT meetings in the 2 months before program initiation in order to orient staff to learning objectives, program structure, and impact on PACT PC-MHI operations. Throughout the first year, the planning committee continued to meet every 2 weeks to review progress, solve implementation problems, and revise learning objectives and activities.

Trainee Clinical Activities

A wide range of educational strategies were planned to meet learning objectives across the 3 domains. There was strong emphasis on experiential learning through daily PACT and PC-MHI clinical work, team huddles and meetings, and trainee-led program improvement projects.

Table 2. Shared Learning Objectives for PC-MHI IPE Program

Domains	Knowledge Objectives	Skills Objectives	Attitudinal Objectives
Interprofessional team-based collaborative practice	<ul style="list-style-type: none"> • Demonstrate understanding of the roles and skills of different team members • Describe core components of quality team-based care, including effective communication, role clarity, leadership, shared mission, mutual support, and respect 	<ul style="list-style-type: none"> • Develop effective working relationships within PACT PC-MHI utilizing clear communication of assessments and recommendations and collaborative treatment planning • Utilize team huddles and meetings to improve patient care and clinic flow • Share knowledge and perspective with other disciplines in clinical discussions and interprofessional education seminars 	<ul style="list-style-type: none"> • Identify interprofessional team-based collaborative practice as a valued and effective model for health care delivery • Identify interprofessional education as a valued and effective model for learning • Acknowledge and respect the unique contributions of different disciplines within PACT PC-MHI
Patient-centered PC-MHI	<ul style="list-style-type: none"> • Describe common behavioral and mental health problems in primary care and an appropriate treatment plan (with focus on depression, anxiety, insomnia, and alcohol use disorders) • Demonstrate knowledge of evidence base supporting PC-MHI • Describe indications and core components of brief therapies in primary care (PST, BA, MI, CBT-I) 	<ul style="list-style-type: none"> • Complete a problem-focused functional PC-MHI assessment that elicits the patient’s narrative, values, health care priorities, and goals for wellness • Develop treatment plans using shared decision making and patient-centered goals • Utilize scales (eg, PHQ9, GAD7) to support measurement-based care in clinical assessment and outcomes tracking • Develop competence in MI through training and supervision of MI recordings 	<ul style="list-style-type: none"> • Identify core components of patient-centered care as highly valued, including sustained relationships with provider and team, focus on patient narrative (values and health care goals), shared decision making, patient self-management, whole health, and wellness promotion
Population health and program improvement	<ul style="list-style-type: none"> • Demonstrate knowledge about basic principles of population health and process improvement 	<ul style="list-style-type: none"> • Work effectively with PACT/PC-MHI teams on panel management and process improvement projects to improve patient care, outcomes, and workflow 	<ul style="list-style-type: none"> • Identify personal involvement in process and program improvement as valued with intention to continue this activity into future practice

Abbreviations: BA, behavioral activation; CBT-I, cognitive behavioral therapy in insomnia; GAD7, Generalized Anxiety Disorder 7 scale; MI, motivational interviewing; PACT, patient aligned care team; PC, primary care; PC-MHI, primary care-mental health integration; PCP, primary care provider; PHQ9, Patient Health Questionnaire-9; PST, problem-solving therapy.

Psychiatry and PGY-2 pharmacy/MH residents focused on direct and indirect medication consultation and problem-focused assessments. Their clinical activities included PC-MHI medication evaluation and follow-up visits; chart reviews and e-consults for medication recommendations to PACT providers; reviews of care management data and consultations on veterans enrolled in depression and anxiety care management;

“curbside consultations” for providers in PACT huddles and meetings and throughout the clinic day; and “warm handoffs,” same-day initial PC-MHI problem-focused assessments performed on PACT provider request. The residents were part of a pool of staff and trainees who performed these assessments.

PGY-1 pharmacy residents made care management phone calls for antidepressant trials for depression and

anxiety. These residents were trained in motivational interviewing (MI). They applied their MI skills during care management calls focused on medication adherence and behavioral interventions for depression (eg, exercise, planning pleasurable activity) and during other clinical rotations, including tobacco cessation and medication management for diabetes and hypertension. Particularly challenging veteran cases from these

clinics were cosupervised with medication management and PC-MHI staff for added consultation on engagement, behavior change, and treatment plan adherence.

Social work interns completed initial PC-MHI psychosocial and functional assessments by phone and directly by same-day warm handoffs from PACT staff. The PC-MHI therapies they provided included problem-solving therapy, behavioral activation, stress management based on cognitive behavioral therapy, and brief alcohol interventions.

Group IPE Activities

All trainees had a weekly protected block of 3 hours during which they came together for group IPE that was designed to elicit active participation; facilitate interprofessional communication; and develop an understanding of and respect for the knowledge, culture, and practice style of the different disciplines.

Trainees participated in a Herrmann Brain Dominance Instrument (HBDDI) workshop focused on developing a better understanding of individual differences in thinking and problem solving, with the goal of improving communication and learning within teams.²² In a seminar series on professionalism and boundaries in health care, trainees from each discipline gave a presentation on the traditional structure and content of their discipline's training and discussed similarities and differences in their disciplines' professional oaths, codes of ethics, and boundary guidelines.

Motivational interviewing training was conducted early in the year so trainees would be prepared to apply MI skills in their daily PACT PC-MHI clinical work. Motivational interviewing is a patient-centered approach to engaging patients in health promot-

ing behavior change. It is defined as a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence."²³

Trainees recorded MI sessions with at least 2 live-patient visits and at least 2 simulated-patient interviews (with staff serving as patient actors). The structure of MI training and supervision was deliberately designed to facilitate interprofessional communication and learning. In accord with a group supervision model for MI recorded reviews, the trainees presented their tapes to the entire learning group in the presence of a facilitating supervisor. Trainees had the opportunity to observe different interview styles and exchange feedback within a peer group of interprofessional learners.

Seminars were focused on core PC-MHI clinical content (eg, depression, anxiety, alcohol use disorders) and organized around case-based learning. Trainees divided into small teams in which representatives of each discipline offered their perspective on how to approach planning patient assessment and treatment. During the seminars, the authors engaged trainees as teachers and leaders whenever possible. All trainees presented on a topic in which they had some discipline expertise. For example, social work interns led a seminar on support and social services for victims of domestic violence, and PGY-1 pharmacy/ambulatory care residents led seminars and a panel management project focused on diabetes and depression.

Trainees participated in several PACT PC-MHI projects focused on population- and measurement-based care, panel management, and program improvement (Table 3). Protected IPE time was used to teach trainees about population health

principles and different tools for process improvement (eg, Vision-Analysis Team-Aim-Map-Measure-Change-Sustain) and provide a forum in which trainees could share their work with one another.

EVALUATIONS

Several tools were used for trainee and program evaluations. Clinical skills were evaluated during daily supervision. Trainees began the year with PC-MHI staff directly observing all their clinical contacts with veterans. Staff evaluated and offered feedback on trainee clinical interviewing and on assessment and treatment planning skills. Once they were assessed to be ready to see veterans on their own, trainees were advanced by staff to "drop-in" direct supervision: Toward the end of a veteran's visit, a staff preceptor entered the room to review relevant clinical findings, assessment and finalized treatment planning with the trainee and veteran. When appropriate for trainee competence level, clinical contacts were indirectly supervised: Trainees discussed their assessment and treatment plan with a staff supervisor at the end of the day.

Motivational interviewing recordings were reviewed during group supervision. To objectively evaluate MI skills, supervisors who were VA-certified in MI used the Motivational Interviewing Treatment Integrity (MITI) coding tool to review and code both the live- and simulated-patient recordings.²⁴ The MITI coding involves quantitative and qualitative analysis using standardized coding items.

Quantitative items included percentage of open-ended questions (Proficiency: 50%; competency: 70%); percentage of reflections considered complex reflections, or reflective statements adding substantial meaning or

Figure 1A. Midyear MITI Coding Items^a

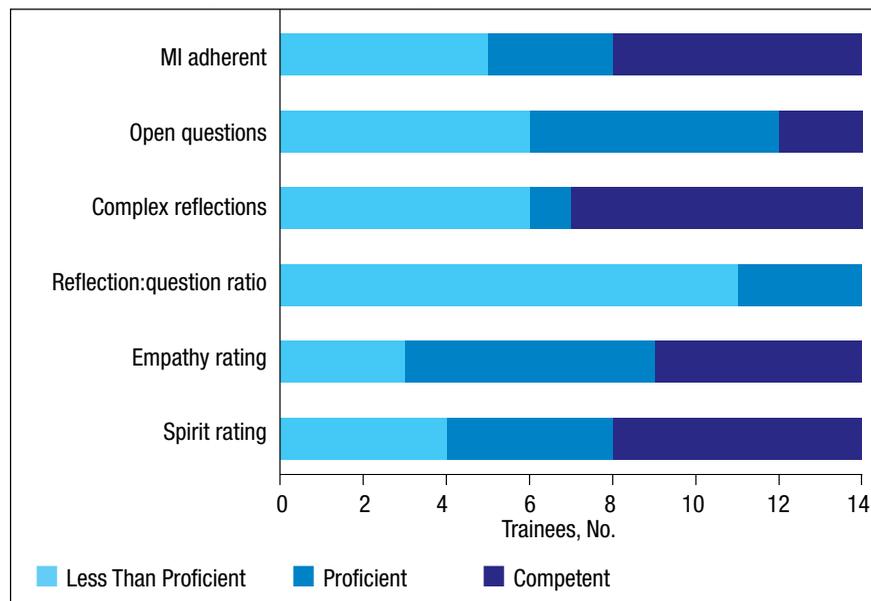
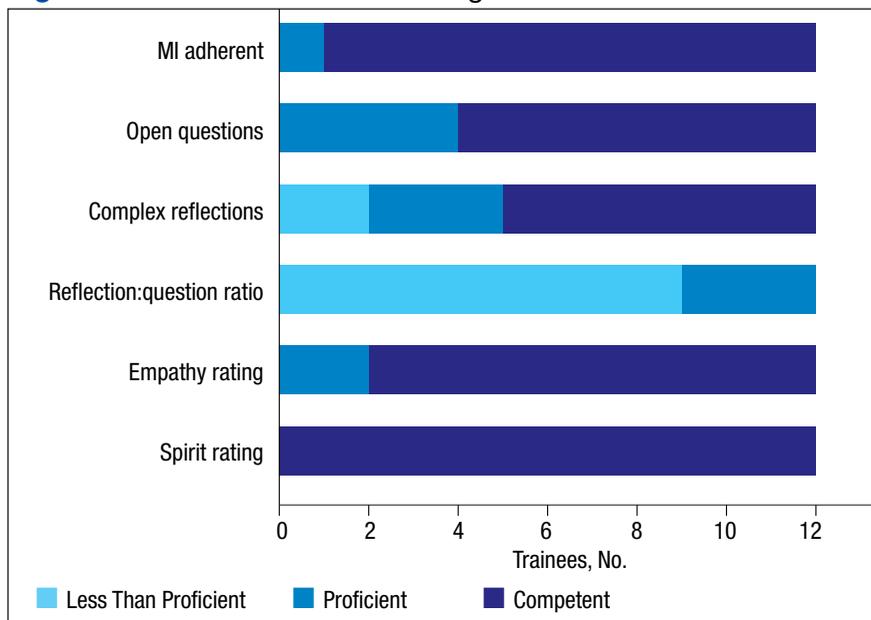


Figure 1B. End-of-Year MITI Coding Items^a



Abbreviations: MI, motivational interviewing; MITI, Motivation Interviewing Treatment Integrity.

^aTotal number of trainees: 14 at midyear; 12 at end of year (2 graduated program early).

emphasis and conveying a deeper or more complex picture of what patients say (Proficiency: 40%; competency: 50%); reflection-to-question ratio (Proficiency: 1:1; competency:

2:1); and percentage of MI-adherent provider statements (Proficiency: 90%; competency: 100%).

Qualitative coding items were a global rating of therapist “empathy,”

which evaluated the extent to which the trainee understood or made an effort to grasp the patient’s perspective, and “MI spirit.” This coding intended to capture the overall competence of the trainee in emphasizing collaboration, patient autonomy, and evocation of the patient experience (Proficiency score: 5; competency score: 6).

The PC-MHI teaching staff met midyear and end of year as a team to complete trainee evaluations focused on the 3 areas of learning objectives: patient-centered PC-MHI, collaborative team-based practice, and population health and program improvement. Patient-centered PC-MHI involves direct observation and supervision of trainee clinical contacts with veterans, including assessment and treatment planning, clinical documentation, and review of live- and simulated-patient MI recordings. Collaborative team-based practice involves review of trainee participation in day-to-day teamwork, huddles, team meetings, and IPE activities. Population health and program improvement involves review of trainee work on a panel measurement-based care management or program improvement project. In each learning objectives area, trainees were rated on a 3-point scale: needs improvement (1); satisfactory (2); achieved (3). Core knowledge about PC-MHI evidence base, structure, and clinical topics was assessed with case-based written examination at midyear and end of year.

Surveys and qualitative interviews were used to assess trainee perceptions about the IPE program. A mid-year and end-of-year survey assessed trainee satisfaction and perceived efficacy of the IPE training program in meeting core learning objectives. A midyear survey designed by pharmacy residents as part of their

Table 3. Trainee Panel Management, Measurement-Based Care, and Process Improvement Projects

Project Focus/Trainee	Project Activities
Diabetes treatment adherence—pharmacy residents (PGY-1)	<ul style="list-style-type: none"> • Review of PACT panels to identify veterans with uncontrolled diabetes and poor treatment adherence • Outreach to engage a veteran in a specific medication management clinic with longer visit time and MI supervisor involvement with a focus on utilizing MI to improve treatment adherence
Depression and diabetes—pharmacy residents (PGY-1)	<ul style="list-style-type: none"> • Review of PACT panels to identify veterans with comorbid diabetes and depression • Outreach to engage with PC-MHI and enroll in phone-based combined depression and diabetes care management
CBT for insomnia and sleep medication in the elderly—psychiatry (PGY-4) and MH pharmacy residents (PGY-2)	<ul style="list-style-type: none"> • Review of PACT panels to identify older veterans using chronic sleep medications • Outreach and offer psychoeducation and MI toward engagement PC-MHI CBT for insomnia • Review of PC-MHI CBT for insomnia outcomes
Chronic benzodiazepine use—pharmacy residents (PGY-2)	<ul style="list-style-type: none"> • Review of PACT panels to identify veterans on chronic benzodiazepine medications • Develop protocols for PACT PC-MHI team outreach, benzodiazepine tapering as appropriate, and to engage in PC-MHI
PTSD treatment plans in PC-MHI—psychiatry residents (PGY-4)	<ul style="list-style-type: none"> • Review of PACT PC-MHI treatment plans and outcomes for veterans with PTSD • Identify areas for improvement, (eg, improve measurement-based care with PTSD check list to track prazosin trials in PC-MHI)
Depression and anxiety care management outcomes—pharmacy residents (PGY-1, PGY-2)	<ul style="list-style-type: none"> • Regular review depression and anxiety care management outcomes and identify factors that predict response and remission (eg, number of contacts, PC-MHI psychiatrist consultation)
Warm handoff process improvement—social work (interns)	<ul style="list-style-type: none"> • Review of process and number of warm handoffs from PACTs to PC-MHI staff • Development of survey and guidance for primary care providers with goal of improving efficiency and reducing obstacles for warm handoffs
PC-MHI brief therapy outcomes—social work (interns)	<ul style="list-style-type: none"> • Review of PACT PC-MHI brief therapy utilization and outcomes

Abbreviations: CBT, cognitive behavioral therapy; MI, motivational interviewing; PACT, patient aligned care team; PC-MHI, primary care-mental health integration; PGY, postgraduate year; PTSD, posttraumatic stress disorder.

program improvement project evaluated attitudes around interprofessional learning and team practice. Trainees met individually with the PC-MHI IPE director at midyear and end of year to gather qualitative feedback on the IPE program.

OUTCOMES

All trainees advanced to the expected level of supervision for clinical con-

tacts (drop-in or indirect clinical supervision). Over the year, there was significant improvement in trainees’ MI skills as measured by MITI coding of at least 2 live-patient or 2 simulated-patient recordings (Figures 1A and 1B). By end of year, most trainees had reached proficiency or competency in several MITI coded items: percentage of open-ended questions (4/12 proficient, 8/12 competent),

percentage of complex reflections (2/12 less than proficient, 3/12 proficient, 7/12 competent), MI adherence (1/12 proficient, 11/12 competent), global empathy rating (2/12 proficient, 10/12 competent), and global MI spirit rating (12/12 competent). Average reflection-to-question ratio for the trainee group increased from 0.63 to 0.96 from midyear to end of year, but only 3 of 12 trainees reached

Figure 2A. Midyear PC-MHI Team Evaluations of Trainee Progress in Competencies^a

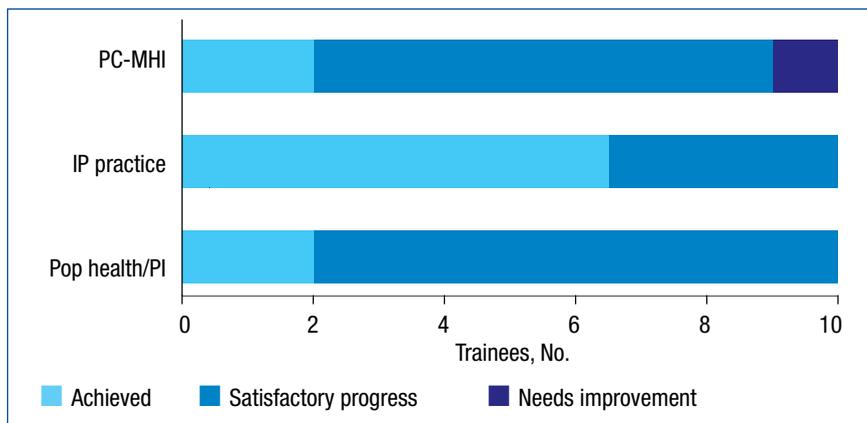
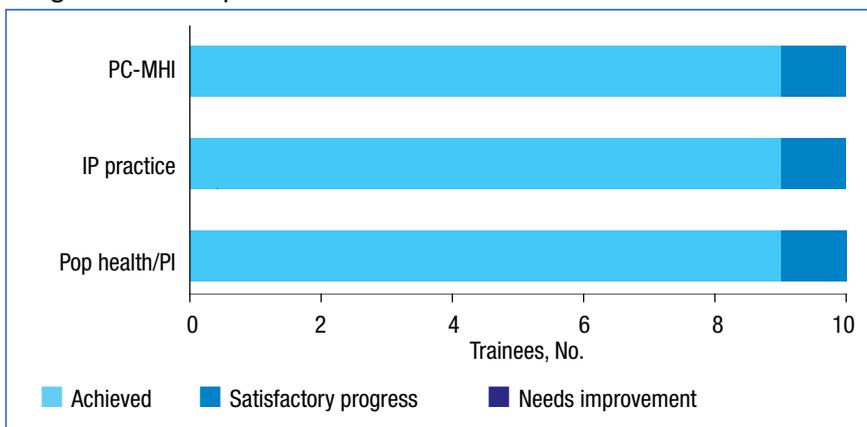


Figure 2B. End-of-Year PC-MHI Team Evaluations of Trainee Progress in Competencies^a



Abbreviations: IP practice, interprofessional practice (collaborative team-based practice); PC-MHI, primary care-mental health integration; Pop health/PI, population health and program improvement.
^aTotal number of trainees: 14 at midyear; 12 at end of year (2 graduated early).

the proficiency level of a 1:1 ratio, and no trainee reached the competency level of a 2:1 ratio.

According to the PC-MHI team's midyear evaluation, most trainees were already making satisfactory progress in the 3 domains of learning objectives for the training program. At end of year, 13 of 14 trainees were assessed as competent in all 3 domains (Figures 2A and B). All trainees passed the midyear and end-of-year written examinations with

overall high scores (average score, 82%) demonstrating acquisition of core PC-MHI clinical knowledge.

Trainee evaluations of the IPE program were overall highly favorable at both midyear and at end of year. Trainees rated the program effective or extremely effective in developing their skills in patient-centered care, interprofessional communication, and collaborative team-based practice. They also rated the program highly effective in preparing them

to use team-based practice skills in other settings. On a midyear survey, trainees moderately to strongly agreed with several positive beliefs and attitudes about team-based care.

In qualitative interviews at program completion, trainees across disciplines rated the MI training with group supervision as one of their most valuable interprofessional learning experiences. Other highly valued training experiences were PACT PC-MHI panel management projects, team-based clinical case reviews, and cross-disciplinary supervision.

DISCUSSION

This article describes the successful development and implementation of a VA-based IPE program in PACT PC-MHI. Interprofessional clinical training and educational experiences were highly valued, and trainees identified positive attitudes and improved skills related to team-based care. These findings support previous findings that IPE is associated with high satisfaction and positive attitudes toward team-based collaborative practice.¹²⁻¹⁷ Program implementation presented several challenges: nonsynchronous academic calendars and rotation schedules, cross-disciplinary supervision regulations, variations in clinical and supervisory requirements for accreditation standards, the traditional health care hierarchy, and measurement of the impact of IPE experiences.^{11,25,26}

Rotation schedules and academic calendars varied across the psychiatry, pharmacy, and social work home programs. Organizing different trainee rotation schedules was a significant challenge. Collaboration with training directors and support staff was crucial in planning rotations that offered a longitudinal training experience in PACT PC-MHI. Given

the participants' different starting dates, protected IPE time early in the calendar year was focused on developing clinical skills specific to the pharmacy and psychiatry trainees who would be starting in July, and IPE activities that required the presence of all trainee disciplines (eg, MI training, HBDDI) were planned for after the September start of the social work interns.

Cross-disciplinary supervision was highly valued by trainees because it offered exposure to the disciplines' different communication styles and approaches to clinical assessment and decision making. Throughout the year, however, trainees encountered several obstacles to cross-disciplinary supervision, with respect to coding/billing and home program supervisory policies. The authors worked closely with the VA administration and each training program to develop and revise supervising policies and procedures to meet the necessary administrative and program supervisory requirements for accreditation standards.

In some cases, this work resulted in dual supervision by a preceptor of the same discipline (to meet requirements for coding/billing and home program supervision) and clinical supervision by a preceptor of a different discipline (eg, in team meetings or in clinical case reviews during protected IPE time). Preceptors from each discipline met regularly to discuss challenges in cross-disciplinary supervision, review scope-of-practice issues, share information on discipline-specific training, and revise supervisory procedures.

Interprofessional education activities during weekly protected time were designed to improve collaboration and to challenge trainees to examine traditional hierarchical roles and patterns of

communication in health care. An emphasis on case-based learning in small groups encouraged trainees to share perspectives on their discipline-specific approach to assessment and treatment planning. Motivational interviewing training, one of the IPE experiences most valued by trainees and staff, created the opportunity for a truly shared learning environment, as trainees largely started at about the same skill level despite having different educational backgrounds. Group supervision of MI recordings offered trainees the opportunity to learn from each other and develop comfort in offering and receiving interprofessional constructive feedback.

Limitations

There were considerable methodologic limitations in the authors' efforts to evaluate the impact of this training program on trainee attitudes and skills in collaborative team-based practice. Although trainee surveys revealed highly positive attitudes and beliefs about team-based care as well as perceived competence in collaborative practice, these were not validated surveys, and changes could not be accurately measured over time (trainees were not assessed at baseline). Trainees also were involved in other clinical teams within the VA during the year, and it is difficult to assess the specific impact of their PC-MHI IPE experiences. The PC-MHI staff evaluations of trainee competence in collaborative team-based practice were largely observational and potentially vulnerable to biases, as the staff evaluating trainee competence also were part of the IPE program planning process and invested in its success.

To address these limitations in the future, the authors will use better assessment tools at baseline and end

of year to more effectively evaluate the impact of the training program on teamwork skills as well changes in attitudes and beliefs about interprofessional learning and teamwork. The Attitudes Toward Interprofessional Health Care Teams Scale and the Perceptions of Effective Interpersonal Teams Scale should be considered as they have published reliability and validity.^{27,28} The authors could improve the reliability and depth of trainee evaluations with use of a "360-degree evaluation" model for trainee evaluations that includes other PACT members (beyond PC-MHI staff) as well as veterans.

Assessment of MI skills and competency was limited by use of both live- and simulated-patient recordings. Simulation is a valuable learning tool but often does not accurately represent actual clinical situations and challenges. To appropriately assess MI competence, future MI training should emphasize live-patient recordings over simulated-patient visits. Furthermore, whereas trainees reached competency in several MI coding items, none reached competency in the reflection-to-question ratio, and only about half reached competency in percentage of complex reflections. Future MI training will need to focus on further development of reflection skills.

Trainee intentions to remain involved in program improvement and collaborative team-based care in future professional work were core attitudinal learning objectives, but neither was adequately assessed in end-of-year surveys. Ideally, future evaluations will assess subjective trainee intentions and goals around team-based work and objectively measure future professional choices and activities. For example, it would be interesting to determine whether trainees who participated in this program will choose to practice in an

interprofessional team-based model or participate in program improvement activities.

Last, the absence of psychology interns was considered a weakness in the learning environment, resulting in a relatively “prescriber-heavy” balance in discipline perspectives for IPE-focused case discussions and other training. Furthermore, the discipline representation in the IPE program did not exemplify the typical PC-MHI team in most VA clinic settings and community practices in which psychology has a strong presence. Adding psychology trainees was an important goal for the IPE program leadership. In 2015, WSMMVH was awarded additional funding for a PACT PC-MHI predoctoral psychology intern through the phase 4 MHEEI. The PC-MHI track psychology intern joined the IPE program in the 2016-2017 training year.

CONCLUSION

There is broad consensus that interprofessional team-based practice is crucial for providers in the VA and all health care systems. Primary care-mental health integration is an area of VA care in which interprofessional collaboration is uniquely important to implementation and sustainability of the model. Interprofessional education is an effective approach for preparing HCPs for team-based practice, but implementation is challenging. Several factors crucially contributed to the successful implementation of this program: collaboration of the interprofessional planning team with representation from key stakeholders in different departments and training programs; a well-established PACT PC-MHI team with experience in collaborative team-based care; a curriculum structure that emphasized experiential educational strategies designed to promote interprofessional

learning and communication; VA leadership support at the national level (MHEEI funding) and local level; and PACT PC-MHI clinical staff committed to teaching and to the IPE mission. ●

Author disclosures

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Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, Frontline Medical Communications Inc., the U.S. Government, or any of its agencies.

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