

Growing a Culture of Feedback: Improving Team member Knowledge Surrounding Feedback

Informed Treatment

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**Abstract**

*Objective:* The project site—a 26-member organization committed to improving the mental health and well-being of its Portland community—lacks a systematic way to evaluate and improve the quality and effectiveness of the mental health services it provides. The purpose of this project was to increase organizational knowledge and understanding about a method of routine outcome monitoring called Feedback Informed Treatment (FIT), and to make steps towards its eventual implementation. Implementation research on FIT indicates that organizations must have a strong existing culture of feedback before attempting to move through the five stages of FIT implementation. This project provided team members at the private practice clinic with training in the essential concepts of FIT to further promote the organizational culture of feedback. *Methods:* The Plan Do Study Act (PDSA) method of quality improvement was used to carry out interventions. Pre- and post-intervention surveys were conducted electronically. Literature review using PubMed, CINHALL, and the Cochrane Library, was conducted to identify relevant articles. *Intervention:* Two, one-hour trainings were conducted via video conference. Pre- and post-intervention surveys were conducted to evaluate individual knowledge of FIT and its basic principles, as well as attitudes regarding the compatibility of the FIT model with organizational values. *Results:* Organizational completion rates of the pre- and post-intervention surveys were 84.6% and 69.2%, respectively. Despite inconsistencies in participation, the results showed a substantial increase in mean level of knowledge of the basic principles of FIT and belief that FIT was in line with organizational values after both educational sessions. *Conclusions:* This quality improvement project was a valuable first step in the multi-phase process of growing and strengthening the practice's existing organizational culture of feedback essential to successful implementation of FIT.

## **Problem Description**

As a “Learning Organization” dedicated to improving the mental health and well-being of its Portland community, the practice lacks a systematic way for clinicians, clients and the organization itself to evaluate and improve the quality and effectiveness of the mental health services it provides. To make steps towards implementing such a system, this project recognized that individuals from all departments of the practice required education surrounding basic tenets of the approach leadership identified as most compatible with its organizational values. Team members needed knowledge regarding FIT.

## **Available Knowledge**

As therapy is conducted in private—between clinician and client—measuring outcomes and effectiveness as a practice, or organization is difficult. It is particularly difficult for clinicians to accurately evaluate their own personal level of effectiveness, as research across numerous professional fields consistently finds a strong presence of self-assessment bias. For example, a 2012 study with a multi-disciplinary sample of mental health professionals found that roughly 25% of the group ranked their skill level in the 90<sup>th</sup> percentile, while none perceived their level of skill as below average (Walfish et al., 2012). These clinicians also tended to report overly positive assessments of client improvement, while underestimating rates of clients experiencing worsening of symptoms (Walfish et al., 2012). Even more interesting is that the literature shows little difference between the effectiveness of recent graduates as compared to seasoned clinicians (Goldberg et al., 2016). In fact, a large-scale longitudinal examination of clinicians’ professional development found that clinicians became slightly *less* effective over time (Goldberg et al., 2016).

The organization hopes to address the problem of measuring the effectiveness of its services through using a transtheoretical, evidence-based approach known as FIT. Through FIT, clinicians routinely gather real-time input from clients using structured, yet flexible measures that identify what *is* and *is not* working in therapy. Treatment is then driven by client input, which allows clinicians the opportunity to make prompt adjustments to the plan of care, preserving or even strengthening the therapeutic alliance. Some of the more popular systematized rating scales which clinicians may use to monitor progress include (but are not limited to): a collaborative outcomes resource network (ACORN), the outcome rating scale (ORS) and the session rating scale (SRS). Scales are completed electronically by the client at either the beginning or end of sessions and generally take less than a minute to complete.

A number of randomized controlled trials and several meta-analyses support the effectiveness of routine outcome monitoring in improving client retention, decreasing no-show rates, decreasing length of treatment, strengthening the therapeutic alliance and improving outcomes in clinical practice (Miller & Schuckard, 2014; Shimokawa et al., 2010; Knaup et al., 2009; McLeod, 2011). Research also indicates, however, that it is the way in which the clinician implements the tools—and the culture surrounding the use of the tools—that improves outcomes (Prescott et al., 2017). The clinician must thoughtfully introduce and explain the rationale behind use of the tools in such a way that dissolves any fear of retribution, while also conveying a deep respect for the client's view of treatment as the ultimate driver of success. The clinician must create a safe space for both positive and constructive feedback.

## **Rationale**

The Transtheoretical Model (Prochaska & Velicer, 1997) underpinning FIT is based on the five stages of change concept, which has been used to study people's ability to change their

behavior (e.g., smoking cessation). The stages of change include: precontemplation, contemplation, preparation, action, and maintenance (Polit & Beck, 2017). To make change, the stage in which one currently exists must be identified. Next, a Plan-Do-Study-Act (PDSA) cycle is carried out. Outcome measures of the PDSA cycle are studied and modified so that the cycle can be repeated until satisfactory results are achieved and can be maintained. These same principles studied in individuals desiring to change health behaviors apply to organizations assessing their readiness to change, or to improve certain behaviors.

Research in implementation science shows that there are typically five stages of development organizations must undergo to successfully effect lasting change (Prescott et al., 2017). These stages include exploration, installation, initial implementation, full implementation, and sustainment. An informal assessment with the practice's leadership indicated that the organization was toggling somewhere between the exploration and installation phases. Leadership agreed that before formally assessing the organization's readiness to implement systematic outcome measures with an assessment tool, all organizational team members needed an opportunity to learn the principles of FIT. Furthermore, implementation research shows that roughly between 70% and 90% of unsuccessful implementation attempts occur when organizations are not committed to the process of moving completely through each stage (Prescott et al., 2017).

### **Purpose**

The purpose of this project was to increase organizational knowledge and understanding about FIT. Implementation research on FIT indicates that organizations must have a strong existing culture of feedback before attempting to move through the five stages of FIT

implementation. This project provided team members at the practice with training in the essential concepts of FIT to further promote the organizational culture of feedback.

### **Specific Aims**

By March 2021, eighty percent or more of team members will report an understanding of the basic tenets of FIT. Eighty percent or more of team members will report that use of routine behavioral health outcome measures, as described in FIT, is in line with organizational values.

### **Methods**

#### **Context**

As a “Learning Organization”, the practice views the personal and professional growth of clinicians as a lifelong discipline, regardless of years of experience. The practice’s organizational core values are based on concepts developed by systems scientist Peter Senge. In his book, *The Fifth Discipline*, Senge explains how team learning, building a shared vision, mental models, personal mastery and systems thinking are all components of what make a “Learning Organization” (Senge, 2006). The ideas of interdependence and a commitment to continuous individual and team learning are central organizational values. The practice’s organizational values provide fertile soil for the culture necessary for the successful implementation of FIT.

#### **Intervention**

To increase clinician knowledge level of FIT and make connections to the practice’s organizational values, this project provided team members with two, one-hour FIT educational sessions. Prior to each session, an email with relevant reading materials was sent to all team members. The one-hour trainings were conducted via video conference, using a power point presentation to highlight important information about FIT, and guide discussion. The second one-hour educational session included a 10-minute breakout group activity, in which individuals

were assigned to groups of three to four team members to role play a client-clinician interaction using the FIT model. This writer provided team members with an example of how to introduce the FIT model as a clinician and instructed team members to switch roles from client to clinician (and vice versa) after several minutes of introduction and explanation of the model. Observing participants and “clients” in breakout groups were encouraged to offer “clinicians” both positive and constructive feedback surrounding effectiveness of delivery and approach. Educational sessions included all staff (26 total team members) who were able to attend and allowed for 10 to 15 minutes for questions and/or discussion at the end of each session. Although both directors were present in the sessions and actively engaged in discussion, they were asked not to participate in pre-test/post-test surveys to avoid potential bias related to their knowledge level of FIT based on previous attendance of trainings and involvement in assisting this writer with scheduling interventions. All other team members (ten therapists, seven PMHNPs, and six administrative team members) were asked to participate.

### **Study of the Intervention**

Participants engaged in a six-question, Likert-type scale pre- and post-test intervention survey to measure level of confidence in knowledge of FIT. The outcome measures of the interventions included observation for impact on 1) individual level of understanding of FIT and its basic principles, and 2) increased consensus among team members that FIT was in line with organizational values. This writer facilitated scheduling and sending invitations to the virtual educational sessions with leadership. The one-hour educational sessions occurred during monthly scheduled team meetings on 02/04/21 and 03/04/21.

### **Measures**

Outcome measures were defined as the percentage of team members who, after attending educational sessions, reported feeling more confident in their knowledge of the basic tenets of FIT, and that FIT principles and organizational values were aligned. The process measures in this intervention included the percentage of team members who were not able to attend the educational sessions. The rationale behind selecting this as the process measure was that team members, for the most part, design their own work schedules—this inevitably meant that not all team members would be available at the same times. This directly tied into the balancing measures for the intervention. Coordinating with leadership to schedule a time for the educational session which maximized the number of participants, yet did not detract from other aspects of work (e.g., asking clinicians to sacrifice personal time and or potential work time to attend), was an important consideration so that the sessions had a net positive organizational impact.

### **Analysis**

Pre-test/post test data were analyzed using univariate statistics (mean, median, mode, etc.) and distribution for outcomes were presented as bar graphs. Due to study design, paired t-tests for pre- and post-educational session survey data were not used to determine if difference between means was statistically significant.

### **Ethical Considerations**

Oregon Health & Science University Institutional Review Board approval was obtained prior to initiating this Doctor of Nursing Practice Project. As all participants in the intervention were team members voluntarily engaging in the educational sessions, this project was Institutional Review Board exempt. Participant pre-tests/post-tests did not include any form of identifying information and disclosure of responses outside of the project was deemed “minimal



risk” (as defined by federal regulation 45 CFR 46) for participants. There are no conflicting interests to report.

## Results

Although fewer post-intervention responses were obtained ( $n = 18$ ) than pre-intervention responses ( $n = 22$ ), the data show a positive trend towards specific aims after the educational sessions. Advanced statistical analysis was not utilized in the design of this improvement project, which did not allow for statistical significance to be achieved; thus, comparison of pre- and post-intervention data only suggests trends. The data do, however, indicate remarkable trends in that team members who attended the educational sessions both 1) increased individual level of understanding of FIT and its basic principles, and 2) increased belief that FIT is in line with organizational values. See Appendix for pre- and post-intervention survey data.

Despite inconsistencies in participation, the results showed a substantial increase in mean level of knowledge of the basic principles of FIT and belief that FIT was in line with organizational values. For example, 14.29% of pre-intervention survey responses indicated that the statement *I can describe the purpose of FIT* was “fully true.” After the second one-hour educational session, 44.44% of survey responses indicated that the statement *I can describe the purpose of FIT* was “fully true.” With respect to selecting survey statements as “fully true,” listed here are the respective differences in pre- and post-intervention survey responses for the remaining five questions: *I understand the core tasks of FIT* (9.52% vs. 38.89%); *I understand how FIT can benefit my clinical work* (13.64% vs. 72.22%); *I understand how FIT can impact client outcomes* (13.64% vs. 61.11%); *I can explain the purpose of FIT to a client* (9.09% vs. 38.89%); *I believe FIT values and organizational values are aligned* (36.36% vs. 76.47%).

These figures point towards the utility of the educational sessions in increasing team member knowledge of FIT.

### **Discussion**

To make steps towards implementing a systematic way for clinicians, clients, and the practice itself to evaluate and improve the quality and effectiveness of the mental health services it provides, this project sought to improve organizational knowledge of FIT. The Transtheoretical Model (Prochaska & Velicer, 1997) underpinning FIT and research in implementation science (Prescott et al., 2017) show that organizations must have a strong existing culture of feedback to successfully move through the five stages of FIT implementation. This project provided team members with education in the essential concepts of FIT to further promote development of the organizational culture of feedback.

Although post-intervention process and outcome measures indicate that the specific aims of this project were not achieved (80% comprehension of FIT and its alignment with organizational values), strong improvements in outcome measures were observed. In fact, the data shows (relative to the process measure) that if summing the number of “fully true” and “mostly true” post-intervention survey responses, the specific aims of the project were achieved. This indicates that future iterations of the PDSA cycle might benefit from placing more emphasis on operationalizing metrics of project aims (e.g., 80 percent of team members will report feeling it is “fully true” that they understand the purpose of FIT).

### **Interpretation**

Perhaps the most unexpected outcome measure of the intervention was related to the statement *I believe FIT values and organizational values are aligned*. 36.36% of pre-intervention survey responses identified this statement as “fully true,” while 31.82% of responses reported the

statement as “mostly true.” This is surprising, as it indicates most participants believed that FIT and the practice’s organizational values were aligned, despite only 9.09% of pre-intervention responses reporting the statement *I can explain the purpose of FIT to a client* as “fully true.” This suggests that the casual conversations, informal exchange of information and formal FIT training several team members attended over the past year likely impacted team member perception of FIT with respect to organizational values.

Post-intervention survey results for the statement *I believe FIT values and organizational values are aligned* show that 76.47% of responses identified this statement as “fully true,” while the remaining 23.53% of responses identified the statement as “mostly true.” This is a significant change, as 18.18% of pre-intervention responses to this statement reported “not applicable,” while the options “not at all true,” “slightly true,” and “somewhat true” were all reported at 4.55%, respectively. As the intervention included team members from all departments (e.g., billing, administration, payroll and benefits, clinicians), the organizational value of interdependence was a central theme in discussion, as it highlighted why a model such as FIT would be relevant to every department of the organization, whether or not the team member was directly implementing it with a client.

The intent of this project was to educate team members with knowledge to better understand the tenets of FIT as they relate to the practice’s mission as a “Learning Organization.” This is a salient point, as the literature suggests that building a strong culture of feedback is foundational to the successful implementation of FIT.

### **Limitations**

One limitation identified in this improvement project was the design of measures. Due to the design of the study, pre- and post- intervention survey responses were not paired; therefore,

paired t-test analysis which would provide statistical significance and correlation was not achievable. Nonetheless, results indicated a strong positive trend towards the aims of this project, which contributed to achieving the general goal of increasing team member knowledge of the basic principles of FIT and aligning this knowledge with the practice's mission as a "Learning Organization."

Another important limitation to acknowledge is the potential for established relationships to influence data. As this writer completed a clinical placement ultimately leading to employment at the practice, this may have accounted for preexistent buy-in of the FIT model, or overly positive appraisal of the intervention due to pre-existing relationships. In addition, several team members completed formal FIT training prior to the time of intervention. This had notable implications for the project's outcome measures, as certain participants entered the educational sessions with a significant knowledge of FIT principles.

The generalizability of this project is limited by the fact that measuring organizational culture of feedback is not a standardized practice among mental health clinics. In addition, organizational readiness to implement FIT was not formally assessed with a tool because—according to the FIT Implementation Checklist—the organization appeared to be in the early stages of development (Prescott et. al, 2017). A future iteration of this project may yield more generalizable results after the organization has passed through the five stages of development and is formally assessed using a tool such as the Feedback Readiness Index and Fidelity Measure (Miller, Mee-Lee, & Plum, 2012).

## **Conclusion**

This quality improvement project was a valuable first step in the multi-phase process of the practice growing and strengthening the existing organizational culture of feedback essential

to successful implementation of FIT. The practice's desire to make steps towards implementing a systematic way for clinicians, clients and the practice itself to evaluate and improve the quality and effectiveness of the mental and behavioral health services it provides is unique. The findings of this quality improvement project are that after being provided with education surrounding the basic tenets of FIT, team members reported that FIT principles were in line with organizational values. This is significant, as it indicates that ongoing steps towards the eventual implementation of FIT are more likely to be successful with team member acceptance and support of the model.

Next steps for the practice might include ongoing communication to all team members surrounding the motivation to change, explicitly defining the organizational mission and how this relates to FIT, defining team member roles, prioritizing learning, and discussing budget requirements (Prescott et.al, 2017). When appropriate, the organization may want to contract with certified FIT trainer to act as a consultant to an internally formed transition oversight group. This group would develop a charter and initiate a training plan, work plan and policy driven approach to providing stakeholders with relevant data (Prescott et.al, 2017). As culture is malleable, dynamic, and subject to change based on the intention and goals of those participating in its creation, regular discussion of organizational culture and values may be beneficial until formal assessment indicates that successful implementation of FIT possible.

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## Appendix

