

Improving the quality and frequency of psychotherapeutic intervention among nurse practitioners at a Veterans Health Administration Outpatient Mental Health Clinic

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Abstract

Background: The Veterans Health Administration (VHA) struggles to hire and retain psychiatric professionals due to systemic and proximal constraints that impede the development of durable, transformative therapeutic relationships. *Local Problem:* Psychiatric mental health nurse practitioners (PMHNP) at a VHA specialty outpatient mental health clinic struggle to use and document psychotherapeutic interventions during brief visits; thus, this project sought to increase the use and documentation of psychotherapeutic interventions. *Method:* The Theory of Constraints method of quality improvement was used to develop interventions. Provider level constraints were characterized using surveys to assess a range of psychotherapeutic competencies. System level constraints were characterized using standardized interview questions. A survey assessing preferred learning modalities was used to establish best formats for didactic interventions. Intervention efficacy was assessed using pre- and post-test outcome measures. Literature review using PubMed was conducted to identify salient data and research. *Intervention:* A PowerPoint booklet consisting of one-page psychoeducation interventions for specific clinical presentations with recommended documentation was created and furnished to PMHNPs via email. The structure and intended use of the PowerPoint booklet was discussed at an all-staff meeting. *Results:* From a population of 14 PMHNPs, five PMHNPs participated in the initial surveys and four PMHNPs supplies pre- and post-test outcome measures. The low rate of participation precluded serious consideration of inferential analysis of both initial surveys and outcome measures. *Conclusions:* This quality improvement project could not determine if the supplied intervention met the needs or impacted the clinical practice of VHA PMHNPs.

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Improving the quality and frequency of psychotherapeutic intervention among nurse practitioners at a Veterans Health Administration Outpatient Mental Health Clinic

It is estimated that 1.7 million veterans from Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn have a mental health need; however, only 48% of this population receives treatment (NASEM, 2018). To expand the availability and quality of treatment, the VHA has expanded efforts to recruit, train, and retain qualified mental health providers; yet, the VHA continues to experience significant mental health provider shortfalls as a function of a protracted hiring process and high rate of turnover (NASEM, 2018). Shortfalls result in excessive provider workloads with troubling implications for burnout and durable patient-provider relationships (NASEM, 2018). At a VHA specialty outpatient mental health clinic in the Pacific Northwest, PMHNPs note that high case volumes impede their capacity to supply targeted psychotherapeutic interventions to patients during brief visits. This observation is corroborated by evidence suggesting that the quality of VHA mental health care suffers as a function of inadequate training around the provision of evidence-based psychotherapies for veterans (RAND, 2019). Providers also note that there are few educational or material resources for incorporating psychotherapy into med-check visits – especially for patients with complex diagnoses that are known to respond favorably to psychotherapeutic interventions.

Traditionally, psychotherapy and psychopharmacotherapy were construed as dichotomous processes that could be combined for additive benefit. New research suggests that the dichotomous paradigm is false as visits that include psychotherapy improve both medication and treatment adherence while promoting diagnostic accuracy (Chatterton et al., 2017; Morrison et al., 2020). Thus, there is an evidentiary compulsion to ensure that all interactions—and especially those focused on medication management—include psychotherapy. Treatment adherence as a function of psychotherapy also functions to improve retention and mitigate

burnout by increasing the likelihood that prescribers will develop durable and transformative relationships with their patients (Vogt et al., 2019).

Available Knowledge

While provider shortfalls and efforts to minimize costs have generated increased interest in brief and integrative approaches to psychotherapy, the notion that patients could benefit from succinct psychotherapeutic interventions has existed since the inception of the science (Baée & Jeyasingam, 2019; Lazar, 2018). In fact, the Freudian term *catharsis* derives from Freud's observation that patients often exhibited substantial improvement after a single session focused on the exploration of repressed emotional and cognitive content (Baée & Jeyasingam, 2019). A burgeoning body of evidence suggests that brief psychotherapeutic interventions are indeed efficacious in reducing symptoms across diagnoses and clinical settings (Orvati-Aziz, 2020; Zhang, 2019; de Rotten et al., 2017; Sloan et al., 2013). In addition to improving symptoms, brief psychotherapeutic interaction has been shown to improve diagnostic accuracy, medication adherence, and patient-provider rapport (Weinberg & Mintz, 2018; Ziv-Beiman et al., 2016). In fact, the application of specific therapeutic modalities, such as Motivational Interviewing, have shown promising results for promoting engagement and adherence among treatment resistant patients with substance use disorders and serious mental illness (Ertem and Duman, 2019). Notably, evidence-based practices like motivational interviewing present few barriers to implementation and produce durable changes in practice after perfunctory training (Lindholm et al., 2019). Psychotherapeutic approaches to treatment may also confer added capacity to assess patient progress by offering unique perspectives on insight, judgement, schemas, core-beliefs, and skill acquisition (Everett et al., 2016; McGuinty et al., 2016).

Rationale

The VHA project site has yet to undertake any analysis of factors impeding the employment of psychotherapeutic interventions in brief visits despite system-wide data and proximal evidence that addressing barriers to care could improve staff retention by reducing caseloads and mitigating burnout while improving quality of care. Theory of Constraints (TOC) is an improvement paradigm that functions via the reverse engineering of processes occurring before and at inefficient or costly constraints—bottlenecks—to eliminate delay and waste (Sadat et al., 2013). TOC is particularly useful in healthcare contexts because it allows for the identification of antecedent processes that convey valuable information about and contribute to identified problem areas—this permits the development of interventions that add resilience across systems versus myopic, problem specific solutions that fail to thoughtfully address all inputs of complex systems (Lubitz et al., 2005). TOC suggests that meaningful interventions supply pragmatic answers to three important questions: what to change, what to change to, and how to cause the change (Sadat et al., 2013)? These questions are answered via logic tools that seek to spur insight into how interventions will address problems via their impact on an array of system inputs (Sadat et al., 2013). Like other performance improvement processes, TOC is cyclical and emphasizes that once a constraint is optimized, the next limiting constraint must be identified and addressed. In this sense, TOC serves dual purposes in the context of this quality improvement project—TOC will identify chief constraints related to the provision of psychotherapy in brief visits at the VHA project site while simultaneously delineating the numerous constraints that broadly impact psychotherapeutic care to provide a foundation for future improvement efforts.

Purpose

The purpose of this project was to increase the use and documentation of psychotherapeutic interventions during brief visits amongst nurse practitioners at the VHA project site. To do this, the project characterized existing system and provider-level constraints around the provision of psychotherapeutic interventions and provided a tailored intervention.

Specific Aims

By February 2022, a representative sample of the population of VHA PMHNPs at the VHA project site would exhibit a statistically reliable increase in the proportion of brief visits during which they employed a psychotherapeutic intervention. Secondly, VHA nurse practitioners would exhibit a statistically reliable increase in the proportion of visits in which they documented a psychotherapeutic interaction.

Materials and Methods

Context

The VHA project site provides mental health care for veterans living throughout the Pacific Northwest. At present, the clinic employs 14 PMHNPs. Due to outstripped demand, each PMHNP has a caseload near or exceeding 400 veterans. While the clinic employs registered nurses and medical assistants, providers remain responsible for a considerable proportion of their scheduling, billing, and coding. Patient interactions occur in a variety of contexts including video conferencing, over the phone, and face-to-face. Visits are typically 30 minutes in duration and focus on medication management. Visits are typically scheduled back-to-back, and double bookings are common. While PMHNPs are encouraged to allocate 2 hours per week to hour-long psychotherapy sessions, this is not always feasible, and providers may not routinely employ psychotherapeutic interventions as a part of their clinical practice.

Interventions

During phase-1, PMHNPs practicing at the VHA project site participated in a standardized interview—the interview characterized systemic constraints and individual providers perspectives on psychotherapy in their clinical practice (Appendix A). At the time of the interview, PMHNPs completed a series of 5-point Likert scale surveys to assess current competency in addressing common psychiatric presentations and using psychotherapeutic interventions. Additionally, PMHNPs completed a survey exploring preferred modalities for learning about specific psychotherapeutic interventions (Appendix B). Survey domains adhered to those described by Lonergan et al. (2020): level of confidence in providing psychotherapeutic interventions for specific clinical issues including acute panic, depression, self-injurious behavior, general distress, acute anxiety, insomnia, negative self-thoughts, substance use with cravings, ambivalence to change, and delusional thoughts; level of confidence teaching skills-based psychotherapeutic interventions including breathing techniques, sleep hygiene, thought monitoring, behavioral activation, mindfulness, meditation, guided imagery, progressive muscle relaxation, decisional balance, distress tolerance skills, coping cards, and functional analysis; and preferred modality for learning psychotherapeutic interventions including narrated PowerPoint, text PowerPoint, text alone, live didactic lecture, video, co-leading a group, role-playing, and supervision.

At the conclusion of phase-1, disparities in PMHNP's confidence around using psychotherapeutic interventions to address specific presentations and deficits in confidence concerning the application of psychotherapeutic techniques were used to develop a targeted educational resource in a preferred format (Appendix C).

In phase-2, the targeted educational resource was employed to augment the use and documentation of psychotherapeutic interventions in brief visits. Phase-2 ran for 1 month before

intervention efficacy was assessed via self-reported, pre and post-test estimates of the proportion of cases in which psychotherapeutic interventions were employed or documented (Appendix D). As a balancing measure, the post-test estimate assessment included inquiry into how existing or changing constraints impacted PMHNP's clinical practice.

Measures

Main outcome measures included the proportion of psychotherapeutic visits in which PMHNPs employed psychotherapeutic interventions and the proportion of visits in which a psychotherapeutic intervention was documented. The proportion of the PMHNP team members who engaged in initial interviews and who utilized the educational intervention was an important consideration, especially given that ability to engage in extraprofessional or non-mandatory education conveyed valuable information about existing constraints.

Analysis

This quality improvement project was conducted from June 2021 to February 2022. During phase-1, deficits in clinical or skill-based competencies were determined by examining initial survey data. Survey data was used to determine preferred learning modalities for the presentation of the educational resource. Subjective data regarding systemic constraints and perspectives on psychotherapy was used to further inform the creation of the educational resource. During phase-2, intervention efficacy was assessed by comparing pre- and post-test estimates using all appropriate statistical analyses.

Ethical Considerations

All PMHNP staff at the VHA project site were informed of the project at an all-staff meeting and via e-mail. Staff participation in the improvement project was voluntary. Consent to participate will be indicated by PMHNPs scheduling the initial standardized interview or the

provision of estimates for the pre- or post-test assessments. All interview and survey responses were deidentified and anonymized. The lead PMHNP at the VHA project site was the preceptor for this project and provided a signed letter of support (Appendix E). This improvement project did not involve any patient data—only the self-reported perceptions of PMHNPs. This project was submitted to both the OHSU Investigational Review Board (Appendix F) and the Portland VHA Investigational Review Board (Appendix G); neither body determined that this quality improvement project constituted research or merited additional review.

Results

From the population of PMHNPs ($N = 14$), five PMHNPs participated in the initial interview and six PMHNPs responded to the outcome measures survey. Of the six PMHNPs who supplied outcome measures, two were unfamiliar with this project and were unable to supply data on intervention efficacy. The low rate of participation raised serious concerns about whether these samples were representative and whether the collected data meet necessary assumptions for analysis using parametric inferences like the paired t-test. That said, there was good reason to consider this project as it applies to the population of PMHNPs engaging in the survey process, especially as it is this population for whom the supplied intervention was developed. Considering the initial survey of PMHNPs as an independent population, there was no statistically reliable variation in confidence regarding PMHNP ability to address common clinical presentations using psychotherapeutic interventions; however, there was reliable variation in PMHNP confidence regarding the application of specific psychotherapeutic techniques ($H = 59.05$, $p < 0.05$). Given the non-normal nature of the data, further parsing variability was not possible; however, salient items with low means included guided imagery ($M = 2.2$), distress tolerance ($M = 3.2$), and coping cards ($M = 3.2$). There was no statistically reliable variation in preferences regarding learning modalities.

Qualitative data suggested that a lack of resources and administrative burdens are impediments to the provision and documentation of psychotherapeutic interventions. Multiple providers stressed that, due to the absence of resources on-hand and adequate information about previous psychotherapeutic engagement, they lacked sufficient time to refresh, teach, and document psychotherapeutic interventions. Providers identified time allocated to decision making about medications, entering mandatory assessment data, and administrative tasks as significant constraints. A single provider commented that a lack of consistency in organizational education on psychotherapeutic tools reduced the likelihood that patients would consolidate specific skills as a result of inconsistent instruction. All interviewed providers shared the perspective that psychotherapy was not a primary focus of their clinical practice.

Irrespective of assumptions about statistical power and the normality of distribution, no inferential tests detected statistically reliable differences in the proportion of visits in which PMHNPs employed psychotherapeutic interventions. No inferential tests detected statistically reliable differences in the proportion of visits in which PMHNPs documented psychotherapeutic interactions. While the mean number of psychotherapeutic interventions employed increased (M from 50% to 62.5%) and the mean number of interventions documented increased (M from 52.5% to 62.5%) increased, these changes cannot be distinguished from random variance; thus, suggesting that these findings represent any trend or meaningful change was not appropriate. Subjective responses from the outcome survey indicated that caseload made finding time to access the educational resource difficult.

Discussion

This project sought to increase the proportion of visits in which PMHNPs at the VHA project site employed and documented psychotherapeutic interventions. To do this, the project leveraged both quantitative and qualitative approaches to characterize provider and systems level

constraints impeding the routine use of psychotherapeutic interventions. Initial data from surveys and interviews was used to create an educational intervention replete with resources specifically tailored to address knowledge gaps and mitigate proximal, provider-level constraints. The created educational resource was a PowerPoint booklet that was disseminated and discussed at a remote-access all-staff meeting and by e-mail. PowerPoint was chosen second the absence of statistically reliable variability in preferred learning modality and due to the ease with which exported document types could be distributed while retaining the ability to link related content like VHA mental health applications. Unfortunately, staff meeting attendance and engagement via e-mail were extremely limited; only four PMHNPs VHA provided responses for outcome measures. As a result, this quality improvement project was not able to draw conclusions about whether the supplied intervention had any effect on the provision or documentation of psychotherapeutic interventions.

Limitations

The chief limitation of this quality improvement project was its inability to access a sufficiently representative sample of PHMNP's. As a result, the collected data lacked the statistical power to detect any meaningful effects. Additionally, as the crafted intervention was premised on data collected from volunteers versus at random, sampling bias may have resulted in the creation of an educational intervention that lacked broad utility, which may help explain the poor response rate for outcome measures. That said, it may have been the case that the very administrative constraints described in provider interviews precluded even modest engagement with non-essential clinical activities even when proximal constraints were thoroughly addressed. Clarifying and addressing systemic constraints will be an important aspect of future clinical inquiry and intervention.

Another limitation was this project's heavy reliance on self-reported measures using non-standardized tools. Both of these factors threatened internal and external validity. Future projects could benefit from the elimination of self-reported measures by operationalizing psychotherapeutic interventions using the presence of psychotherapy billing codes in samples of PMHNP's charts. If clinical data remained unavailable and self-reported measures could not be eliminated, tool pretesting could be completed on a large sample to ensure internal validity and promote the generalizability of significant findings.

Conclusion

This quality improvement project sought to increase the use and documentation of psychotherapeutic interventions at a VHA project site. Unfortunately, population engagement was not sufficient to collect representative data to develop and measure an appropriate intervention. While limited engagement may reflect broad trends impacting the quality and sustainability of rewarding psychiatric practice amongst VHA PHMNPs, such speculation is beyond the scope of this project. Future projects would likely benefit from identifying constraints related to more foundational aspects of healthy advanced practice and should include variables like team engagement as a function of meeting attendance and administrative support of PMHNP staff.

References

- Baée, J., & Jeyasingam, N. (2019). Short-term psychodynamic psychotherapy: A brief history. *Australian Psychotherapy*, 27(6), 581-583.
- Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: Network meta-analysis. *British Journal of Psychiatry*, 210(5), 333–341.
<https://doi.org/10.1192/bjp.bp.116.195321>
- de Roten, Y., Ambresin, G., Herrera, F., Fassassi, S., Fournier, N., Preisig, M., & Despland, J.-N. (2017). Efficacy of an adjunctive brief psychodynamic psychotherapy to usual inpatient treatment of depression: Results of a randomized controlled trial. *Journal of Affective Disorders*, 209, 105-133.
- Ertem, M. Y., & Duman, Z. Ç. (2019). The effect of motivational interviews on treatment adherence and insight levels of patients with schizophrenia: A randomized controlled study. *Perspectives in Psychiatric Care*, 55(1), 75–86. <https://doi.org/10.1111/ppc.12301>
- Lazar, S. G. (2018). The place for psychodynamic therapy and obstacles to its provision. *Psychiatric Clinics of North America*, 41(2), 193–205. <https://doi.org/10.1016/j.psc.2018.01.004>
- Lindholm, L. H., Koivukangas, A., Lassila, A., & Kampman, O. (2019). What is important for the sustained implementation of evidence-based brief psychotherapy interventions in psychiatric care? A quantitative evaluation of a real-world programme. *Nordic Journal of Psychiatry*, 73(3), 185–194. <https://doi.org/10.1080/08039488.2019.1582698>
- Lonergan, B. B., Duchin, N. P., Fromson, J. A., & AhnAllen, C. G. (2020). Skills-based psychotherapy training for inpatient psychiatry residents: a needs assessment and evaluation of a pilot curriculum. *Academic Psychiatry*, 44(3), 320–323. <https://doi.org/10.1007/s40596-019-01163-2>

Lubitsh, G., Doyle, C., & Valentine, J. (2005). The impact of theory of constraints (TOC) in an NHS trust. *Journal of Management Development*, 24(2), 116–131.

<https://doi.org/10.1108/02621710510579482>

McGuinty, E., Nelson, J., Carlson, A., Crowther, E., Bednar, D., & Foroughe, M. (2016). Redefining outcome measurement: A model for brief psychotherapy. *Clinical Psychology & Psychotherapy*, 23(3), 260–271. <https://doi.org/10.1002/cpp.1953>

Morrison, A. P., Pyle, M., Maughan, D., Johns, L., Freeman, D., Broome, M. R., Husain, N., Fowler, D., Hudson, J., MacLennan, G., Norrie, J., Shiers, D., Hollis, C., James, A., Morrison, A. P., Pyle, M., Maughan, D., Johns, L., Freeman, D., James, A. (2020). Antipsychotic medication versus psychological intervention versus a combination of both in adolescents with first-episode psychosis (MAPS): A multicentre, three-arm, randomised controlled pilot and feasibility study. *The Lancet Psychiatry*, 7(9), 788–800. [https://doi.org/10.1016/S2215-0366\(20\)30248-0](https://doi.org/10.1016/S2215-0366(20)30248-0)

NASEM - Committee to Evaluate the Department of Veterans Affairs Mental Health Services, Board on Health Care Services, Health and Medicine Division, & National Academies of Sciences, Engineering, and Medicine. (2018). *Evaluation of the Department of Veterans Affairs Mental Health Services* (p. 24915). National Academies Press. <https://doi.org/10.17226/24915>

Orvati Aziz, M., Mehrinejad, S. A., Hashemian, K., & Paivastegar, M. (2020). Integrative therapy (short-term psychodynamic psychotherapy & cognitive-behavioral therapy) and cognitive-behavioral therapy in the treatment of generalized anxiety disorder: A randomized controlled trial. *Complementary Therapies in Clinical Practice*, 39, 101-122.

<https://doi.org/10.1016/j.ctcp.2020.101122>

RAND. (2019). *Improving the Quality of Mental Health Care for Veterans: Lessons from RAND Research*. 12.

- Sadat, S., Carter, M. W., & Golden, B. (2013). Theory of constraints for publicly funded health systems. *Health care management science, 16*(1), 62–74. <https://doi-org.liboff.ohsu.edu/10.1007/s10729-012-9208-9>
- Sloan, D. M., Marx, B. P., Lee, D. J., & Resick, P. A. (2018). A brief exposure-based treatment vs cognitive processing therapy for posttraumatic stress disorder: A randomized noninferiority clinical trial. *JAMA Psychiatry, 75*(3), 233-239.
- Vogt, E. L., Mahmoud, H., & Elhaj, O. (2019). Telepsychiatry: Implications for Psychiatrist Burnout and Well-Being. *Psychiatric Services, 70*(5), 422–424.
<https://doi.org/10.1176/appi.ps.201800465>
- Weinberg, E., & Mintz, D. (2018). The overall diagnosis. *Psychiatric Clinics of North America, 41*(2), 263–275. <https://doi.org/10.1016/j.psc.2018.01.008>
- Zhang, A. (2019). The effectiveness of four empirically supported psychotherapies for primary care depression and anxiety_ A systematic review and meta-analysis. *Journal of Affective Disorders, 19*.

Appendix A

VHA NP standardized interview questions

- Please provide a brief description of your typical day working as an NP at the Portland VHA Outpatient Mental Health Clinic.
- What factors promote your application of psychotherapeutic interventions?
- What factors inhibit your application of psychotherapeutic interventions?
- What sorts of structural supports would you need to feel confident in applying psychotherapeutic interventions in the majority of your visits?
- What sorts of educational supports would you need to feel confident in applying psychotherapeutic interventions in the majority of your visits?
- How would increased support and resources around supplying psychotherapeutic interventions impact the quality of your patient care?

Appendix B

PMHNP Survey

Below is a list of clinical situations in which psychotherapeutic intervention is indicated. Please read each one carefully, then circle one of the numbers to the right to indicate how competent you are providing a psychotherapeutic intervention in each situation.

	Not at all	A little Bit	Moderately	Quite a bit	Extremely
A patient presenting with acute panic	1	2	3	4	5
A patient presenting with acute panic	1	2	3	4	5
A patient presenting with depressive symptoms	1	2	3	4	5
A patient presenting with self-injurious behavior	1	2	3	4	5
A patient presenting with general distress	1	2	3	4	5
A patient presenting with acute anxiety	1	2	3	4	5
A patient presenting with insomnia	1	2	3	4	5
A patient presenting with negative self-thoughts	1	2	3	4	5
A patient presenting with cravings in the context of substance use disorder	1	2	3	4	5
A patient who is ambivalent to change	1	2	3	4	5
A patient presenting with delusional thoughts	1	2	3	4	5

Below is a list of psychotherapeutic interventions. Please read each one carefully, then circle one of the numbers to the right to indicate how competent you are providing the described psychotherapeutic intervention.

	Not at all	A little Bit	Moderately	Quite a bit	Extremely
breathing techniques	1	2	3	4	5
sleep hygiene	1	2	3	4	5
thought monitoring	1	2	3	4	5
behavioral activation	1	2	3	4	5
mindfulness, meditation	1	2	3	4	5
guided imagery,	1	2	3	4	5
progressive muscle relaxation,	1	2	3	4	5
decisional balance	1	2	3	4	5
distress tolerance skills,	1	2	3	4	5
coping cards	1	2	3	4	5
functional analysis	1	2	3	4	5

Below is a list of educational modalities. Please read each one carefully, then circle one of the numbers to the right to indicate how confident you are that you will be able to learn information presented in the specific modality.

	Not at all	A little Bit	Moderately	Quite a bit	Extremely
Narrated powerpoint	1	2	3	4	5
Text powerpoint	1	2	3	4	5
text alone	1	2	3	4	5
live didactic lecture	1	2	3	4	5
video	1	2	3	4	5
co-leading a group	1	2	3	4	5
role-playing	1	2	3	4	5
Supervised practice	1	2	3	4	5

Appendix C

Please respond to the following questions by first clicking reply and then checking the appropriate box (just click!) or entering free text.

1. During the month **before** the psychotherapeutic intervention resource was shared - November 2021, the proportion of visits in which I employed psychotherapeutic interventions was closest to

10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

2. During the month **before** the psychotherapeutic intervention resource was shared - November 2021, the proportion of visits in which I documented psychotherapeutic interventions was closest to

10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

3. During the month **after** the psychotherapeutic intervention resource was shared - December 2021, the proportion of visits in which I employed psychotherapeutic interventions was closest to


10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

4. During the month **after** the psychotherapeutic intervention resource was shared - December 2021, the proportion of visits in which I documented psychotherapeutic interventions was closest to

10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

Additionally, I would like to hear if any aspect of your work - including caseload, administrative tasks, electronic integration, etc. - prevented you from accessing or employing the resource I shared. Please respond here:

Appendix D



Anxiety Insomnia Depression Cravings Delusions

Psychotherapeutic Interventions for Brief Visits

Anxiety **Insomnia** **Depression** **Cravings** **Delusions**

Current Evidence

- **Cognitive behavioral therapy (CBT)** is the gold standard psychotherapeutic intervention for anxiety disorders and associated disorders with anxious symptomology
 - CBT is most efficacious for treating generalized anxiety disorder and obsessive-compulsive disorder. CBT is moderately useful for treating social anxiety disorder and panic disorder. CBT is less useful in PTSD
 - CBT in brief, primary care visits exhibits efficacy comparable to formal psychotherapy
- **Mindfulness** based interventions and manualized mindfulness based stress reduction show comparable ability to reduce anxiety symptoms when compared with CBT; however, there is a paucity of data on their ability to treat anxiety disorders
 - mindfulness interventions have been shown to facilitate GABAergic pathways, regulate cortisol plus associated catecholamines, and decrease subjective salience of anxiety symptoms
 - Mindfulness interventions may be particularly useful in reducing the frequency or intensity of benign palpitations, which frequently manifest in severe distress and healthcare resource overutilization
- **Acceptance and commitment therapy (ACT)**, which combines aspects of CBT and mindfulness, has shown promising effects across anxiety disorders; thus, combining CBT and mindfulness interventions are clearly supported in the existing literature



Anxiety Insomnia Depression Cravings Delusions

Interventions

- **Progressive Muscle Relaxation**
 1. Provide psychoeducation about how progressive muscle relaxation modulates psychological and psychophysiological stress
 2. Use a rating scale to establish baseline measures of both muscle tension and anxiety
 3. Model muscle relaxation by tightening and then relaxing your fist ask veteran to do this too
 4. Encourage Veteran to achieve maximum relaxation of their fist using conscious control, stretching, massage or other salient calming techniques
 5. Coach Veteran through progressive relaxation of all the major muscle groups of the body
 6. Repeat measures of tension and anxiety

Suggested Documentation

Veteran was introduced to progressive muscle relaxation to modulate anxiety. Care was taken to explain and explore the relationship between somatic states and the cognitive experience of anxiety with the intent to demonstrate Veteran's capacity to reduce anxiety by affecting muscle tension. Veteran was instructed to utilize flexion and relaxation of major muscle groups in a consistent, stepwise pattern to facilitate employment of progressive muscle relaxation as a coping strategy irrespective of threat to cognitive reserve produced by heightened anxious states. Veteran was able to identify contraindications to the use of progressive muscle relaxation such as muscle spasms or acute injury.



Interventions

- **Breathwork**
 1. Provide psychoeducation about how irregular rapid and shallow-breathing patterns activate the sympathetic response and may exacerbate anxiety or panic symptoms. Explain that the opposite is true: metered, full breaths reduce the experience and perception of threat, which in turn reduces anxiety and panic symptoms
 2. Starting at a place of rapid and shallow breathing, model regaining control by taking several deep breaths and ultimately adjusting to normal rate and rhythm
 - there are numerous breathing techniques that may assist in this process including square breathing or using a count to meter the respiratory cycle. Using well delineated techniques may be particularly useful in providing distraction from unhelpful cognitions
 3. Encourage Veteran to practice by progressing from an irregular rapid and shallow- pattern to a eupneic pattern to reinforce capacity to modulate the emotional and cognitive experience of anxiety



Suggested Documentation

Veteran was introduced to breathwork as a tool for reducing symptoms of anxiety and panic. Veteran was taught to recognize how physiologic manifestations of anxiety as rapid shallow breathing- function as a form of positive feedback that perpetuates anxious cognitions and symptoms. Veteran demonstrated capacity to modulate anxiety and panic symptoms by employing breathing techniques to transition from a state of physiologic hyperarousal to a state of calmness. Veteran was given instruction to practice using breathing exercises to transition to a calm state to support employment of tool irrespective of threat to cognitive reserve implied by experiences of acute anxiety or panic. Veteran was able to identify contraindications to utilizing breathwork as an intervention- versus seeking emergency care including persistent tachypnea, dyspnea, chest tightness, or chest pain.




Anxiety **Insomnia** **Depression** **Cravings** **Delusions**

Interventions

- **Mindfulness meditation**
 1. Provide psychoeducation about how mindfulness trains the brain to gently observe rather than serve automatic thoughts. Explain that shifting attention from thoughts to the present experience reduces the extent to which thoughts can influence emotions or affect psychophysiological arousal
 2. Instruct Veteran to assume a comfortable seated position and initiate gentle, diaphragmatic breathing
 3. Explain goal of gently shifting attention to the sensation of breathing, the body, and the present environment
 4. As thoughts and distractions arise, offer that Veteran should acknowledge them before returning attention to the breath and present moment
 5. Start with 2 minutes of practice in session

Suggested Documentation


Veteran was introduced to mindfulness meditation to reduce the intensity of anxious cognitions. Veteran learned strategies to draw attention from automatic thoughts to the present moment including focusing on the physical sensation of breathing and other sensory information. Veteran was taught to construe thoughts or distractions as neutral and to gently refocus on physical sensation in instances of distraction. Process of deidentification was used to illustrate mechanism by which mindfulness could reduce anxiety.



Anxiety Insomnia Depression Cravings Delusions

Veterans Administration Resources

- **Progressive muscle relaxation**
 - [Patient Handout](#)(clickable link)
- **Breathwork**
 - [Patient Handout](#)(clickable link)
- **Mindfulness Meditation**
 - [Patient Handout](#)(clickable link)
 - [Mobile Application](#)(clickable link)



Anxiety **Insomnia** Depression Cravings Delusions

Evidence

- **Cognitive behavioral therapy for insomnia (CBTi)** is the most efficacious treatment for insomnia. When compared to common soporifics, CBTi offers a vastly preferable safety profile with equal or better short-term efficacy and impressive long-term durability. For this reason, CBTi is considered the first line intervention for primary or secondary insomnia by numerous clinical decision resources
 - CBTi typically consists of five discreet components:
 1. Relaxation
 2. Sleep Restriction Therapy
 3. Stimulus Control Therapy
 4. Paradoxical Intention
 5. Cognitive Therapy



Interventions

- **Relaxation training**
 1. Offer broad education on the impact physiologic arousal can have on thoughts and behaviors
 2. Use a 0-100 rating scale to rate both muscle tension and anxiety
 3. Demonstrate voluntary control over muscle tension by instructing Veteran to tighten and then relax their fist
 4. Encourage Veteran to achieve maximum relaxation of their fist using conscious control, stretching, massage or other salient calming techniques
 5. Coach Veteran through progressive relaxation of all the major muscle groups of the body
 6. Repeat 0- 100 measure of tension and anxiety



Suggested Documentation

Veteran was introduced to progressive muscle relaxation to modulate Insomnia. Care was taken to explain and explore the relationship between somatic states and cognitions that could impede sleep with the intent to demonstrate Veteran's capacity to address insomnia by affecting muscle tension. Veteran was instructed to utilize flexion and relaxation of major muscle groups in a consistent, stepwise pattern. Veteran was tasked with practicing progressive muscle relaxation during times of low stress during the day to enhance the chance of successful nighttime application. Veteran was able to identify contraindications to the use of progressive muscle relaxation such as muscle spasms or acute injury.



Anxiety **Insomnia** Depression Cravings Delusions

Interventions

- **Sleep Restriction**
 - Sleep restriction involves limiting a veteran's total time spent in bed while simultaneously eliminating any napping.
 - Sleep restriction is better construed as sleep efficiency training as the goal is not to restrict sleep but to consolidate sleep.
 - Typically, sleep restriction begins with 2week sleep inventory or journaling exercise.
 - The completed journal is used to determine average hours slept per night.
 - The Veteran is then limited to spending no more time in bed than their average hours slept per night.
 - As sleep is consolidated, 15-30 minutes are added to the allowed time in bed each week so long as interruption remain minimal.



Suggested Documentation

*As sleep restriction will necessitate close assessment of individual Veteran's sleep habits, generic documentation is not provided. Providers wishing to intervene for patients with disrupted sleep patterns should consider that sleep restriction can be employed in the context of brief visits with some added time for brief follow -ups at 1 - or 2-week intervals.



Anxiety **Insomnia** Depression Cravings Delusions

Interventions

- **Stimulus Control**
 1. Offer broad education on the role thoughts, beliefs, and behaviors can have on sleep
 2. Aid veteran in identifying stimuli that may exacerbate insomnia for instance nightly screentime or timing and amount of caffeine consumed throughout the day
 3. Help patient identify a sleep routine
 - Routine should include evidence based recommendations such as eliminating ambient light and reducing room temperature.

Suggested Documentation

Veteran was educated on stimulus control for improved sleep hygiene to address insomnia. Veteran considered their exposure to stimuli that could impede sleep initiation and sleep maintenance. Veteran developed a sleep routine that included avoidance of unhelpful stimuli and incorporated evidence based environmental modification such as eliminating ambient light, reducing noise, and lower room temperature. Veteran expressed understanding that their sleep routine would function to cue physiological preparation for sleep in addition to ensuring ideal environmental and personal preparedness.



Anxiety **Insomnia** Depression Cravings Delusions

Interventions

- **Paradoxical Intention**
 1. Offer psychoeducation on how reactive thoughts and behaviors related to attempts to control insomnia may actually increase physiological arousal and perpetuate difficulty sleeping
 2. Encourage Veteran to identify the difference between reasonable commitment to CBTi and counterproductive efforts such as forcing themselves to remain in bed or desperately searching for a solution
 3. Offer that Veteran could experiment with a carefree approach to insomnia - for instance, attempting to conceptualize wakefulness as an opportunity to do something useful or enjoyable

Suggested Documentation

Veteran was introduced to paradoxical intention to promote decreased psychophysiological arousal and improve sleep by decreasing counterproductive thoughts and behaviors related to their conceptualization of insomnia. Veteran was guided to identify thoughts and behaviors consistent with broader principles of CBTi versus thoughts and behaviors with unhelpful valence, rigidity, and historical efficacy. Veteran was encouraged to modulate their conceptualization of insomnia and behaviors undertaken during periods of unwanted wakefulness in a manner that promotes acceptance and calmness.




Anxiety **Insomnia** Depression Cravings Delusions

Interventions

- **Cognitive therapy**
 1. Offer psychoeducation about how schemas and beliefs may perpetuate thoughts that influence emotions and behaviors. Explain that identifying cognitive errors provides useful opportunities to challenge assumptions and influence emotions and behaviors
 2. Instruct Veteran to identify beliefs and automatic thought(s) related to insomnia. If useful, assist veteran in labeling salient cognitive distortions
 3. Encourage veteran to consider an alternate thought. Ask them to provide evidence that supports that alternate thought
 4. Ask veteran to use the alternate thought to balance their beliefs or automatic thoughts about insomnia

Suggested Documentation

Veteran was introduced to paradoxical intention to promote decreased psychophysiological arousal and improve sleep by decreasing counterproductive thoughts and behaviors related to their conceptualization of insomnia. Veteran was guided to identify thoughts and behaviors consistent with broader principles of CBTi versus thoughts and behaviors with unhelpful valence, rigidity, and historical efficacy. Veteran was encouraged to modulate their conceptualization of insomnia and behaviors undertaken during periods of unwanted wakefulness in a manner that promotes acceptance and calmness.



Anxiety **Insomnia** Depression Cravings Delusions

Veterans Administration Resources

- [Cognitive behavioral therapy for insomnia](#)
 - [Infographics and guide](#) (clickable link)
 - [CBTi mobile application](#) (clickable link)



Anxiety Insomnia **Depression** Cravings Delusions

Current Evidence

- **Cognitive behavioral therapy (CBT)**
 - CBT exhibits efficacy in brief visits; however, effect sizes are smaller when compared with formal psychotherapy
 - Prominence of comorbid anxiety symptoms and insomnia in major depressive disorder suggest that relevant CBT interventions will benefit treatment
 - While CBT is effective in addressing hopelessness and suicidality, salient interventions are included in the Veterans Administration's safety planning procedure- they are omitted here
- **Interpersonal Psychotherapy**
 - Formal interpersonal psychotherapy exhibits slightly better efficacy than other modalities
- **Nondirective supportive treatment**
 - Nondirective supportive treatment was found to be less impactful than other psychotherapeutic modalities
- **Other modalities**
 - Behavioral activation, psychodynamic psychotherapy, problem-solving therapy, and social skills training exhibit comparable efficacy
- **Anxiety**
 - Given the prevalence of comorbid anxiety symptoms, many interventions discussed in the anxiety section of this document may be successfully deployed for individuals with a primary depressive illness



Interventions

- **Functional Analysis (ABCs)**
 1. Provide psychoeducation about how functional analysis can promote rapid behavioral adaptation by considering the many variables and consequences associated with a particular maladaptive behavior
 2. Guide the client in identifying behavior antecedents. These may include environments, people, or any triggering stimulus
 - Link antecedents to accompanying thoughts
 3. Identify how antecedents and their associated thought promote a specific behavioral response
 4. Determine the consequences associated with the antecedent behavior sequence
 5. Determine which portions of the antecedent behavior sequence could be addressed to produce durable, adaptive behavior change



Suggested Documentation

Veteran was introduced to functional analysis to modify maladaptive behavioral patterns that perpetuate anxiety symptoms. Veteran learned that behaviors are influenced by and bound to environmental and cognitive contexts. By considering these contexts as behavioral antecedents veteran was able to identify ways in which their environment and thought processes could be modified to produce alternate behaviors with positive consequences. Veteran was provided with resources to guide their independent practice of functional analysis.

Anxiety Insomnia **Depression** Cravings Delusions

Interventions

- **Thought monitoring**
 1. Provide psychoeducation on the relationship between situations, thoughts, and feelings
 2. Explore the origins of thoughts—explain that automatic thoughts are often rooted in schemas and deeply rooted core beliefs
 3. Explain how challenging negative automatic thoughts can positively impact one's emotions
 4. Introduce the thought record as a means for identifying and challenging possible negative automatic thoughts
 5. Coach the veteran through the thought record using a salient, recent, and extremely specific example from the veteran's life

Suggested Documentation

Veteran was introduced to thought monitoring and the thought record to modulate emotional responses to automatic negative thoughts. Veteran learned that automatic thoughts are often rooted in schemas and core beliefs that may or may not exhibit congruence with a specific environment. Veteran identified a specific negative automatic thought from a recent personal experience and used the thought record to positively influence their cognate emotional experience. Veteran was provided resources to guide their independent practice of thought monitoring.



Anxiety Insomnia **Depression** Cravings Delusions

Interventions

- **Behavioral Activation**
 1. Provide psychoeducation that just as mood may influence desire to participate in activity, activity may influence mood
 2. Aid veteran in compiling a list of previously enjoyed or valued activities
 3. Set goals around engagement in activities; consider using SMART goals
 - SMART goals are specific, measurable, achievable, realistic, and timely
 4. Prioritize activities that have the capacity to reduce social isolation
 5. Set realistic expectations about initial difficulty of exercise and offer support

Suggested Documentation

Veteran was introduced to behavioral activation to improve mood. Veteran learned that engaging in enjoyed or valued activities - even in the absence of present desire to do so - could improve mood. Veteran created a list of enjoyed or valued activities. Veteran set realistic goals to engage in these activities.



Anxiety Insomnia **Depression** Cravings Delusions

Veterans Administration Resources

- **Cognitive behavioral therapy**
 - [CBT manual with patient handout](#)(clickable link)
 - Please note document is indexed, user friendly!
- **Cognitive processing therapy for PTSD, behavioral change**
 - [CPT Manual with functional analysis worksheet](#)(clickable link)
 - [CPT mobile application](#)(clickable link)
- **Acceptance and commitment therapy for mindfulness, behavioral change**
 - [ACT mobile application](#)(clickable link)



Anxiety Insomnia Depression **Cravings** Delusions

Current Evidence

- **Cognitive behavioral therapy (CBT)**
 - CBT and CBT derived psychotherapeutic interventions exhibit at least some efficacy in addressing numerous aspects of substance use disorder
 - High heterogeneity between trials makes robust comparison and generalization difficult; thus, a patient centered approach to intervention selection should be utilized
- **Motivational Interviewing**
 - Many trials are of low quality; however, moderate quality trials suggest that MI is effective in reducing substance consumption and promoting physical activity
 - Subjective experiences of patients treated with MI trend positive
- **Self help programs (AA/NA)**
 - Some studies suggest self help programs promote recovery; however, benefit is consistent on patient engagement, which is universally low
- **Other management paradigms**
 - Interventions such as contingency management may be efficacious but are poor candidates for brief visits and are omitted from the present discussion

Anxiety Insomnia Depression **Cravings** Delusions


Interventions

- **Decisional Balance**
 1. Explain pitfalls of typical decision-making paradigms that focus on what we “should do” or “shouldn’t do”
 2. Reinforce utility of pros/cons approach to decision making and sustained change
 3. Guide veteran in using decisional balance to consider the pros and cons associated with a recent, specific example from their life
 - See resource table on next page



Suggested Documentation

Veteran was introduced to decisional balance to promote behavioral change by reducing ambivalence. The pitfalls of traditional or habitual decision-making paradigms were illustrated by contrasting the thoroughness and durability of the pros and cons approach to decision making. Veteran successfully demonstrated ability to employ decisional balance by considering a specific example from their life in session. Veteran was provided resources to guide their independent use of decisional balance as a decision-making strategy.

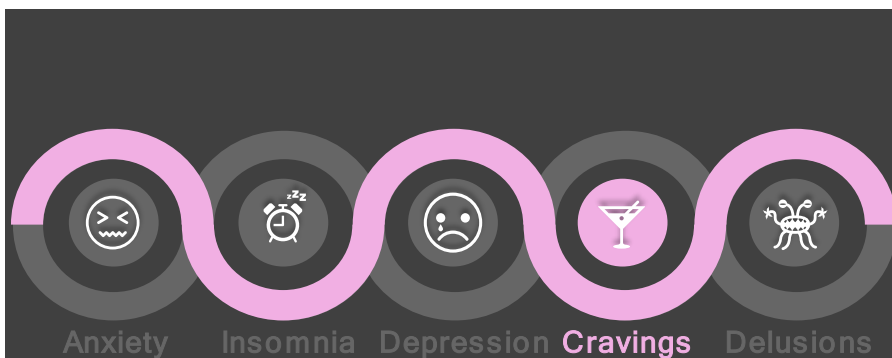


Anxiety Insomnia Depression **Cravings** Delusions

Interventions

- [Decisional BalanceTool](#)

	Pros	Cons
Changing		
Not Changing		



Anxiety Insomnia Depression Cravings Delusions


Interventions

- Coping Cards
 1. Explain rationale of creating an icon to cue coping strategies in the context of psychiatric symptoms that impede decision making like cravings
 2. Offer coping card structure that includes
 - a) Identification of emotional experience and associated thoughts
 - b) A cognitive intervention
 - c) A behavioral intervention
 - d) Any salient environmental modifications
 - e) Activation of support system if necessary
 3. Assist Veteran in creating a coping card to address a specific emotional, behavioral, or situational concern



Suggested Documentation


Veteran was introduced to coping cards to promote emotional and behavioral modification in the presence of complicating psychiatric symptoms. Veteran created a coping card to address a specific emotional -behavioral -situational concern. Veteran included activation of their support system to mitigate dysregulation if interventions specific to cognition, behavior, or the environment were ineffective.



Anxiety Insomnia Depression Cravings Delusions

Veterans Administration Resources

- Cognitive behavioral therapy
 - [Stay Quit Smoking Prevention App](#)(clickable link)
 - [VetChangeDrinking Habits App](#)(clickable link)



Anxiety Insomnia Depression Cravings Delusions

Current Evidence

- [Cognitive behavioral therapy \(CBT\)](#)
 - CBT, when specifically formulated for patients with psychosis, reduces symptom severity and promotes treatment adherence
 - There is high variability in efficacy between different CBT for psychosis formulations. Additionally, therapy is often modified for individual patients, which complicates robust metaanalysis



Anxiety Insomnia Depression Cravings Delusions

Basic Approach

- **Establish rapport- "Befriending"**
 - Determine patient's values and hopes
 - Determine where treatment goals and individual goals overlap
- **Acceptance**
 - The goal of therapy is not symptoms remission; rather, goal is symptoms management in pursuit of patient-centered treatment plan
 - Allows for symptom exploration from a neutral perspective understanding of Veterans experience
- **Normalization**
 - How common are the Veterans experiences what experiences are shared by both Veteran and provider?
- **Building insight within the delusional framework**
 - Explore how thoughts influence behaviors
 - Challenge automatic negative thoughts related to delusional or disorganized thoughts without challenging specific delusions
 - May use thought monitoring framework if appropriate



Anxiety Insomnia Depression Cravings Delusions

Interventions

- **Behavioral Experiments**
 1. Explain that behavioral experiments are useful ways of exploring thoughts, feelings, and behaviors in the context of specific challenging situations
 2. Assist Veteran in identifying a challenging situation and associated behaviors
 3. Devise way to operationalize impact of current behavior and possible alternate behaviors
 4. Develop specific plan to implement alternate behaviors and measure them
 5. Instruct client to bring measurements and observations to next session for discussion

Suggested Documentation

Veteran was introduced to the behavioral experiment as a means for assessing the relative adaptive or maladaptive impact of specific behaviors. The Veteran identified a specific challenging situation or thought in which behavioral modification could improve outcome. The veteran identified several specific behaviors that they could implement and measure in the context of the challenging situation. The veteran agreed to bring their measurements and observations to the next session so that they could be discussed from a cognitive-behavioral perspective.



References

- Borza, L. (2017). Cognitive behavioral therapy for generalized anxiety. *Dialogues in Clinical Neuroscience*, 19(2), 6.
- Cape, J., Whittington, C., Buszewicz, M., Wallace, P., & Underwood, L. (2010). Brief psychological therapies for anxiety and depression in primary care: Meta-analysis and meta-regression. *BMC Medicine*, 8(1), 38. <https://doi.org/10.1186/1745-2751-8-38>
- Carpenter, J. K., Andrews, L. A., Witcraft, S. M., Powers, M. B., Smits, J. A. J., & Hofmann, S. G. (2018). Cognitive therapy for anxiety and related disorders: A meta-analysis of randomized placebo-controlled trials. *Depression and Anxiety*, 35(6), 502-514. <https://doi.org/10.1002/da.22728>
- Chen, K. W., Berger, C., Manheimer, E., Forde, D., Magidson, J., Dachman, & Lejuez, C. W. (2012). Meditative therapies for reducing anxiety: A systematic review and meta-analysis of randomized controlled trials. *Depression and Anxiety*, 29(5), 5-562. <https://doi.org/10.1002/da.21964>
- Cognitive behavioral therapy for insomnia: A meta-analysis of long-term effects in controlled studies. (2019). *Sleep Medicine Reviews*, 11.
- Cuijpers P., van Straten A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of consulting and clinical psychology*, 96(6), 20.
- Espie, C. A. (2011). Paradoxical intention therapy in behavioral treatments for sleep disorders. *Elsevier*. <https://doi.org/10.1016/B978-0-23815224-00006-7>
- Frost, H., Campbell, P., Maxwell, M., O'Carroll, R. E., Dombrowski, S. U., Williams, B., Cheyne, H., Coles, E., & Zuckerman, A. (2018). Effectiveness of motivational interviewing on adult behavior change in health and social care settings: A systematic review of reviews. *PLOS ONE*, 13(10), 0204890. <https://doi.org/10.1371/journal.pone.0204890>
- Guglietti, C. L., Daskalakis, Z., Radhu, N., Fitzgerald, P. B., & RJN. (2013). Meditation-related increases in GABA-modulated cortical inhibition. *Brain Stimulation*, 6(3), 397-402. <https://doi.org/10.1016/j.brs.2012.08.005>
- Hoge, E. A., Bui, E., Mete, M., Phillip, S. R., Gabriel, C., Ward, M. J., Suzuki, R., Dutton, M. A., & Simon, N. M. (2020). Treatment for anxiety: Mindfulness meditation versus escitalopram (TAME): Design of a randomized, controlled superiority trial. *Contemporary Clinical Trials*, 95, 965. <https://doi.org/10.1016/j.cct.2020.105965>
- Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., Horvath, K., Kijas, L. A., Kirk, T., Kivlahan, D., Daudet, A., McCrady, B. S., McLellan, A. T., Morgenstern, J., Townsend, M., & Weiss, R. (2004). Self-organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 153-158. [https://doi.org/10.1016/S0740-7472\(03\)00212-5](https://doi.org/10.1016/S0740-7472(03)00212-5)
- Kopelovich, S. L., & Turkington, D. (2021). Remote CBT for psychosis during the COVID-19 pandemic: Challenges and opportunities. *Community Mental Health Journal*, 57(4), 34. <https://doi.org/10.1007/s10597-00718-0>
- Lin, L. (Allison), Casteel, H., Higekawa, E., Weyrich, M. S., Roby, D. H., & McMenamin, S. B. (2019). Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. *Journal of Substance Abuse Treatment*, 123, 49. <https://doi.org/10.1016/j.jsat.2019.03.007>
- Locke, A. B. (2015). Diagnosis and management of generalized anxiety disorder and panic disorder in adults. 91(9), 8.
- Naeem, F., Farooq, S., & King, D. (2015). Cognitive behavioral therapy (brief versus standard duration) for schizophrenia. *Cochrane Database of Systematic Reviews*. <https://doi.org/10.1002/14651858.CD010646.pub3>
- Owens, J. E., Schorling, J., Plew, G., M., Goodman, M., Moorman, R., Zaklin, R., & Dent, J. (2016). A randomized controlled trial evaluating Mindfulness-Based Stress Reduction (MBSR) for the treatment of palpitations: A pilot study. *International Journal of Cardiology*, 223, 25-27. <https://doi.org/10.1016/j.ijcard.2016.08.183>
- Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression. *Psychiatric Clinics of North America*, 40(4), 717-70. <https://doi.org/10.1016/j.psc.2017.08.009>
- Wright, J. H., Sudak, D. M., Turkington, D., & Hase, M. E. (2010). Cognitive behavior therapy for brief sessions: An illustrated guide. American Psychiatric Publishing. DOI: 10.1176/appi.ajp.2010.10081139

Appendix E



DEPARTMENT OF VETERANS AFFAIRS
Health Care System
3710 SW US Veterans Hospital Road
Portland OR 97239



June 10th, 2021

Dear Phillip Bergreen,

I am writing this letter in support of your plan to complete your DNP Final Project at our clinical site (pending VA IRB approval). The project will take place from approximately June, 2021 to December, 2021.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor (myself):

- **Project Site(s):**
 - VA Portland Health Care System, 3710 SW US Veterans Hospital Rd., Portland, OR 97239
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
 - **Identified Clinical Problem:** Limited structural and educational resources lead to reduced rates of psychotherapeutic interventions in brief visits at the VA Portland specialty mental health clinic.
 - **Rationale:** The efficiency of multistep processes is often limited by specific constraints. Theory of Constraints provides a rationale for assessing and addressing processes that limit output: constraints – at the VA, caseload, administrative burden, and provider competency are assumed constraints limiting the provision of psychotherapeutic interventions to patients in brief visits.
 - **Specific Aims:** Portland VA nurse practitioners will report increased competency with and application of psychotherapeutic interventions for brief visits by December, 2021.
 - **Methods/Interventions/Measures:** Structural resources will be assessed by using thematic analysis to identify salient constraints related to the provision of psychotherapeutic interventions as discussed in structured interviews with VA Portland PMHNPs. 5-point Likert scale surveys will be used to assess current interest in, competency with, and preferred modalities for learning about psychotherapeutic interventions in addition to the frequency with which psychotherapeutic interventions are supplied. Following the implementation of both structural and educational interventions, surveys will be repeated and compared using paired t-tests.
 - **Data Management:** All interview and survey responses will be deidentified and anonymized. No patient data will be collected at any point during this quality improvement project.
 - **Site(s) Support:** The VA Portland specialty mental health clinic will provide access to PMHNP staff members who consent to participate in this quality improvement project.

During the project implementation and evaluation, Phillip Bergreen will provide regular updates and communicate any necessary changes to the DNP Project Preceptor. Our organization looks forward to working with you to complete your DNP project. If we have any concerns related to this project, we will contact you or Andrea Hughes (your DNP Project Chairperson).

Sincerely,

Kasey McCracken, PMHNP-BC
Psychiatric Mental Health Nurse Practitioner

Appendix F



Notification of Not Human Research Determination

To: Phillip Bergreen

Link: [STUDY00023267](#)

P.I.: [Rodney Olin](#)

Title: Psychotherapeutic interventions for brief visits

Description: The committee reviewed this submission and assigned a determination of Not Human Research. For additional details, click on the link above to access the project workspace.

Oregon Health & Science University
Research Integrity Office
3181 SW Sam Jackson Park Road - L106R1
Portland, Oregon 97239-3008
(503)494-7887 irb@ohsu.edu

VA Portland Health Care System
Research and Development Service
3710 SW U.S. Veterans Hospital Road - R&D
Portland, Oregon 97239-2900
(503)273-5125 pvamc-irb@va.gov

Appendix G

VHA IRB Non-Human

VA Portland Health Care System (VAPORHCS)
Institutional Review Board (IRB)
CHECKLIST: QUALITY ASSURANCE OR IMPROVEMENT (QA/QI) OR RESEARCH?

ACOS/R&D or IRB Analyst Comments:

VAPORHCS ACOS/R&D Signature: DAVID M COHEN
386526

Digitally signed by DAVID M
COHEN 386526
Date: 2021.06.24 16:37:06 -07'00'

Date: _____

Reference:

[VHA Handbook 1058.05](#): VHA Operations Activities That May Constitute Research

¹Examples of operations activities include activities designed for internal VA purposes, including routine data collection and analysis for operational monitoring, evaluation and program improvement purposes, VHA system redesign activities, patient satisfaction surveys, case management and care coordination, policy and guidance development, benchmarking activities, Joint Commission visits and related activities, medical use evaluations, business planning and development such as cost-management analyses, underwriting, and similar activities.

²Any change made before, during, or after implementation that results in an intent to expand the knowledge base of a scientific discipline or scholarly field of study, or otherwise contribute to generalizable knowledge, constitutes research and must be submitted to an IRB or other pertinent review committee.

³Potential risks (including physical, psychological, social, financial, privacy, and confidentiality, and other foreseeable risks) associated with non-research operations should be evaluated and appropriate protections established to mitigate them.

⁴Please note it is the responsibility of this individual and/or each VA author and coauthor (in cases of publication) to retain a copy of this form signed by the ACOS/R&D for a minimum of 5 years after publication and in accordance with any applicable records retention schedules. A copy will also be retained by Research Service and Quality & Performance Service.

Appendix I

Cause and Effect Diagram

