PARTNERs Project

Presenters:

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AGENDA

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Introduction	Population	Engagement	Experience of PCPs	Telephone Acceptability
Vanessa Garofalo	Eleni Kelly	Alexandra Kubica	Annie Zhu	Salaha Zaheer

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Introduction

Presenter Disclosure

Presenters:

- Vanessa Garofalo
- Eleni Kelly
- Alexandra Kubica
- Salaha Zaheer
- Annie Zhu

All presenters have not received any commercial support and have no conflicts to declare.

Learning Objectives

- The role of a Mental Health Technician as developed for the CAMH PARNTERs Project in supporting and enhancing the interprofessional collaboration between primary care and mental health providers
- Factors that influence the implementation of evidence-based integrated care projects in addressing mental health and addiction in the primary care settings
- Understanding factors that influence the acceptability and challenges of telephone-based mental health care from patients' perspectives

CAMH PARTNERs Project

- Randomized controlled trial comparing Enhanced Usual Care with Integrated Care.
- Aim 1: Assess implementation of telephone-based intervention for common mental health problems in primary care patients in partnership with 11 Family Health clinics (FHTs, FHOs, CHCs, solo providers) in Ontario.
  - Our program is focusing on: depression, anxiety, and at-risk drinking.
- Aim 2: To compare the effectiveness of Enhanced Usual Care and a telephone based intervention which includes psychoeducation, regular monitoring and support from a Mental Health Technician.
- Goal: To have 500 randomized participants.

Project Design

Enhanced Usual Care	Integrated Care (Intervention)
❖ Contacted for baseline, 4, 8, and 12 months assessments. ❖ Summaries of the assessments sent to their PCP who continue care as usual.	❖ Contacted for baseline, 4, 8, and 12 months assessments. ❖ Summaries and recommendations sent to PCP. ❖ Patient contacted on a regular basis to monitor their symptoms, treatment adherence, and to provide psychoeducation. ❖ MHT sends monthly updates to PCP and contacts them on an as-needed basis.

What is a Mental Health Technician?

- Bachelor level provider (BA, BSc) with specialized training and experience working with diverse patient populations
- Conducts regular telephone monitoring with intervention participants:
  - Symptom monitoring using evidenced based tools (PHQ-9, GAD-7, 7 day TLFB)
  - Treatment adherence (Side effects, medication compliance)
  - Goal setting and supporting healthy life style changes
  - Psychoeducation (antidepressants, sleep hygiene)
- Supervised by Project Psychiatrist

Role of the Primary Care Provider

- Identify and refer patients who meet the eligibility criteria.
- Treatment decisions made solely by them in collaboration with the patient, based on recommendations sent by the research team.
- Communicate with the Mental Health Technician monthly or on an as-needed basis to provide and receive updates on patients' progress and treatment plan.

Patient Identification

Patient identified with **depression, anxiety, or at-risk drinking** and meets the eligibility criteria:

Inclusion Criteria:

- Age 18 and older
- Receiving care from a primary care provider in your FHT
- Access to a telephone
- Willingness and ability to converse in English by telephone
- Willingness and ability to provide informed consent

Exclusion Criteria:

- Complex mental health disorder (BPD, OCD, PTSD, etc.)
- Current substance abuse or dependence
- Clinically significant cognitive impairment
- High risk for suicide
- Physically unstable (needing to be hospitalized)
- Expected by one's PCP to die during the next 6 months, i.e. terminal illness

Note: If patient is already part of another program, seeing a psychiatrist/counsellor, or taking an antidepressant; they are still **ELIGIBLE** to participate in our study.

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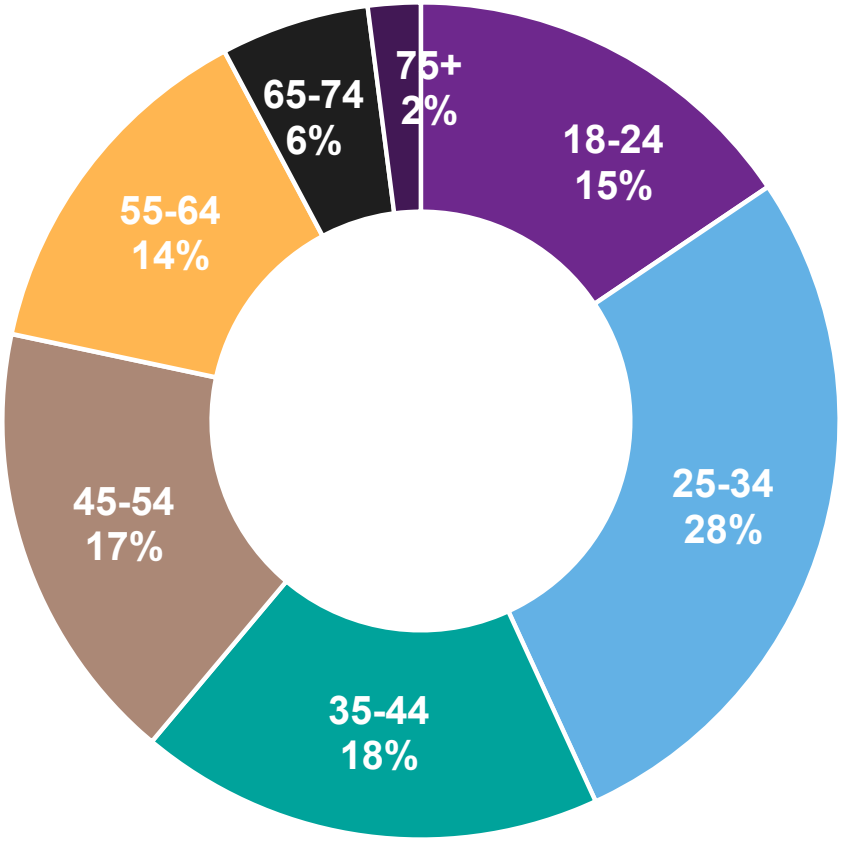
Population

Site Locations

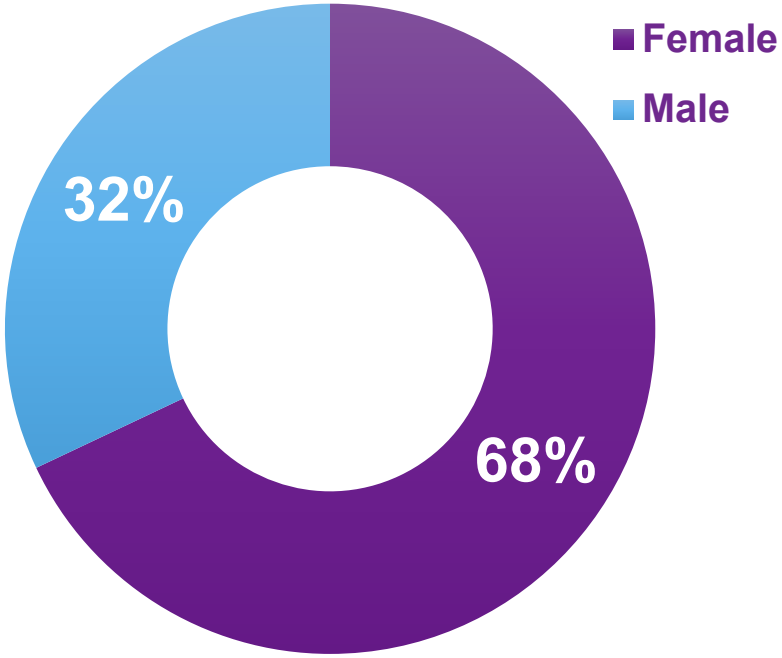
- As of May 31, 2018 the project has collaborated with 8 unique organizations at 23 different sites:
  - FHT, FHO, 8 individual solo practitioners in private practice, & a University healthcare center
- 180 PCPs (family physicians, social workers, and nurse practitioners)
- Coverage across urban, suburban, and rural settings across Southern Ontario

Patient Demographics

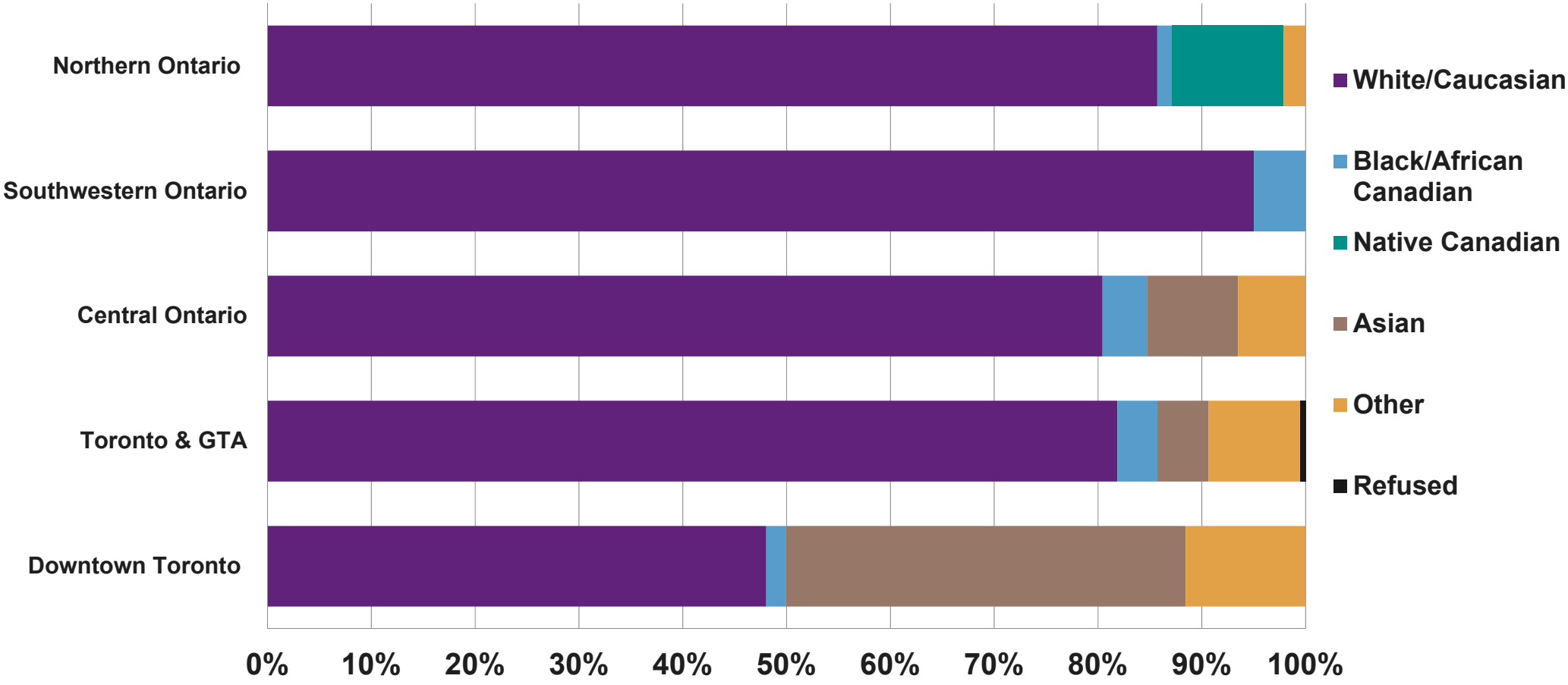
Age at onset of baseline assessment



Self identified gender

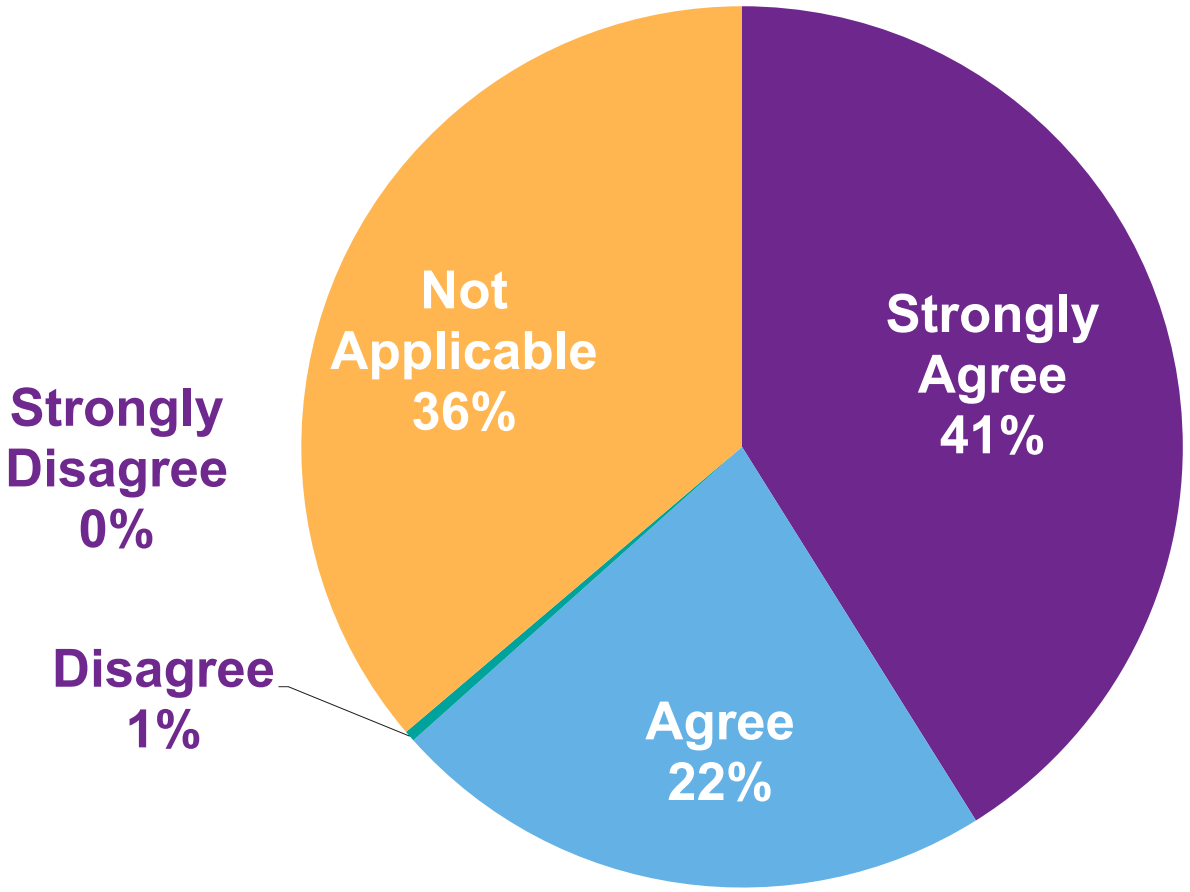


Ethnicity of participants by geographic regions



Ethnicity	PARTNERs	OHS
White/Caucasian	↓ 79.09%	↑ 82.4%
Black/African Canadian	↑ 2.96%	↓ 2.4%
Native Canadian	↑ 3.15%	↓ 0.3%
Asian	↑ 8.33%	↓ 7.9%

Project Satisfaction Survey Results



"Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, race)"

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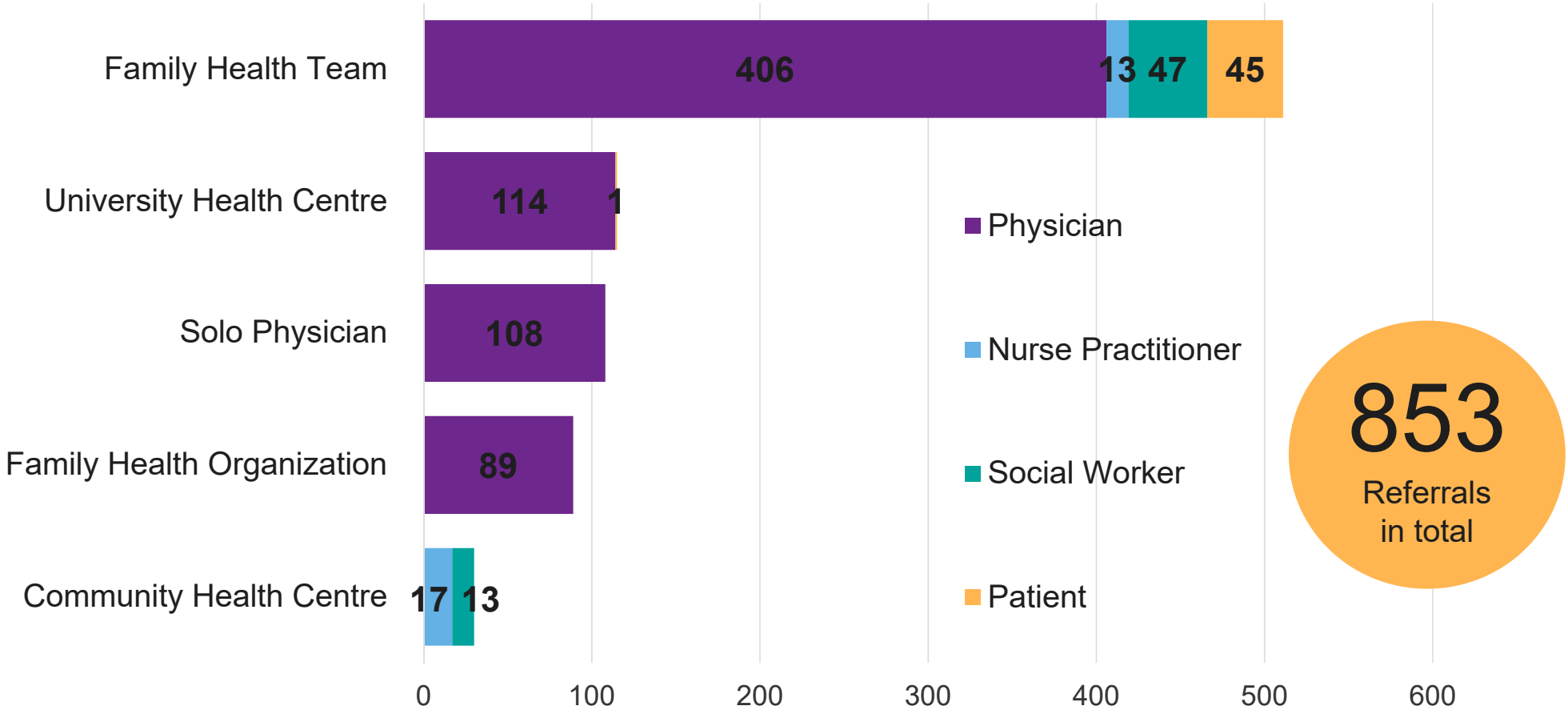
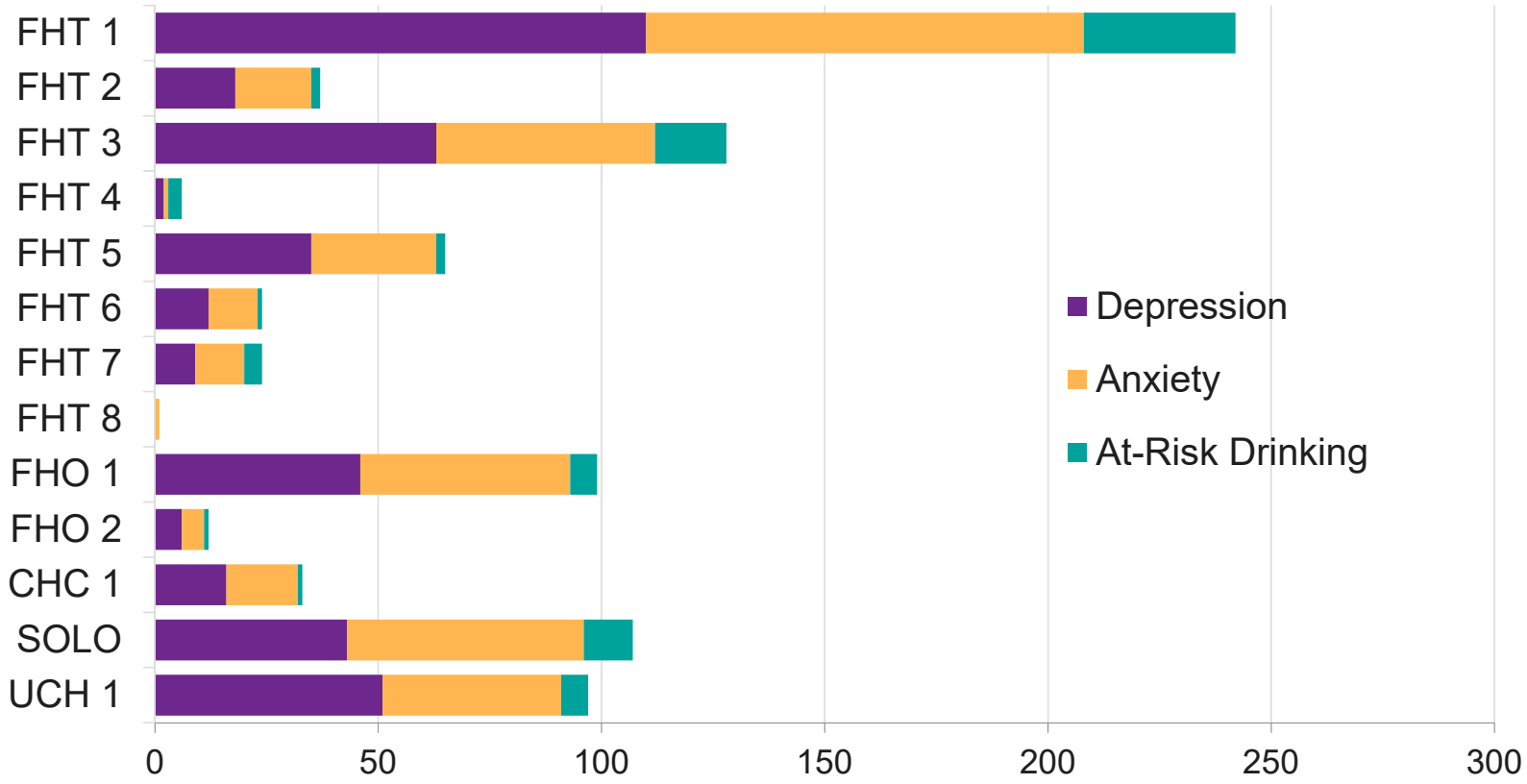
Engagement

Referral Source



Reason for Referral



Engagement

Site	Location	Number of Referring PCPs	Total Number of PCPs	Percentage Engaged
FHT 1	Urban	13	13	100.00%
FHT 5	Rural	11	11	100.00%
FHO 1	Suburban	8	9	88.89%
UCH 1	Urban	18	24	75.00%
SOLO	Mixed	5	7	71.43%
CHC 1	Rural	5	8	62.50%
FHT 3	Suburban	20	43	46.51%
FHT 2	Suburban	10	24	41.67%
FHT 7	Rural	2	5	40.00%
FHT 8	Suburban	2	10	20.00%
FHO 2	Suburban	2	14	14.29%
FHT 4	Suburban	1	12	8.33%
FHT 6	Rural	0	21	0.00%

Strategies to Improve Engagement

- Opening up the referral process to all team members
- Sending quarterly newsletters to provide updates about FHTs progress
- Circulating referral information ‘Tip Sheet’
- Facilitating Lunch and Learns at FHTs
- Providing PCPs with information cards to give to interested patients
- Sending monthly updates regarding referral numbers to teams

Discussion Question 1:

What challenges would you anticipate with implementing this type of integrated care model ?

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Experience of PCPs

Learning Objectives

- Analyze barriers and facilitators of implementing collaborative care intervention studies in primary care settings
- Recommend practical strategies to increase uptake of collaborative care research in diverse primary care practices
- Describe how implementation science frameworks can guide study design, data collection, and interpretation of qualitative findings to advance collaborative care

Understanding referral patterns

- PARTNERs experienced variable and overall low referral rates from primary care providers (PCPs)
- Seek to understand PCPs' perspectives and preferences regarding:
  - Components of collaborative care models
  - Participation in research (study referrals)
  - Barriers and enablers to uptake of the care model as implemented in PARTNERs
  - Design and conduct of future collaborative care research

Methods

Semi-structured telephone interviews

Stratified purposive sampling framework

- Urban, suburban, rural sites
- High, low, no referrals to PARTNERs (practice, provider)

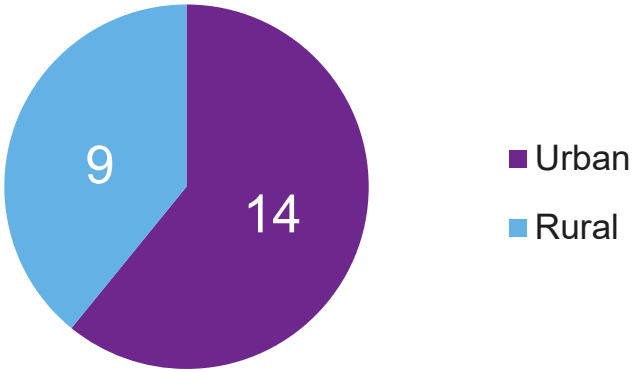
Thematic analysis performed to understand PCPs' experiences

- Guided by Consolidated Framework for Implementation Research (CFIR) & Theory of Planned Behavior (TPB)

Results

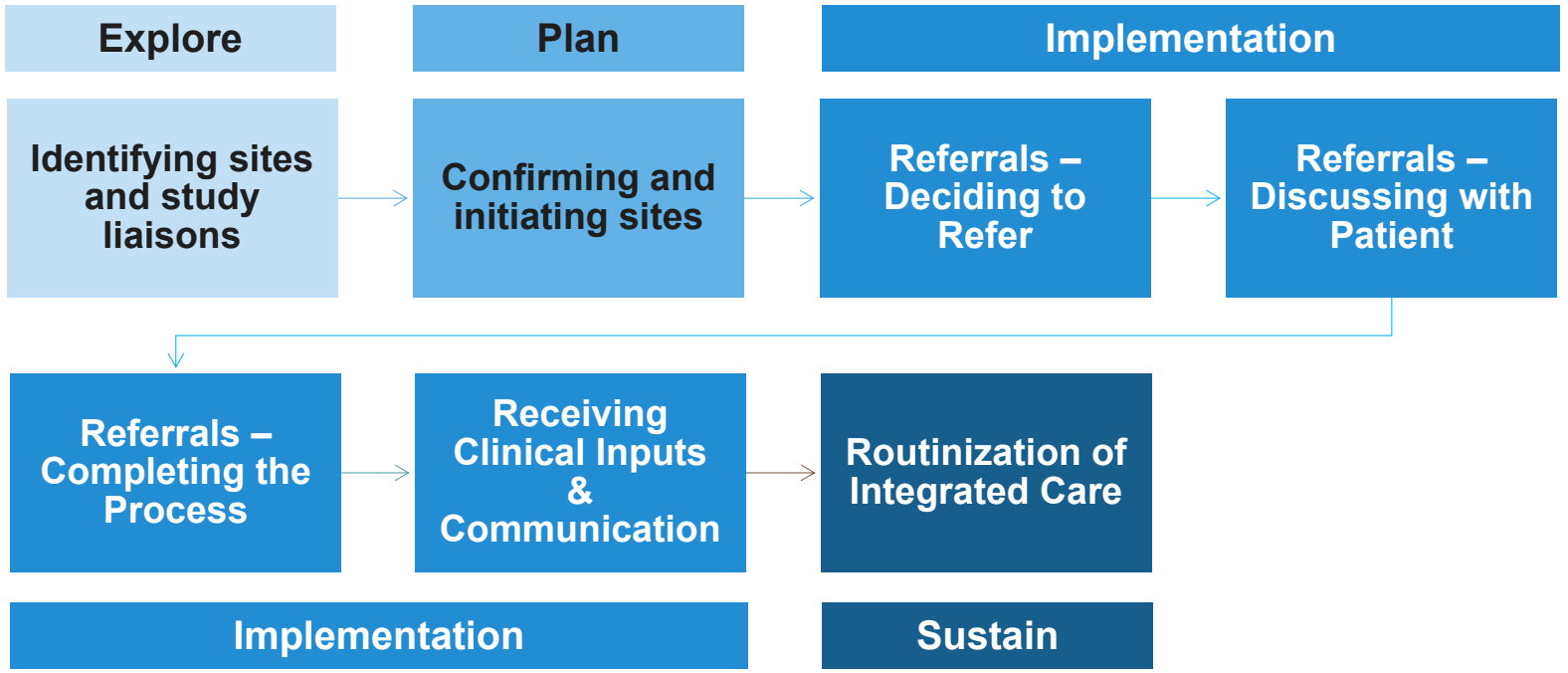
Interviewed 23 key informants from 12 of 14 practices across Ontario participating in PARTNERs

Geographic location

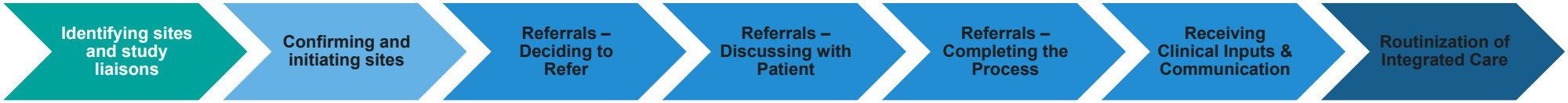


Health Discipline	Percent (%)
Family physician	52%
Nurse practitioner	22%
Executive Director	13%
Social Worker	9%
Registered nurse	4%

Experience of PCPs



Experience of PCPs

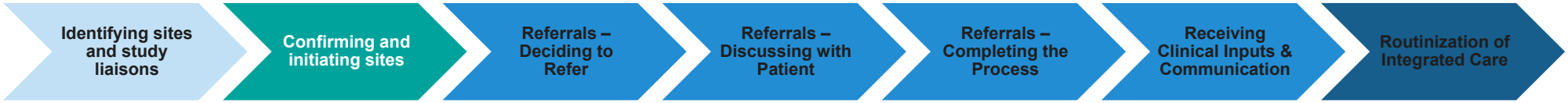


Identifying sites and study liaisons:

- Credibility of organization
- Perceived need in the site and relative advantage of intervention

"Mental health issues [are] absolutely huge in this area. And there's not much resources."

Experience of PCPs

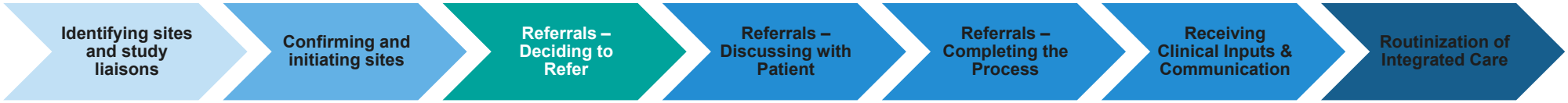


Confirming and initiating sites:

- Variable team & provider buy-in
- Study leaders & champions
- Creating site-specific infrastructure and process

"I would have to be convinced that this would take minimal time from our frontline staff and providers, and at the same time, how do we roll it out knowing it's not going to be a make-work on anybody within the organization."

Experience of PCPs

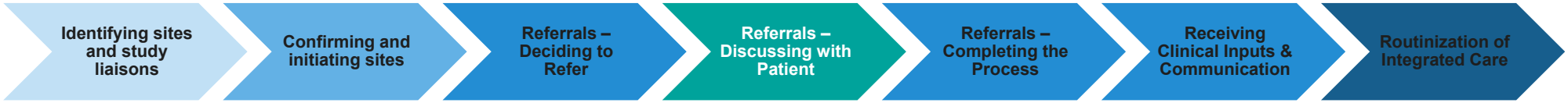


Referrals – Deciding to Refer:

- Forgetting & remembering
- Anticipated outcomes and experience of previous patients
- Perceptions of the study as time-saving vs. time burden
- Acceptability of randomization based on patient acuity
- Eligibility criteria

"The main things I think about are if I think it's going to have a positive patient outcome benefit, either in the study or after the study. And 2) is it going to be a lot of extra work for me?"

Experience of PCPs

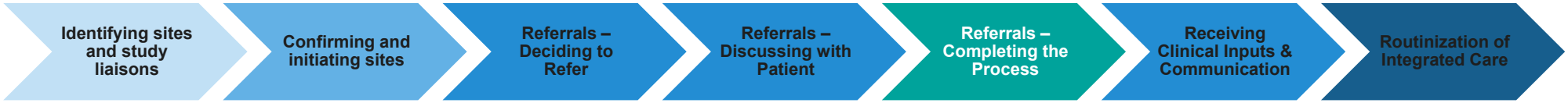


Referrals – Discussing with Patient:

- How study is presented to patients
- Patients often declined referrals – don't know why

"I didn't really have any other reservations. Some patients did. [...] Not everyone I recommended it to said yes, sign me up."

Experience of PCPs

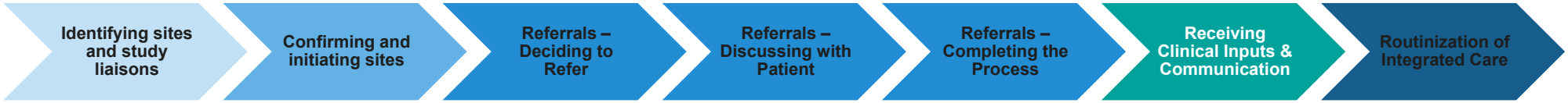


Referrals – Completing the Process:

- Identification of eligible patients and referral process is often physician-reliant and visit-triggered
- Integration into existing workflow
- Ease of referral and rapid response

"Practically it's very easy to refer. Like we just put it as a form on our EMR. […] And so it's pretty easy to refer… it's not long to recommend to someone."

Experience of PCPs

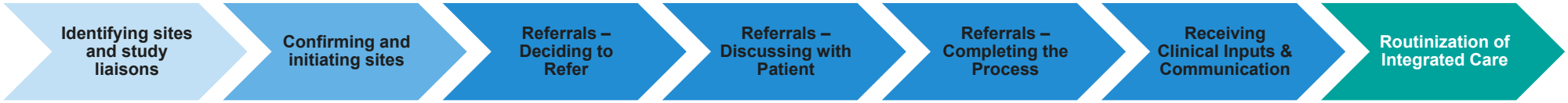


Receiving Clinical Inputs & Communication:

- Value clinical input as resource to patients and referring providers
- Reports are meaningful reminder of the study
- Recommendations may have already been tried in the past → reducing value of reports

"[The report] made me feel more involved in the patient care, as well as sort of having a side effect of reminding me about the project."

Experience of PCPs

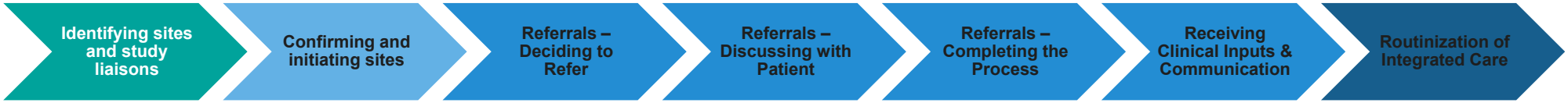


Routinization of Integrated Care:

- Inclusion of intervention information within wider circle of care of patient
- Commitment of the practice to engage with study

""Maybe the effort would be better in terms of making the relationship between the technician and myself, and talking about patients […] I think that kind of interaction would have been more valuable than a graph that shows how many referrals this month."

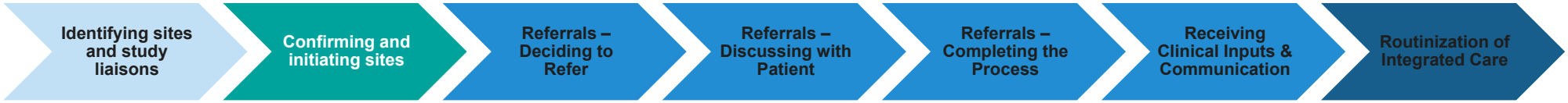
Recommendations



Recommendations for identifying sites & study liaisons:

- In-person meetings with potential site liaisons and study champions

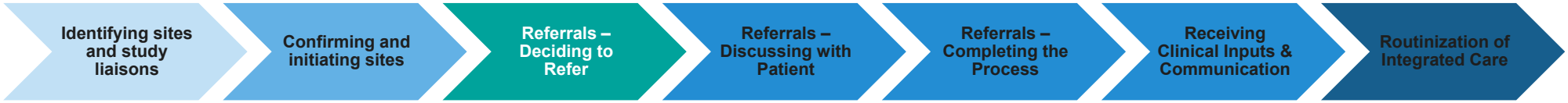
Recommendations



Recommendations for confirming and initiating sites:

- Develop relationships with sites at different opportunities
- Peer/word of mouth recruitment
- Identify a champion and ensure leadership support
- Co-create a local implementation plan & process

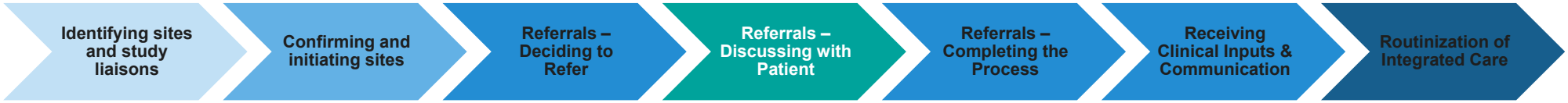
Recommendations



Recommendations for referrals – deciding to refer:

- Frequent and clinically relevant reminders to sites using their preferred communication modalities
- Develop specific workflow for patient identification

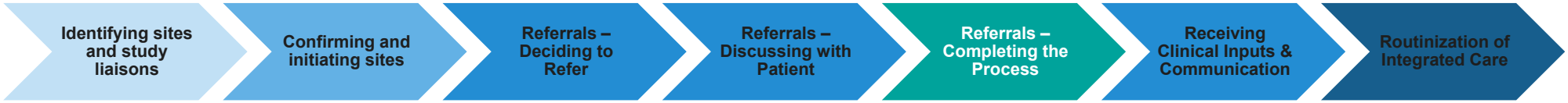
Recommendations



Recommendations for referrals – discussion with patient:

- Re-evaluate referrals, e.g. why are patients declining the study despite active recruitment efforts?
- Train potential referrers in how to introduce the study

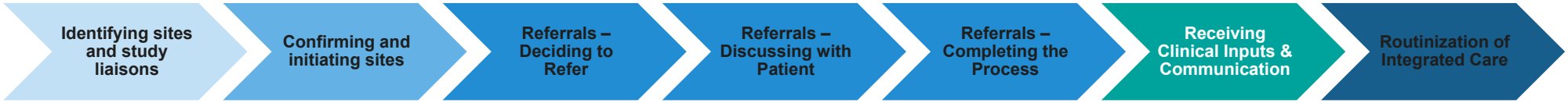
Recommendations



Recommendations for referrals – completing the process:

- Involve other team members to identify and communicate with eligible patients about the study (e.g. EHR)

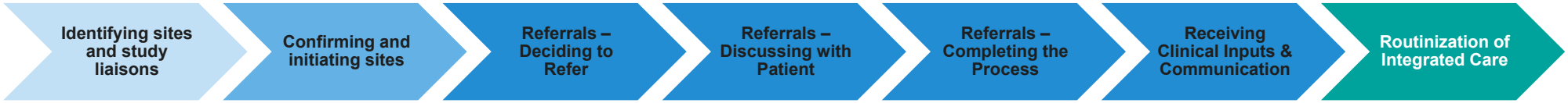
Recommendations



Recommendations for receiving clinical inputs & communication:

- Opportunity for two-way & real-time communication between MHT and PCPs

Recommendations



Recommendations for routinization of integrated care:

- Maintain relationship with site liaison
- Regular teleconference with site liaisons
- Jointly plan methods to share study results when available

Implications

- Challenges found in PARTNERs are common universal challenges in recruitments in other primary care studies
- E.g. Time Burden, Champions & Leadership
- Most PCPs valued PARTNERs and collaborative care models → strong belief of benefit for patient population
- Implementation of recommendations can further uptake in future collaborative care studies

5

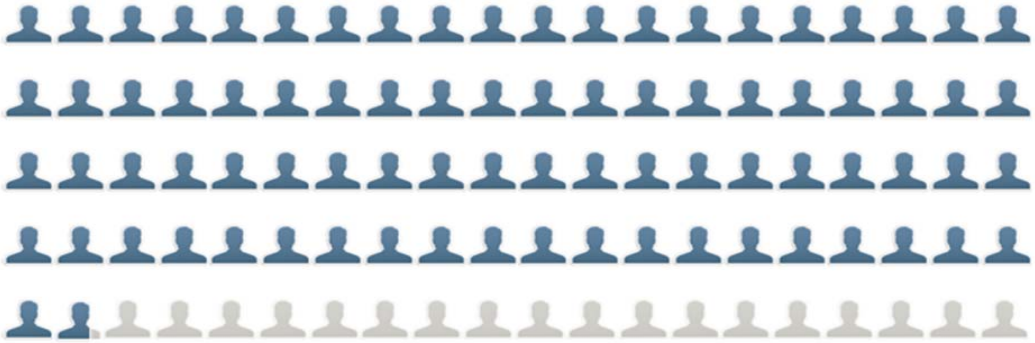
Telephone Acceptability

Rationale for a Telephone Based Mental Health Intervention

- Almost 75% of mental health visits are related to mood and anxiety disorders (McRae et al., 2016))
- Most of the mental health visits occur in primary care settings than in psychiatric settings (Kurdyak et al., 2017)
- An estimated 1.6 million Canadians reported that their needs for mental health were unmet and 36% reported that their needs for counselling services were either unmet or partially met (Sunderland et al., 2013)
- A survey found that wait times to see a psychiatrist ranged from 15 to 59 weeks and wait times to start psychotherapy ranged from 3 to 22 weeks (Barua & Fathers, 2015)

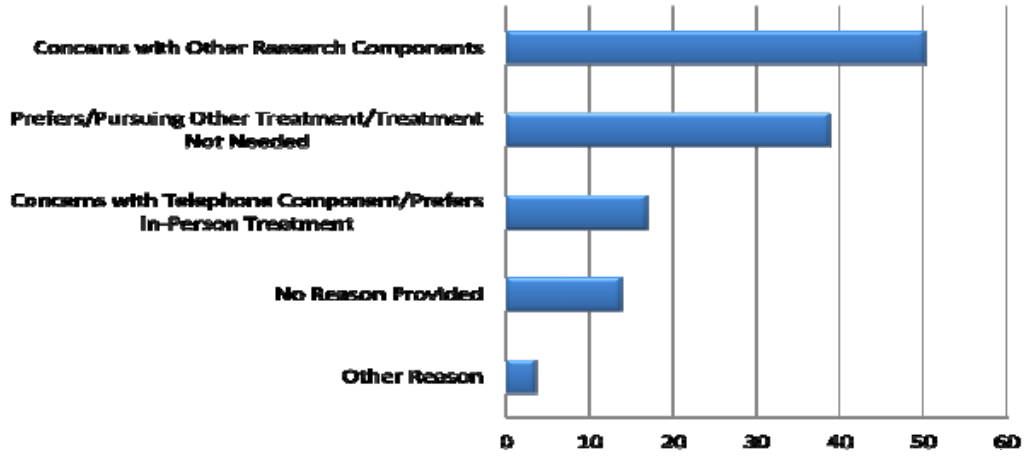
Acceptability of Telephone Based Mental Health Support

- Methods: Retention rate, Satisfaction survey results, Reasons provided during consent process, Reasons provided for withdrawal
- Retention rate in the study was 81.8%



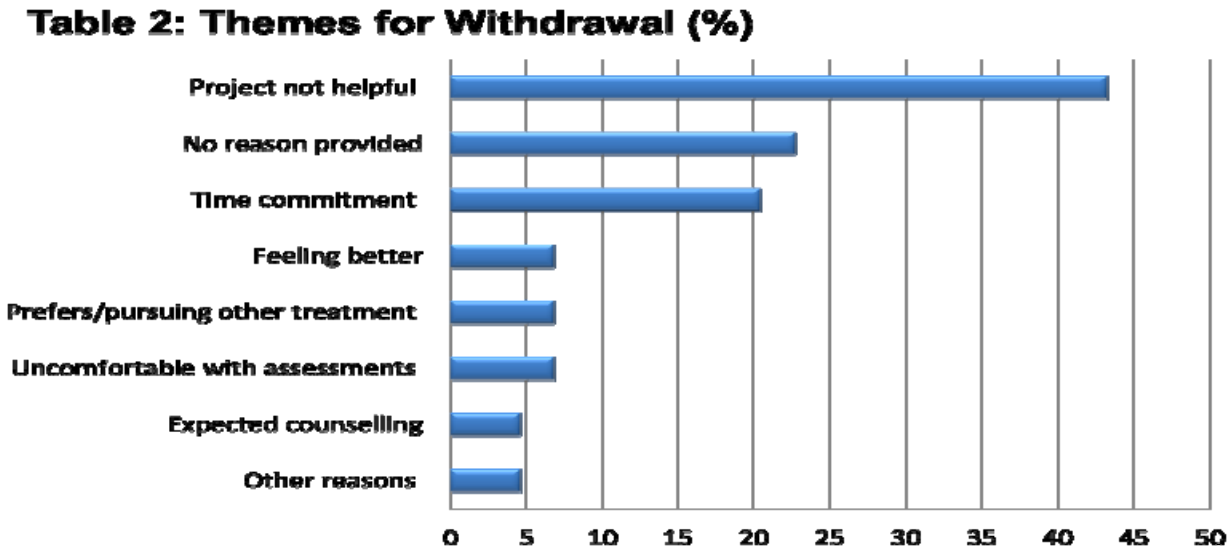
Acceptability of Telephone Based Mental Health Support

- Of the 663 patients referred to the study, 114 declined consent or withdrew prior to their baseline assessment.
- About 50% cited research related factors (i.e., time commitment), whereas only 16.8% cited telephone service delivery as their reason to decline participation.



Acceptability of Telephone Based Mental Health Support

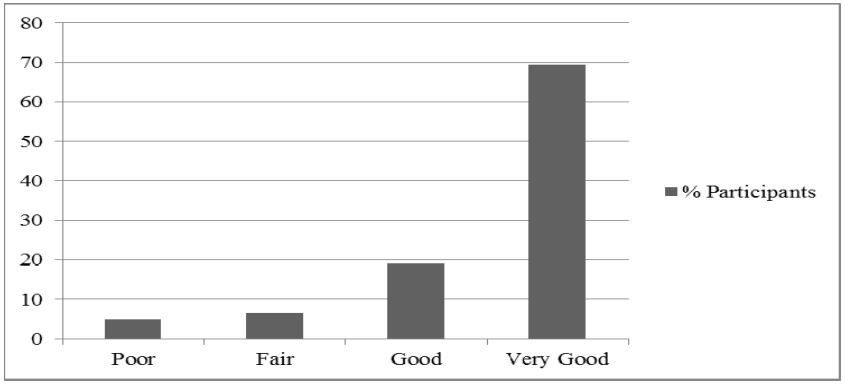
- 44 participants withdrew. Most did not provide a reason for withdrawal. None cited the telephone intervention as a reason for withdrawal.



Acceptability of Telephone Based Mental Health Support

- Overall most patients found the services “very good”
- 97.4% of comments related to the telephone components of the study were positive

Distribution of responses to the question “overall, how would you rate the services you received?” (n =121)



Common themes identified from the satisfaction survey responses

Limitations & Conclusion

Study design does not directly assess the acceptability of the telephone intervention

Self-selection bias

Conclusion: Telephone model is a feasible alternative to meet the growing need for mental health services.

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Discussion Question 2:

How can this telephone model be used in collaborative care ?

How do you see this model being implemented on a larger scale ?

Questions?

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