Communication Between Primary Care Providers and Medical Family Therapists: Reducing Barriers to Collaborative Care

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Communication Between Primary Care Providers and Medical Family Therapists:
Reducing Barriers to Collaborative Care

by

Mary Margaret Waschka Killmeyer

An Applied Clinical Project Presented to the
Graduate School of Humanities and Social Sciences of Nova Southeastern University
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Marriage and Family Therapy

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Graduate School of Humanities and Social Sciences

This Applied Clinical Project was submitted by Mary MW Killmeyer under the direction of the Faculty Supervisor and Reviewer of the Applied Clinical Project listed below. It was submitted to the Graduate School of Humanities and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Marriage and Family Therapy in the Department of Family Therapy at Nova Southeastern University.

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Abstract

A review of the research related to Medical Family Therapy demonstrates that the inclusion of marriage and family therapists as part of the healthcare team offers benefits such as decreased utilization of healthcare, decreased costs, increased positive outcomes for patients and healthcare systems. However, studies demonstrate the difficulty with communication between providers limiting access to marriage and family therapists. Results of this study identified benefits to working with medical family therapists including broadening the understanding and using a collaborative effort to help the patient improve and get better. Participants also identified barriers to collaboration such as the lack of knowledge of and access to MedFTs, their inclusion in the system, MDs finding value in the MedFT profession, and that the communication process is lacking. Further need for improved communication at the referral and follow-up stages in collaborative practices is shown. In order to move more toward collaborative practices, PCPs and MedFTs need to develop and disseminate training on treatment notes, communication, team meetings, and continuance of collaborative work with one another.
CHAPTER I: INTRODUCTION

Inspiration

During my clinical training as a doctoral student at the Brief Therapy Institute of the Department of Family Therapy at Nova Southeastern University (NSU), I had the opportunity to work with clients experiencing a wide array of mental and behavioral health issues. One client, in particular, stood out to me because the problems he presented were connected to chronic medical illness. He suffered from seizure activity requiring surgical intervention. He experienced significant impairment in cognitive functioning; his relationships and ability to support himself suffered as a result. I worked with this client for an extended period of time, and the case spurred an interest in working with clients who suffered from acute and chronic illnesses.

The Graduate School of Humanities and Social Sciences of Nova Southeastern University offers a Graduate Certificate in Family Systems Healthcare for students in professional studies. Students focus on relationships between the biological, psychological, and sociological components of health in the treatment and prevention of illness (Nova Southeastern University, 2015). The preparation for students of NSU to work in diverse healthcare settings is described below:

Specific areas of study include adjustment patterns of patients and their families to chronic and acute illnesses; models of integration and collaboration among medical systems and other health care professionals; the role of the family health care provider in the continuum of services; the politics and economics of health care; understanding human systems in health care; and brief interventions and systemic assessments useful in the treatment and care of patients, their families, and

MedFT is a field of family therapy that utilizes systems thinking to work with families with health issues. MedFT challenges therapists to think about illness and health in complex ways that are both collaborative and effective. From this perspective the family therapist can work in collaboration with traditional medical providers in primary care and specialty fields.

I reviewed research in a field of my choice to explore current literature in the area of medical family therapy. My ideas for this project remained with me while I completed other coursework and clinical experience. MedFT is an emerging field and the research available is scarce. I found few studies (Caldwell et al., 2006; Clark et al., 2009; Law et al., 2003) that geared their research toward that better understanding this field.

Through a national study of family physicians, Clark et al. (2009) identified barriers that placed limitations on ideal collaborative practices including difficulty with referral, awareness of marriage and family therapy specialty areas, availability of therapists, and attitudes toward family therapists. Law et al. (2003) found that participants in marital and family therapy reduced their healthcare utilization significantly by 53%. Participants of individual therapy also decreased utilization significantly by 48%. Caldwell et al. (2006) found that there were many reasons for the inclusion of complementary and alternative medicine (CAM) strategies. The most common reasons were chronic or recurring pain, the belief that combining CAM with conventional medicine would be more effective, recommendations by a medical professional, giving up on conventional medicine, and conventional medicine being too costly. These researchers demonstrated that the
collaboration of mental health professionals with traditional medical physicians can benefit patients. However, barriers continued to exist that prevent effective collaboration, including awareness of the family therapy MedFT specialty, availability of therapists, difficulty of referral, and attitudes toward family therapists.

**Conceptualization**

Over the years in my independent clinical practice, I have worked to market my skills in MedFT to local physicians who have demonstrated interest in collaborative care, integrative care, or the bio-psychosocial approach to wellness. When it came time to conduct research on this Applied Clinical Project, I focused on MedFT and how to best serve my clients who suffer from medical issues or who are referred from primary care physicians. I reconsidered the research review described previously and recognized that the suburban area in which I am located naturally provided a reduction of the barriers to collaboration, such as awareness of the family therapy specialty and attitudes toward family therapists. Other factors that assist in reducing barriers include the amount of time between the studies reviewed and this 2015 current study allowing more awareness of and exposure to the field. Political marketing and lobbying provided by national organizations and special interest groups has also helped to increase awareness and alter attitudes regarding the family therapy profession.

Originally, the intent of this study was to examine the overall experience of both physicians and patients with the intentions to reduce barriers to collaborative care, reduce fragmentation, and examine the efficacy of including MedFT in the treatment of patients suffering from acute or chronic illness. However, it was evident that at the outset that these goals were outside the boundaries of this project and would require additional research. The
logical concept raised was to focus on the point at which the relationship begins—at referral.

Returning to the barriers discussed earlier that exist, the referral and communication between providers was an important aspect to me, as this was a barrier I felt experienced and impacted my own practice and clinical experiences. It was very difficult for me to abandon the patient aspect of experience; I have designated more of my time to patients and the helping nature of both family therapists and physicians lends itself to caring for clients and patients more than other aspects of case management.

At the best possible time, a close friend of mine reached out to reconnect. She asked probing questions that helped me view the dilemma differently. She and her family were precisely the type of clients I was looking to help. Her sister, at a young age, was diagnosed with advanced stage breast cancer requiring surgical intervention, medical/chemical intervention, as well as family, community, and spiritual support. Thankfully, her sister had undergone treatments and her prognosis was looking very positive despite the long hard road they had traveled. After listening to me discuss concerns about not focusing on the clinical intervention or client experience, she suggested that in their experience referral and communication between a family therapist and treating physicians would have been welcomed. In particular she noted that the time allotted for questions and concerns was not always available, scheduling conflicts prevented certain members from participating in appointments, among other difficulties. From her experience, she could have been better supported by having a third party professional, trained in relationships and emotional/mental health to provide additional attention to the difficulties associated with her sister’s illness. After our conversation, I recommitted to my project with a belief that developing a system of referral and communication would be the first steps in providing better, more comprehensive
services to patients. Therefore the research question, “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers?” emerged.

In the following chapter, I provide a review of the literature that demonstrates an overview of the field of MedFT, collaboration between providers, clinical considerations, as well as the relevant research available. Important to note is that collaborative care differs from integrated care in the approach and delivery of services, despite being used interchangeably in some texts. For this reason, literature on integrative care has been excluded for the purposes of this project. Integrated care refers to the integrations of psychological or behavioral health interventions from within the same facility or location (Sperry, 2014). This practice often includes healthcare teams, in which practitioners regularly share patients and discuss cases. Collaborative care does not require sharing of location as in integrated medicine, but does allow for practitioners to work together and consult on cases for a dynamic treatment approach.
CHAPTER II: LITERATURE REVIEW

Medical Family Therapy

Overview

Over thirty years ago, McDaniel, Hepworth, and Doherty (1992) coined the term “medical family therapy” in the first text on the subject after many years of interest and writing on the topic with the knowledge that “there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications,” (McDaniel et al., 1992, p. 2). Family systems theory offers a multifaceted view of complex problems and circular interactions involving patients, family members, providers, and other stakeholders. MedFT is aimed at promoting involvement of patient’s and families in their own care, known as agency, as well as caring for the emotional bonds that are often affected by illness and disability (McDaniel et al., 1992). Medical family therapists practice in a variety of setting including primary care and training settings, specialty medical settings, as well as private practice and other mental health settings (McDaniel et al.).

The two major approaches to illness are the biomedical approach and the biopsychosocial approach. Developed by a psychiatrist, George Engel, in 1977, the biopsychosocial approach is a response to criticisms of the biomedical approach.

The biopsychosocial model is both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the patient’s subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care. (Borrell-Carrió, F., Suchman, A., & Epstein, R., 2004, p.576)
Despite offering a great deal of expertise, the biomedical practitioner may tend to ignore the person who has the disease. This humanistic approach to medicine became a foundation for patient-centered care (Boyd & Watters, 2013). The biopsychosocial approach acknowledges the hierarchical relationships between individuals, families, and groups in relation to illness factors such as somatic and psychophysiological responses (McDaniel et al., 1992). This is an excellent fit for systemic family therapists as they are trained to attend to the multiple factors that affect their clients.

Issues facing individuals coping with illness or disability is a surprisingly overlooked topic in therapy literature. Rolland (1994) lists a handful of exceptions to this phenomenon. He states that with new technology and improved standards of living, individuals are living with illnesses that were once fatal. This means that the number of acute and chronic illnesses that individuals are living with is growing. Illness places a large strain on individuals across many facets of life: emotional, cognitive, behavioral, physical, and social (Peterson, Bull, Propst, Dettinger, & Detwiler, 2005). Current therapeutic interventions used with one example of chronic illness, cancer, are cognitive and behavioral approaches (Peterson et al., 2005). These interventions, while fitting with the medical system’s philosophy, assist with many functions of health management including compliance, coping, symptom control, and sense of control over the self or illness (Peterson et al.). Another area of concern for individuals facing illness is the demands placed on relationships with family and others. The illness places a strain on intimacy and communication and skews beliefs about the problem, boundaries, roles, gender, sexuality, and spirituality (Rolland, 1994).

Recent trends in the fields of medicine and mental health have identified the increasing awareness of a connection between mind and body. Some “early pioneers [of
family therapy] such as John Weakland, Lyman Wynne, Carl Whitaker, Murray Bowen, Salvador Minuchin, and Edgar Auwerswald foresaw the benefits of using family therapy to address problems of both mental and physical health (McDaniel et al., 1992, p. 5). Marriage and family therapy establishes a strong foundation for collaborative practices due to its systemic approach, as evidenced by research produced by Law, Crane, and Berge (2003). In their study, the researchers found that the participants in marital and family therapy as well as individual therapy decreased their healthcare utilization significantly.

**Collaboration**

Collaboration between professionals is the more commonly known practice where medical professionals and mental health professionals work together as a team, along with the patient toward achieving a health care goal. This collaboration is central to comprehensive medical care for patients; studies have shown that a collaborative approach leads to higher rates of kept appointments, and increased compliance with prescribed medication. Collaboration between clinical, operational, and financial systems is less often addressed in texts, but is an essential consideration for great clinical care. Clinical care refers to all the clinical interactions between the staff and the patient. The operational level refers to the processes necessary to be productive and efficient. The financial level refers to the business and financial operations required to allocate resources. When examining from a larger perspective, a hospital or organization will only function successfully in the long term if each of the three systems are succeeding. When examined from the individual perspective, the treatment outcome is not likely to be positive without success at all three levels (Kessler & Stafford, 2008).
Although the outcomes to integration of collaborative efforts could have multiple positive benefits, Kessler and Stafford (2008) identify some concerns they have experienced that may arise. First, administrative planning requires making difficult decisions about the allocation of resources that not only promote the financial well-being of the organization while also attending to the balance between services offered. A second obstacle to integration is the vastly different approach required of the medical field to that of the mental health field. Medical practitioners are generally more accustomed to the fast-paced nature of their field, where the mental health clinician’s approach is more gradual. The integration of these two separate approaches requires understanding and respectful appreciation on both parts for either to be successful. The third barrier to implementation is the assumption that the administrators, financers, and practitioners are on the same page in terms of policy, implementation, and practice. If information is disseminated without an open and clear discussion of expectations, it is likely that each team member has a different perspective on the information provided. The final difficulty to integration is the use of data to direct not only treatment procedures, but also to research the effectiveness and outcomes for patients.

The list of barriers is not a surprising one. These are similar to any barriers that might impede a relationship not only in healthcare, but also in business, education, and personal life. It seems as though the only effective measure to overcome these obstacles is open communication during all stages of an organization’s development. During the planning phases, strategies, and expectations should be clear and well thought out. The initial implementation of procedures should also include systematic feedback from all levels of the organization including administration, financers, support staff, clinicians, and patients. Feedback should be reviewed and discussed to find more effective or efficient ways to
deliver services. This process should be continuous as an organization continues to provide services to fit an ever-changing population.

In their original text, McDaniel, Campbell, and Seaburn (1990) (as cited by McDaniel et al., 1992, p. 39) offered the table below, to list the varied challenges to collaboration:

### TABLE 1

| Differences in the Working Styles of Primary Care and Mental Health Professionals |
|---------------------------------|---------------------------------|---------------------------------|
| **Language**                    | **Primary care professionals**  | **Mental health professionals** |
| Traditional paradigm            | Medical                         | Humanistic, psychoanalytic, or systems |
| New paradigm                    | Biomedical                      | Psychoanalytic                  |
| Professional style              | Action-oriented                 | Process-oriented                |
|                                 | Advice-giving, MD takes initiative | Avoids advice                 |
| Standard session time           | 10-15 minutes                   | 45-50 minutes                   |
| Demand for services            | Around the clock                | Scheduled sessions except for emergencies |
| Use of medications              | Frequent                        | Infrequent                      |
| Use of individual and family history | Basic                          | Extensive                      |
| At risk for                     | Somatic fixation                | Psychosocial fixation           |

The above table demonstrates some of the many differences in approach to patients and treatment that create barriers to communication and collaboration between primary care and mental health professionals. “These differences, if not acknowledged, impede collaborative work” (McDaniel et al., 1992, p. 40).
Clinical Considerations

One development made in the therapeutic treatment of families coping with illness is Rolland’s (1994) typology of illness. In the typology Rolland presents five categories or characteristics of illness that will ultimately determine the type of therapy necessary and the challenges the clients will face. The first characteristic is the illness’s onset. This can be either gradual, meaning a slow progression of symptoms, or acute, meaning a quick progression of symptoms or a rapid event that alters one’s health. Each type of onset carries its own set of challenges as it relates to diagnosis and treatments, possible uncertainty, and may require flexibility on the part of the family to adapt and adjust to varying symptoms. The second category of Rolland’s typology is course, which refers to whether the illness is progressive, maintaining, or relapsing and remitting. Outcome, the third characteristic, refers to the ultimate prognosis of the illness. This characteristic helps the family define long-term goals for their treatment if the prognosis is known. The fourth characteristic, incapacitation, helps clients and therapists determine what, if any, incapacitation has occurred because of the illness, as well as any challenges that may be presented due to that incapacitation. The fifth category of Rolland’s typology refers to the degree of uncertainty an illness brings with it. If it is unclear how an illness will affect the family that clues the therapist to discuss and be aware of the family’s level of flexibility and adaptability, as they may need to be able to quickly recover from new and unexpected events. As demonstrated above (Kessler & Stafford, 2008; McDaniel et al., 1992) primary care physicians are engaged in a high demand, fast-paced environment that may not allow for the provider to offer their time and attention to discuss these variants of illness and the many impacts they may have on the patient and the family.
Education and Training Settings

While there are many specialties that provide little direct interaction with patients and families, those that do require increased interaction or the ability to assess, plan intervention, or provide family therapy are moving to a competency based system (Reitz & Sudano, 2014). Several authors, as cited by Reitz and Sudano, have presented competencies necessary by behavioral health practitioners in medical settings including Bischoff, Springer, Reisbig, Lyons, and Likcani (2012) and Tyndall, Hodgson, Lamson, White, and Knight (2012). Reitz and Sudano present a selection of these competencies, along with a crosswalk to other professional competencies, to demonstrate the requirements for training across professions. These competencies include (but are not limited to) understandings of healthcare systems; understanding of evidence-based models of Marriage and Family Therapy; demonstration of skills in managing demands of illness, empowerment of patients; ability to motivate health-related change, ability to refer, document, and communicate with other professionals, and sensitivity to systems; as well as evaluate and design interventions (p. 179). The authors identify a significant overlap between competencies, however it is not clear that the varied professions possess the same underlying definitions and understandings of these competencies. In addition the authors cite the value of utilizing a reciprocal relationship in training and knowledge sharing among specialties. Reitz and Sudano suggest that transdisciplinary training should include clinical precepting, hospital attending and rounding, formal didactics, as well as offering support and insight.

Research

The study conducted by Law et al. (2003) attempted to identify which of the three methods of psychotherapy (individual, marital, or family) will have the highest offset effect
on high utilizers of health care services. An offset effect is defined as, “when people reduce their use of medical services following some type of therapy or behavioral health intervention” (Law et al., 2003, p. 353). This idea relates to a systemic approach to reducing healthcare in that the effects of therapeutic treatment will have effects in physiological presentation. The researchers hypothesize that family therapy will be most effective in reducing healthcare utilization because it involves the highest number of clients being involved in therapeutic services.

For the Law et al. (2003) study, medical records of prior research for 65 randomly selected participants from a health maintenance organization (HMO) were examined for six months before, during, and after therapy services. Outcomes identified that the most common diagnoses were relationship problems, mood disorders, and anxiety disorders. Other diagnoses included childhood disorders, adjustment disorders, gender concerns, eating disorders, and non-relational concerns. As discussed in Chapter I, participants in marital and family therapy as well as individual therapy decreased their healthcare utilization significantly. The study provided evidence that “mental health professionals can have a meaningful impact on the utilization of health care services by high utilizers” (Law et al., 2003, p. 361).

Caldwell et al. (2006) identified the call to engage in collaborative practice between mental health professionals and medical practitioners. As family therapists begin to become essential members of medical teams, a new shift is being presented toward the mind/body connection. “An important manifestation of this shift is represented by expanding awareness and greater utilization of complementary alternative medicine (CAM)” (Caldwell et al., 2006, p. 101).
The purpose of Caldwell et al.’s (2006) study was to assess family therapists’ perceptions of CAM and their awareness and inclusion of CAM practices in their therapy. To do this, the researchers gathered information from 424 clinical members of the American Association for Marriage and Family Therapy (AAMFT) about their contexts of practice, use of CAM, and relationships with CAM providers. Complementary and Alternative Medicine, typically considered non-conventional methods of medical treatment, includes five categories:

1. Alternative Medical Systems.
3. Biologically Based Therapies.
4. Manipulative and Body-Based methods.
5. Energy Therapies.

This study found that there were many reasons for the inclusion of CAM strategies, most commonly were chronic or recurring pain, belief that combining CAM with conventional medicine would be more effective, recommendation by a medical professional, given up on conventional medicine, and conventional medicine has become too costly. The results of this study revealed that significant numbers of respondents have used or have clients that use CAM strategies in addition to or in place of traditional medical treatments. As the mind-body connection becomes more prevalent in western society, “practices that are based on this interconnection are likely to become even more widely accepted . . .” (Caldwell et al., 2006, p. 111).

Clark et al. (2009) conducted a research study to determine the perspective of medical practitioners on collaborating with marriage and family therapists as a part of the healthcare
team. The researchers cite another study (Moon, 1997) that identified more than 60% of patients visit their healthcare professional with mental health concerns. MedFT, as a specialty of marriage and family therapy, has already made advances in collaboration with family physicians in a systemic, bio-psychosocial-spiritual perspective on family or relational problems presented. Trained family therapists have effectively collaborated with physicians on cases with multiple medical problems ranging from infertility to cancer. Clark et al. surveyed a nationwide random sample of 240 physicians regarding their perspectives and experiences of collaboration with marriage and family therapists. The results revealed that family physician respondents felt that 48% of their patients could possibly benefit from mental health services, however only 12% of their patients had been referred to those services. Additionally a majority of those respondents had divulged that they either had or would be interested in collaborating with a marriage and family therapist on some of their cases. Further investigation identified roadblocks to this collaboration however. These barriers included limitations on ideal collaborative practices, difficulty with referral, awareness of marriage and family therapy specialty areas, availability of therapists, and attitudes toward family therapists. This study suggests that despite the barriers involved, collaborative practices would be beneficial.

**Discussion**

After a review of the current literature, it became evident that there was a need for continued research studies identifying the utility and effectiveness of including marriage and family therapists as a part of healthcare teams. The research reviewed here (Caldwell et al., 2006; Clark et al., 2009; Law et al., 2003) identifies that inclusion of marriage and family therapists and other complementary alternative medicine practices play and integral role in
decreasing the utilization of healthcare services among patients who are identified as high utilizers of healthcare services. These studies also show that the use of collaborative practices may benefit both healthcare systems and patients, as healthcare outcomes are more positive and cost effective. The need to replicate and expand upon these studies is necessary to broaden the awareness of the availability and effectiveness of these services. In order to move toward collaboration, it is necessary to encourage cross-disciplinary discussion to bridge the gap and promote more effective patient care. Given the preceding discussion, the question addressed by this research was: “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers?” The methodology to study the question follows in Chapter III.
CHAPTER III: METHODOLOGY

Project Conceptualization

When taking this project into consideration I envisioned many ways the research might occur. However, the organization of the research provided more clarity in how the research could be developed. The initial concern was with the delivery of services and client experience, as previously mentioned, however the research required would not fit the boundaries of this project. I decided that the ideal study would examine all aspects of the collaborative relationship between medical and mental health professionals, however, for the purposes of this study would limit the research question to examine the referral process. More specifically, “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers?” In reflecting on the research question, I was able to look more closely at such things as knowing the stakeholders and participants, identifying a method of research suitable for the project-action research, as well as becoming more aware of the procedure and steps for conducting the study.

Stakeholders

In taking a collaborative perspective of the treatment system and referral process, it became obvious the invested parties for the research project would be any medical or mental health professional interested in engaging in collaborative health care practices. For this study these would involve myself, representing the mental health provider, and five primary care physicians. I chose primary care physicians because they are often the first point of contact for many individuals seeking healthcare services. Shi and Singh (2008) refer to primary care as first-contact care serving as gatekeepers to the healthcare system, and
coordinators as well as advisors to their patients (p. 127). Primary care is a longitudinal service with the provider offering treatment and care to their patients over long periods of time (Shi & Singh, 2008). This aspect of primary care providers lends to their value in researching not only the referral but also the follow-up communication practices as they are invested and concerned about patient outcomes.

Research Methodology

The choice for selecting action research was clear to me as I considered my goals for collaboration. Action research as a methodology will be discussed in depth in the following section. Ladkin (2007) describes action research as such:

Action research is grounded in the belief that research with human beings should be participative and democratic. Researchers working within this frame are charged with being sensitive to issues of power, open to the plurality of meanings and interpretations, and able to take into account the emotional, social, spiritual and political dimensions of those with whom they interact. . . . A primary purpose of action research is to produce practical knowledge that is useful to people in the everyday conduct of their lives. (p. 478)

From this perspective, the use of action research is conspicuously described. It explains the researchers requirement to be aware of, and sensitive to, issues of power, emotion, multiple perspectives and meanings. MedFT’s are specifically trained to be sensitive to these and more issues with clients (McDaniel et al., 1992). Applying this concept to research, action research is a natural fit. Chenail, St. George, and Wulff (2007) shared in the idea that action research is conducted by those most affected by the goals and outcomes of the study. Furthermore, the explanation of the primary purpose fits with this study as well. The primary
goal of this study was to examine communication between PCPs and MedFTs, an ongoing and frequent activity for MedFT’s. In focusing on collaborative practices, it seemed fitting that the definition above includes the importance of a participative and democratic process. Chenail et al. (2007) identified a distinctive quality of action research being that the participative nature, or “publicness” (p. 451), of the research lends to building relationships within and outside of an organization.

**Action Research**

**Definition**

There is much debate over the definition of action research. Ladkin (2007) cites practitioners and theorists (Ahar, et al., 2001; Fals Borda & Rahman, 1991; Mills, 2000; McKernan, 1996; Toulmin & Gustavsen, 1996; Whyte, 1991) noting that the development in such varied fields contributes to the evolving and varied definitions. To add further confusion, the name action research has been used interchangeably with types of action research-action inquiry and action science. Reason (1994) identifies the purpose of action inquiry and action science as follows:

The purpose of both [action inquiry and action science] is to engage with one’s own action and other in a self-reflective way, so that all become more aware of their behavior and its underlying theories. Both practices base their work on the ‘raw’ data of accounts and recordings of practice (usually in the form of talk) gathered by the actors themselves, and both encourage public testing of one’s own perceptions and the use of action experiments to test new theories of action and to develop new skills. (as cited by Ladkin, 2007 p. 479)
Torbert (1991) furthers this definition in his writing:

Action science and action inquiry are forms of inquiry into practice; they are concerned with the development of effective action that may contribute to the transformation of organizations and communities toward greater effectiveness and justice. (as cited by Ladkin, 2007, p. 479)

Ladkin (2007) identifies the distinction between the two as such:

Action inquiry is one way of conduction action research, with a particular emphasis on the researcher’s role in a situation, and action science emphasizes the creation of theory from cycles of action and reflection. (p. 479)

As defined by Ladkin, action research through several assumptions: (a) that there is intentionality on the part of the research for an outcome; (b) it embraces multiple ways of understanding the situation; (c) the approach of including the researcher as part of the process of the research is as, if not more, important than the result; and (d) it acknowledges that all observation is biased.

For the purposes of this study, the form of action research to be utilized will be action science, as defined by Ladkin (2007), with a focus on cycles of action and reflection. This study will also encompass the definitions by Reason (1994) and Torbert (1991), as cited above, reviewing the action of the stakeholders through open-ended questions, challenging behaviors and perceptions to develop new skills in hopes to contribute to the transformation toward greater effectiveness. This study acknowledges the integration of Ladkin’s assumptions as part of the research construction as such: (a) the research is intended to produce an effective means for communication between MedFTs and primary care physicians for the referral and follow-up processes; (b) the research incorporates stakeholders
from both sides of the referral process to be inclusive of different perspectives; (c) the researcher is included as part of the research study and provides experiential knowledge from within the framework of the study; and (d) the study will acknowledge the bias of the researcher and stakeholders.

**First-, Second-, and Third-person Inquiry**

In order to better conceptualize the process for action research, Marshall and Reason (1994) and Torbert (1998) identified that it is useful to frame it as first-, second-, and third-person inquiry (as cited by Ladkin, 2007). First-person inquiry occurs at the level of the researcher him or herself. This approach examines choices, experiences, assumptions, and biases of the researcher. This may be done through journaling, story-telling or narrative reflection (Ladkin). Second-person inquiry focuses on encounters between individuals and small groups. Reason and Torbert (2001, as cited by Ladkin) suggest that second-person, or cooperative, inquiry implies that all involved are co-researchers who contribute to the design and management of the project. They further suggest that all involved are co-participants in the question or action being researched. Second-person research occurs in the dialogical process of encounters between individuals (Ladkin). Third-person research is typically used to address issues of power or oppression, particularly in communities allowing individuals to have a voice in creating the policies that govern them. This research can be carried out through questionnaires, interviews, or the collection of quantitative data (Ladkin).

**Cycles of Action and Reflection**

It is imperative to understand that the process of action research necessitates a cyclical and participative approach to research that (a) identifies a problem; (b) takes action; (c) observes or analyzes; and (d) reflects upon action taken. See Figure 1 on p. 22. Ladkin
(2007) offers reports of researchers that identify the frequent lack of clarity and discreteness arising from research involving multiple cycles of action and reflection. The collaborative nature of action research is paramount for the process of reflection; however, a certain level of leadership is required on the part of the researcher, “to begin with an intention and some idea of method, and enable a process to unfold” (Ladkin, p. 486). This requires the researcher to be open-minded to allow the unfolding to occur with a respect for not-knowing (Ladkin). Chenail et al. (2007) write about unexpected outcomes or events explaining, “These occurrences are likely a result of the fact that action researchers are setting constructive process into motion and their outcomes cannot be wholly predicted” (p. 457).

Figure 1. Spiral of action research cycles. This figure illustrates the cycles of action with three completed cycles. (Coughlan & Brannick, 2001, as cited by McPherson and Jose Miguel 2002).
Validity

The standard criteria of validity examine more traditional studies in which the experimenter bias is removed, control groups are utilized, and statistical significance is measured. Action research is by its very nature is therefore forced to utilize other means to measure quality and trustworthiness (Ladkin, 2007). Reason and Bradbury (2001) suggest the following five criteria:

1. The extent to which the research demonstrates emergence and enduring consequences.
2. The extent to which the research deals with pragmatic issues of practice and practicing.
3. The extent to which the inquiry demonstrates good qualities of relational practice, such as democracy and collaboration.
4. The extent to which the research deals with questions of significance.
5. The extent to which the research takes into account a number of different ways of knowing. (as cited by Ladkin, p. 481)

Chenail et al. (2007) suggest that assessment of action research must include an assessment of the successfulness of stimulating change and involving the stakeholders, without prioritizing on over another. Additionally the authors write that the occurrence of unexpected and positive events or outcomes could be a measure of the effectiveness of action research.

Self of the Researcher

As discussed, the researcher is an integral part of the research process. The researcher designs the study and identifies an intention for the outcome of the study. In addition the researcher is seen as a participant in the research, bringing knowledge, experience, and
biases. The process of identifying these occurs in the initial stages of project design, as well as a reflective process. This is particularly important as the researcher serves as a leader and guide for decision-making. The role of the researcher fits with this study, as does the research method, in that it provides a collaborative framework for the process and outcome of the study. As collaboration is the overarching goal of the study, I embarked on this process. The level of collaboration possible for this research is only limited by the amount allowed by its participants.

Prior experience with collaborative practice and reading about collaborative practice informed this study and therefore shapes my knowledge of the research. I had pre-conceived ideas as to what collaboration should “look like”—teaming with physicians in an open and cooperative manner by all involved. However, this was my ideal and may not exist in actuality. Additionally, I work under the assumption that PCPs are inclined to refer to MedFTs in most circumstances when deemed necessary. Furthermore, I assumed that the PCPs would be aware of the MedFT field and the ability of MedFT’s and marriage and family therapists in general to address a wide array mental health concerns including, but not limited to, anxiety, depression, trauma, or addiction rather than issues pertaining directly to the marital or familial relationship. By adding the follow-up communication to the study, I am including an assumption that the referring PCP will desire this communication. I operated under the belief that most PCPs are limited in their time and, therefore, are unable to fully address mental health concerns. This belief also led to the decision to produce a document for referral and follow-up that can be completed at the leisure of the PCP or the nurse or staff under the direction of the PCP.
Procedure

This study based on the action research method addressed the question, “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers? As previously stated the process of action research begins with an intention and some idea of a method.

Stage 1. The initial stage of identifying or diagnosing a problem began several years ago when I became interested in MedFT and started researching the topic more. This first stage came to a conclusion with the development of a concise research question: “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers?” Identifying the gap of knowledge in the literature review developed this question. I found that there was evidence demonstrating that the inclusion of marriage and family therapists as part of the healthcare team offers benefits such as decreased utilization of healthcare, decreases costs, increased positive outcomes for patients and healthcare systems. However, these studies (Caldwell et al., 2006; Clark et al., 2009; Law et al., 2003) demonstrated difficulty with communication between providers limiting access to marriage and family therapists.

Stage 2. From here, stage two involved taking action to address the question stated. The first step in this process was to recruit participants. As mentioned in Chapter I, I work with primary care physicians in my private clinical practice. It was my intention to extend an invitation to participate to these individuals, as well as other local physicians, as I believed it might help build a collaborative, working relationship. In addition, I requested permission from a national organization for collaborative practice, The Collaborative Family Healthcare Association (CFHA), of which I am a participating member. Other members of this
organization include mental health providers such as myself, and various medical professionals interested in collaborative practices. The third method was to recruit participants from a university program director in the field who has written extensively in the field of MedFT and works at a university offering a doctoral degree in the practice of Medical Family Therapy. The recruitment letter included a link to the online survey via Survey Monkey (www.surveymonkey.com), allowing participants to view informed consent and initiate the questionnaire. The survey was designed to gain insight from the primary care physician perspective regarding the communication that does and, should occur. See Appendix D on p. 36 for questions included in the questionnaire.

Stage 3. The third step in this cycle was to review or observe the action taken. For this, I analyzed the data collected from the surveys, utilizing thematic analysis. The responses were reviewed for salient points, categories, or themes providing information to include in referral and follow-up documentation. Using the results of the survey I developed standard forms for referral and follow-up communication.

Stage 4. The fourth and final stage of the cycle of action is to review and reflect on the process and action taken. In doing this, I reviewed the documentation developed and reflect on the utility and implications for current practice. A more detailed description of the survey, creation of the documents, and reflection on the documentation is discussed in Chapters IV and V.
CHAPTER IV: RESEARCH FINDINGS AND DISCUSSION

Participants

Seven participants responded to the survey; the responses from two participants have been omitted due to incomplete response sets. The following demographic information was collected from questions 1, 20, 21, and 22. Of the five included responses, two participants worked in private practice, one in a community or agency setting, one described their practice as cancer support, and the fifth worked in outpatient family practice. Two participants had been in practice between 0 and 5 years. One participant represented each of the following years of practice: 6-10, 11-15, and 16-20. One participant reported living in an urban area, another in a rural, with the remaining three participants describing their area of practice as suburban. Three of the participants responded that they do currently refer to a medical family therapist, whereas two do not. Other mental health professionals the participants refer patients to are listed in the table below.

Question 2:

Table 2

Other Mental Health Professionals Referred to by Participants

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number of Responses</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Mental Health Counselor</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Licensed Professional Counselor</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>(Other) Marriage and Family Therapist</td>
<td>1</td>
<td>20%</td>
</tr>
</tbody>
</table>
Responses to Questions

Question 3: With patients with mental or behavior health concerns, what do you do?

Three participants replied that they would help or treat with medication, two included using referral as a tool, and two respondent discussed the use of screening tools and discussing treatment options with the wants and needs of the patient.

Question 4: How do you handle issues with mental or behavioral health?

Two of the respondents replied that they would either treat the presenting issue or refer if it is a complicated case. One participant answered that he or she would create shared goals; it was not identified who these goals would be developed with. Another response stated speaking to the patient to get information and refer to a MedFT.

Question 5: How do you conceptualize the next steps of what to do?

One participant response was to refer out if beyond the scope of their practice, one participant would base this on therapeutic benefit and patient results, and another respondent replied that this would depend on factors such as the patient, situation, support system, severity of issues, other medical issues, medications, and relationship with the family or patient.

Question 6: When do you refer to a medical family therapist?

Two respondents replied that they do refer to a medical family therapist. One of these specified that they do so when there are psychosocial aspects that MD’s cannot understand. A third respondent would refer as soon as possible. Two remaining responses replied they do not refer. One of these participants elaborated that they are not sure if there are any medical family therapists near their practice.
Question 7: How do you make these decisions?

Of the five responses to this question, three responded based on their referral experience, while one responded “n/a”. One respondent included the use of insight and judgment, while another stated the limited availability and viability of resources in their community so decisions are based on these factors. Another participant affirmed their use of medical family therapists, but did not elaborate on the decision process. One participant shared trying to make the connections based on the patient’s willingness and staff availability.

Question 8: What process is in place for referrals?

The five responses varied on this question. One participant stated that he or she uses common referrals, another utilizes a referral specialist in their office, two participants had a range of processes that vary from onsite referral to a computer-based system. The final respondent varies their referrals based on insurance coverage/situation.

Question 9: How do you communicate with or refer patient to medical family therapists?

Of the three participants referring to a medical family therapist, one uses a “warm handoff”, another communicates by electronic or face-to-face means, while the other makes a phone call or sends a direct note.

Question 10: What are some of the barriers to communication and collaboration with medical family therapists?

Two of the participants identified that a barrier is a lack of access to or knowledge of medical family therapists in the area, one stated that another difficulty is that medical family therapists are not integrated into the system. The fourth participant stated that they rarely
received office visit notes from counselors or psychiatrists they refer to as another barrier, and the fifth participant cited their frequency in the clinic and language as barriers.

**Question 11: What are some of the benefits to you in regards to referring to a medical family therapist?**

One participant would like to broaden the understanding of medical family therapy while the second response stated the need for a collaborative effort to help the patient improve and get better. The third response to this question stated a benefit as the availability to talk to patients and willingness to refer patients to appropriate resources.

**Question 12: What would reduce barriers to communication and collaboration with medical family therapists?**

One participant replied that if the medical profession valued medical family therapists it could reduce barriers. Another repeated the need for a collaborative effort to help the patient improve and get better. The third response stated it would be helpful to receive office visit notes from psychiatrists and therapists. The fourth respondent would prefer there be more availability and the need for bilingual therapists.

**Question 13: What other ideas do you have to make referrals more beneficial to you?**

Three participants responded to this question. One requested specificity while the other requested to open bidirectional communication between their site and the referral source. This respondent added that there is a tremendous void when it comes to referring individuals to an offsite specialist, specifically providers of mental health and psychiatric services. Another response echoed the need to collaborate meetings and staff for updates.
Question 14: What follow-up is important or would you prefer after referring a patient to a medical family therapist?

Two participants stated the desire to know what advice was given. Another participant requested the office visit notes. A fourth would like to know the patient has “landed” somewhere. The fifth respondent stated preferring a written note, but did not specify what information should be included.

Question 15: At what point should the follow-up communication occur from the medical family therapist?

One participant preferred communication after the initial visit or with any changes in issues or medications, while another preferred communication only when it links back into medical health. A third participant requested a written note, but did not specify the timing that this should occur. The fourth respondent would like to communicate on a monthly or quarterly basis.

Question 16: What process do you have in place for follow-up communication or collaborative conversations?

One participant suggested that team meetings be used, while another stated difficulty in “closing the loop” with communication. A third participant stated that he or she receives fax, email, or phone calls for follow-up communication.

Question 17: To increase the benefit to you, what other ideas do you have related to follow-up communication that can benefit you?

One respondent stated that accountability would be beneficial for communication. Another suggested to collaborate meetings and staff for updates.
Question 18:

Table 4.3

What information is important to include for patient referral?

<table>
<thead>
<tr>
<th>Information</th>
<th>Number of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Age</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Demographic Information</td>
<td>5</td>
<td>40%</td>
</tr>
<tr>
<td>Release of Information</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Medical Diagnosis</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Current Medical Concerns</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Treatment History</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Medical Treatment</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Plan/Prognosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Goals for Therapy Services</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Request for Follow-Up</td>
<td>5</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0%</td>
</tr>
</tbody>
</table>
Question 19:

Table 4.4
What information is important to include for follow-up communication?

<table>
<thead>
<tr>
<th>Information</th>
<th>Number of Respondents</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Age</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Marital Status</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>Demographic Information</td>
<td>5</td>
<td>0%</td>
</tr>
<tr>
<td>Release of Information</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>Mental Health Diagnosis</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Current Mental Health Concerns</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Ongoing Medical Concerns</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Identified Goals</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Progress Toward Goals</td>
<td>5</td>
<td>80%</td>
</tr>
<tr>
<td>Treatment Plan/Prognosis</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Emerging Themes**

While reviewing the responses from the participants several themes emerged from the data collected. During the conceptualization and understanding of mental health issues by primary care providers, there were several responses demonstrating the PCP’s desire to treat
or become directly involved with the treatment process. Sixty percent of respondents would refer to medical family therapist, while one hundred percent would be willing to refer to either a psychologist or psychiatrist and 80% were willing to refer to Licensed Social Workers, Licensed Mental Health Counselors and Licensed Professional Counselors. Benefits reported to working with Medical Family Therapists include broadening the understanding and using a collaborative effort to help the patient improve and get better.

Barriers to referring to a Medical Family Therapist include the lack of knowledge of and access to these providers, their inclusion in the system, and MDs finding value in the MedFT profession. Additionally, “closing the communication loop” was reported as problematic. Several responses requested a more personal or direct communication from the medical family therapist or other providers, particularly if the provider is offsite. The type of information that should be communicated upon referral is demonstrated in Table 4.3 on page 32. The information that should be communicated at referral is demonstrated in Table 4.4 on page 33.

**Reflections of the Researcher**

While reflecting and reviewing the information provided by the participants, I see parallels in practice. It is difficult to raise awareness about the Medical Family Therapy profession to busy primary care professionals. Additionally, timing the communication or receiving the permission from the patient to share information is a major barrier that occurs when communicating about referral and follow-up.
CHAPTER V: DISCUSSIONS AND IMPLICATIONS OF STUDY

Discussion

The research presented demonstrates that while a desire for collaborative practice exists, with the goal of being patient-centered, there are logistical barriers that occur to collaborative services. The participants revealed an interest to continue or maintain a relationship with their patient by remaining informed of the treatment process. This aligns with information presented by Shi and Singh (2008) regarding the role of the PCP as a coordinator and gatekeeper to the healthcare system as well as the longitudinal relationship between medical providers and their patients. This research also established willingness on the part of PCPs to refer to a mental health specialty and create a collaborative relationship between providers. Similarly, Caldwell et al. (2006) found there was a call to engage in collaborative relationships. However, approximately half the participants identified there was a lack of awareness or accessibility to a medical family therapist in their area. These findings build upon previous studies cited in Chapter II with the identification of a common goal, yet the continuation of similar difficulties. Barriers such as the awareness of and access to referral sources, communication at referral and follow-up, and perspectives of MDs toward MedFTs are closely aligned with the outcomes of the 2009 study by Clarke et al. Overcoming these barriers is critical as discussed by Kessler and Stafford (2008) at both an organizational level, for physicians, as well as for the patients and families.

Limitations of this Study

A broad topic of communication was reviewed in an effort to better understand the current needs related to communication between PCPs and MedFTs. Future studies will need to be completed to research specific communication tools and their efficacy in promoting
collaboration. Additional studies are necessary in specific fields of medicine and specialty areas, as the communications needs may vary by specialty. The number of participants also limits this study; further research should be completed with a larger population. It is important to consider possible explanations for the lack of responses by two participants. It is possible that the respondents were unable to complete the questionnaire due to a lack of time and the requirement to answer open-ended questions; the participants may have also felt incapable of answering questions directly related to their communication with MedFTs if they do not refer to this specialty area. Future research should ask participants about their survey experience to help develop questions. Additional topics to be addressed that are limited by the study are providing continuity of care across multi-professional teams as well as across the life span.

**Implications for Practice and Collaboration**

In order to move more toward collaborative practices, PCPs and MedFTs should engage in networking and development activities to promote collaboration and awareness of the medical family therapy field. With cross-disciplinary teams working together to develop and disseminate training on treatment notes, communication, team meetings, and ways to continue to work collaboratively with one another. A further evaluation of the crosswalk of PCP/MedFT competencies presented by Reitz and Sudano (2014) can be conducted to better understand the definitions of competencies and subcomponents of these competencies. In considering collaborative practice in medical settings, the use of electronic methods of communication and record keeping needs to be taken into account. The MedFT profession may benefit from a more in-depth understanding of and training in electronic records and communication.
The needs of private practices may be different than that of larger systems of practice such as a hospital or other institution. Thus, multiple tools could be developed for particular practice settings. A multi-professional team should be considered in authoring these tools, to ensure utility and efficacy for each discipline. Referral tools for private practice settings utilizing data collected from PCPs are shown in Table 5 and Table 6 below. The use of action research in the development and execution of this study includes this researcher’s perspective in addition to the participants allowing for the multiple perspectives of stakeholders to be expressed in these tools. Evaluation of these tools will provide supportive information for education, collaboration, and practice. These tools imply a single referral source or relationship when sending information. It may be beneficial to provide a list of local MedFT providers, or a referral documentation to furnish to the patient who may then seek out a MedFT (or other specialty) of their choosing.
Figure 5.2

Proposed Referral Documentation

(PCP to MedFT)

Request Phone Consultation – Contact #: ________________________________________

Patient Name: _________________________________________________________________

Age: __________ Marital Status: Single Married Divorced

Medical Diagnosis: _____________________________________________________________

Current Medical Concerns: _____________________________________________________

______________________________________________________________

Treatment History (attach additional pages if needed): _____________________________

______________________________________________________________

Treating Plan/Prognosis (attach additional pages if needed): __________________________

______________________________________________________________

Reason for Referral: __________________________________________________________

______________________________________________________________

Goals for Therapy: __________________________________________________________

______________________________________________________________

Please include a release of information from patient with referral.
Law et al. (2003) described the benefit of including marriage and family therapists into the medical setting: “Mental health professionals can have a meaningful impact on the utilization of health care services” (p. 361). Although utilization was not addressed by this researcher’s study, it was noted by PCPs that collaborative practices can benefit the patient.
To help create opportunity for this benefit an additional recommendation as a result of this study would include the development of a training manual or certification for MedFTs. This would possibly allow for integration of the profession into larger systems, such hospitals, institutions, and third-party payer systems – all barriers to collaborative relationships identified in this research as well as previous studies (Caldwell et al., 2006; Clark et al., 2009; Kessler & Stafford, 2008). This would entail input at multiple levels including the providers, researchers, educational institutions, governmental and regulatory boards, professional and accrediting organizations, as well as third-party payer systems.

Summary

This study was designed to better understand the question, “What communication does and should exist at referral and follow-up to reduce barriers and promote a collaborative relationship between providers?” The participants provided valuable information demonstrating the importance of collaborative practices, barriers to communication, and elements important to communication at referral and follow-up. Additional studies will be required to address larger systems such as hospitals or institutions and third-party payers, efficacy of communication tools, and varied communication needs by specialty.
References


Reitz, R. & Sudano, L. (2014). The Medical Family Therapist as Transdisciplinary Trainer. In J. Hodgson et al. (Eds.), *Medical family therapy: Advance applications* (pp. 177-195). Switzerland: Springer International Publishing


Appendices
Appendix A

Letter to Invite Primary Care Physicians to Participate

A Research Opportunity for Primary Care Physicians Interested in Engaging in Collaborative Practices with Medical Family Therapists

Date:

Dear Participant:

My name is Mary Killmeyer and I am a doctoral candidate in the Marriage and Family Therapy (MFT) program at Nova Southeastern University, specializing in Medical Family Therapy (MedFT). MedFT is a field of family therapy that utilizes systems thinking to work with families with health problems. MedFT challenges therapists to think about illness and health in complex ways that are both collaborative and effective. From this perspective the family therapist can work in collaboration with traditional medical providers in primary care or specialty fields.

I invite you to participate in a research study for my Applied Clinical Project (ACP), the research study to be completed as partial requirement for completion of the degree. My ACP is titled “Communication Between Primary Care Providers and Medical Family Therapists: Reducing Barriers to Collaborative Care”. You are eligible to participate if you are Primary Care Physician (PCP) currently in practice, interested or engaged in collaborative practices with Medical Family Therapists (MedFTs), you are English speaking, and willing to share your thoughts about the communication between PCPs and MedFTs during the referral and follow-up processes.

The purpose of the study is to move toward collaboration between Medical Family Therapists by examining communication at referral and follow-up. If you choose to participate, you will be asked to complete an online survey consisting of open-ended questions regarding communication between PCPs and MedFTs. You will also be requested to provide demographic information. There will be no costs or payments made for participating in this study. However, a potential benefit of your participation in this study is that this research may expand the collaborative relationship between physicians and MedFTs.

Maintaining privacy and confidentiality is highly important to this study. Only demographic information will be disclosed in the results of this study. All responses and transcripts will be destroyed 36 months after the completion of the study. All information obtained in this study is strictly confidential unless law requires disclosure. The university’s human oversight board, regulatory agencies, or Dr. Tommie Boyd may review research records.
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive.

I have received approval for this study from Nova Southeastern University’s Institutional Review Board. My ACP chair is Tommie V. Boyd, Ph.D. (tommie@nova.edu). If you or anyone you know of are interested in participating in this study or would like more detailed information, please contact me via email at waschka@nova.edu or by phone at 954-609-8175.

Thank you and I look forward to hearing from you.

Sincerely,

Mary M.W. Killmeyer, LMFT, Medical Family Therapist

IRB protocol #:

Principal Investigator: Co-Investigator:
Mary M.W. Killmeyer, D.M.F.T. Cand. Tommie V. Boyd, Ph.D.
1650 NW 100th Way 3301 College Ave.
Plantation, FL 33322 Fort Lauderdale, FL 33314
954-609-8175 954-262-3027

For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954) 262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu
Appendix B

Permission to Disseminate Participant Invitation (CFHA)

Date:

To Whom It May Concern:

My name is Mary MW Killmeyer and I am doctoral candidate in the Marriage and Family Therapy (MFT) program at Nova Southeastern University and a member of the CFHA community. I am writing to request permission to disseminate a research proposal to the email distribution list. I would like to invite members of our community to participate in a research study for my Applied Clinical Project (ACP), the research study to be completed as partial requirement for completion of the degree. My ACP is titled “Communication Between Primary Care Providers and Medical Family Therapists: Reducing Barriers to Collaborative Care”. Attached is a copy of my letter inviting participation that will be sent to the Institutional Review Board of Nova Southeastern University. My ACP chair is Tommie V. Boyd, Ph.D. (tommie@nova.edu). If you would like more detailed information, please contact me via email at waschka@nova.edu or by phone at 954-609-8175.

If for some reason this is not a possibility I would greatly appreciate any alternative suggestions you might provide. Thank you for your time and consideration.

Sincerely,

Mary M.W. Killmeyer, LMFT, Medical Family Therapist
Appendix C

Request to Disseminate Participant Invitation (Angela Lamson)

Date:

Dear Dr. Lamson:

My name is Mary MW Killmeyer and I am doctoral candidate in the Marriage and Family Therapy (MFT) program at Nova Southeastern. I am aware of your extensive work in the field of Medical Family Therapy and am hoping for your assistance. I am writing to request you to disseminate a research proposal to your network of medical professionals (primary care physicians) interested in collaborative practices. I have additionally reached out to the CFHA, of which I am a member.

I would like to invite PCPs to participate in a research study for my Applied Clinical Project (ACP), the research study to be completed as partial requirement for completion of the degree. My ACP is titled “Communication Between Primary Care Providers and Medical Family Therapists: Reducing Barriers to Collaborative Care”. Attached is a copy of my letter inviting participation that will be sent to the Institutional Review Board of Nova Southeastern University. My ACP chair is Tommie V. Boyd, Ph.D. (tommie@nova.edu). If you would like more detailed information, please contact me via email at waschka@nova.edu or by phone at 954-609-8175.

If for some reason this is not a possibility I would greatly appreciate any alternative suggestions you might provide. Thank you for your time and consideration.

Sincerely,

Mary M.W. Killmeyer, LMFT, Medical Family Therapist
Appendix D

Online Survey

**Communication Between Primary Care Providers and Medical Family**

**Voluntary Consent by Participant:**
By clicking "Next" below, you indicate that:

- this study has been explained to you
- you have read this document or it has been read to you
- your questions about this research study have been answered
- you have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- you have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- you are entitled to a copy of this form after you have read and signed it
- you voluntarily agree to participate in the study entitled: Communication Between Primary Care Providers and Medical Family Therapists: Reducing Barriers to Collaborative Care
**Communication Between Primary Care Providers and Medical Family**

Medical Family Therapy (MedFT) is a field of family therapy that utilizes systems thinking to work with families with health problems. MedFT challenges therapists to think about illness and health in complex ways that are both collaborative and effective. From this perspective the family therapist can work in collaboration with traditional medical providers in primary care or specialty fields.

1. **Do you currently refer to a medical family therapist?**

   ![Checkbox]

   If you have answered no to this question, please continue with the survey to the best of your ability.

2. **What other mental health professional(s) do you refer to? Check all that apply.**

   - [ ] Psychiatrist
   - [ ] Psychologist
   - [ ] Social Worker
   - [ ] Mental Health Counselor
   - [ ] Licensed Professional Counselor
   - [ ] Other (please specify)

   ![Input Field]
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. With patients who present with mental or behavioral health concerns, what do you do?</td>
<td></td>
</tr>
<tr>
<td>4. How do you handle issues with mental or behavioral health?</td>
<td></td>
</tr>
<tr>
<td>5. How do you conceptualize the next steps of what to do?</td>
<td></td>
</tr>
<tr>
<td>6. When do you refer to a medical family therapist?</td>
<td></td>
</tr>
<tr>
<td>7. How do you make these decisions?</td>
<td></td>
</tr>
<tr>
<td>8. What process is in place for referrals?</td>
<td></td>
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<tr>
<td>9. How do you communicate with or refer patients to medical family therapists?</td>
<td></td>
</tr>
<tr>
<td>10. What are some of the barriers to communication and collaboration with medical family therapists?</td>
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<tr>
<td>11. What are some of the benefits to you in regards to referring to a medical family therapist?</td>
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<tr>
<td>Communication Between Primary Care Providers and Medical Family</td>
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<tr>
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</tr>
<tr>
<td>12. What would reduce barriers to communication and collaboration with medical family therapists?</td>
<td></td>
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<tr>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>13. What other ideas do you have to make referrals more beneficial to you?</td>
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<tr>
<td>14. What follow-up is important or would you prefer after referring a patient to a medical family therapist?</td>
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<tr>
<td>15. At what point should the follow-up communication occur from the medical family therapist?</td>
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</tr>
<tr>
<td>16. What process do you have in place for follow-up communication or collaborative conversations?</td>
<td></td>
</tr>
<tr>
<td>17. To increase the benefit to you, what other ideas do you have related to follow-up communication that can benefit you?</td>
<td></td>
</tr>
</tbody>
</table>
### Communication Between Primary Care Providers and Medical Family

**18. What information is important to include for patient referral? Check all that apply.**

- [ ] Name
- [ ] Age
- [ ] Marital Status
- [ ] Demographic Information
- [ ] Release of Information
- [ ] Medical Diagnosis
- [ ] Current Medical Concerns
- [ ] Medical or Treatment History
- [ ] Medical Treatment Plan/Prognosis
- [ ] Reason for Referral
- [ ] Goals for Therapy Services
- [ ] Request for Follow-up
- [ ] Other (please specify)

**19. What information is important to include for follow-up communication? Check all that apply.**

- [ ] Name
- [ ] Age
- [ ] Marital Status
- [ ] Demographic Information
- [ ] Release of Information
- [ ] Mental Health Diagnosis
- [ ] Current Mental Health Concerns
- [ ] Ongoing Medical Concerns
- [ ] Identified Goals
- [ ] Progress Toward Goals
- [ ] Treatment Plan/Prognosis
- [ ] Other (please specify)
<table>
<thead>
<tr>
<th>Communication Between Primary Care Providers and Medical Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>20. Which of the following best describes your practice setting?</strong></td>
</tr>
<tr>
<td><img src="https://example.com/choice.png" alt="Choice" /></td>
</tr>
<tr>
<td><strong>21. How many years have you been in practice?</strong></td>
</tr>
<tr>
<td><img src="https://example.com/choice.png" alt="Choice" /></td>
</tr>
<tr>
<td><strong>22. The area in which I live is best described as...</strong></td>
</tr>
<tr>
<td><img src="https://example.com/choice.png" alt="Choice" /></td>
</tr>
<tr>
<td>Communication Between Primary Care Providers and Medical Family</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Thank you for participating in this survey designed to examine the collaborative practices between Primary Care Physicians and Medical Family Therapists. Your feedback is very important.</td>
</tr>
<tr>
<td>Click 'Submit' below to complete the survey.</td>
</tr>
</tbody>
</table>
Biographical Sketch

Mary MW Killmeyer is a Licensed Marriage and Family Therapist in Florida. She earned a Bachelor’s of Science in Child Development from Florida State University. She earned her Master’s degree from Nova Southeastern University in Marriage and Family Therapy and her Doctorate degree in Marriage and Family Therapy with a specialization in Family Systems Healthcare.

Killmeyer’s experience includes offering therapeutic services to individuals, couples, and families, and in community, agency, and educational settings. She works with children and adults coping with issues such as depression, anxiety, goal setting, marriage conflict, parenting, academic success skills, as well as acute and chronic illnesses. As a guest lecturer for graduate students on the topics of Collaborative Family Therapy and Medical Family Therapy, Mary has focused on teaching, training, and clinical advancement. Mary is a Clinical Fellow of the American Association of Marriage and Family Therapy.