Task-Sharing Program for Behavioral Health in Rural Primary Care Medicine

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Project Overview

High quality delivery of evidence-based psychosocial interventions (EBPIs) in primary care medicine is a function of many variables, clinician ability to implement the therapeutic elements of EBPIs to fidelity and with competence Clinicians in low resource settings like FQHCs report that while elements of EBPIs are important, their design is cumbersome, complex, overwhelming, inflexible, and minimize the nonspecific factors clinicians feel are crucial for quality delivery of care. In short, EBPIs demonstrate low usability (i.e., the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency, and satisfaction in a specified context of use (International Standards Organization, 1998). We hypothesized that UCD driven modifications to EBPI usability (target mechanism) will result in enhanced clinician ability to deliver EBPI elements competently, and that better competence results in better patient reported outcomes. We planned to modify Problem-Solving Therapy for Primary Care (PST-PC) because it is the EBPI used in Collaborative Care and Cognitive Processing Therapy, because the rates of trauma in rural primary care medicine is high.

Aim 1: Discover Phase (3 months). Using an iterative and participatory methods, we intended to interview 10 clinicians from WPRN affiliated FHQCs, and observe them using PST-PC and CPT to identify usability challenges.

Aim 2: Design/Build Phase (6 months) After identification of potential targets, the research team planned to work with the original 10 clinicians to engage in a rapid cycle of iterative prototype development and testing (e.g.: storyboarding, paper prototypes) of PST-PC and CPT modifications.

Aim 3: Test Phase (15 months). We planned to test and compare the PST-P+ CPT modification to unmodified PST-PC in a small-scale RCT with 24 patients and 6 newly identified clinicians will be randomized to the two conditions.

Population/Sample

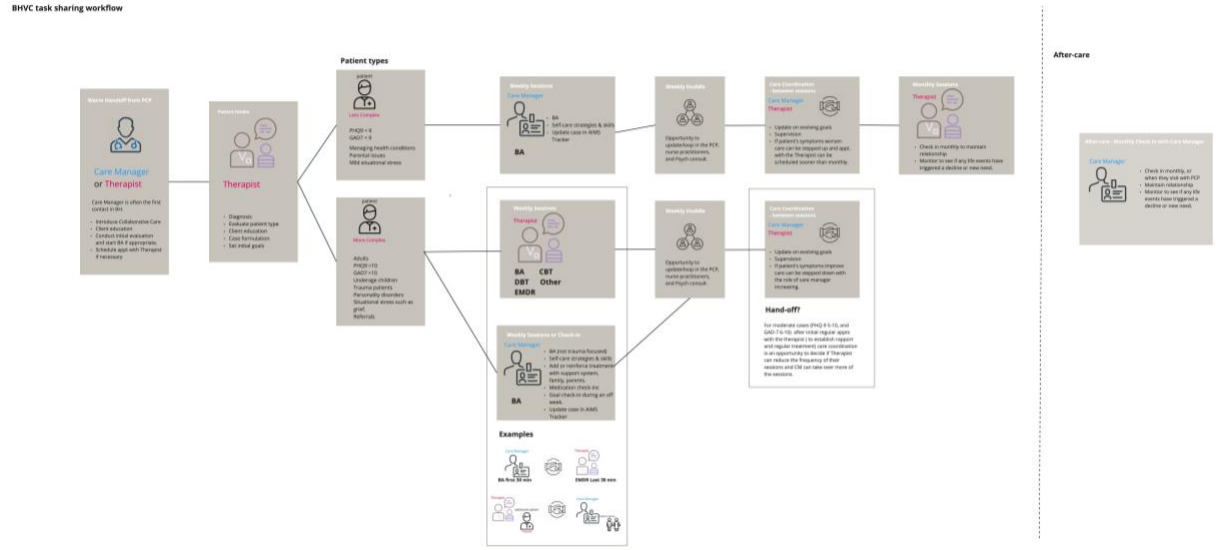
COVID-19 was a huge factor in our ability to work with rural primary care clinics. We were able to work with licensed behavioral health providers and paraprofessionals employed by Big Horn Valley Healthcare, a 5 clinic FQHC serving South Eastern MT. After we participated in the redesign of behavioral health care services (see key findings below), 10 patients were enrolled in a 3 month trial of the new intervention, and 10 addition patients were selected a historical controls to test the impact on clinical outcomes and treatment access.

Key Findings

1. Clinicians did not find interventions like PST-PC or CPT to be particularly difficult to use; however, they did find that regular visits were challenging because it was often difficult for patients to come to clinic on a regular basis, making the delivery of best practices complicated because of spotty attendance. Tele-based treatment was not a solution because of inconsistent broadband and lack of privacy in the home.

2. One of the five sister clinics had developed and tested a task-sharing model, whereby BA level paraprofessionals would support psychotherapy treatment plans by going into the patient's community and conducting as needed treatment checks. The FQHC planned to role this model out to the other four clinics, but this was met with resistance from the licensed clinicians, and the paraprofessionals felt ill-equipped to provide the needed support for treatment plans.

3. After conducting a series of remote workshops, the clinicians and paraprofessionals modified the task sharing model as well as aspects of PST-PC and CPT that was more acceptable to the clinicians and paraprofessionals felt they could learn. This model identified which cases paraprofessionals could manage on their own, which could be co-shared, and which needed to be largely managed by the clinician (see diagram).



4. The expert team, based on feedback from the paraprofessionals and concerns from the clinicians, reduced the intervention to behavioral activation (BA), which has been found to be effective for depression and PTSD. They further modified BA to address the challenges clinicians identified has being particularly difficult in their delivery of BA, namely: poor affect regulation, psychiatric co-morbidity, cognitive control challenges, and low motivation.

5. After testing this new model on 10 patients, we found that the task sharing model resulted in better treatment adherence by patients, but no differences in depression or PTSD symptoms compared to controls.

Measures used

- PHQ-9
- PCL
- claims data

Methods

For Discovery and Testing phases we conducted pre and post Interviews with providers. To redesign the task-sharing model, we engaged in 2 remote co-design workshops using Miro and Zoom.

Next steps

The Big Horn Valley FQHC is currently using this new model. No other plans are in place to further study the intervention.