Lessons learned from implementing EBPs into community based primary care medicine

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Background

• 15 years training experience in safety net clinics;
• EBPs and collaborative/integrated care;
• Nurses, social workers, psychologists, Mas;
• Alameda, Contra Costa, Los Angeles, Marin, San Francisco, Santa Clara counties; NHS Scotland as well.

• I’ve just about seen/heard it all...
Challenges

- Every county and clinic is different.
- Moving existing staff to new setting without preparation;
- No clear model for helping staff adjust;
- Most staff not educated in brief models;
- Re-training takes far too long;
- No clear incentive (other than keeping the job);
- Velvet glove versus iron fist management.

- We need training programs for existing staff and new clinicians.
Skills needed by clinicians

- Experience/exposure to working in primary care;
- Measurement based decision making skills (panel management);
- Collaborative;
- Assertive (don’t be afraid of the doctor);
- Efficient with time/good time management skills;
- Brief treatment;
- Willingness to let go of cases, move them on to specialty care;
- Willingness to check in with medications.
Method for developing those skills

• Scaffolding:
  • Introduce them to primary care culture – shadow a doc for one week;
  • Start with simple management approaches;
  • Use of case-based training.

• Consultation:
  • Review of cases with team;
  • Reinforce the integrated care model by working with the team initially, until it runs itself;

• Start early!
  • Programs in graduate school focused on integrated care;
  • Internships that focus only on integrated care.
Not just the clinician...

- “transformative” leadership to inspire change (Aarons, et al, 2012);
- Better workplace training – allow time to learn;
- Better access to experts (and experts need to be in the clinic);
- Involve HR to develop assessments, work goals, and incentives.
- Work with HR to help them hire the “right” person, or identify clinicians willing to change their practice.
Moving forward

• Clear on-the-job training;
• Access to consultants to help the transition;
• Graduate (or undergraduate) programs focused specifically on a “new breed” of clinician who can work in PCM;
• Better HR directives to sustain practices.