## Behavioral Science in Health and Health Care:
An ACCORDS Seminar Series

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### The Science of Patient Centered Decisions:
An ACCORDS Seminar Series

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Recorded seminars can be found on our website [https://goo.gl/1q9nUx](https://goo.gl/1q9nUx)

Request a Planning or Support Consultation with the Education Program
Behavioral Science in Health and Healthcare

An ACCORDS seminar series

Objective:
- To prepare researchers to identify and apply appropriate behavioral science theories and frameworks to the design and testing of interventions intended to change human behavior
Ecological Models of Health

Five principles

◦ Multiple levels of influence on health
◦ Environmental contexts are significant determinants of health
◦ Influences on health interact across levels
◦ Health behavior-specific
◦ Multilevel interventions should be most effective

Danielle Loeb, MD, MPH

- Practicing general internist
- Fellowship-trained Dissemination and Implementation scientist focus on implementing team-based care for patients with mental and physical illness in primary care
- Research has focused specifically on fostering primary care provider adoption of, and leadership within, team
- In addition to formal research, significant experience implementing practical evidence-based models of care for depression in her primary care clinic, Anschutz Internal Medicine
- Assistant Professor, Department of General Internal Medicine, University of Colorado School of Medicine
- Pilot Funding - NIMH: K23MH100162
Bethany Kwan, PhD, MSPH

Social health psychologist with expertise in application of psychological theory to health behavior change

Dissemination and implementation scientist focused on design and testing of chronic disease management interventions in primary care

Stakeholder engagement, healthcare informatics

Assistant Professor, Department of Family Medicine, University of Colorado School of Medicine

ACCORDS Education program lead and D&I program member

CU Data Science to Patient Value (D2V) initiative Dissemination, Implementation, Communications, and Engagement core co-lead
An exploration

What is a health problem we need to address?
What is a health behavior that needs to change?
What is an evidence-based intervention for changing that behavior and improving that health problem?
Why aren’t we all better yet?
IF AN INTERVENTION WORKS

AND NOBODY CAN USE IT.....

DOES IT STILL MAKE AN IMPACT?
Dissemination and Implementation (D&I) Science

The study of translating research to practice

D&I Definitions

Evidence-Based Intervention: Interventions with proven efficacy and effectiveness

Dissemination is an active approach of spreading evidence-based interventions to the target audience via determined channels using planned strategies

- Dissemination research is the systematic study of processes and factors that lead to widespread use of an evidence-based intervention by the target population
- Dissemination strategies describe mechanisms and approaches that are used to communicate and spread information about interventions to targeted users.
D&I Definitions

**Implementation** is the process of putting to use or integrating evidence-based interventions within a setting.

- **Implementation research** seeks to understand the processes and factors associated with successful integration of evidence-based interventions within a particular setting (e.g., worksite, school, clinic).
- **Implementation strategies** are the systematic processes or methods, techniques, activities, and resources that support implementation of evidence-based interventions in practice.
A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project

Byron J Powell1*, Thomas J Waltz2, Matthew J Chinman3,4, Laura J Damschroder5, Jeffrey L Smith6, Monica M Matthieu6,7, Enola K Proctor8 and JoAnn E Kirchner6,9

Abstract

Background: Identifying, developing, and testing implementation strategies are important goals of implementation science. However, these efforts have been complicated by the use of inconsistent language and inadequate descriptions of implementation strategies in the literature. The Expert Recommendations for Implementing Change (ERIC) study aimed to refine a published compilation of implementation strategy terms and definitions by systematically gathering input from a wide range of stakeholders with expertise in implementation science and clinical practice.
Use of concept mapping to characterize relationships among implementation strategies and assess their feasibility and importance: results from the Expert Recommendations for Implementing Change (ERIC) study

Thomas J. Walz1,2, Byron J. Powell3, Monica M. Matthew4,5,10, Laura J. Damschroder4, Matthew J. Chinman6,7, Jeffrey L. Smith3,10, Enola K. Proctor9 and JoAnn E. Kirchner10,11,10

Fig. 1. Point and cluster map of all 73 strategies identified in the ERIC process. The map reflects the product of an expert panel (valid response n = 32) sorting 73 discrete implementation strategies into groupings by similarity with each strategy being depicted by a yellow dot and accompanied by a number supporting cross-referencing to the strategies enumerated in Table 1. Spatial distances reflect how frequently the strategies were sorted together as similar. In general, the closer two points are together, the more frequently those strategies were sorted together. Strategies distal from one another were infrequently, if at all, sorted together. These spatial relationships are relative to the sorting data obtained in this study, and distances do not reflect an absolute relationship (i.e., a 5-mm distance in the present map does not reflect the same relationship as a 5-mm distance on a map from a different data set). The legend provides the label for each of the nine clusters of strategies. Dotted lines within the Develop stakeholder interrelationships cluster indicate the two separate clusters were merged into one large cluster due to conceptual similarity among their items. Dotted lines extending between other clusters are due to the reassignment of strategies from their original cluster to a neighboring cluster to which there was a better conceptual fit (i.e., strategies #48, #58, and #60).
Fig. 2 Go-zone plot for all 73 strategies based on expert ratings. Note. The range of the x and y axes reflect the mean values obtained for all 73 of the discrete implementation strategies for each of the rating scales. The plot is divided into quadrants on the basis of the overall mean values for each of the rating scales. Quadrant labels are depicted with roman numerals next to the plot. Strategies in quadrant I fall above the mean for both the importance and the feasibility ratings. Thus, these strategies are those where there was the highest consensus regarding their relative high importance and feasibility. Conversely, quadrant III reflects the strategies where there was consensus regarding their relative low importance and feasibility. Quadrants II and IV reflect strategies that were relatively high in feasibility or importance, respectively, but low on the other rating scale.
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<tr>
<th>Table 1 A summary of the 73 implementation strategies, organized by cluster with mean importance and feasibility ratings</th>
</tr>
</thead>
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<td></td>
</tr>
<tr>
<td>Use evaluative and iterative strategies</td>
</tr>
<tr>
<td>4 Assess for readiness and identify barriers and facilitators</td>
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<td>5 Audit and provide feedback</td>
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<td>46 Obtain and use patients/consumers and family feedback</td>
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<td>14 Conduct cyclical small tests of change</td>
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<td>Provide interactive assistance</td>
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<tr>
<td>33 Facilitation</td>
</tr>
<tr>
<td>54 Provide local technical assistance</td>
</tr>
<tr>
<td>53 Provide clinical supervision</td>
</tr>
<tr>
<td>8 Centralize technical assistance</td>
</tr>
</tbody>
</table>
Discrete implementation strategies

Use evaluative and iterative strategies
Provide interactive assistance
Adapt and tailor to context
Develop stakeholder interrelationships
Train and educate stakeholders
Support clinicians
Engage consumers
Utilize financial strategies
Change infrastructure

Implementation Frameworks

Replication Effective Programs (REP)

Promoting Action on Research Implementation in Health Services (PARIHS)


Selecting Implementation Strategies

How might you know which implementation strategies will work for which clinical interventions, in which settings, for which people?
Applying D&I Theories and Frameworks to Health Services Research

Guiding identification of specific factors within a particular setting that influence dissemination and implementation of an intervention

- Formative research
- Stakeholder engagement

Selecting interventions that meet the needs of the target setting

Mapping measures and D&I strategies to the components of the selected model to understand determinants of and/or measure outcomes

Designing D&I strategies to target determinants of change in the target setting
Concept Mapping for Implementation Strategies

What are the determinants of (aka barriers and facilitators) implementation in a given context?
  ◦ Stakeholder engagement
  ◦ Theory
  ◦ Literature
  ◦ Formative research

What implementation strategies map to those determinants?


**Figure 4**

Example matrix of determinants, learning objectives, theory-based methods, and implementation strategies

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Learning objectives for the insurance physician</th>
<th>Theory-based method</th>
<th>Practical strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Familiarity with the content of the guideline</td>
<td>Dissemination of training material</td>
<td>Making guideline available in combination with practical instruments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Active learning from experts</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td>The ability to apply knowledge in practice</td>
<td>Interactive group training</td>
<td>Interactive training in use of the guidelines</td>
</tr>
<tr>
<td>Attitude</td>
<td>Willingness to accept the guidelines and use them to improve quality</td>
<td>Persuasion by opinion leaders</td>
<td>Benefits highlighted during training and by staff and the Netherlands Association for Insurance Medicine</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Belief in ability to use the guidelines in practice and finding answers to questions</td>
<td>Performance-related feedback</td>
<td>Positive individualised feedback during training and subsequently in practice, assistance with questions</td>
</tr>
<tr>
<td>Expectations</td>
<td>Expectation that the guideline will contribute to more evidence-based assessments</td>
<td>Individualized feedback and group performance audit data</td>
<td>Training in use of the guidelines with exercise case-histories, feedback at group and individual level</td>
</tr>
</tbody>
</table>

**Change objectives for the environment**

| Availability | The ability to practise, ask questions and work on personal performance | Feedback, personal improvement, planning | Practice in training, feedback on performance, support with questions |
| Uniformity   | All insurance physicians covered by similar requirements | Quality-monitoring and quality-management | Staff physician appraises all insurance physicians using the same indicators |
| Support      | Support from colleagues, staff, management and professional association, facilitation and, where necessary, amendment of the work process | In-built process reminders, quality management, support from opinion leaders | Quality evaluation by management, staff quality-oriented direction, promotion by the Netherlands Association for Insurance Medicine |
Identify implementation determinants

Causal Pathway for Clinical Effectiveness

II. Select an evidence-based practice for the health problem that fits the context

Set of Implementation Determinants
- Capability
- Opportunity
- Motivation
- Practice Culture

Practice-Level Outcomes
Implementation of POWER interventions for weight loss in clinical practice

Patient-Level Outcomes
Body Mass Index

III. List determinants of implementation of the evidence-based practice

I. Determine what health problem needs to be addressed

Select implementation strategies

Set of Implementation Strategies
- Skills Building Strategies
- Planning Strategies
- Communication Strategies
- Leadership Strategies

Set of Implementation Determinants
- Capability
- Opportunity
- Motivation
- Practice Culture

Practice-Level Outcomes
Implementation of POWER interventions for weight loss in clinical practice

Patient-Level Outcomes
Body Mass Index
Clinical Problem

Mental Illness
Pervasive in the US --with a quarter of the population suffering from psychiatric illness at some point in their lives
  • 9.5% of US with mood disorders in the last 12 months
Worsens outcomes in patients with chronic medical illnesses (both morbidity and mortality)
Negatively impacts psychiatric outcomes— both functional outcomes and severity of symptoms
Clinical Context

Approximately 10% of primary care patients suffering from psychiatric illnesses such as anxiety and depression. 43%-60% of treatment for psychiatric conditions occurs in primary care. Many patients struggle to access care with mental health specialists. Yet, primary care struggles to adequately fill this need:

- Primary care providers (PCPs) report high levels of uncertainty in their clinical skills for managing mental illness.
- Patients rarely receive guideline-concurrent care for mental illness in primary care settings.
Evidence-Based Intervention

The Collaborative Care Model (CCM) and other team-based models known to improve outcomes for mental illness in primary care (over 90 RTCs)
These models emphasize the need for PCPs to work within a healthcare team, which includes nurses, social workers, and care managers
Measurement-based care (MBC) – using validated instruments to systematically measure patients’ symptoms and adjust treatment accordingly – is a core component of multiple models of behavioral health integration including the CCM

Determinants of Implementation

Primary care practices have been slow to adopt these models

Practical:
- Training, space, workforce availability, workflows, billing, reimbursement, and documentation procedures

Psychosocial:
- PCP Self-efficacy in mental illness management and team-based care
- Role Change: Although PCPs generally prefer team-based care for patients with behavioral health needs, transitioning to team-based care can be challenging
- Clinic climate: recurring patterns of behavior, attitudes and feelings that characterize working in the clinic
- Team Relational Coordination: a theory of organizational management focusing on the interdependent relationships between people working in teams
Implementation Strategy: Practice Facilitation

Practice facilitation:
Promotes practice improvement in clinical teams, individual clinics, or healthcare systems
Characterized by support from a practice facilitator (PF) who is a health care professional trained in practice improvement methods who facilitates system-level changes
Improves multiple aspects of Team-based Care
  1) communication across specialties
  2) increased adoption of practice change
  3) consensus building

Implementation Strategy: Practice Facilitation

PFs can be used to help implement integrated behavioral health as they often have expertise in specific areas of primary care practice, specifically the management of patients with psychiatric illness.

However, practice facilitation does not explicitly address the psychosocial factors essential to sustainable practice change.
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
<table>
<thead>
<tr>
<th>Description</th>
<th>PCP Clinical Supervision and Coaching (Coaching)</th>
<th>Practice Change Activity Team (PCAT)</th>
<th>Standard Practice Facilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Facilitator observes PCPs in 4+ visits with complex patients; facilitator uses clinical psychology and coaching techniques during 1-on-1 debriefs with PCPs.</td>
<td>Facilitator guides implementation of a practice change; in this process, maladaptive team dynamics are identified and addressed.</td>
<td>Facilitator guides implementation of a practice change and builds internal capacity for improvement activities.</td>
</tr>
<tr>
<td>Participants</td>
<td>• PCPs • Patients whose visits are observed</td>
<td>• Clinic team (i.e., PCPs and staff representatives, leadership) • Patient representatives</td>
<td>• Clinic team (i.e., PCP and staff representatives, leadership)</td>
</tr>
</tbody>
</table>

**Implementation Factors**

<table>
<thead>
<tr>
<th>Mental Illness Management</th>
<th>Distinguishing Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>⇒ Knowledge</td>
<td>• Tailored group didactics on mental illness • Communication practice</td>
</tr>
<tr>
<td>⇒ Skills</td>
<td></td>
</tr>
<tr>
<td>⇒ Communication</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practical</th>
<th>Training:</th>
</tr>
</thead>
<tbody>
<tr>
<td>⇒ Quality improvement processes</td>
<td>• Quality improvement methods • Measurement-Based Care (MBC)</td>
</tr>
<tr>
<td>⇒ Practice monitoring systems</td>
<td>Facilitation:</td>
</tr>
<tr>
<td>⇒ Improvement Plans</td>
<td>• Assess current system • Create improvement plan (for MBC)</td>
</tr>
<tr>
<td>⇒ Modified Workflows</td>
<td>• Implement improvement plan (for MBC) • Evaluate/modify improvement plan targeting sustainability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial</th>
<th>Team dynamics focus on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>⇒ Interpersonal relationships</td>
<td>• Non-hierarchical communication and leadership behaviors • Mutually agreed upon processes</td>
</tr>
<tr>
<td>⇒ Clinic Culture</td>
<td>• Role clarity • Psychological safety</td>
</tr>
<tr>
<td>⇒ Attitudes</td>
<td>• Past practice change experiences</td>
</tr>
<tr>
<td>⇒ Role change</td>
<td>Group process emphasizing:</td>
</tr>
<tr>
<td>⇒ Role clarity</td>
<td>• Role clarity • Communication workflows • Team-building activities</td>
</tr>
</tbody>
</table>

**Distinguishing Features**

- Use of interdisciplinary team and available mental health resources

**Bolded text indicated shared features.**
RELATED Conceptual Map

Implementation Strategies
- Standard PF
- RELATED

Implementation Determinants
- Mental Illness Management
- Practical
- Psychosocial

Implementation Mediators
- Clinic Relational Coordination
- PCP Relational Coordination
- PCP Self-efficacy

Clinical Intervention
- Implementation of MBC

Patient Outcomes
- Change in PHQ-9 scores
| Use evaluative and iterative strategies | 4.19 | 4.01 | – |
| 4 Assess for readiness and identify barriers and facilitators | 4.60 | 4.57 | I |
| 5 Audit and provide feedback | 4.40 | 4.13 | I |
| 56 Purposefully reexamine the implementation | 4.40 | 4.03 | I |
| 26 Develop and implement tools for quality monitoring | 4.37 | 3.63 | I |
| 27 Develop and organize quality monitoring systems | 4.33 | 3.37 | I |
| 23 Develop a formal implementation blueprint | 4.30 | 4.47 | I |
| 18 Conduct local need assessment | 4.27 | 4.33 | I |
| 61 Stage implementation scale up | 3.97 | 3.77 | I |
| 46 Obtain and use patients/consumers and family feedback | 3.67 | 3.80 | I |
| 14 Conduct cyclical small tests of change | 3.63 | 4.03 | I |
| Provide interactive assistance | 3.67 | 3.29 | – |
| 33 Facilitation | 4.13 | 3.77 | I |
| 54 Provide local technical assistance | 3.97 | 3.20 | IV |
| 53 Provide clinical supervision | 3.83 | 3.10 | IV |
| 8 Centralize technical assistance | 2.73 | 3.10 | III |
Discrete implementation strategies

Use evaluative and iterative strategies
Provide interactive assistance
Adapt and tailor to context
Develop stakeholder interrelationships
Train and educate stakeholders
Support clinicians
Engage consumers
Utilize financial strategies
Change infrastructure

Coaching Component

Strategies:
- Assess for readiness and identify barriers
- Provide clinician supervision
- Train and educate stakeholders
- Support clinicians
PCAT Component

Strategies:
- Facilitation
- Develop formal implementation blueprint
- Train and educate stakeholders
- Develop stakeholder interrelationships
- Provide interactive assistance
- Engage consumers
Pilot Trial: 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
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
<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>1 month</th>
<th>6 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=36</td>
<td></td>
<td>N=36</td>
<td>N=33</td>
</tr>
<tr>
<td>M (SD)</td>
<td>3.7 (0.3)</td>
<td>3.8 (0.3)</td>
<td>3.7 (0.4)</td>
</tr>
</tbody>
</table>

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

SE = Self-efficacy; MDD = Major Depressive Disorder; GAD = Generalized Anxiety Disorder; BPD = Bipolar Disorder
<table>
<thead>
<tr>
<th>Component</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability positive</td>
<td>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</td>
</tr>
<tr>
<td>Acceptability negative</td>
<td>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</td>
</tr>
<tr>
<td>Acceptability (staff)</td>
<td>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</td>
</tr>
<tr>
<td>Effect on hierarchy</td>
<td></td>
</tr>
<tr>
<td>Feasibility positive</td>
<td>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</td>
</tr>
</tbody>
</table>

Focus group participants: 13 PCPs, 6 leaders, 12 staff
<table>
<thead>
<tr>
<th>Component</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team functioning</td>
<td>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</td>
</tr>
<tr>
<td>Effect on hierarchy</td>
<td>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</td>
</tr>
<tr>
<td>Patient perspective</td>
<td>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</td>
</tr>
<tr>
<td>Inclusivity</td>
<td>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</td>
</tr>
</tbody>
</table>

Focus group participants: 13 PCPs, 6 leaders, 12 staff
Pilot trial: 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 highly valuable for PCPs

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

Please contact me for further information
Danielle.loeb@ucdenver.edu