Good to Great: Improving Interdisciplinary Team Dynamics and Optimizing Evidence-Based Delivery of Integrated Behavioral Health Using RELATED

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Faculty Disclosure

The presenters of this session <u>have NOT</u> had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- List the methods by which stakeholders were repeatedly engaged to develop an intervention targeted at need.

- Describe the RELATED intervention and how it improves team dynamics, PCP care of patients with co-morbid medical and mental illness, and adherence to evidence-based components of integrated behavioral health models.

- Report the pilot results of RELATED and discuss those in the context of future opportunity within the field.

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Learning Assessment

- A learning assessment is required for CE credit.

- A question and answer period will be conducted at the end of this presentation.

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BURDEN OF MENTAL ILLNESS

❖ Pervasive in the US

❖ Worsens outcomes in patients with chronic medical illnesses (both morbidity and mortality)

❖ 43%-60% of treatment occurs in primary care

❖ **Gap: Primary care providers have concerns about their training to treat mental illness**

Mechanic, 2014
http://www.ahrq.gov/research/mentalhth.htm

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TEAM-BASED MODELS CAN IMPROVE OUTCOMES FOR PATIENTS WITH MENTAL ILLNESS IN PRIMARY CARE

❖ The Collaborative Care Model and other integrated behavioral health models improve outcomes

❖ Primary care practices slow to adopt these models

❖ Financial issues often cited as the cause

❖ **Gap: PCPs view their role within the healthcare team quite differently from how other team members view their role**

Song et al., 2015

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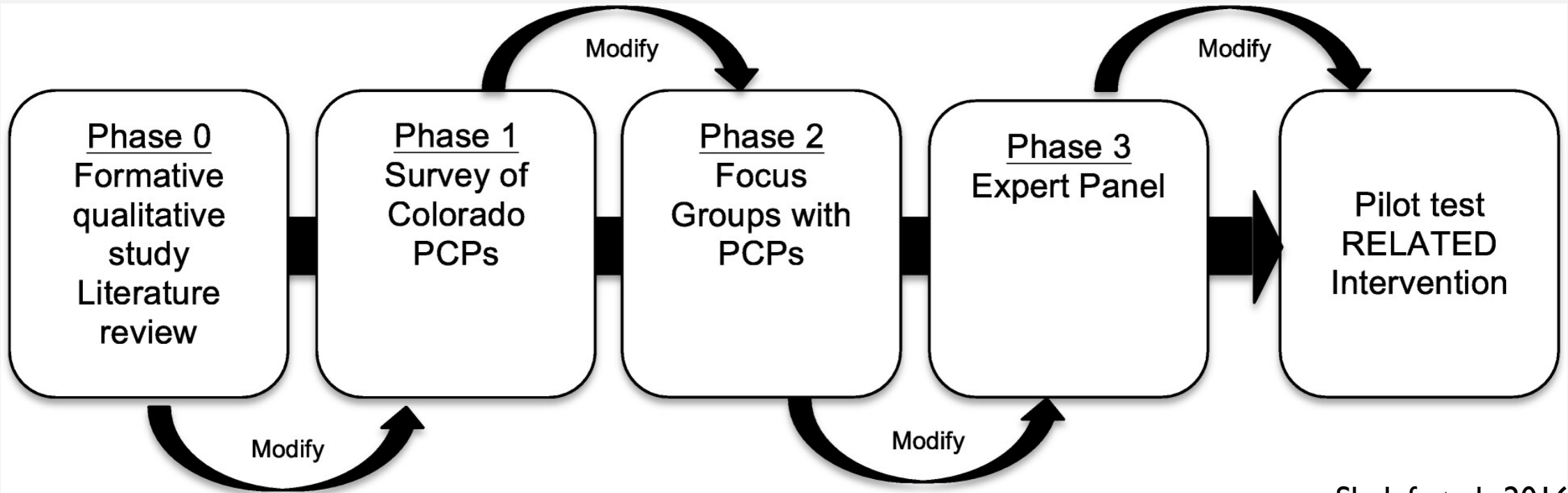est. 1860
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PRACTICE FACILITATION

❖Practice facilitators (PFs) are health care professionals trained in primary care practice improvement methods who facilitate system-level changes

❖Practice facilitation has been shown to improve multiple aspect of team-based care:
  ❖improved communication across different specialties
  ❖increased adoption of practice change consensus building

❖**Gap: However, it often does not directly address relational aspects of team culture that can be integral to sustainable practice change.**
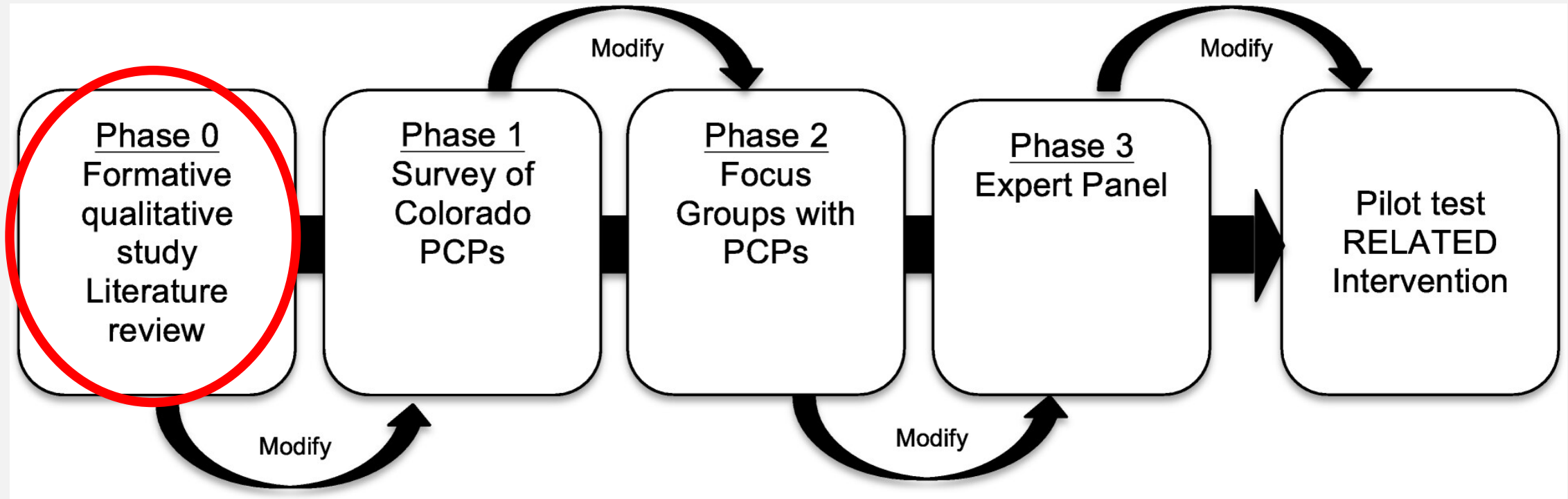
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RELATIONAL TEAM DEVELOPMENT (RELATED): A TAILORED PRACTICE FACILITATION INTERVENTION

❖ Developed to address:
  ➢ Gaps in PCP skills and knowledge in management of complex patient with mental illness
  ➢ Dysfunctional team dynamics that can impede sustained practice change
❖ Delivered by a practice facilitator with specialized training in clinical psychology to influence relational aspects of team culture

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ITERATIVE DEVELOPMENT OF RELATED INTERVENTION

Phase 0
Formative qualitative study
Literature review

Modify

Phase 1
Survey of Colorado PCPs

Modify

Phase 2
Focus Groups with PCPs

Modify

Phase 3
Expert Panel

Modify

Pilot test RELATED Intervention

Shelef et al., 2016
Loeb et al., 2019

ITERATIVE DEVELOPMENT OF RELATED INTERVENTION

PHASE 0: FORMATIVE QUALITATIVE STUDY

❖ Methods: in-depth semi-structured interviews of 15 internal medicine PCPs working in two academic and three community health clinics
  - ❖ examine perceptions of patient complexity and identify domains that PCPs felt affected care of patients they defined as complex

Loeb et al., 2016

PHASE 0: FORMATIVE QUALITATIVE STUDY

❖Results:
  ❖PCPs have variable competence levels in treating mental illness
  ❖Both clinic-level and larger system barriers inhibit PCPs' ability to care for patients with mental and physical illness
  ❖PCPs need additional training in patient communication
  ❖PCPs prefer didactic and experiential training in the management of patients with mental and physical illness

Loeb et al., 2016

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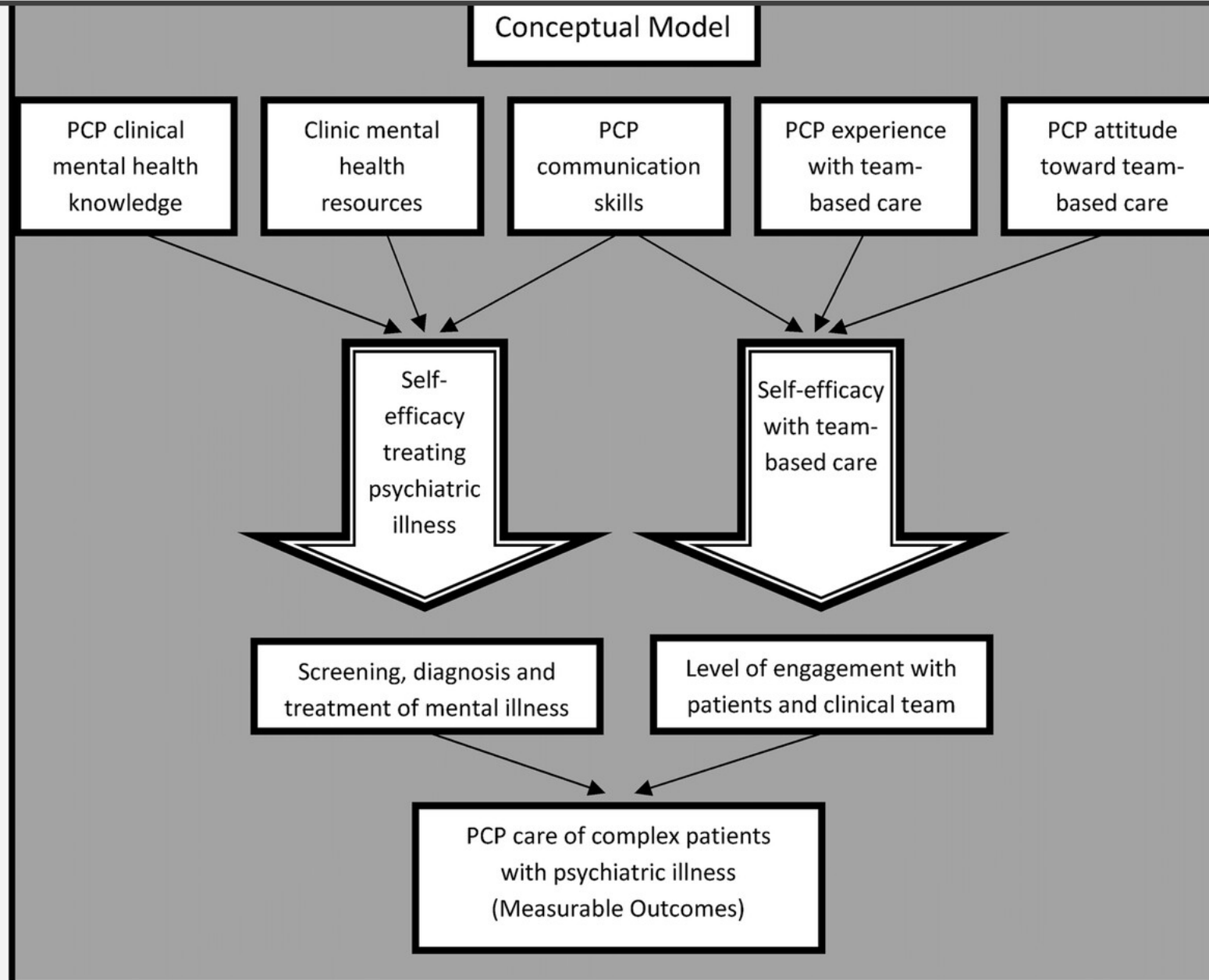UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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Loeb et al., 2018

PHASE 0: LITERATURE REVIEW

❖ Methods: Informed by the needs expressed by PCPs in their management of patients with mental and physical illness in the primary care setting, we performed a review of practice facilitation and psychology clinical supervision models.

  ❖ These constructs were selected due to their known impact on factors similar to those hypothesized in our PCP self-efficacy model.

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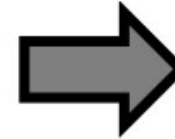UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

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Traditional Practice Facilitator

+

Clinical Psychotherapy Supervisor

→

Relational Team Development

Select Roles
1. Train practices in QI processes and CCM techniques
2. Serve as educational resource
3. Provide feedback to practices
4. Help practices problem-solve
5. Promote adoption of specific evidence-based practices

Select Roles
1. Case management, monitoring, and quality control
2. Emotional Support and processing
3. Develop supervisee's (PCP) skills and knowledge
4. Assist clinical decision-making

Modified Roles
1. Train PCP in CCM techniques
2. Serve as educational resource
3. Provide feedback to PCP
4. Help PCP problem-solve
5. Coach PCP in adoption of evidence-based practices
6. Case management
7. Emotional Support and processing
8. Develop supervisee's skills and knowledge
9. Assist clinical decision-making

QI= Quality Improvement; CCM= Chronic Care Model

RELATED AT THE END OF PHASE 0

❖ Practice facilitator would observe PCPs in visits with patients with co-morbid mental and physical illnesses and provide tailored feedback on identified targets:
  ❖ PCP clinical knowledge
  ❖ Mental health resources available in clinic
  ❖ PCP communication skills
  ❖ PCP experience with team-based care
  ❖ PCP attitudes toward team-based

ITERATIVE DEVELOPMENT OF RELATED INTERVENTION
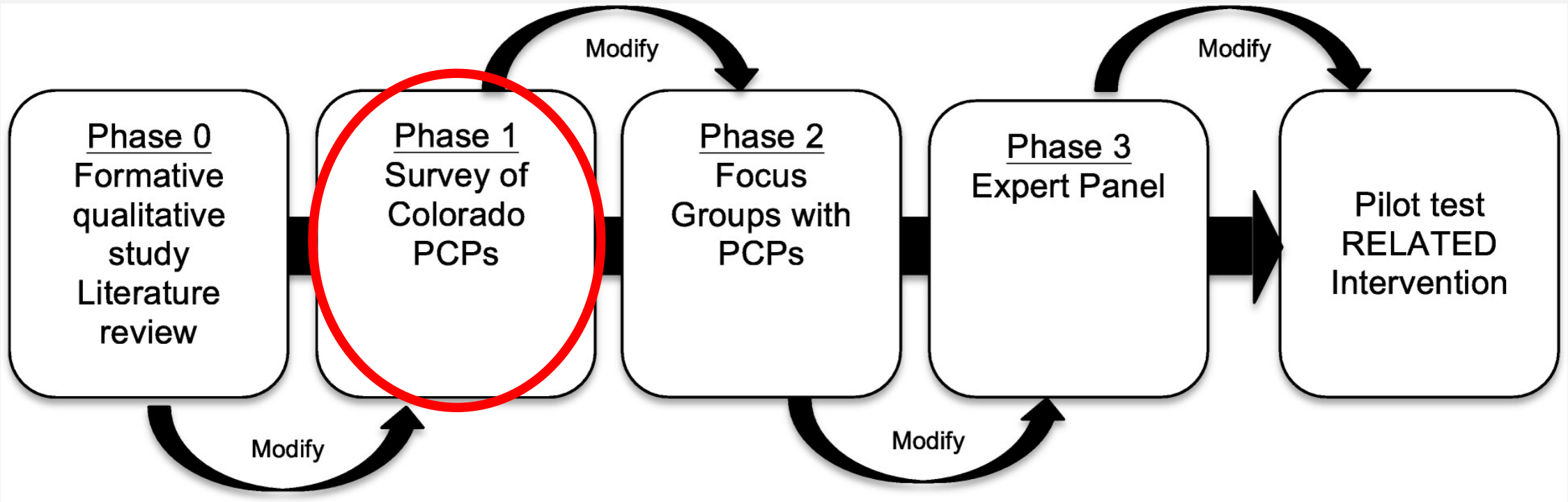
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PHASE 1: SURVEY OF COLORADO PCPS

❖ Methods: In the survey of 900 Colorado PCPs, we validated two self-efficacy scales:
  ❖ Team-Based Care (TBC) - communication within the team, care coordination, population management, self-management support, and continuity of care
  ❖ Mental Illness Management (MIM) – diagnosis and treatment of depression, generalized anxiety disorder, and bipolar disorder, and management of concomitant psychiatric and medical illness

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PHASE 1: SURVEY OF COLORADO PCPS

❖ Results:
  ❖ 49% response rate (441 of 900 surveyed)
  ❖ On a 0 ("not at all confident" to 10 ("extremely confident") Likert scale, mean scores (standard deviation) were 7.7 (1.7) and 7.1(1.4) for the TBC and MIM scales, respectively
  ❖ The multivariable analysis supported a focus on PCP mental illness management knowledge, communication skills, attitudes toward team-based care, and experience of treating serious mental illness such as bipolar disorder.

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RELATED AT THE END OF PHASE 1

❖Practice facilitator would observe PCPs in visits with patients with co-morbid mental and physical illnesses and provide tailored feedback on identified targets from Phase 0 PLUS emphasizes:
  ❖Communication skills
  ❖Mental illness management evaluation and treatment,
  ❖Attitudes toward engaging their interdisciplinary team

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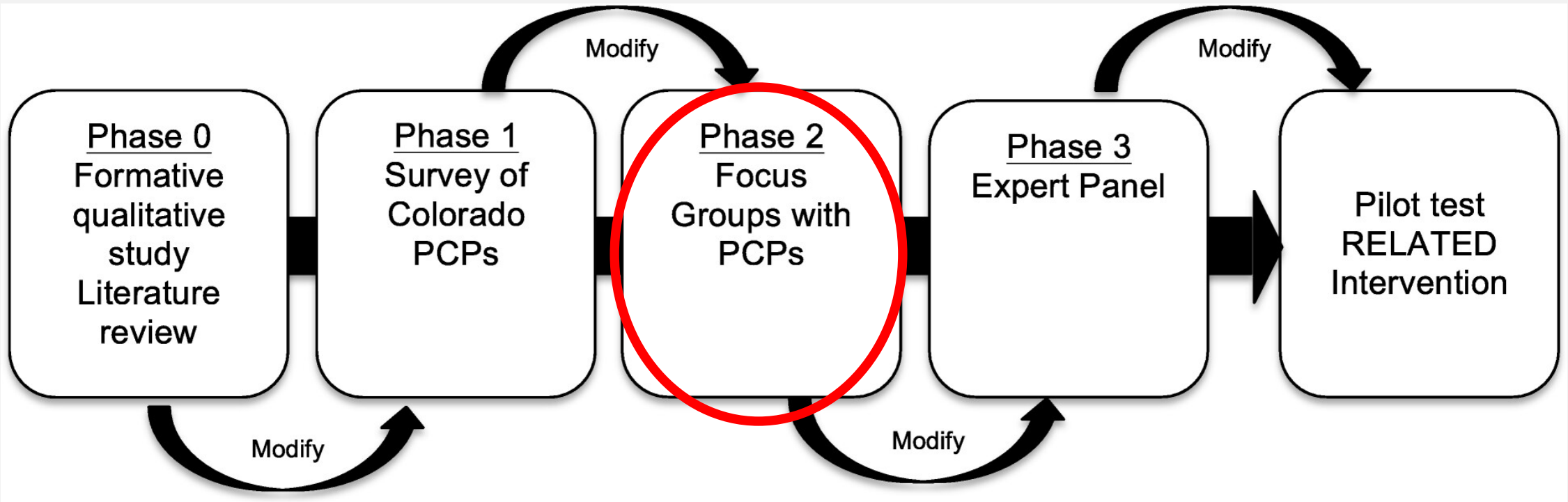SCHOOL OF MEDICINE

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ITERATIVE DEVELOPMENT OF RELATED INTERVENTION

PHASE 2: FOCUS GROUPS WITH PCPS

❖ Methods: We conducted focus groups with local PCPs from stakeholders similar to those who would receive the intervention.

  ❖ Focus groups were used to obtain feedback on the modified RELATED intervention that emerged following survey results.

  ❖ Two research team members reviewed the transcripts to identify thematic elements in a content analysis.

PHASE 2: FOCUS GROUPS WITH PCPS

❖Results: two focus groups with a total of 9 PCPs and 1 care manager

    ❖Participants thought the one-on-one coaching sessions could reasonably be expected to impact PCP behavior with their patients and that it would be therapeutic for the stress of managing patients, calling it "therapy for doctors."

    ❖However, they did not think it would help them work within a team and participate in practice improvement.

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RELATED AT THE END OF PHASE 2

❖ Practice facilitator would observe PCPs in visits with patients and provide tailored feedback.
❖ PLUS practice facilitator would facilitate a practice change activity in which PCPs could engage with their interdisciplinary team members.
  ❖ The team would work together on developing and implementing a clinical practice improvement to address an identified gap in care. This activity would offer the practice facilitator the opportunity to observe and intervene on team dynamics in real time.

ITERATIVE DEVELOPMENT OF RELATED INTERVENTION

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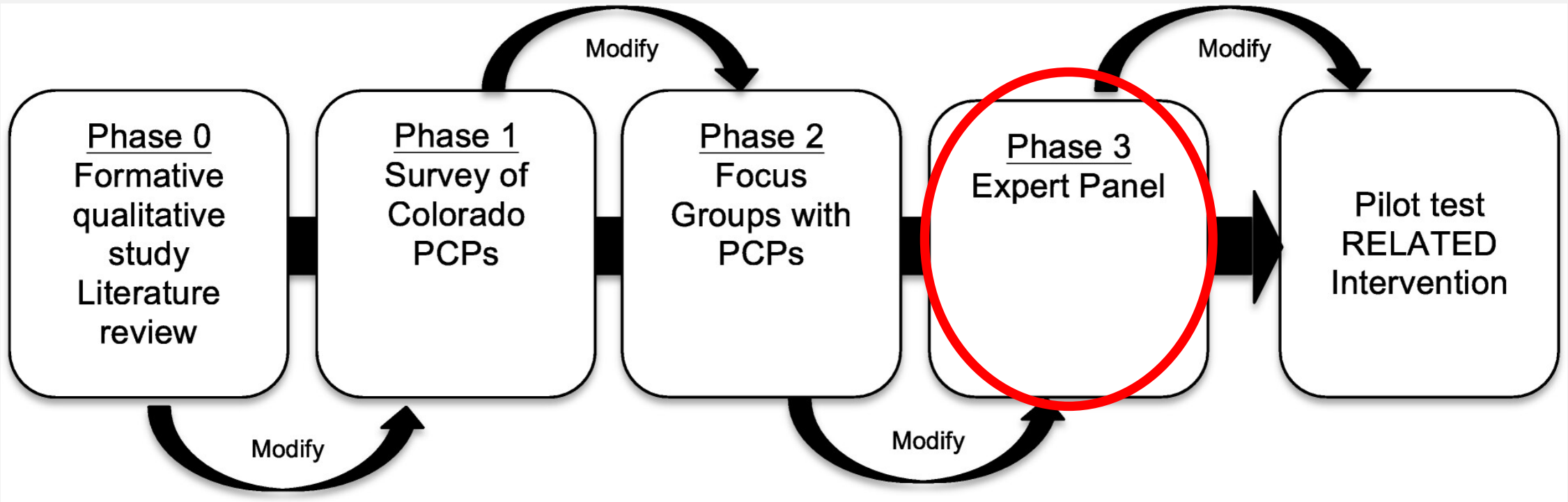
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PHASE 3: EXPERT PANEL

❖ Methods: Two 90-minute phone calls with the research team and expert panel.
  - ❖ Medical and mental health professionals were recruited.
  - ❖ Members of the expert panel were chosen based on expertise in the subject area and methods planned for the RELATED intervention.
  - ❖ Two research team members reviewed the transcripts of the expert panel calls and outlined key findings. These were consolidated into themes.

PHASE 3: EXPERT PANEL

❖ Results: The RELATED intervention was finalized and made pilot ready through the expert panel.
  - ❖ We developed a detailed structure for the one-on-one coaching sessions and the practice change activity.
  - ❖ Burden for the PCPs and clinical team was a primary concern.
  - ❖ One-on-one coaching sessions should lead the intervention to enable rapport development and clinic culture understanding, in addition to direct intervention benefits.
  - ❖ Noted the absence of patients and recommended including them in the practice change activity.

PILOT READY RELATED AT THE END OF PHASE 3

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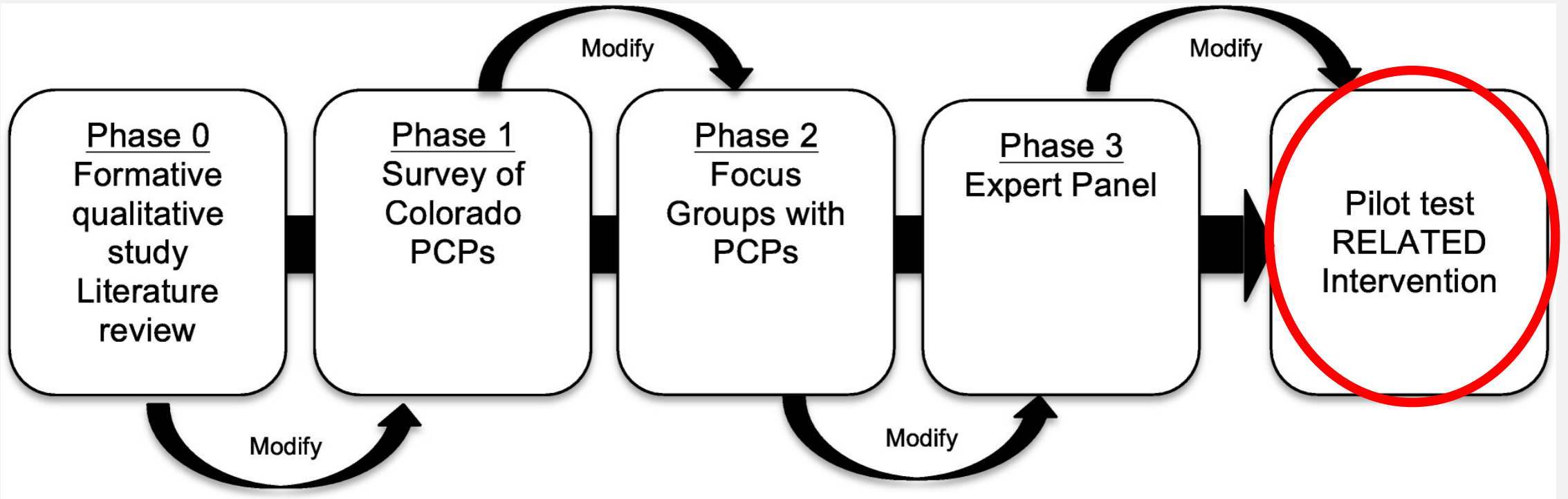
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Table 1: Components of Relational Team Development (RELATED)

	PCP Clinical Supervision and Coaching (Coaching)	Practice Change Activity Team (PCAT)
Description	Practice facilitator shadows PCPs in 4+ visits with complex patients - Use clinical psychology and coaching techniques in one-on-one debriefs with PCPs after visits	Practice facilitator guides clinical team (with PCP participants) through a practice change activity in 6 meetings focused on the care of complex patients with mental illness -In this process maladaptive team dynamics are identified and addressed
Content	-Mental health diagnosis and treatment -Patient and team communication skills -Tailored to individual goals -Personal transformation focus	-Quality improvement methods -Evidence-based practices for team-based care -Team dynamics
Participant(s)	-PCPs -Patients whose visits are observed	-PCPs -Staff representatives -Leadership -Patient representatives (coaching component)

ITERATIVE DEVELOPMENT OF RELATED INTERVENTION

PILOT TEST RELATED INTERVENTION

Loeb et al., in press

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SETTING AND PARTICIPANTS

❖ 2 primary care clinics associated with a safety-net hospital in Denver, Colorado 2017-18
❖ PCPs recruited for the full intervention
❖ Complex patients defined as those with a mood disorder or anxiety disorder + a chronic medical illness
❖ Clinic staff and leadership recruited for the PCAT only
❖ Patient representatives in PCAT recruited from those shadowed in Coaching component

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PRIMARY OUTCOME MEASURES

❖ **Feasibility:** ease of recruitment and implementation of the RELATED intervention

❖ **Acceptability:** modified 4-item measure of acceptability for behavioral health interventions

➢ 4-point Likert scale

➢ 1 month and 6 months post intervention

SECONDARY OUTCOME MEASURES

❖ **Team-based Care and Mental Illness Management Self-efficacy**

➢ Our team developed and validated two self-efficacy scales

➢ Based on Bandura's social cognitive theory

➢ PCPs (n = 402, response rate = 49%) from diverse practice settings completed surveys

➢ Reported on a scale of 0 to 10 with 0 being 'not at all confident' and 10 being 'extremely confident'

❖ Additional Measures: modified Communication Skills Self-assessment, Mental Health Knowledge and Management Instrument, Attitudes toward Health Teams Scale, and Team Climate Inventory

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QUANTITATIVE ANALYSIS

❖ Descriptive data analysis

❖ Pre-post evaluations of survey measures using paired t-tests

❖ All statistical tests performed with a level of significance of 0.05

❖ Data analyzed using SAS version 9.4 software

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QUALITATIVE FOCUS GROUPS

❖ Three focus groups:

   ➢ PCPs

   ➢ staff and patients

   ➢ clinic leadership

❖ Semi-structured interview guide

❖ Recorded and Transcribed

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QUALITATIVE ANALYSIS

Content analysis on focus groups:

❖ 2 members of the research team identified codes using:

➢ Pre-identified themes (feasibility and acceptability)

➢ Team-based inductive process

❖ All transcripts were double coded with discrepancies reconciled through consensus

❖ Coded transcripts were entered into Atlas.ti (vs 8.0) for data management

❖ Coded transcripts were analyzed to identify major themes

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Table 1: Provider Demographics (N=18)	
Gender N (%)	
Female	12 (67)
Male	6 (33)
Age M (STD)	39 (7)
Race N (%)	
African-American/ Black	1 (6)
American Indian/ Alaskan Native	1 (6)
Asian (includes Southeast Asian, Indian)	3 (17)
Caucasian/ White	11 (61)
Other	1 (6)
Ethnicity N (%)	
Hispanic	2 (11)
Non-Hispanic	16 (89)
Professional Background N (%)	
Nurse Practitioner	4 (22)
Physician	12 (67)
Physician Assistant	2 (11)
Medical Specialty N (%)	
Family Medicine	7 (39)
Medicine-Pediatrics	1 (6)
Internal Medicine	10 (56)
Years since completing residency N (%)	
Missing	3 (17)
10 – 19	4 (22)
5-9	4 (22)
< 5	7 (39)
N=Number; SD=Standard Deviation	

Table 2. Acceptability Survey Results

Overall N=36	1 month N=36	6 month N=33
M (SD)	M (SD)	M(SD)
3.7 (0.3)	3.8 (0.3)	3.7 (0.4)

SD= Standard Deviation

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Table 3. Pre-post Changes in PCP Survey Scores

Survey Scale/Subscale	Pre-Post Mean Difference (95%CI)	Paired T test P-value
Team Based Care SE (0-10)	0.8 (-0.3,1.9)	0.14
Mental Health Care SE (0-10)	0.9 (0.5,1.4)	<.01
Communication SE (0-10)	0.4 (-0.1,0.9)	0.09
Overall Knowledge of Treatment (0-100)	4.0 (-0.8,8.8)	0.10
Knowledge of MDD Treatment	6.7 (0.1,13.3)	0.05
Knowledge of GAD Treatment	2.9 (-4.3,10.2)	0.40
Knowledge of BPD Treatment	3.1 (-4.7,10.9)	0.42
Attitude Toward Team Based Care (1-5)	-0.1 (-0.3,0.1)	0.38
Team Climate (1-%	-0.1 (-0.4,0.3)	0.61

SE = Self-efficacy; MDD = Major Depressive Disorder; GAD = Generalized Anxiety Disorder; BPD = Bipolar Disorder

Table 4. Focus Groups: feasibility and acceptability

Component	Quote
Acceptability positive	I think it was a good use of our time. I think it was something that needed to be looked at with better access for behavioral health consultants, and I think it's probably going to make a difference. –Nurse Leadership
Acceptability negative	In terms of how many hours have we spent doing that [PCAT]. Even though in the world of QI it's pretty efficient, for me it's not. It's probably ten hours in the past couple months… That's a lot of time."–PCP
Acceptability (staff) Effect on hierarchy	It was nice to have input on what was going on in the clinic and how to troubleshoot issues and just to be involved as a medical assistant. We usually don't get the opportunity to work as a group and have that kind of input." –Staff
Feasibility positive	I liked how Sxxx [PF] worked through the project cause I think it was a little difficult in the beginning and helping us decide what we wanted to work, but I think you did a really good job at narrowing it down and getting it to something that was attainable. –Leadership

Focus group participants: 13 PCPs, 6 leaders, 12 staff

Table 5. Focus Groups: Team-based Care

Component	Quote
Team functioning	It's a different level of respect because now we have more of an understanding of what each of our role is, and how important it is once the patient reaches that certain person because we didn't have an understanding of what their job entails, and how much work they're putting in to it. –Staff
Effect on hierarchy	It was nice to have input on what was going on in the clinic and how to troubleshoot issues and just to be involved as a medical assistant. We usually don't get the opportunity to work as a group and have that kind of input." –Staff
Patient perspective	It's changed my perspective… It makes me a little bit more patient-centered when I deal with things… aware of what's really going on in the clinic or why people are responding the way they are. –Staff
Inclusivity	I liked the chance to come together with lots of team members in different roles across the clinic… It made me feel more connected with the clinic. –Staff

Focus group participants: 13 PCPs, 6 leaders, 12 staff

CONCLUSIONS

❖ **Feasible:** recruited more PCPs and staff than originally planned and the intervention implementation had no major obstacles

❖ **Highly acceptable** among PCPs, staff, and clinic leadership on both survey and focus groups

❖ Statistically significant improvements in PCP self-efficacy in management mental illness and a trend toward improvement in self-efficacy in team-based care (though not powered for those outcomes)

❖ Coaching component felt to be higher value than PCAT for PCPs

❖ RELATED has the potential to significantly impact outcomes for patients with mental illness in primary care

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NEXT STEPS

❖ Submitted R-21 to NIMH for pilot testing RELATED as an implementation strategy for measurement-based care

❖ Submitting AHRQ grant for pilot testing RELATED as an implementation strategy for advanced care planning for chronic medical illness

❖ Developing and producing online RELATED facilitator training with support of a local foundation

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THANK YOU!

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Session Survey

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