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A.C.T. like a champion: Primary care providers' responses to an integrated care initiative

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ABSTRACT

Background: Primary care and mental/behavioral health (MBH) integration is designed to improve patient outcomes and enhance access to care. To achieve system-level change, embedded integrated care "champions" are needed; however, no known conceptual model for identifying champion primary care providers (PCPs) of integrated care has been articulated. To address this gap, we propose that PCP championship consists of greater (1) *A*wareness of patients' MBH needs, (2) Comfort assessing patients' MBH needs, and (3) dedication to MBH Training (A.C.T.).

Method: A provider survey was administered yearly (n = 4 time points, 2013–2016) at a large multi-site Federally Qualified Health Center actively working to achieve MBH integration. The survey assessed PCPs' *Awareness* of a variety of MBH needs, *Comfort* diagnosing MBH disorders, and interest in MBH *Training*.

Results: As expected, the cohort of PCPs demonstrated significantly increased *Awareness* of MBH needs, greater *Comfort* diagnosing MBH disorders, and increased interest in MBH *Training* over time. Overall prevalence of "champions," indicated by both high levels of comfort and an expressed interest in training, decreased initially and then consistently increased across time (37%, 19%, 22%, and 52%).

Conclusions: The A.C.T. model may aid in future MBH integration efforts by providing a framework for assessing and facilitating PCP integrated care championship.

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KEYWORDS

Primary care providers; integrated care; mental and behavioral health; champions

Introduction

As the primary provider of health care for low-income, uninsured, or Medicaid recipient populations [1], Federally Qualified Health Centers (FQHCs), and the primary care providers (PCPs) who practice within FQHCs are challenged with meeting the holistic needs of a medically underserved population. The current team-based primary care model of healthcare within the United States often positions the PCP as the leader of a multi-disciplinary health care team responsible for overseeing the full care of the patient [2]. As such, the FQHC PCP is responsible for (1) leading team huddles to monitor patient progress; (2) assessing, treating, and managing a variety of health conditions; and (3) assuring the quality of services delivered by the entire healthcare team.

Due to barriers to accessing traditional mental/behavioral health (MBH) services, "primary care settings have become the gateway to the behavioral health system" [3]. An estimated 75% of primary care patients struggle with MBH-related symptoms; depression is among the most prevalent psychological disorders diagnosed and treated within primary care settings [4]. Despite the prevalence of MBH needs and the responsibility of PCPs to oversee holistic patient-centered care, existing PCPs often feel as though they have an insufficient understanding of mental illness [5] due to receiving inadequate MBH training [6]. Insufficient knowledge and familiarity

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in treating mental illness often contribute to an overall lack of awareness of psychological distress and reduced comfort with treating patients who are explicitly expressing MBH concerns. Facilitating effective management of MBH concerns by PCPs within primary care, therefore, requires increased PCP *awareness, comfort, and training* regarding MBH symptoms, disorders, and treatment.

To meet the increased patient demand for MBH services and comply with the national push for integrated care, FQHCs are initiating efforts to incorporate MBH services into the standard of practice. Evolving standards of care include routine assessment of symptoms of depression and anxiety [7] as well as the provision of brief, same-day interventions for a range of conditions including depression, medication noncompliance, and life stress [8]. By addressing emergent health and MBH concerns from an integrated perspective, health care providers can augment existing care and give individualized recommendations that increase the likelihood of sustained wellness. However, level of *awareness*, *comfort*, and *training* of PCPs represents a pivotal factor in the successful enactment of integrated care, as, in many settings, PCPs determine the level of collaboration with MBH.

Further, large-scale transformation, such as implementation of integrated care, is influenced by multiple drivers of change (1) planning and infrastructure (e.g., vision/aim, resources), (2) individual, group, organizational, and systems factors (e.g., *champions*/change agents, leadership roles), (3) process of change (e.g., change theory), and (4) performance measures and evaluation (e.g., measurement and feedback systems) [9]. At an individual level, cooperation from PCPs is needed; successful and sustainable integrated care implementation require full buy-in, support, and dedication from clinical "PCP champions" [10–13].

"Champions" are individuals within an organization who "emerge to take creative ideas … and bring them to life. They make a decisive contribution to the innovation process by actively and enthusiastically promoting the innovation, building support, overcoming resistance, and ensuring the implementation is implemented" [14]. Schon [15], the originator of the concept of "product champions" argued, "Where radical innovation is concerned, the emergence of a champion is required…the new idea either finds a champion or dies" [15]. Given the cultural transformation required for the successful and sustainable implementation of integrated care, as well as the leadership role of PCPs within FQHCs, creating, identifying, and supporting PCP champions are crucial to integration efforts. However, the characteristics of a PCP champion have yet to be described. Instead, many have identified the need for a "physician champion" or "physician-led healthcare team" [16–21] without explicitly outlining the characteristics of a champion. This study addresses that gap and considers the development of PCP champions in a busy FQHC seeking to advance integrated care across a 4-year time interval.

A.C.T. Like a Champion

Specifically, it is proposed that the identification of PCP champions requires evaluation and development in three domains: *Awareness*, *Comfort*, and *Training* (A.C.T.). PCP champions must be (1) *aware* of MBH needs of patients, (2) feel *comfortable* assessing MBH needs, particularly depression and suicide risk, and (3) be dedicated to ongoing *training* related to the assessment and treatment of MBH. In keeping with the A.C.T. model, the current study evaluated MBH *awareness*, *comfort*, and *training* dedication across 4 years among PCPs practicing within a large FQHC located in an urban city in the Southern United States. Given evaluation was occurring across time within an FQHC in the process of implementing full MBH integration, *awareness*, *comfort*, and *interest* in training were expected to be lower at T1 (e.g., few MBH needs identified, relative discomfort with assessing and treating MBH, less interest in training) than at T4.

Method

Participants

PCPs from a large multi-site FQHC were surveyed yearly across a 4-year period. Demographic information was not collected from the first iteration of survey administration (T1; n = 19) to promote PCP *engagement* in the early stages of integration (e.g., FQHC administration preferred complete anonymity). However, demographics from the second (T2, n = 27), third (T3, n = 19), and fourth (T4, n = 28) iterations indicated PCPs consisted of Nurse Practitioners (48%, 53%, and 46%), Medical Doctors (MDs, 33%, 32%, and 43%), and Physician Assistants (PAs, 11%, 5%, and 10%). Most PCPs were female (67%, 79%, and 71%) with a mean age of 45.9 (SD = 14.58). Ethnicity of participating PCPs changed significantly over the 4-year period (74% white at T2; 29% white at T4). See Table 1 for details regarding the demographics of PCPs at each

Table 1. Demographics of PCP participants across time.[a]

	T2 (*n* = 27)		*T3* (*n* = 19)		*T4* (*n* = 28)	
Age	*M*	SD	*M*	SD	*M*	SD
	46.29	15.05	45.93	15.05	45.40	14.49
Sex	67% Female (*n* = 18)		79% Female (*n* = 15)		71% Female (*n* = 20)	
	26 % Male (*n* = 7)		21% Male (*n* = 4)		25% Male (*n* = 7)	
Race	74% White (*n* = 20)		68% White (*n* = 13)		29% White (*n* = 8)	
	11% African Amerizcan (*n* = 3)		26% African American (*n* = 5)		29% African American (*n* = 8)	
					5% Native American/Hawaiian/ Pacific Islander (*n* = 1)	
Profession	48% NP[b] (*n* = 13)		53% NP[b] (*n* = 10)		46% NP[b] (*n* = 13)	
	33% MD[c] (*n* = 9)		32% MD[c] (*n* = 6)		43% MD[c] (*n* = 12)	
	11% PA[d] (*n* = 3)		5% PA[d] (*n* = 1)		10% PA[d] (*n* = 2)	
			5% DO[e] (*n* = 1)			

[a]Demographic information was not collected at T1.
[b]NP = Nurse Practitioner.
[c]MD = Medical Doctor.
[d]PA = Physician's Assistant.
[e]DO = Doctor of Osteopathic Medicine.

time point. Across the 4-year period, 93 PCP surveys were completed, with many PCPs participating in multiple time waves.

Measures

PCP champion survey

A brief self-report measure was developed to assess A.C.T. across time. The measure assessed (1) perceived MBH needs within FQHC patients (*Awareness*); (2) perceived comfort level with MBH diagnosis, utilization of screening tools, risk assessment, and intervention (*Comfort*); and (3) interest in training and preferred training opportunities (*Training*). The third and fourth iterations included two additional response options for possible MBH needs of patients (abuse and anger management).

Awareness

The characteristic of *awareness* was assessed via the question, "In your opinion, what types of MBH needs do you see presenting in your patients most frequently?" Participants were provided with a list of 20 possible MBH needs and asked to "check all that apply." Needs included: alcohol abuse, insomnia/sleep difficulty, depression, anxiety, suicide ideation, stress, substance abuse, psychosis, attention difficulty, attention difficulty with hyperactivity, oppositional/defiant, intermittent explosiveness, eating (anorexia or obesity), trauma, adjustment difficulty, adherence, postpartum depression, grief/loss, and "other." As previously noted, abuse and anger management were added at T3 and T4. The percentage of PCPs who endorsed each need was calculated to determine the top five or six MBH needs identified at each of the four times points as well as changes in awareness of particular MBH needs. A frequency count of the number of MBH needs identified by PCPs was also created. Conceptually, a greater number of needs identified by PCPs was used as an indicator of greater awareness of and attention to MBH needs in their patients.

Comfort

The characteristic of *comfort* was assessed via the question, "How comfortable do you feel diagnosing a mental/BH disorder?" Comfort levels were scored such that 1 = *very uncomfortable* and 5 = *very comfortable*. Comfort level was used dimensionally to determine changes in PCPs' comfort level across time. Conceptually, greater comfort reported by the PCP is indicative of greater "championship" of integrated healthcare.

Training

The characteristic of interest in *training* was assessed via the question, "Would you be supportive of and participate in training sessions regarding mental and BH needs?" scored dichotomously (yes/no). PCPs were also asked to indicate if they would be interested in specific training (e.g., treating depression in primary care, motivational interviewing, psychotropic medication, chronic illness and MBH, and other). Conceptually, interest in MBH training reported by a greater percentage of PCPs is another indicator of "championship."

Procedure

Data were collected during four routinely scheduled "all-hands" meetings with all FQHC's PCPs.

The meeting in which the survey was administered was held annually in the fall, approximately 1 year apart (2013, 2014, 2015, and 2016). Participation in the project was encouraged but voluntary. Numbers of participating PCPs in each year's cohort varied some across time, (n = 19, 27, 19, and 28). Names were not provided on the survey to retain anonymity; some PCPs also chose to leave certain demographic information blank. Institutional Review Board approval for this study was obtained and ethical procedures were utilized throughout.

Results

Awareness of patients' presenting mental and behavioral health needs

The top five/six MBH needs identified by each PCP cohort across the time points are displayed in Table 2. Consistency in identified needs was observed across time; depression (79% of PCPs at T1; 96% at T4), anxiety (79%; 96%), stress (47%; 82%), substance abuse (47%; 71%), and insomnia (53%; 64%) were in every year's top patient need list. However, as shown in Table 3, a significantly greater percentage of PCPs endorsed suicide ideation, lack of treatment adherence, psychosis, eating disorders, explosiveness, grief/loss, and stress as concerning symptoms in their patients at T4 compared to T1, indicating greater awareness of a variety of concerns. Changes in the endorsement of all other symptoms were not significant.To determine overall changes in awareness of MBH needs by PCP cohort across time, a within-group univariate ANOVA was calculated with means from all 4 years. As predicted and in keeping with the development of integration champions, PCPs endorsed a greater number of MBH patient symptoms as needs across time, $F_{(3, 89)} = 7.09$, $p = < 0.001$ (T1: $M = 6.11$, SD = 2.60; T2: $M = 9.00$, SD = 3.46; T3: $M = 11.32$, SD = 4.19; T4: $M = 10.82$, SD = 4.94).

Table 2. Top five MBH needs identified by PCPs by Time Point.

Rank	*T1* (*n* = 19)		*T2* (*n* = 27)		*T3* (*n* = 19)		*T4* (*n* = 28)	
1	Depression	78.9%	Depression	92.6%	Depression	100%	Depression	96.4%
2	Anxiety	78.9%	Anxiety	92.6%	Anxiety	89.5%	Anxiety	96.4%
3	ADHD	52.6%	Stress	85.2%	Insomnia	89.5%	Stress	82.1%
4	Insomnia	52.6%	Insomnia	66.7%	Stress	78.9%	Substance abuse	71.4%
5	Stress	47.4%	Substance abuse	66.7%	Substance abuse	73.7%	Eating disorders[a]	64.3%
	Substance abuse	47.4%			Eating disorders[a]	73.7%	Insomnia	64.3%

[a]The category of *Eating Disorders* includes both anorexia and obesity. ADHD = attention deficit hyperactivity disorder.

Table 3. Increased awareness of specific MBH symptoms in patients.[a]

BH symptom	Percent PCPs endorsing problem at T1 *N* = 19 (%)	Percent PCPs endorsing problem at T4 *N* = 28 (%)	Chi-Square df = 1	*p*-value
Depression	78.9	96.4	3.64	0.056
Anxiety	78.9	96.4	3.64	0.056
Insomnia	52.6	64.3	<1	0.424
ADD	52.6	53.6	<1	0.949
ADHD	52.6	42.9	<1	0.510
Stress	47.4	82.1	6.30	0.012
Substance abuse	47.4	71.4	2.77	0.096
ODD	42.1	46.4	<1	0.770
Alcohol abuse	36.8	57.1	1.87	0.172
Eating disorders	26.3	64.3	6.53	0.011
Treatment adherence	26.3	60.7	5.38	0.020
Adjustment	21.1	35.7	1.16	0.281
Grief/loss	15.8	46.4	4.72	0.030
Suicide ideation	10.5	64.3	13.38	0.000
Trauma	10.5	25.9	1.68	0.195
Post-partum	10.5	28.6	2.20	0.138
Psychosis	0	21.4	4.67	0.031
Explosiveness	0	19.2	4.11	0.043

[a]Concerns about patient's symptoms of abuse and anger were not assessed at T1 and thus are not included in this table.
ADHD = attention deficit hyperactivity disorder; ADD = attention deficit disorder; ODD = oppositional defiant disorder.

Perceived comfort level assessing MBH

To determine changes in PCPs' comfort diagnosing mental and BH needs across T1, T2, T3, and T4, a univariate within group ANOVA was calculated. Contrary to expectation, the overall analysis was not significant $F_{(3, 88)} = 1.67$, $p = 0.18$. However, pairwise comparisons indicated PCPS expressed more comfort diagnosing a MBH disorder at T4 ($M = 3.21$, SD = 0.99) compared to T2 ($M = 2.58$, SD = 1.10). T4 was the first time mean comfort level exceeded 3 on a scale from 1 "very uncomfortable" to 5 "very comfortable."

Interest in training regarding MBH

To determine changes in PCPs' interest in training regarding MBH across time, a Chi-square test was performed to compare expressed interest at T1 to interest at T4. As expected, more PCPs endorsed being supportive of, and willing to participate in, training related to MBH at T4 (100% interested) compared to T1 (84.2% interested), $X^2(1, N = 44) = 4.24$, $p = 0.04$. Averaging across the four time points, PCPs expressed interest in training regarding treating depression in primary care (59.1%), psychotropic medications (49.5%), motivational interviewing (34.4%), and chronic illness and depression (33.3%).

"Championship" across time

Survey responses were subsequently used to classify "PCP champions" in the participating FQHC across time. Categories of "championship" were created based on the level of comfort diagnosing MBH and interest in training at each of the four time points. Overall prevalence of "champions," indicated by both high levels of comfort (4 or 5) and an expressed interest in training "yes," decreased from T1 to T2. Prevalence of "champions" then consistently increased from T2 to T3 to T4 (37%, 19%, 22%, 52%, see Figure 1). Only a few PCPs were identified as non-champions (uncomfortable and not interested in training) at the inception of the integrated care initiative (5.3%); by T4, no PCPs remained in this category.

Discussion

Sustainable integration of MBH services into primary care settings requires thoughtful implementation and formative evaluation. Key areas of focus include *engaging* PCPs and administrators regarding the need for MBH services, *establishing* MBH pathways and services that address identified needs within the organization, and *embedding* MBH services in the existing organizational system including into the workflow, electronic health record, and billing protocols [8]. The level of integration achieved within an organization relies substantially on the degree of collaboration and leadership of the agency's PCPs, as they have a major influence on day-to-day service delivery, MBH referral/warm hand-offs, and patient care. As such, we proposed a conceptual model of necessary competencies for

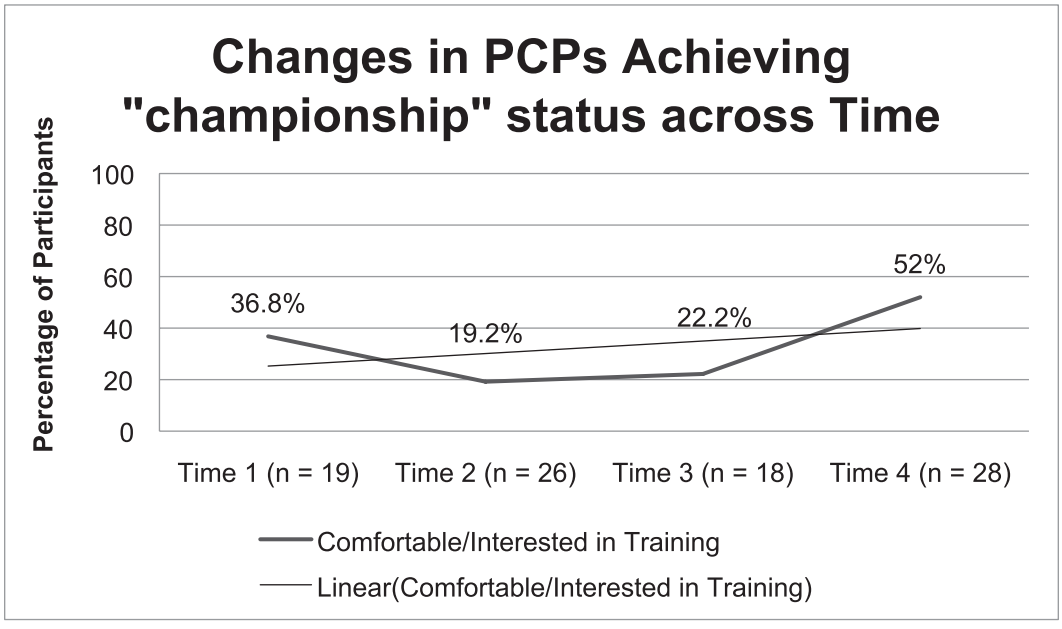

Figure 1. Percentage of participants identified as PCP "champions" by Time Point.

an integrated care PCP champion. Specifically, a PCP champion must possess (1) *Awareness* of the MBH needs of their patients, (2) *Comfort* assessing and diagnosing MBH signs and symptoms, and (3) interest in *Training* regarding MBH integration and care. Use of this framework may prove instructive in designing formative program evaluation plans; site-specific data on PCP's A.C.T. status may also help to guide training activities and the delivery of brief on-site MBH interventions.

Awareness

Findings suggest that PCPs were aware of many common MBH concerns. Consistent with reports by the World Health Organization [22], depression and anxiety were the most common MBH needs identified by PCPs who participated in the current study; stress was also frequently identified. Insomnia and substance abuse were additional commonly identified patient needs. Given the stability with which the five patient concerns were endorsed, tailored interventions relating to the conditions were implemented by on-site MBH providers as integration was established.

As expected, providers were aware of a greater number of patient needs over time. Specifically, a greater number of PCPs were concerned about patients' suicide ideation, grief/loss, and stress between T1 and T4. Likewise, more PCPs noted concerns with patients' ability to adhere to their medical treatment at T4 compared to T1. The information allowed MBH providers to provide tailored interventions; for example, given increased awareness and concern regarding suicide ideation and in conjunction with the FQHC's implementation of a universal depression and suicide ideation screening process, training by a nationally renowned expert in suicide prevention was delivered to all FQHC PCPs and MBH providers during year 3 [23]. Given the importance of identifying BH needs for referral/warm handoff to BH services, assessment of PCP awareness is a critical component of promoting integrated health.

Comfort

Accurate diagnosis of MBH concerns is essential for selecting treatment options and providing appropriate care; an evaluation of comfort with MBH diagnosis is an essential element of integrated care implementation. As anticipated, PCPs expressed greater comfort diagnosing MBH disorders at T4 compared to T2. The trend noted here, a brief drop in comfort and then steady increases, is consistent with models of how competency builds over time (e.g., conscious competence learning model) [24].

Training

Interest in training was consistently high across all four time points, which suggests PCPs were desirous of ongoing professional development related to MBH; 100% of PCPs at T4 expressed interest in receiving additional MBH training. PCPs were particularly interested in training related to treating depression in primary care settings and learning more about psychotropic medications. By increasing integrated healthcare training opportunities based on PCPs' expressed interests, organizations can capitalize on the inherent motivations of potential integrated care champions.

Championship

By creating categories of "championship," based on the level of comfort and interest in training, the current study evaluated the prevalence of "championship" across time. As expected, there was an increase in the number of PCPs who could be classified as integrated care "champions" as FQHC integration moved from "engagement" to "establishment" and "embeddedness." However, even at the end of Year 4, only 52% of the PCPs were classified as "champions." Assessment via the A.C.T. framework provided a multi-dimensional evaluation of PCP development. Although documented success was occurring across the life of the MBH integration project, additional integration work is needed.

Some limitations to the current study require acknowledgment. This study's assessment measure was intentionally brief to allow for its administration during an annual provider meeting with a full agenda. When assessing *awareness* of MBH needs, PCPs were asked to check all that apply rather than rating the importance of assessing patients for each MBH need. Additionally, this study relied on PCPs' self-report, which may be problematic when assessing *comfort*. Although PCPs' perception of comfort is an important marker of "championship," more objective markers of comfort assessing MBH needs would be ideal. Moreover, self-reported comfort may not necessarily translate to competence assessing MBH needs. Observation of competence would add to the validity of this study. Interest in *training* was assessed dichotomously, potentially missing nuanced differences in providers' level of interest in training. Additionally, the study assessed a single PCP cohort across time. An in-depth study of how particular providers changed over time, using both quantitative and qualitative measures, would provide additional insight into how to develop and cultivate integration

champions. Finally, while the proposed A.C.T. model provides a foundational framework for a PCP champion of integrated care, the current study contained a small sample size gathered from a single FQHC health system; this framework may not generalize to all settings and/or providers.

The aim of the current paper was to develop and evaluate a model for conceptualizing PCP involvement in MBH integration. As the healthcare landscape continues to shift, under-resourced patients are likely to experience greater stressors with less access to MBH services. Integrated primary care settings are essential in the management of MBH concerns; patients in integrated care settings are more likely to receive quality care and have better health outcomes [25]. However, integrated settings develop over time through an ongoing and intentional effort by stakeholders. Future research should explicitly evaluate the downstream impact of "champion" versus "non-champion" providers. For example, in addition to an assessment of "championship" among PCPs, individuals within and outside the organization (i.e., administrators, staff, patients, community members) could provide quantitative and qualitative feedback at regular intervals to evaluate changes in the organizational climate, including perceptions of PCPs contribution to the climate. Other outcomes of interest may include providers' job satisfaction/enthusiasm and longevity, patients' impressions of care, and patients' health outcomes. Expanding our understanding of how to best foster and support PCP champions, particularly through ongoing training and professional development activities, will be vital in continuing to engage, establish, embed, and ensure high-quality integrated care [8].

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Conflict of Interest

None.

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