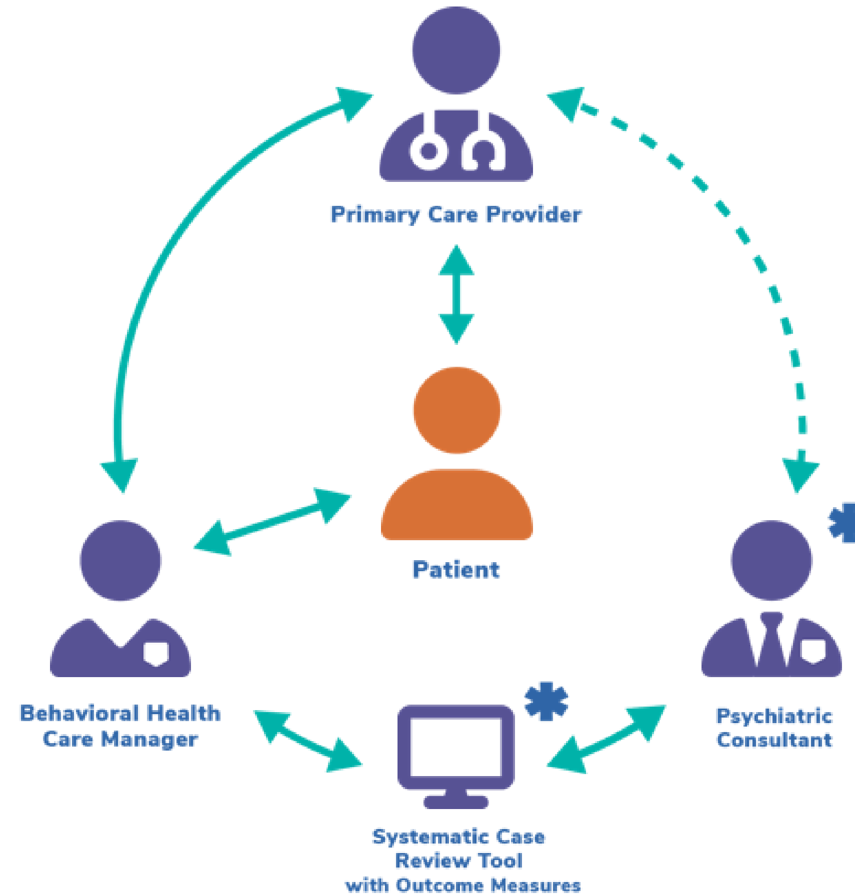
Program performance and sustainability

Learning objectives

- Define roles of additional team members involved in successful Collaborative Care implementation.
- Discuss ways to measure performance of a Collaborative Care program.

Additional team members in Collaborative Care implementation

- Medical director
- Provider champion
- Other team members

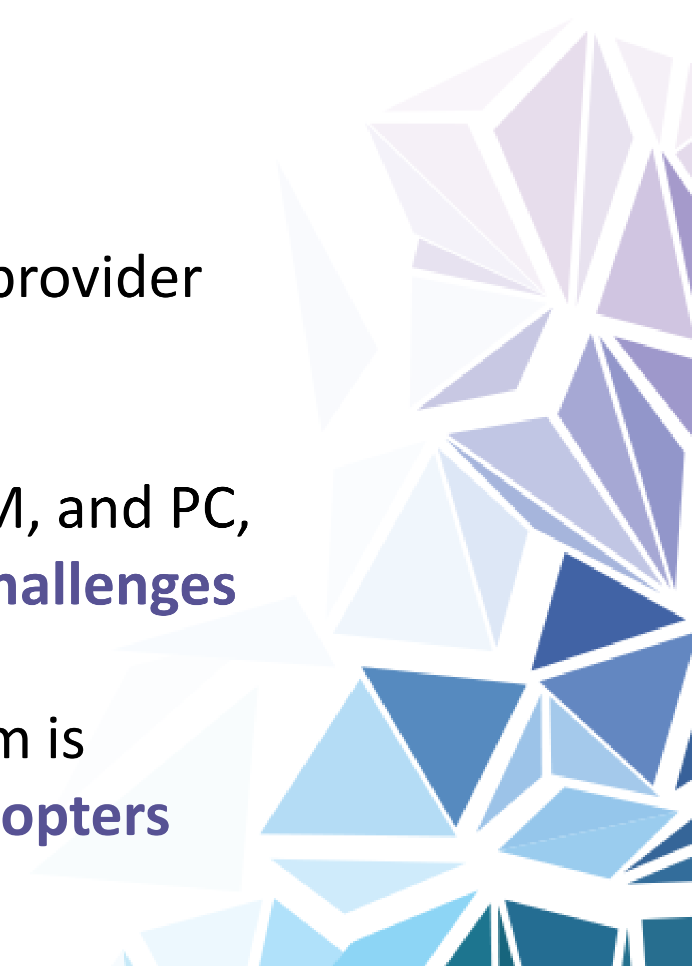


Medical director

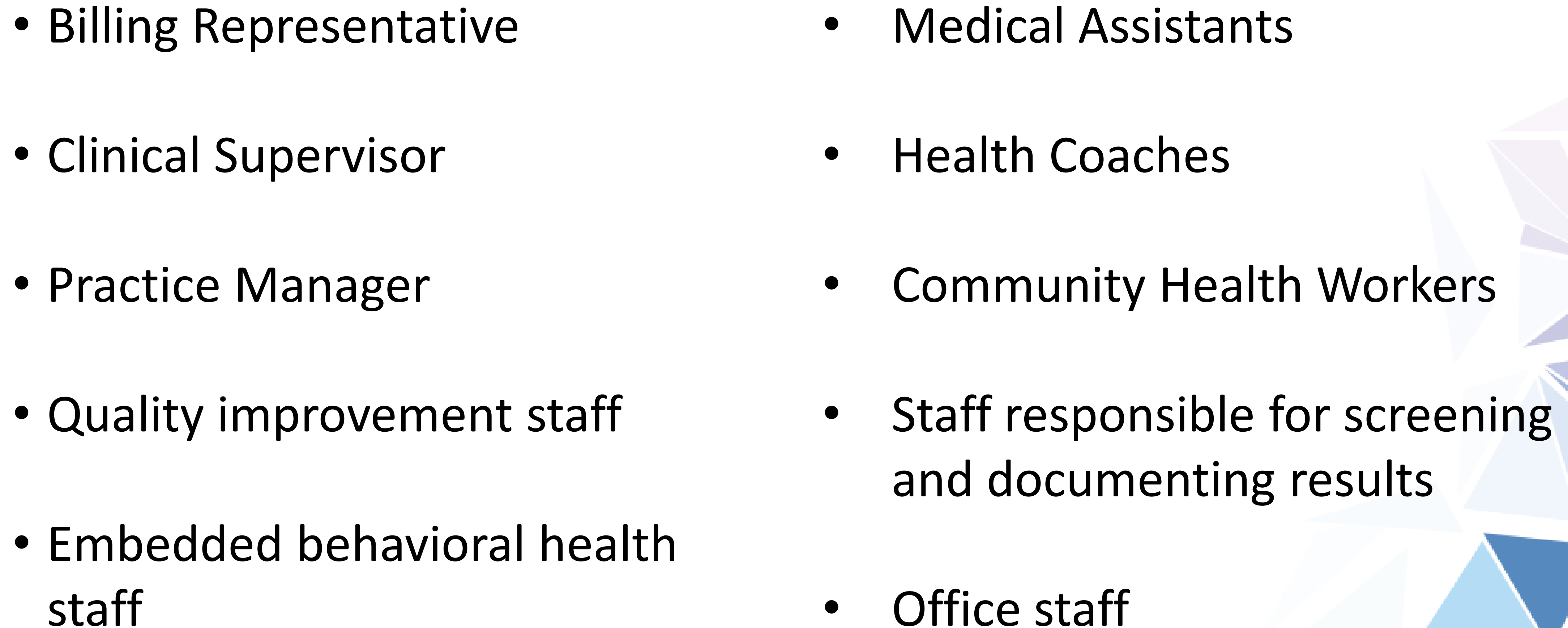
- Creates and implements practice **policies** to ensure safe, effective, and sustainable delivery of care
- Ensures all CoCM team members have appropriate **qualifications, training, and credentialing** to provide the activities specific to their role
- Ensures all CoCM team members **adhere to professional responsibilities** with respect to standards of care, documentation, privacy, etc.

Provider champion

- **Educates their colleagues** and practices the model with fidelity and enthusiasm
- Assists in **hiring** the other CoCM team members
- Communicates **practice change expectations** to their treating provider colleagues and supports them in overcoming challenges
- Acts as a liaison between the treating provider team, the BHCM, and PC, providing communication channels to **solve implementation challenges**
- Provides **ongoing monitoring** of how the treating provider team is adopting the model and provides additional **support to late adopters**



Other CoCM team members



- Billing Representative
- Clinical Supervisor
- Practice Manager
- Quality improvement staff
- Embedded behavioral health staff
- Medical Assistants
- Health Coaches
- Community Health Workers
- Staff responsible for screening and documenting results
- Office staff

Practice-wide awareness

All practice staff should be able to:

- Identify the **target population** for Collaborative Care
- **Talk with patients** about the program
- Describe how **referrals** are generated and the **general workflow** of the model

Personnel influence outcomes[1]

- **Engaged** psychiatric consultant leads to **more patients achieving remission**
- **Buy-in** from primary care providers is **crucial to patient engagement** as they introduce the model to patients
- Treating provider **champions** help **rally colleagues** around the model
- Behavioral health care managers ensure **key clinic tasks are performed** without other distractions. Defining the BHCM role is crucial to patient engagement.
- Strong support from top leadership is necessary to provide the **team resources** critical to meeting defined goals as well as encouragement throughout the process

Integrating new team members

BHCM

- Private workspace
- Time dedicated to CoCM apart from other responsibilities
- Access to computer and EHR
- Training and ongoing support

All other roles

- Identification of their role in CoCM
- Training for clinic staff appropriate to their role

BHCM caseload size guidelines 1.0 FTE

Program and patient characteristics	Caseload size range	
• **Insurance**: high commercial payer • **Predominant conditions**: depression and anxiety; low clinical acuity • **Complicating factors**: minimal social needs, comorbid medical conditions	90	120
• **Insurance**: commercial, public payer or uninsured • **Predominant conditions**: PTSD, depression, or anxiety • **Complicating factors**: substance use, comorbid medical conditions	70	90
• **Insurance**: Public payer, uninsured, low commercial payer • **Predominant conditions**: bipolar disorder, PTSD, depression, or anxiety • **Complicating factors**: homelessness, substance use, comorbid medical conditions	50	70

Maintaining appropriate caseloads

Caseload	Risk	Possible interventions

Too low	• Clinic not be maximizing use of the psychiatric consultant
	• Financial sustainability
		• Discuss ways to increase referrals:
		  • Case finding
		  • Remind treating providers about CoCM

Just right		
Too high	• BHCM may find it challenging to appropriately care for all enrolled patients	• Assess opportunities to keep the caseload fluid • Cap the caseload • Discuss increasing BHCM FTE

Tracking referrals to CoCM

- In your workflow, how will referrals be **communicated**?
- How will they be **documented**?
- Document and report on **number of patients referred** and **how many accepted and declined**
    - Of those who declined, what was the reason?

Recommended program oversight activities

Meeting	Goal	Participants	Developing programs (3-6 Mo)	Mature programs (6+ Mo)
Clinical Caseload Supervision (Clinical)	• High-level review of caseload. • Keep the caseload "fluid" by discussing appropriate enrollment, treatment, and discharge.	• BHCM and clinical supervisor • Optional: psychiatric consultant	Monthly	Quarterly

Program Performance Review (Administrative)	• Review performance and operations of CoCM services, including:
	  • patient outcomes
	  • fidelity
	  • billing
	  • program operations
		• Program manager, clinical supervisor, QI staff
		• Optional: BHCM, provider champion, leadership, psychiatric consultant, EHR or HIT staff
			Monthly	Quarterly

Clinical caseload supervision

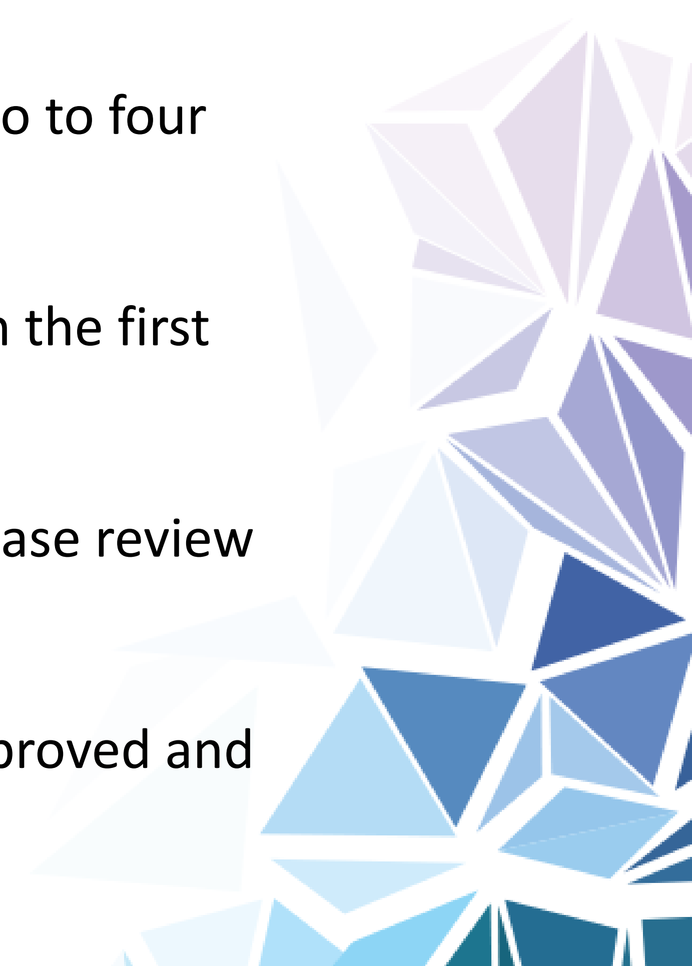
- Use the systematic case review tool to conduct a **high-level clinical review** of the caseload
  - Evaluate caseload volume, acuity, and needs
- Discuss which patients would benefit from **treatment adjustments**:
  - Relapse prevention planning
  - Different level of care
  - Being contacted at a different frequency
  - Discontinuing CoCM services
- Discuss BHCM's **ongoing skill development**

Program performance review

- **Use data** to guide conversation on program performance and optimize service delivery
- Discuss:
  - Clinical performance
  - Adherence to the evidence-based model
  - Program operations
  - Financial performance
  - Workforce changes

CoCM process measures[2]

- **Early engagement** in CoCM activities is a strong indicator of patients' future success
- Patients should be contacted **at least twice per month** in the first two to four months of treatment
- Outcome measures (e.g., PHQ-9) should be **administered monthly** in the first two to four months of treatment
- Patients are discussed with the psychiatric consultant in systematic case review **within two weeks after being enrolled**
- Treatment recommendations from the psychiatric consultant are approved and implemented by the treating provider and patient



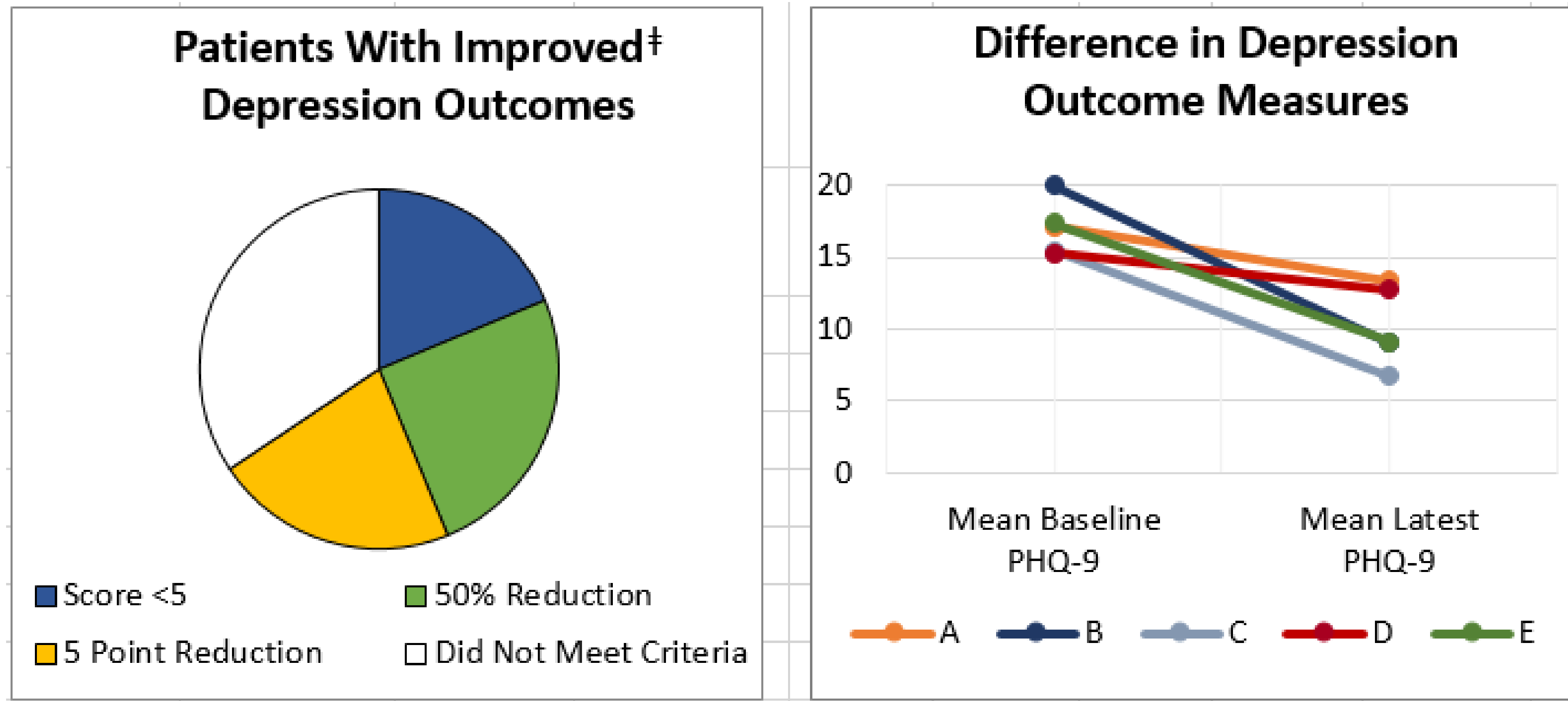
Example: tracking process measures

Process measures			Practices		
Type	**Name and target**	**Definition**	**A**	**B**	**C**
Patient engagement	Early Contact Rate (Target: 75%)	Percentage of patients with 2 or more contacts in the first month	75%	**73%**	97%
	Early Outcome Measure Completion Rate (Target: 75%)	Percentage of patients with 2 or more outcome measures completed within the first 3 months	95%	96%	90%
Systematic case review	Early Systematic Case Review Rate (Target: 90%)	Percentage of patients discussed with a psychiatric consultant in systematic case review within their first 2 weeks	**88%**	**82%**	100%
	Recommendation Implementation Rate (Target: 80%)	Percentage of psychiatric recommendations that have been implemented	86%	85%	85%
Evidence-based care	Brief Intervention Use Rate (Target: 90%)	Percentage of patients with documented use of a brief intervention (e.g., MI, BA, Med monitoring)	95%	100%	95%

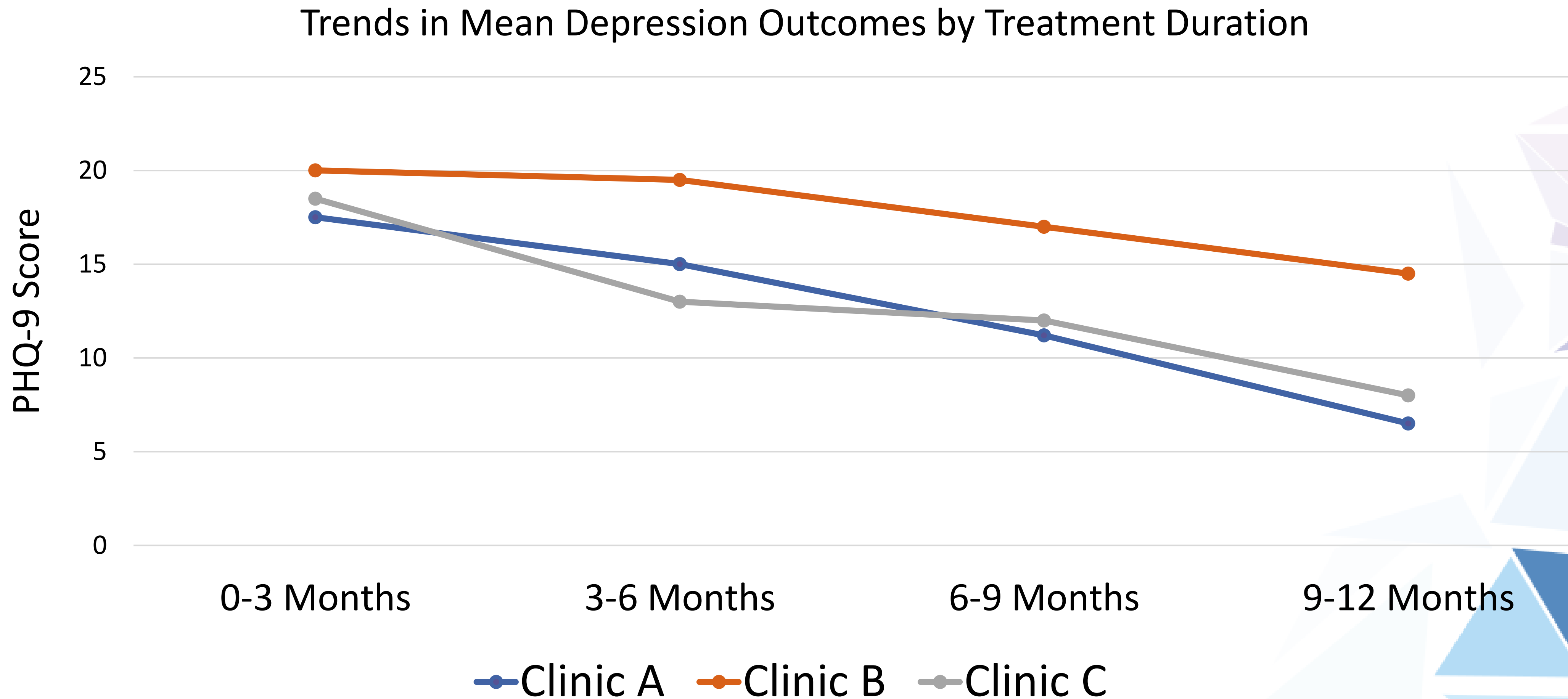
Monitoring clinical performance

- Are your patient **population's outcome measures improving as expected**? Aggregate practice outcomes will vary based on patient population
- Review patient outcomes **grouped by BHCM, treating provider, practice, and time in treatment** (e.g., 0-3 months, 3-6 months)
- Treatment duration range 3-12 months, average of 6 months
- Target: Approximately **50% of patients should show improvement after three months** of treatment:
    - 5-point reduction
    - 50% reduction
    - Score less than 5 on PHQ-9 and/or GAD-7

Example: tracking patient outcomes

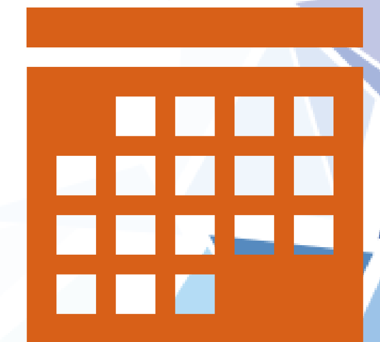


Example: patient population outcome trends



Capturing minutes of care

- Billing codes are based on the **cumulative number of minutes of care** provided by the BHCM
- Billable activities include **direct service provision**, activities related to preparing for and participating in **systematic case review**, and **coordination of care**
- CoCM codes are **billed once per calendar month**
- How will you capture the minutes of care provided to bill accurately?
  - Set targets for percentage of patients with billed activity
  - Review program financials at least quarterly



Implementation considerations

- **Start slow.** Consider choosing 1 provider at a time to refer to the program and perhaps 1-3 patients in the first month
- Consider "cherry picking" first couple of patients who are appropriate for the program but **less complicated**
- Showcase a CoCM **patient success story** (reduction in PHQ/GAD, remission) during a practice staff meeting

Additional support from PRISM

Advanced training

- https://micmt-cares.org/upcoming-trainings
    - Implementing Collaborative Care with Perinatal Patients
    - Implementing Collaborative Care with Adolescent and Pediatric Patients
    - Treating Substance Use in Collaborative Care Settings

Upcoming webinars

- https://micmt-cares.org/events?type%5B4639%5D=4639

BHCM monthly discussion group

- 3rd Thursday of the month from 12:00pm–1:00pm ET

Ongoing implementation support

- Discuss scheduling with your Implementation Specialist

Resources

- Caseload Size Guidelines: Collaborative Care Programs
- Sustainability Toolkit: Collaborative Care Programs
- Monitoring and Evaluation: Collaborative Care Programs
- Caseload Review Meeting Guide
- Program Review Meeting Guide

References

1. Raney, L. E., Lasky, G. B., & Scott, C. (Eds.). (2017). Integrated care: A guide for effective implementation. American Psychiatric Pub.

2. Unützer, J., Katon, W., Williams, J. W., Callahan, C. M., Harpole, L., Hunkeler, E. M., Hoffing, M., Arean, P., Hegel, M. T., Schoenbaum, M., Oishi, S. M., & Langston, C. A. (2001). Improving Primary Care for Depression in Late Life: The Design of a Multicenter Randomized Trial. Medical Care, 39(8), 785–799. http://www.jstor.org/stable/3767968