Using Provider and Patient Feedback to Refine the Treatment Manual for a Brief Primary Care Anxiety Intervention

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Introduction
- Anxiety is common,1,2 yet under-treated in primary care.3,4
- Behavioral health providers (BHPs) working in integrated Primary Care Behavioral Health (PCBH) can help address this treatment gap.5
- Evidence-based, brief anxiety interventions that are patient-centered and feasible for delivery in PCBH are critically needed.6
- Feedback from key stakeholders (e.g., patients, BHPs) is helpful for refining interventions prior to large-scale evaluation or implementation.
- The overall objective of this research program is to develop, refine, and evaluate a brief anxiety intervention that is acceptable to patients and feasible for BHPs to deliver in PCBH settings.

Method

Intervention Development
Adapted evidence-based, cognitive-behavioral techniques into a brief modular anxiety intervention for IPC (up to 6 30-minute sessions, 9 possible modules). Developed treatment manual and patient handouts.

Phase 1: Provider Feedback
Conducted semi-structured interviews with 5 BHPs to collect feedback on the acceptability and feasibility of the intervention and modules.

Phase 2: Patient Feedback
Conducted a pilot open trial with 6 primary care patients with elevated anxiety symptoms (GAD7≥8). Collected feedback on the acceptability of the intervention overall as well as each of the 9 modules.

Intervention Refinement
Revised treatment manual and patient handouts based on feedback.

Phase 3: Pilot Randomized Controlled Trial
Ongoing pilot hybrid 1:1 RCT to examine the effect of the intervention vs. PCBH usual care on anxiety symptoms for Veterans (N = 48).

Modules

<table>
<thead>
<tr>
<th>Name</th>
<th>Intervention Technique</th>
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<tr>
<td>Initial Session</td>
<td>Psycho-education</td>
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<tr>
<td>Identify Anxious Thinking</td>
<td>Cognitive restructuring</td>
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<tr>
<td>Relax Your Body</td>
<td>Relaxation training</td>
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<tr>
<td>Face Your Fears</td>
<td>Exposure therapy</td>
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<tr>
<td>Live in the Here &amp; Now</td>
<td>Mindfulness meditation</td>
</tr>
<tr>
<td>Improve Your Mood</td>
<td>Behavioral activation</td>
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<tr>
<td>Improve Your Sleep</td>
<td>Stimulus control</td>
</tr>
<tr>
<td>Manage Your Stress</td>
<td>Stress management</td>
</tr>
<tr>
<td>Maintain Your Progress</td>
<td>Relapse prevention / referral</td>
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</tbody>
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Results: Patients
- N = 6, 33% female, 100% White, M age = 55.2 (18.9) years
- Baseline GAD7 M = 14.3 (5.0) or moderate severity
- 6 improved significantly on all clinical outcomes
- For all modules, mean helpfulness and relevance ≥4.0 out of 5
- High overall treatment satisfaction
- Acceptability interviews yielded only a few minor suggestions
- Mean satisfaction ratings from 1 (not at all) to 5 (extremely)

Results: Providers
- N = 5, 100% female, 60% White, 40% Black, M age = 35.0 (11.0) years
- 60% psychologist, 40% social worker, M = 2.9 (2.7) years in PCBH
- Sessions occur every 2 to 4 weeks
- Maximum of 6 sessions
- Phone visits are challenging
- Deliver manualized intervention
- Start with 1 of 3 core modules
- Collaboratively select modules

Provider Feedback
- Some patients may need more than 6 sessions (e.g., low readiness to change, struggling with skills)
- Telephone sessions may be challenging (e.g., may miss non-verbal cues, hard to hear patient)

Refinements Made
- Add rationale for BHPs to manual, provide scripting for BHPs, allow flexibility based on patient needs
- Encourage face-to-face for certain modules, offer phone or video based on patient preference

Reservations about manualized treatments (e.g., inflexible, creates artificiality, limits creativity)
- Add rationale for BHPs to manual explaining benefits & evidence base, debunking misconceptions

Tough to jump right in during first BHP visit (e.g., need time for assessment & other requirements, complex patient unsure if anxiety is top concern)
- Offer option of having “Session 0” for first BHP visit, provide scripting for BHPs to offer intervention, start with intervention initial session at second BHP visit

Conclusions
- Collecting feedback from key stakeholders was extremely helpful in refining the anxiety intervention to increase acceptability for patients and providers.
- BHP feedback identified several important feasibility considerations. We made refinements consistent with PCBH practice when possible, and otherwise developed explanations, tips, and scripting to assist BHPs in implementation.
- Taking time to collect and incorporate patient and provider feedback prior to the current ongoing pilot RCT was a worthwhile investment that has improved the intervention and enhanced the likelihood of a successful trial.
- We will continue this iterative procedure in the pilot RCT. We are conducting a process evaluation to collect similar patient and provider feedback, which will be used to further refine the treatment manual ahead of a planned multisite RCT.

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