19TH CANADIAN COLLABORATIVE MENTAL HEALTH CARE CONFERENCE

COLLABORATING ACROSS CULTURES

An Incentive Model to Improve Quality Care of Common Mental Disorders in Ontario Family Health Teams – Findings of a Grounded Theory Study

PRESENTER DISCLOSURE

- **Presenters:** Dr. Rachelle Ashcroft, Dr. Jose Silveria, Dr. Matthew Menear

- **Relationships with commercial interests:**
  - **Grants/Research Support:** Canadian Institutes of Health Research (CIHR), MOP – 142435
  - **Speakers Bureau/Honoraria:**
  - **Consulting Fees:**
  - **Other:**

MITIGATING POTENTIAL BIAS

- **Presenters:** Dr. Rachelle Ashcroft, Dr. Jose Silveria, Dr. Matthew Menear

- **Mitigation of conflict:** No conflicts

LEARNING OBJECTIVES

1. Explain a qualitative process being used to help stakeholders evaluate which incentives to leverage to improve the quality of care for common mental disorder in FHTs;

2. Describe how financial and non-financial incentives influence the quality of care for depression and anxiety disorders in Family Health Teams (FHTs);

3. Together share perspectives on how various incentives influence different quality of care dimensions (e.g. access, technical quality, person-centred care, equity, costs).

RESEARCH TEAM

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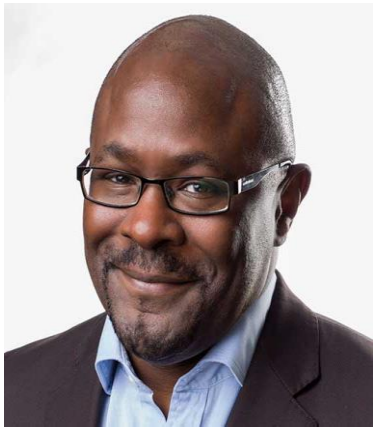

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CARING FOR PATIENTS WITH DEPRESSION & ANXIETY IN PRIMARY CARE

- **Family Health Teams (FHTs):** Ontario's flagship initiative for primary care reform since mid-2000s
  - 183 FHTs across the province
  - Serve over 3 million people (≈ 22% of the population)
  - Focus on interprofessional care

UNDERSTANDING THE PROBLEM

- Family Health Teams seem well positioned to improve access to high quality mental health care in primary care
  - Case Identification
  - Reduced delay to effective treatment
  - Continuity of care

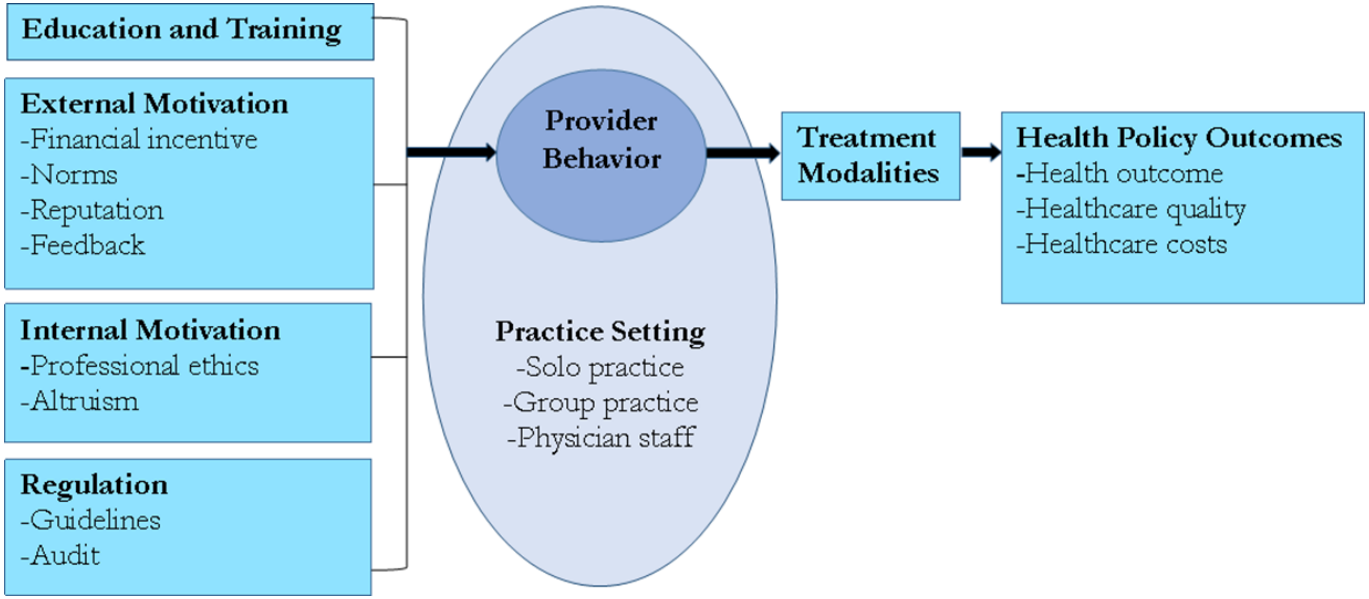
INCENTIVES & DISINCENTIVES

- **Incentive**
  - A catalyst that encourages a particular action, something that motivates an individual or organization to perform an action, makes it more likely that they will do something

- **Disincentive**
  - Something that discourages or deters a particular action, makes it less likely that an individual will do something

  - (Biller-Andorno & Lee, 2013; Enjolras, 1999; Scott & Connelly, 2011

TYPES OF INCENTIVES IN PRIMARY CARE

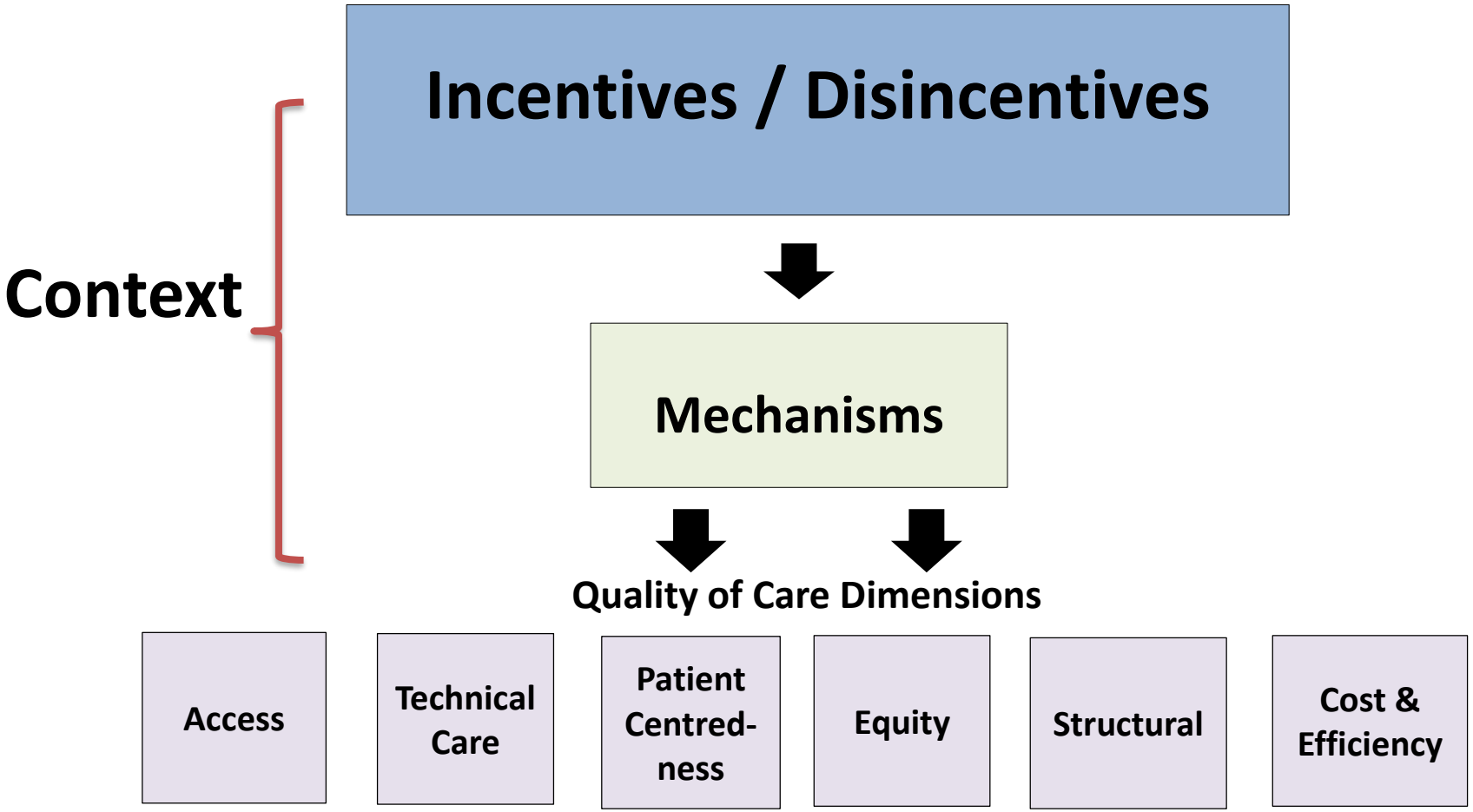


(Yip et al., 2010)

STUDY PURPOSE

To develop a model that describes the **system of incentives** that can be leveraged by stakeholders to improve **access** to **high-quality** care for depression and anxiety in **interprofessional primary care** teams.

STUDY PURPOSE: Developing a Model



QUALITATIVE METHODS

- **Grounded Theory** Approach
- **Individual in-person interviews**
  - Family Health Team Providers
  - Policy Informants
  - Community Stakeholders
- **Analysis**
  - Line-by-Line Coding, Constant Comparison, Weekly Analysis Meetings

METHODS:
Analysis Process

- Initial
- Focused

Core Data Analysis Team
(Rachelle, Matthew, Monica, Jocelyn)

- Axial
- Theoretical

Core Research Team
(Rachelle, Matthew, Simone, Jose, Kwame)

Model Development

METHODS

- **Phase 1: 2015-2017**
  - Descriptive
  - Completed Interviews (n=50)
- **Phase 2: 2017-2018**
  - Explanatory
  - Completed Interviews (n=33)
  - Scheduled Interviews (n=4)

Where we are now

- **Final Aim**: N=100

SAMPLE

- **83 interviews** completed with **70 participants**
- **17** Family Health Teams
- **9** Local Health Integration Networks (LHINs)

SAMPLE: Participant Roles (N=70)

- **Family Health Team Participants (n=59)***

Executive Director (9)
Primary Care Physician (8)
Psychiatrist (6)
Psychologist (2)
Program Manager (2)*
Social Work (14)*
Mental Health Counsellor (9)
Nurse Practitioner (2)
Nurse (1)
Systems Navigator (3)
Occupational Therapist (2)
Outreach Worker (1)
Pharmacist (1)

- **Policy Informants (n=4)**
- **Community Key Informants (n=7)**

*One participant held two part-time positions

SAMPLE:
Participant Disciplinary Background

- Family Medicine*(10)
- Psychiatry (6)
- Public Health/Specialized Health Sciences* (3)
- Social Work (19)
- Counselling Training (2)
- Management/Business Training (8)
- Nurse Practitioner (2)
- Nursing (6)
- Occupational Therapist (3)
- Psychology (2)
- Nutrition Sciences/Dietetics (3)
- Pharmacy (1)
- Life Experience (2)
- Recreation Sciences (1)

*One participant from two disciplinary backgrounds

PHASE 1:
INTERVIEW GUIDE QUESTION EXAMPLES

Access to care	**What makes it more or less likely** that family physicians or other clinicians at your FHT will take on and care for a patient with depression or anxiety?
Technical quality	**What incentives or disincentives** influence whether psychotherapy is delivered to patients in your FHT?
Structural quality	**What** incentives or disincentives **influence** your ability to **provide collaborative care** for depression and anxiety disorders?

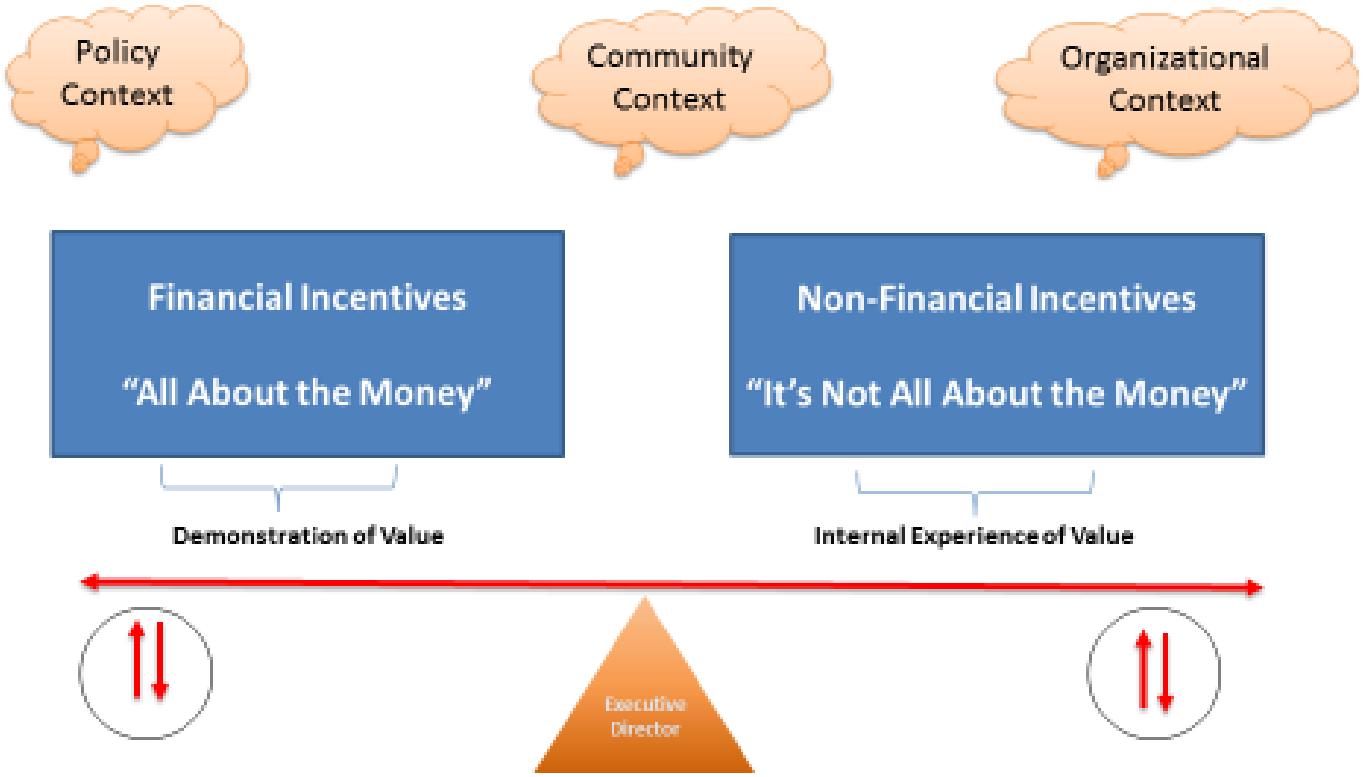
PHASE 2:
INTERVIEW GUIDE QUESTION EXAMPLES

Access Bonus	What are main mental health services impacted by access bonus? **How** is the access bonus impacting collaboration?
Intrinsic Motivators	How do you **maintain** your personal motivation for mental health care?
Autonomy	Many providers cite autonomy as a key driver for mental health care in FHTs. **How does autonomy improve quality of care** for depression & anxiety?

FINDINGS

- **Incentives and Disincentives**
  - Range of Levels
  - Range of Categories
  - Non-Financial and Financial
- **Context**

FINANCIAL & NON-FINANCIAL INCENTIVES



INCENTIVES & DISINCENTIVES: Range of Categories

- **Financial**
  - Physician remuneration
  - Interprofessional Health Provider Salary
  - Psychiatry Remuneration

INCENTIVES & DISINCENTIVES: Range of Categories

- **Non-Financial**
  - Provider intrinsic motivators
  - Making an impact (seeing improvement)
  - Education & training
  - Collaborative support
  - Receiving recognition
  - Performance indicators
  - Peer Comparison

CONTEXT
Practice Context

Nurturing	Challenges
• Leadership • Relationships • Acknowledgement	• High demand • Isolation • Provider burden • Unknown outcomes, unknown impact

CONTEXT
Community Context

Nurturing	Challenges
• Partnerships • Connectivity & flexibility (rare)	• Limited resources: urgent/crisis, longer term psychotherapy, case management • Resource gatekeeping (especially when complex) • Referrals "into the void" • Lack of communication with community/hospital providers (no feedback loop) • Inequitable resourcing • Limited connectivity to 'communities of practice'

CONTEXT
Policy Context

Nurturing	Challenges
• Funding for mental health providers • Potential for engagement at sub-regional level	• Inequities in mental health funding / salaries • Mental health not viewed as a priority • Accountability measures • Leadership & advocacy

FINANCIAL INCENTIVES
Physician Remuneration

There's **no incentives** to support patients with depression or anxiety….The **true cost** needs to be captured…
The **disincentives** are the **amount of time and care** that someone dealing with those issues requires.
(Executive Director)

Physician Remuneration

Capitation works well when people need **longer visits**…or things where you have to bring a team together… **It doesn't work as well** when people need **lots and lots of visits**…and this is actually where it probably hurts mental health care the most… That becomes a disincentive.
(Physician)

Access Bonus

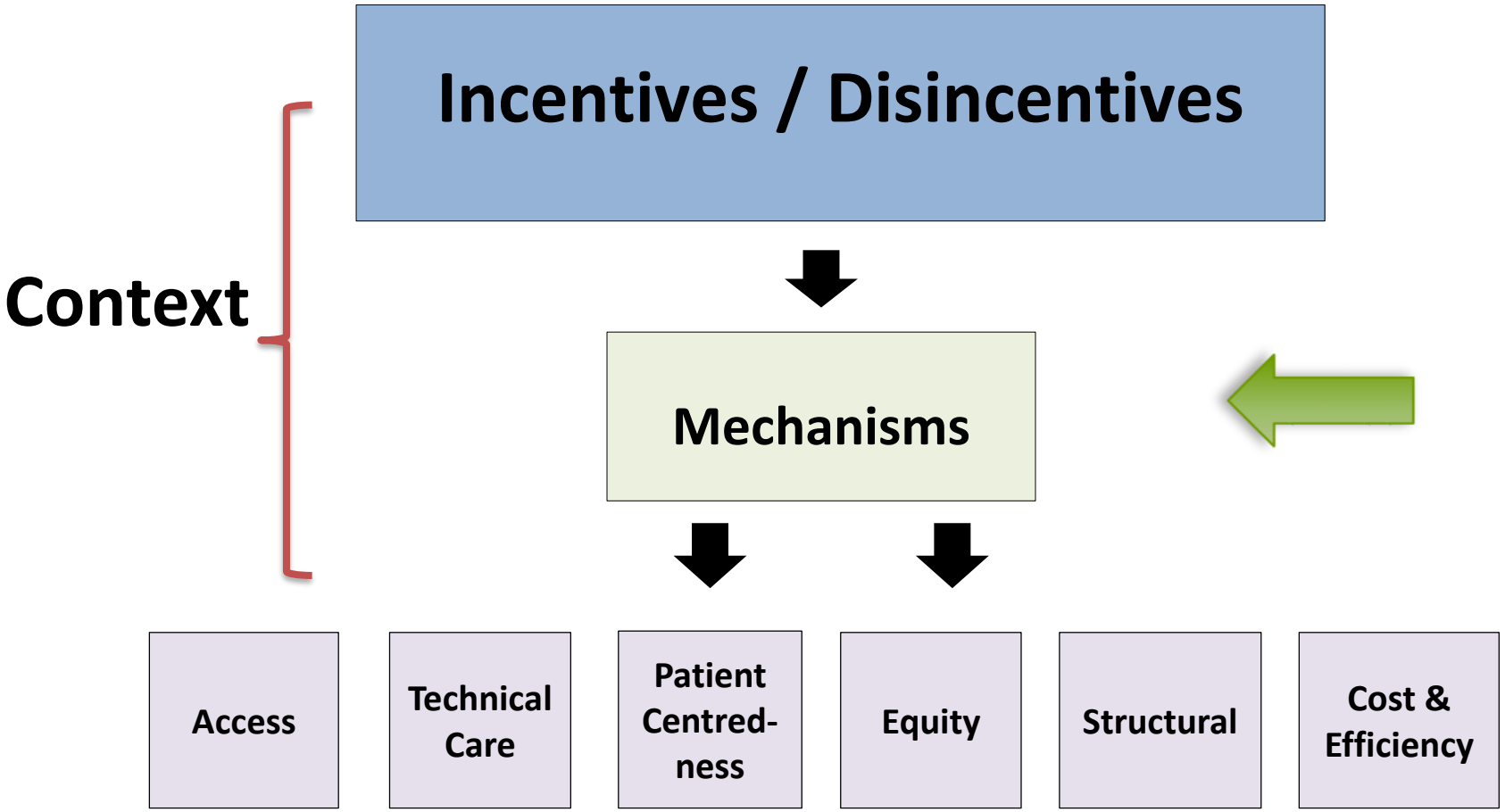
It's meant to promote is access…Unfortunately, many of our patients see family physicians for counselling…for depression and anxiety counselling…
HUGE barrier!
(Executive Director)

NON-FINANCIAL INCENTIVES
Intrinsic Motivators

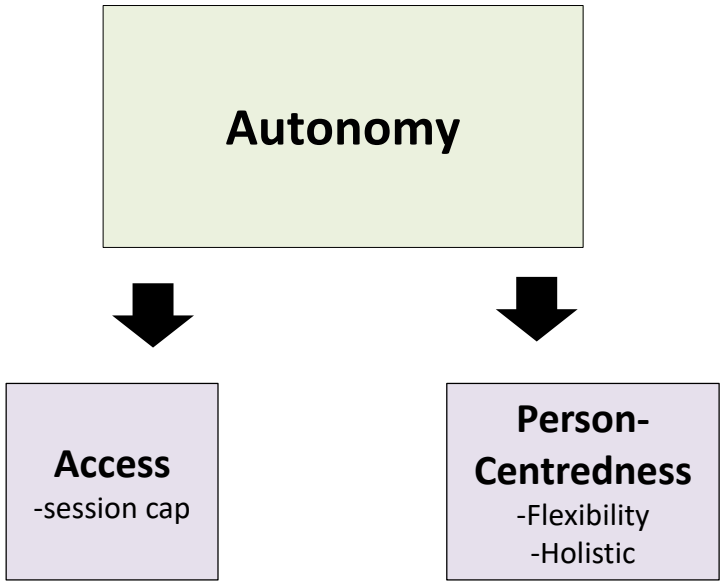
…There's **incentives from a more personal and compassion** perspective…if you actually help someone through their mental illness and they're getting better, you've made a big difference.
Physician

I think I get asked by my patients a lot. "Aren't you tired" like "No, I get to bear witness to your amazing change and your resilience, and what a privilege to do this job.
Psychologist

MODEL-in-DEVELOPMENT
How does it all fit together?



MECHANISM ONE EXAMPLE
Importance of Autonomy

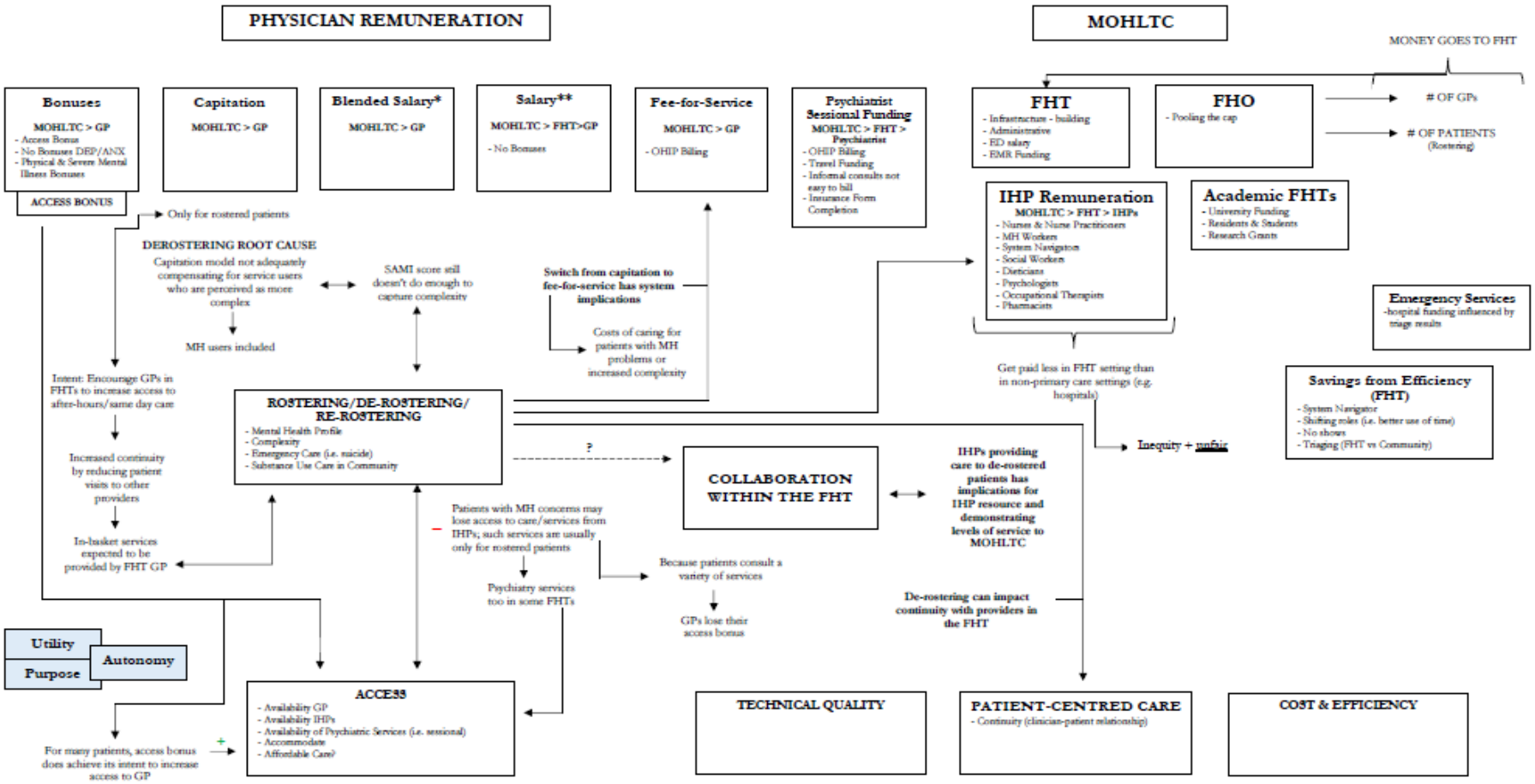


MECHANISM EXAMPLE:
Importance of Autonomy for Collaboration

Autonomous practice means being able to **focus** on **all** of **patient's needs**.
(Occupational Therapist)

Individual autonomy **builds teams**.
(Executive Director)

MODEL-in-DEVELOPMENT: Example of Making the Linkages



CONCLUSIONS

- Family Health Teams are improving capacity to deliver mental health care in primary care

- However, there are **clear misalignments** in the current system of incentives and disincentives that impact care delivered to people with depression and anxiety disorders and impact collaboration
  - **Especially vulnerable patients that have more chronic presentations or greater needs for services**

Next Steps

- **Multi-Level Model**
- **Recruitment of Final Participants** (~n=17)
  - Primary care physicians
  - Executive directors
  - Policy informants
  - Others?
- **Advisory Committee**
- **Focus Groups with Patients**

Acknowledgements

- Participants
- Advisory Committee
- CIHR MOP-142435

DISCUSSION

- **Questions for the Audience**
  - What do you see as some of the key incentives or disincentives influencing the quality of collaboration in Family Health Teams?
  - What do you see as the most influential contextual factors impacting on quality of mental health care in Family Health Teams?

Thank you!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