Working Better Together: Integrated Care Models and the Role of Neuropsychology

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Disclosures

- Presenters Carolyn Parsey, PhD, and Christine Petranovich, PhD declare no conflicts of interest
- We do not have any financial relationships to disclose

Quick Poll

What is the scope of your practice?
- Adult
- Pediatrics
- Life-span

Another question on the scope of practice?
- Neuropsychology/ assessment only
- Intervention only
- Mix of both

Which of the following do you best fall into?
- I am a provider who already works in collaborative care team and wants to trouble-shoot.
- I am a provider that is looking to start or join a collaborative care team and am seeking information about how to go about it.
- Other?

Overview

- **Part I: Evidence for Collaborative Care**
  - What is collaborative care?
  - Types of multiple discipline clinical teams
  - Origins of collaborative care models
- **BREAK**
- **Part II: Principles of Effective Collaborative Care**
  - 10 principles of effective care teams
- **Part III: Overcoming Barriers to Effective Collaborative Care**
  - Challenges to team-based practice
  - Applications of collaborative care models
    - Memory Disorders Clinic
    - Acquired Brain Injury Clinic
  - Breakout session & Discussion
- **PART IV: Neuropsychology Training for Collaborative Care**

Part I: Evidence for Collaborative Care

The Problem With "Silos"

The Problem With "Silos"

- Primary Care vs. Specialty Care
- Inpatient vs. Outpatient
- Access of Care
- EHR and patient information

- Today's focus: Integration of teams and information

- A lack of coordination between mental health and physical healthcare
  - Provider communication, documentation, treatment planning

Co-Location vs. Collaboration

- Co-Location
  - Providers located close by, but not integrated in treatment or care planning
- Collaborative Care
  - Supported by 80+ RCTs and growing to promote better health outcomes for patients
    - e.g., primary care and behavioral/mental health integration
  - Better patient and provider interactions
  - Improved functioning in patients and care teams
  - Reduction in healthcare costs (over long-run)

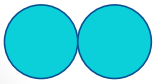
Three Team Approaches

- Multidisciplinary: "Co-located"
- Interdisciplinary: "Collaborative"
- Transdisciplinary: "Integrative"

Choi & Pak, 2006

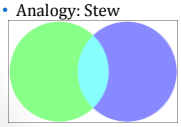
Multidisciplinary Team

- Work *with* several disciplines
- Independent work on a case
  - Work is parallel or sequential
- Team members maintain separate, individual roles & goals
- Outcome = sum of parts
- Example: PCP at HMO site, Neurologist at a hospital, Psychologist at community-based clinic
- Analogy: Salad Bowl



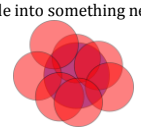
Interdisciplinary Team

- Working *between* several disciplines
- Joint work on the same case or project
- Shared goals with individual and team goals
- Outcome is more than sum of parts
- Example: Rehab team with physiatrist, neurologist, psychologist, PT and OT, social worker who meet about a single patient
- Analogy: Stew



Transdisciplinary Team

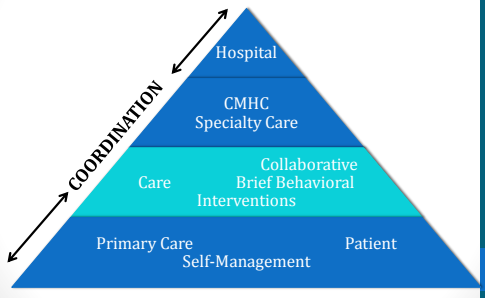
- Working *across and beyond* disciplines
- Involves additional stakeholders outside patients and providers (e.g., healthcare organization, insurance)
- Shared goals and skills, shared conceptual framework
- Holistic, integrative, transcendental
- Individual components are indistinguishable
- More common in a research setting, rather than clinical
- Example: Team members that can assume roles of others, transforming a role into something new
- Analogy: Cake



The Rise of Collaborative Care

- Collaborative Care Model was result of inadequate management of depression in primary care settings
  - Most initial presentations and follow-up for depression occur in primary care, not mental health specialty
  - Katon et al., 2012
- CCMs can increase initial cost of care, but creates reduced total medical expenditures in the long-run (Serrano, 2014)

Mental Health in Primary Care Settings



Other Models of Behavioral Health Delivery

Traditional Consultation	Co-Location	Primary Care Behavioral Health
Limited access	Access and interaction	Solidly grounded in a clinical practice culture
Limited feedback	Better communication	Generalist BHP
Expensive	Long waitlists and limited available providers	Rapid access to brief behavioral interventions
One Pass	Limited ability for follow through	Limited evidence base

Evidence Base for Collaborative Care

Shown across clinical populations to result in better medical outcomes and increased patient satisfaction

- More efficient care (Sander, Raymer, Werthheimer, & Paul, 2009)
- Mixed evidence regarding cost-effectiveness (Ke et al., 2013; Kubu, 2016)
- More effective communication among providers

More than *80 randomized controlled trials* have shown collaborative care to be more effective than usual care for common mental health conditions such as depression and anxiety.

First demonstrated in the IMPACT Trial.

Evidence-Based Care: IMPACT Study


Prepared, Pro-active Practice Team


Informed, Active Patient

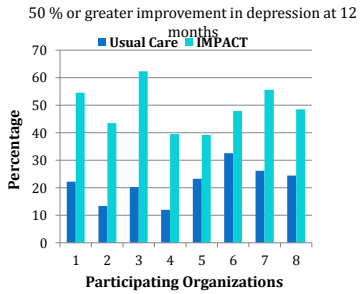
Outcome Measures


Population Registry

Treatment Protocols


Psychiatric Consultation

Twice as Many People Improve



Unützer et al., 2002, 2004

IMPACT: Summary

- Improved Outcomes
  - Less depression
  - Less physical pain
  - Better functioning
  - Higher quality of life
- Greater patient and provider satisfaction
- Reduced healthcare costs

"I got my life back"

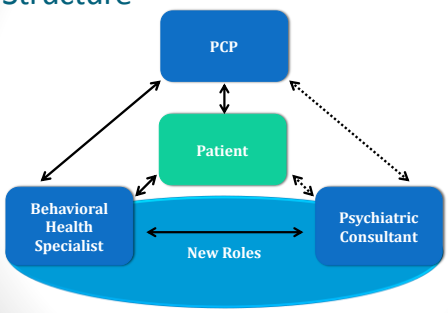
THE TRIPLE AIM

Collaborative Care for Other Mental Health Conditions

Evidence Base Established	Emerging Evidence

• Depression
  - Adolescent Depression
  - Depression, Diabetes, and Heart Disease
  - Depression and Cancer
  - Depression in Women's Health Care
• Anxiety
• Post Traumatic Stress Disorder
• Chronic Pain
• Dementia
• Substance Use Disorders
	• ADHD
	• Bipolar Disorder

Collaborative Care Team (CCT) Structure

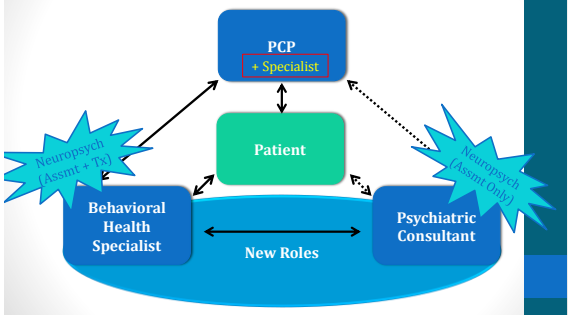


Expanding the CCM to Include Neuropsychology

- Collaborative Care stemmed from mental health and substance use diagnoses
- What about applications for neurological issues?
  - Neurodegenerative disease, TBI, or neurodevelopmental disorders

PCP + Psychiatry → PCP & Specialist + Neuropsych & Psychiatry

Sample CCT w/ Neuropsychology



Effectiveness of Collaborative Care for Older Adults With Alzheimer Disease in Primary Care

A Randomized Controlled Trial

Christopher M. Callahan, MD; Malaz A. Boustani, MD, MPH; Frederick W. Unverzagt, PhD; et al

Article Information
JAMA. 2006;295(18):2148-2157. doi:10.1001/jama.295.18.2148

- Indiana University/Purdue University
- 153 older adults with AD and their caregivers
- 1 year of care management
  - Random assignment to Collaborative Care (n=84) or Augmented Usual Care (n=69)
- Neuropsychiatric Inventory (NPI), depression scales, (CSDD, PHQ-9), cognitive screening (TICS), ADL questionnaire (AD Cooperative Study ADLs)
- Included pharmacological and non-pharmacological interventions

RCT for Collaborative Care for Alzheimer's Disease

Findings for Collaborative Care Group:

- More likely to receive cholinesterase inhibitors and antidepressant medications
- Fewer behavioral and psychological symptoms (per NPI scale ratings) at 12 and 18 months
- Caregivers reported significant improvements in distress (NPI) at 12 months and improved in depressive symptoms at 18 months

Table 2. Intervention Patients Receiving Nonpharmacological Protocols

	No. (%) of Intervention Patients Receiving Nonpharmacological Protocol (n = 84)
Offered to all intervention patients	
Stress/coping	76 (90.5)
Exercise	76 (90.5)
Communication	74 (88.1)
Legal and financial	72 (85.7)
Offered based on reported symptoms	
Caregiver's physical health	75 (89.3)
Depression	69 (82.1)
Repetitive behavior	62 (73.8)
Aggression	60 (71.4)
Mobility	52 (61.9)
Personal care	35 (41.7)
Sleep disturbances	31 (36.9)
Delusions	26 (31.0)
Optional participation	
Support group attendance	47 (56.0)

Collaborative care model for childhood behavior problems

- Randomized to collaborative care or enhanced usual care
- Most common services were parent training and child skill implementation
- Average age = 8.7 (2.4)
- Range of diagnoses, including anxiety (47%), ADHD (45%), and ODD (49%)
- Groups well matched for pre-treatment parent report

Kolko, Campo, Kilbourne, & Kelleher, 2012

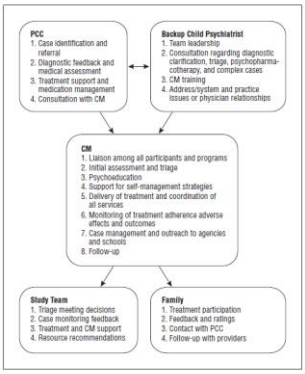


Figure 2. Clinical staff and functions integrated into the doctor-office collaborative care model. CM indicates care manager; PCC, primary care clinician.

Kolko, Campo, Kilbourne, & Kelleher, 2012

- Collaborative care greater improvements after, particularly with respect to ADHD symptoms
- 71% of parents were satisfied

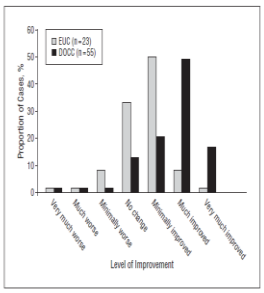


Figure 4. Clinical Global Impression Scale ratings by clinical care managers for children in the enhanced usual care (EUC) and doctor-office collaborative care (DOCC) conditions.

Kolko, Campo, Kilbourne, & Kelleher, 2012

Core Principles of Collaborative Care

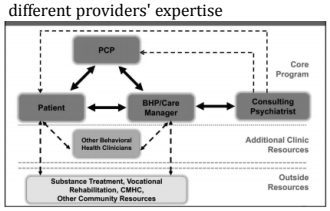
1. Patient-Centered & Team-Driven Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care

2016 APA/APM Report on Dissemination of Integrated Care

Full report available online:
https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care

1) Patient-Centered & Team-Driven Care

- "To promote a systematic, planned approach to care" (Wagner, 2001)
- *Physical* health providers collaborate with *behavioral* health providers
- Shared care plans
- Focused on the needs of the patient, from the lens of different providers' expertise



2) Population-Based Care

- Team is responsible for provision of care and health outcomes of a defined patient population
- Components to Consider:
  - Monitor population outcomes
    - Regular data collection, aggregation, and analysis
    - Use findings to inform practice
  - Patient-centered services
    - "No shows" as opportunities for engagement to prevent decline
  - Elevate capacity of specialty and primary care
    - Shift focus of primary care for less-complex cases, greater involvement of specialists for greater complexity
  - Attend to social issues
    - Identify barriers to care (e.g., SES, homelessness) and advocate for resources

3) Measurement-Based Treatment to Target

- Systematic, disease-specific, *patient*-reported outcome measures to drive clinical decision-making (Hatfield, 2009)
- Patient report > Clinician report/observation
- Measures should be correlated with disease process and treatment
- Instruments must be reliable, sensitive to change, available and usable by the clinical team
- Collect measures frequently and accurately
- Measures can also allow communication between providers
  - Beginning to be associated with healthcare plans, insurance
  - Can help with advocacy for resources (community, federal)

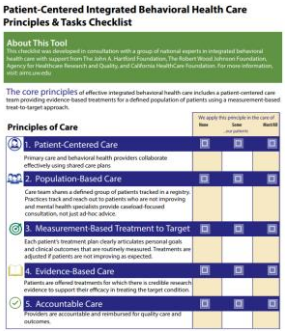
4) Evidence-Based Care

- Team adapts empirically-supported treatments within an individual clinical context
- "Conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996)
- Measurements should *directly* result in improved function
  - Vague measurements (e.g., quality of life, generalized risk scores) are interesting, but difficult to apply practically
    - Specific values that are linked to disease severity are better
- Evidence-based care allows teams to have greater confidence in treatments and better expectations of outcomes

5) Accountable Care

- Opportunity for quality improvement within a clinic
- Performance measures of the practitioners
  - How these performances impact patients and stakeholders
- Patient-Reported Outcome Measures (PROM)
  - Structured feedback from patients collected by payers and accreditors to keep providers accountable for outcomes of populations served
- Periodic review of caseloads, team work distribution
- WHAT services are offered, HOW the care is coordinated, and WHEN the services are given

AIMS Center Tool


Patient-Centered Integrated Behavioral Health Care
Principles & Tasks Checklist

About This Tool

The core principles of effective integrated behavioral health care includes a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

Principles of Care

1. Patient-Centered Care
Primary care and behavioral health providers collaborate effectively using shared care plans.

2. Population-Based Care
Care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving, and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

3. Measurement-Based Treatment to Target
Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.

4. Evidence-Based Care
Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

5. Accountable Care
Providers are accountable and reimbursed for quality care and outcomes.

https://aims.uw.edu/sites/default/files/CollaborativeCarePrinciplesAndComponents_2014-12-23.pdf

Break

Neuropsychologists on Collaborative Care Teams

- Two Examples
  - Memory Disorders Clinic
  - Pediatric Acquired Brain Injury Program
- Recent *Archives of Neuropsychology* special series
  - Vol. 33, Issue 3 (May 2018)
  - Primary Care, Epilepsy, MS, Memory Disorders, TBI, etc.

UW Medicine: Memory and Brain Wellness Center

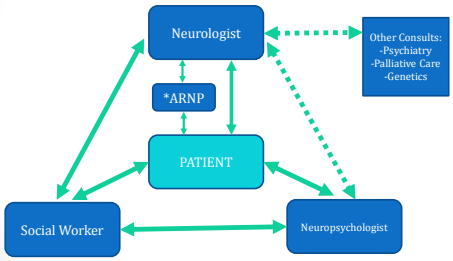
- Outpatient evaluation of neurodegenerative disorders
- Team Members
  - Neurologists
  - Geriatricians
  - Psychiatrists
  - ARNPs
  - Neuropsychologists
  - Social Work and Case Managers
  - Support Staff (medical assistants, nurses, administrative staff)
- Weekly full team meetings for patient care
  - Additional meetings for case consensus as needed
- Rotating meetings for Journal Club, Research Updates, Operations and Administrative needs, etc.

UW Medicine: Memory and Brain Wellness Center

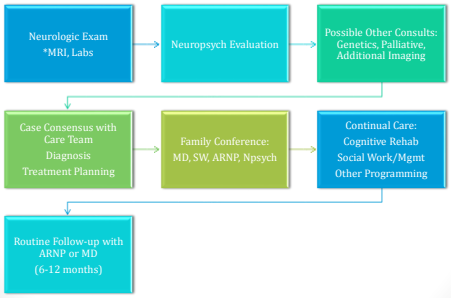
- Team Goal/Vision: Holistic and Comprehensive Care
  - Evidence-based and collaborative care of disciplines for diagnosis and treatment
  - Pharmacological and non-pharmacological strategies
  - Help patients discover ways to use their strengths to promote brain health and overall well-being
  - Maintaining "personhood"
  - Community outreach and education
    - "Momentia"
  - Advocacy
    - Dementia Action Collaborative
    - WA State Plan to Address Alzheimer's Disease & other dementias

- Patients are not "demented," they are *living with dementia*

UW Medicine: Memory and Brain Wellness Center



UW Medicine: Memory and Brain Wellness Center



MBWC Case Example

- 54yo, female patient, 18yrs education
- Problems with organization and planning at work
- Neurologist exam (1st appointment)
  - Unremarkable neurologic exam, labs normal, MRI normal
  - MoCA screening w/Neurologist = 28/30 (cube, del. recall)
- Neuropsychology eval
  - WAIS-IV PRI = 3rd percentile; RCFT = <1st percentile
- Report routed back to Neurologist
  - Likely PCA → Order PET
- Review full case in team meeting → Diagnostic Consensus & Tx Plan
- Family Meeting
  - Patient, spouse, Neurologist, ARNP, Neuropsych, Social Worker
  - Discuss diagnosis (education), treatment plan, patient resources, care partner resources, family resources
- Routine follow-up with Neurologist
  - ARNP for routine follow-up by phone, questions
  - Social Work as needed
  - Neuropsychologist for cog rehab, repeat evaluation (if needed)

MBWC Case Example

- Feedback from patient and spouse
  - Felt "heard" by provider and team (previous providers and insurance unwilling to believe symptoms in 'young' woman)
  - Family conference helpful for education and answering questions
    - "I could tell that the team was all on the same page. They each had something to say that was helpful. They were focused on me and things going forward."
  - Support from multiple specialties, if needed
    - "I might not need it right now, but I am glad that [SW] is available for me and my husband"

Children's Hospital Colorado Acquired Brain Injury Program

- Mostly TBI, other acquired brain injuries
- Inpatient: cognitive monitoring, psychosocial support/ education, and discharge testing
- 1 year follow-up: patient meets with entire team after having a comprehensive neuropsychology evaluation
- Team:
  - Speech, occupational, and physical therapies
  - Rehabilitation psychology and neuropsychology
    - Interns and fellows
  - Rehabilitation medicine
  - Education
  - Child Life
  - Social work

Children's Hospital Colorado Acquired Brain Injury Program

- Co-treatment
  - Support behavior and emotional adjustment in the context of therapy and other services
    - PT and psychology: anxiety, impulsivity, and safety when moving; self-perception
    - OT and psychology: self-image around grooming and hygiene
    - SLT and psychology: family education, assessment, coping and compensatory strategies
    - Education and psychology: manage behavior and emotional problems in the classroom, support social engagement, inform IEP and transition back to school

Children's Hospital Colorado Acquired Brain Injury Program

- Goal/ vision for future:
  - Subacute program
  - Increasing supports to transition home
  - Standardized interventions/ protocols based on diagnosis
  - Systematic tracking of outcome
  - Increasing opportunities for training

CHCO ABI Case Example

- 7-year-old with TBI and stroke sustained under psychologically traumatic circumstances
- High functioning at baseline, possible subclinical anxiety
- Remained average in many aspects of cognition
  - Higher-level cognitive problems
  - Increased anxiety
  - Frustration
  - Emotional indifference

CHCO ABI Case Example

- Better understand changes in functioning
- Relationship of cognition and his emotional and behavioral presentation
- Supported anxiety and social competence in the context of therapies and school

Part II: Principles of **Effective** Collaborative Care

10 Principles of **Effective** Care Teams

253 staff from 11 community rehabilitation and intermediate care teams in the UK

"A dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value added, patient, organizational, and staff outcomes"

Nancarrow et al., 2013

1. Leadership

- Clear vision, role, and purpose
  - Willing to act *and* listen
  - Clear direction and management of team
- Democratic, shared power
- Support and supervision
- Values are visible and consistently portrayed
- Demonstrates a team culture of trust

Nancarrow et al., 2013

2. Communication

- Emphasis on the leader to implement and uphold
- Appropriate systems to promote communication within team
  - In-person meetings (team, pairs, subgroups, etc.)
  - Agenda items
  - Collaborative calendars and schedules
- Ability to discuss and resolve issues
- Must be "two-way"
  - Concern that some members' perspectives are not valued as highly

Nancarrow et al., 2013

3. Personal Rewards and Training

- Training and development
- Opportunities to share knowledge with the rest of the team
- Individual rewards and opportunities
  - Career development
  - Financial
  - Autonomy
  - Challenges
  - Morale and motivation
- Perceives the importance of individual returns on the broader team

Nancarrow et al., 2013

4. Appropriate Resources

- Basics: office space, parking, computers, etc.
- Privacy
- Procedures to uphold the team vision
  - Communication within the team and to outside providers
  - Referral criteria
- Team members value being asked for input
- Procedures and responsibilities don't impede patient care
  - Paperwork
  - Charting
  - Meetings
- Reasonable work load/ sufficient time to complete job well

Nancarrow et al., 2013

5. Appropriate Skill Mix

- Diversity
- Mix and breadth of staff
  - Sufficient and appropriate skills, experiences, and competencies
  - Provider mix meets the demands of the patients
  - Personalities
- Timely replacement and coverage during absences and changes in team structure

Nancarrow et al., 2013

6. Culture

- Largest theme
  - Flexibility: both of the team itself and its members
  - Trust
  - Mutual respect
  - Reliability
  - Commitment
  - Informal relationships
  - Valued contributions of others
  - Camaraderie
  - Fun
  - Friendship

Nancarrow et al., 2013

7. Individual Characteristics

- Knowledge, experience, initiative
- Listening skills
- Interest in common goal
- Approachability
- Compromise
- Decisiveness
- Empathy
- Organized
- Self-awareness
- Open to learning
- Personal responsibility

Nancarrow et al., 2013

8. Clear Vision

- Clear set of values that drive direction of service
  - Referral criteria
  - Services offered
- Uniform and consistent external image
  - Accurate information given to referring providers
  - Portrayal of the team within my system and externally
  - Physical representation of staff
  - External marketing

Nancarrow et al., 2013

9. Quality of Care Outcomes

- Patient-centered care focus
- Ways to measure effectiveness and outcome
- Mechanisms in place for feedback to provider and to other services

Nancarrow et al., 2013

10. Respect and Understanding of Team Member Roles

- Shared power
- Working jointly
- Autonomy
- Boundaries
- Clear understanding of how my role fits into the team and impacts other providers

Nancarrow et al., 2013

Part III: Overcoming Barriers to Effective Collaborative Care

Challenges

- Lack of clear vision (Nancarrow et al., 2013)
- Satisfaction with involvement in goal-planning (Sivaraman Nair & Wade, 2003)
- Balance between collaboration and the inevitable need for someone to hold decision making power
  - Frustrations as MD opinions may be valued differently (Mickan & Rodger, 2000)
- Insufficient communication

Challenges

- Managing differing opinions
  - Particularly important as conflict can interfere with patient-focus (Mickan & Rodger, 2000)
- Lack of resources to complete job effectively (Nancarrow et al., 2013)
- Feeling underappreciated
- Accessibility of other team members

Challenges Specific to Neuropsychology

- Overlapping roles with therapists and other psychologists (Sander, Raymer, Werthheimer, & Paul, 2009)
- Unrealistic expectations
- Time needed for assessment
  - Work load
  - Sharing patient's time with other providers
- Billing
  - Can be sticky when multiple providers are present

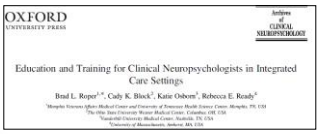
Breakout

1. What works well in my current setting?
2. What are challenges and barriers in my setting?
3. What has been harmful to my team?
4. Which of the principles of good interdisciplinary team work resounded most with you?
5. What are ways to overcome communication challenges?
6. What are strategies that have worked well for me in navigating and establishing my role as a neuropsychologist?
7. Does my institution have policies and procedures in place to support collaborative care? Are there procedures that discourage it?

Part IV: Training in Collaborative Care

Training in Collaborative Care

- Recent survey showed many NPs are involved in integrated care but lacked formal training (Kubu et al., 2016)
- Roper and colleagues (2018) propose 3 broad competency areas for NPs
  - Foundational Competencies Related to Integrated Care
  - Functional Competencies Relevant to Integrated Care
  - Knowledge and Skills Specific to the Team/Setting


OXFORD UNIVERSITY PRESS

Archives of CLINICAL NEUROPSYCHOLOGY

Education and Training for Clinical Neuropsychologists in Integrated Care Settings

Brad L. Roper[1,*], Cady K. Block[2], Katie Osborn[3], Rebecca E. Ready[4]

8 Foundational Competencies

- Range includes processes, relationships, collaboration, and outcomes that advance patient care and research
- Interdisciplinary systems competency is conceptualized as being relevant to all professional activities of neuropsychologists and is especially relevant to integrated-care settings
- 8 elements could be part of a curriculum for collaborative care training

8 Foundational Competencies

- (5) Neuropsychologist will have knowledge of…
  - Roles, responsibilities, skills, and values/attitudes of different disciplines and arranges settings (e.g., health care, education, forensic, policy, community)
  - Different systems relevant neuropsychological practice and strategies to negotiate these systems effectively
  - Interprofessional collaboration and its role in contributing to optimal care
  - General and setting-specific contributions and limitations of neuropsychological expertise
  - Functional impact of neuropsychological disorders on patient abilities to negotiate systems and relevant management strategies

8 Foundational Competencies

- (3) Neuropsychologist will be able to…
  - Collaborate effectively with individuals and systems across disciplines, adapt indications to context appropriately, address questions about neurobehavioral functioning, and contribute to integrated understanding
  - Work cooperatively across systems, validating shared values and demonstrating mutual respect
  - Work collaboratively, providing neuropsychological expertise in clinical and research teams
  - Roper et al., 2018; CNS, 2016; Rey-Casserly et al., 2012)

Functional Competencies

- Assessment
- Intervention
- Consultation
- Research/evaluation
- Teaching/supervision
- Management/administration
- Advocacy

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- **Assessment**
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"Core" competencies for Team Settings

Training in Collaborative Care

- Achieving Competencies for Neuropsychology Trainees
  - **Doctoral Programs**
    - Didactics for collaborative and interdisciplinary models
      - Screening tools, measurement for efficiacy
      - Learning brief interventions
      - Interprofessional relationships
      - Contributions to quality improvement projects
      - Issues related to diversity, access to care, cultural influences
    - Interviewing and communication techniques
      - Ability to communicate information in a fast environment
      - Communication between patients, families, and physicians
    - Published guidance is available for training directors
      - Hunter et al., 2017; Robinson & Reiter, 2007

Training in Collaborative Care

- Achieving Competencies for Neuropsychology Trainees
  - **Internship**
    - Intentional placement at a site that offers major and minor rotations in assessment, intervention, and consultation
      - May cut across patient population (race, gender), intensity (inpatient, outpatient), care setting (hospital, forensic, academic), care line (mental health, psychiatry, neurology, primary care, transplant)
    - Learn to adapt neuropsychological evaluation skills to various populations and teams
    - Develop communication skills (written and oral)
    - Research opportunities within a clinic
      - Collaboration between providers or departments

Training in Collaborative Care

- Achieving Competencies for Neuropsychology Trainees
  - **Post-doctoral Training**
    - Expand range, efficiency, and flexibility of skills
    - Involvement in program evaluation or quality improvement projects
      - Understanding and addressing gaps in patient care
    - Interdisciplinary research collaborations
    - Administrative opportunities and involvement in organizational, legislative or institutional committees
    - Encourage collaborative decision-making in team settings
    - Providing educational talks on value and utility of neuropsychology to other services, promoting collaboration
    - Supervise, mentor, and educate other trainees and professionals from other disciplines

Training in Collaborative Care

- Achieving Competencies for Neuropsychology Trainees
  - **Post-license Training**
    - Seek CE opportunities to learn and develop skills
      - APA offers CEs related to integrated primary care
    - On-the-job training
    - Participate in legislative and institutional committees
    - Educate other disciplines about neuropsychology
      - Communicate the value of neuropsycholoy services
      - Learn about other disciplines as well
    - Be open to adapting communication (written and oral) to the setting and team
    - Seek or develop team-based training opportunities for your team

Additional Information & Resources

- *Archives of Clinical Neuropsychology,* Vol. 33, Issue 3

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- AIMS Center (University of Washington)
  - https://aims.uw.edu/
- APA/APM
- WIHPT: Webkit for Interdisciplinary Health Service Psychology Trainees

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