PRISM

Monitoring and Evaluation: Collaborative Care Programs

Regular review of program measures will help the Collaborative Care (CoCM) treatment team maintain fidelity to the evidence-based model, which promotes good patient outcomes. This guide reviews the measures within each report and outlines corresponding questions to consider to assist teams in recognizing opportunities for program improvement.

Fidelity Report

Purpose: to evaluate if the model is being delivered as intended.

Evidence shows there are several key components of CoCM that improve patient outcomes. Look at the current rate for each measure. If the current rate is not meeting the target or is on a downward trend, use the questions to guide discussion with members of the CoCM treatment team and clinical staff to identify opportunities for improvement. Explore the data in the following reports to identify additional interventions to consider.

Patient Engagement

Enrollment Rate (Target: 75%)

Enrolling patients is the first step in their treatment. This measure evaluates if the program pitch is appropriate and effective for the population and explores why patients may not be interested in this model of care.

1. How are patients introduced to CoCM? Is the messaging effective?
2. Are appropriate patients being referred to CoCM? Is the messaging effective?

Early Contact Rate (Target: 75%)

Early engagement with the treatment team has been shown to predict patient success. This measure evaluates if patients are contacted as much as recommended in their first months of treatment.

1. What is the current system for determining which patients to contact?
2. Would another form of communication (e.g., phone, CHW/MA) make contacts more successful?

Outcome Measure Completion Rate (Early and Sustained) (Target: 75%)

Outcome measures indicate how patients are responding to treatment and help specify when treatment changes are needed. This measure evaluates if outcome measures are being administered at an appropriate frequency to guide the treatment team.

1. What is the current system for determining which patients need outcome measures?
2. What is the current system for administering outcome measures?

Patient Engagement: Interventions to Consider

- Assess the BHCM FTE for CoCM. Do they have enough time to contact patients (i.e., engage with new and existing patients, complete outcome measures)?
- Administer outcome measures in new ways (e.g., phone, patient portal, CHW/MAs).
- Use the EHR/registry to flag patients that are due for repeat outcome measures.
- Retrain the CoCM program pitch; include positive patient feedback.

Systematic Case Review

Systematic Case Review Rate (Early and Sustained) (Target: 90%)

Routine psychiatric treatment recommendations help guide patient success within CoCM. This measure evaluates if a patient is being reviewed by the psychiatric consultant when they are first enrolled and that they are continually monitored and receiving recommendations throughout their treatment.

1. What is the current system for identifying patients requiring review?
2. Is the frequency and duration of systematic case review appropriate for the caseload size?

Critical Treatment Period Identification Rate (5-point and 50% reduction) (Target: 75%)

Research shows that if a patient is not improving after eight weeks of treatment, providing a revised treatment recommendation predicts improved outcomes at six months of treatment. This measure evaluates if the treatment team is identifying and discussing patients who are not improving.

1. What is the current system for identifying a patient is not improving and should be reviewed?

Recommendation Implementation Rate (Target: 80%)

It is important that the psychiatric consultant is integrated with the treatment team and that their recommendations are successfully implemented. If they are not being implemented, the treatment team is missing a key piece of the model and adjustments should be made.

1. What is the communication loop for implementing recommendations? How can this improve?
2. Is there a common theme for why recommendations are not implemented?
3. If a recommendation is refused by the treating provider, are the psychiatric consultant and treating provider discussing why? Does the psychiatric consultant make a revised recommendation? If so, is the revised recommendation followed?

Systematic Case Review: Interventions to Consider

- Block sufficient time for regularly occurring systematic case review (two hours/week for 1.0 FTE BHCM).
- Use the EHR/registry to identify patients that are due to be discussed in systematic case review (e.g., new patients, patients in the critical treatment window, patients with worsening symptoms).
- Review patients' perception of certain medications and opportunities to improve messaging.
- Provide targeted education to treating providers to improve their comfort prescribing specific medications.
- Walk through the clinical workflow for sending, receiving, and implementing recommendations. Are there gaps in the communication loop?

Evidence-Based Care

Brief Intervention Use Rate (Target: 90%)

Brief evidence-based therapeutic interventions have been shown to improve patient outcomes. These interventions include motivational interviewing, behavioral activation, problem-solving treatment, etc.

1. Are brief interventions being used and documented? If not, how can this be improved?
2. What additional training would help BHCMs better utilize brief interventions?

Evidence-Based Care: Interventions to Consider

- Review the EHR/registry to ensure all brief interventions are being documented appropriately.
- Discuss utilization of brief interventions with the psychiatric consultant.

Program Report (Dashboard)

Purpose: to evaluate overall program impact

This report summarizes referrals, enrollment, outcomes, and demographics for all patients, active and inactive, who have ever been enrolled in the program. Use this report to understand the program's reach and impact on patient outcomes.

Enrollment

1. **Patients Referred, but Not Enrolled - Reason Not Enrolled**:
    a. Is there a common theme for why referred patients are not enrolling in the program?
    b. Does the BHCM have sufficient time to contact referred patients in a timely manner?
    c. Is the program being marketed in a successful manner?

Outcomes

1. **Patient Outcomes Data:**
    a. Are patient outcomes showing response to treatment and/or remission?
    b. Consider the mean treatment duration (**Enrollment Data - Mean Days of Treatment**); a reasonable proportion of patients will observe outcome improvements after three months of enrollment. This will vary based on clinic acuity.

Inactive Patients

1. **Patients Previously Enrolled, Now Inactive – Reason Inactive:**
    a. Is there a common theme for why patients are no longer active in the program?

Interventions to Consider

- Adapt messaging surrounding the CoCM program; address expressed concerns and include positive patient feedback.

Longitudinal Patient Outcomes Report

Purpose: to evaluate if patients are improving.

This report summarizes caseload size and outcomes for all patients ever engaged in the program.

Caseload Size and Acuity

1) Is the FTE of each BHCM appropriate for the caseload size and clinical acuity?
   Are patients being discharged, "stepped-down" to relapse prevention, or referred to a higher level of care when appropriate?
   a. Appropriate timing for discharge, stepping down care, and referring-out can vary. BHCMs should discuss this clinical decision-making with their psychiatric consultant and/or clinical supervisor during scheduled systematic case review and caseload review times.

Outcomes

1. Review outcomes over time, including for all active patients, active patients enrolled for three to six months, and active patients enrolled for six to nine months.
   a. Consider the mean treatment duration; the clinic may expect to see 50 percent of patients achieving remission (PHQ-9 or GAD-7 score < 5) after three months of enrollment (Garrison, 2016). This may vary based on clinic acuity.
   b. If a patient is not improving at six months, are active treatment changes being made or should the patient be triaged to a different level of care?
2. Review patient outcomes for each BHCM/psychiatric consultant dyad. If outcomes are not improving, review the interventions to consider.

Interventions to Consider

- Block time for regular caseload review with the BHCM and clinical supervisor to help determine when to move patients off of the caseload.
- Cap the caseload or inform clinical staff of open enrollment for CoCM.
- Adjust the BHCM FTE to adapt to the caseload size and clinical severity.

Garrison, G. M., Angstman, K. B., O'connor, S. S., Williams, M. D., & Lineberry, T. W. (2016). Time to remission for depression with collaborative care management (CCM) in primary care. J Am Board Fam Med, 29(1), 10-17.

New Patient Engagement Report

Purpose: to evaluate how new patients are engaging with the program.

Early engagement in CoCM activities is a strong indicator of future success. Evaluate how new patients are engaging with specific components of CoCM to ensure they are on track to observe outcome improvements. This report only includes data for patients enrolled within the past three months.

Referrals and Enrollment

1. Are patient referrals appropriate for the program (e.g., baseline PHQ-9 and/or GAD-7 > 9)?
    - If no, is this intentional or are changes needed?

Interventions to Consider

- Review the clinic schedule each morning, identity appropriate patients (e.g., PHQ-9 or GAD-7 >9) and inform treating providers of opportunity to enroll in CoCM program.
- Discuss the CoCM program during a staff meeting, review target population, program pitch, doors to engage patients, overall program goals, and clinic success stories.
- Display flyers and/or brochures advertising the program.

Program Engagement

These process measures match measures in the fidelity reports. However, this report focuses on a narrower timeframe, allowing teams to evaluate performance at one-month intervals during the last three months.

1. Are patients engaging with the program per target rates?

Interventions to Consider

- Use the registry as a work queue. Sort caseload by date of last outcome measure or last contact to identify patients who have outcome measures or contacts due.
- During systematic case review, use the registry to systematically sort the caseload to identify which patients need to be discussed (e.g., not improving, not recently discussed).

Psychiatric Consultant Recommendations

1. Are psychiatric consultant recommendations being implemented at the target rate (90 percent)? If no, why **(New Patient Engagement – Reason Recommendations Not Implemented)**?

Interventions to Consider

- Walk through the clinical workflow for sending, receiving, and implementing recommendations. Are there gaps in the communication loop?
- Review additional interventions, such as the "Treating Provider Report: Psychiatric Consultant Recommendations (Page 6)."

Treating Provider Report

Purpose: to allow treating providers to review their patient outcomes.

Treating providers are important members of the CoCM treatment team. Share this report with treating providers to show how their patients are improving.

Referrals

1. Are all treating providers referring? If not, what are opportunities to reengage them in the program?

Interventions to Consider

- Talk with treating providers about their understanding of and feelings about the CoCM program. Offer clarification about their role and responsibilities as needed.
- Review the clinical workflow to identify potential "doorways" for the CoCM program.

Outcomes

1. **Caseload Summary – Mean Days in Treatment**:
    i. Are patient outcomes showing response to treatment and/or remission for each treating provider?
    ii. Consider the mean treatment duration in reviewing outcome improvements; a reasonable proportion of patients will observe outcome improvements after three months of enrollment. This will vary based on clinic acuity.

Psychiatric Consultant Recommendations

1. Are psychiatric consultant recommendations being implemented by each treating provider? If no, why? The target implementation rate is 90 percent.

Interventions to Consider

- Assign a nurse to liaise with the treating provider to help close the "communication loop."
- Ask treating providers how they would like to receive the recommendation and follow-up.
- Reorganize the EHR note to display the psychiatric recommendation at the top.
- Discuss with clinic leadership and treating providers whether it might be helpful to have a nurse send prescriptions to the pharmacy to save treating providers' time.
- Talk with the treating provider about whether recommendations are feeling consistently uncomfortable. If so, consider increasing engagement between the treating provider(s) and the psychiatric consultant to improve comfort or share knowledge.
- Determine whether the psychiatric consultant could adapt to the prescribing culture of the clinic.