PRISM

Sustainability Toolkit: Collaborative Care Programs

Collaborative Care (CoCM) programs require routine monitoring to prevent drift from the evidence-based model and to ensure long-term sustainability. This toolkit outlines **three components** to support sustainability: 1) establishing and maintaining program oversight; 2) evaluating the program by routinely reviewing reports as a team; and 3) monitoring for signs of program drift and intervening when needed**. Use the check boxes to ensure the appropriate infrastructure is in place.** Click the embedded links to review corresponding resources.

1. Establish and maintain program oversight.

Staff the CoCM Team

CoCM is a team-based model. Ensure all CoCM positions are staffed and appropriately trained.

Hiring and Staff Requirements

- ☐ Behavior Health Care Manager(s) (BHCM)
- ☐ Psychiatric Consultant(s)
- ☐ Treating Provider Champion
- ☐ Clinical Supervisor (Behavioral health clinical experience is strongly encouraged)
- ☐ Program Manager
- ☐ Quality Improvement Coordinator

The clinical supervisor, program manager, and QI coordinator may be played by one or more person.

- ☐ Are the interpersonal qualifications and experience of a successful BHCM considered?

Program Size

- ☐ Are the BHCM's FTE and dedicated time appropriate for caseload size and clinical acuity?
- ☐ Are systematic case review duration and frequency appropriate for caseload size and clinical?

Training

- ☐ Have all new CoCM team members completed the required training?
- ☐ Are all new staff aware of the CoCM program and workflow?
- ☐ Are BHCMs provided continuing education as needed (e.g., motivational interviewing training)?

Maintain a Routine Meeting Schedule

These meetings ensure patients, the caseload, and the overall program are appropriately monitored. **Block time for attendees to participate in the following meetings:**

☐ Systematic Case Review – Weekly
Attendees: BHCM and Psychiatric Consultant

☐ Caseload Review – Quarterly*
Attendees: BHCM and Clinical Supervisor; Psychiatric Consultant, as able

☐ Program Review (use reports – see next page) – Quarterly*
Attendees: BHCM, Clinical Supervisor, Program Manager, Quality Improvement Coordinator; Psychiatric Consultant, other leadership (as able and appropriate)

* This is the minimum frequency. Activities may occur more frequently during initial rollout stages.

2. Evaluate the program by routinely reviewing reports as a team.

Establish an Evaluation Plan

- ☐ A team member has been identified to create program and fidelity reports
- ☐ Reports are generated on at least a quarterly basis, or more frequently as needed
- ☐ Reports are regularly reviewed by the CoCM team; at what frequency?
- ☐ Reports are regularly reviewed by CHC leadership; at what frequency?

Generate and Review Program Reports

Use the program monitoring and evaluation guide to analyze fidelity measures and program reports. Fidelity is defined as the extent to which the clinical model is being delivered as intended. Fidelity and engagement goals are based on research surrounding improved patient outcomes. The goal, population, and review frequency of each report is summarized below.

Developing programs are those continuing to revise the clinical workflow or undergoing programmatic changes. All CoCM programs are typically considered "developing" for at least the first three months following roll-out.

Mature programs demonstrate strong fidelity, successful patient outcomes, and have not undergone recent programmatic changes.

Fidelity Report	
Goal:	To evaluate if the program is being delivered as intended
Population:	All patients, active and inactive
Frequency:	Monthly (developing programs), quarterly or biannually (mature programs)

Program Report (Dashboard)	
Goal:	To understand the overall impact of the program (outcomes, enrollment, demographics).
Population:	All patients, active and inactive
Frequency:	Monthly (developing programs), quarterly or biannually (mature programs)

Longitudinal Patient Outcomes Report	
Goal:	To analyze patient outcomes to ensure the model is being practiced effectively.
Population:	Active patients, aggregated by BHCM and time-based cohorts (i.e., 0-3 months, 3-6 months)
Frequency:	Monthly (developing programs), quarterly or biannually (mature programs)

New Patient Report	
Goal:	To evaluate program fidelity for new or changing programs.
Population:	Active patients that have been enrolled within the past three months, aggregated by BHCM
Frequency:	Monthly (developing programs)

Treating Provider Report	
Goal:	To understand treating provider engagement and to allow each treating provider to review
Population:	their patient outcomes.
Frequency:	Active patients, aggregated by treating provider.
Note:	Monthly (developing programs), quarterly or biannually (mature programs)
	This report should be shared with participating treating providers, as determined by the CHC.

3. Monitor for signs of program drift and intervene when needed.

Signs of Drift	Best Practices	Interventions
Patient outcomes not improving	• A reasonable proportion of patient outcomes are improving around three months of enrollment. This may vary based on clinic acuity.	• Review fidelity measures (i.e., evaluate if the service is being delivered as intended) and identify opportunities for improvement • Review referrals: Are patients appropriate?
Systematic Case review held inconsistently and curbside consultations over-utilized	• Weekly systematic case review (2 hours/week for 1 FTE BHCM) • Goal: 6-10 patients discussed/hour • Review registry every week	• Block systematic case review time for the BHCM and psychiatric consultant • Use the case presentation template to efficiently discuss patients
Outcome measures completed too infrequently	• Minimum of two outcome measures completed in the first 3 months • Minimum of one outcome measure completed each quarter	• Review clinical workflow and caseload size • Flag patients needing measures in EHR/registry • Try administering measures in new ways (e.g., phone, patient portal, CHW/MAs)
Patient registry not regularly utilized	• Systematic sorting of registry during systematic case review • BHCM uses registry as a work queue (i.e., identifies patients with contacts or outcome measures past due)	• Systematically sort caseload during systematic case reviews to identify patents who are not improving, whose cases have not been reviewed recently, etc. • Have clinical supervisor attend systematic case review
Patient registry not maintained	• Data is recorded following clinical activities	• Schedule routine time for documentation • Have clinical supervisor regularly review registry
Program and fidelity measures not reviewed consistently by all team members	• Review monthly (until program is stable), and then quarterly • Request broad involvement (e.g., leadership, supervisor, BHCM)	• Schedule a regular meeting time to review • Prepare reports prior to meeting • Review program status and patient outcomes to identify areas in need of change
Evidence-based brief interventions not being used	• At least 90% of patients should receive a brief intervention (e.g., motivational interviewing, behavioral activation, tangible resource) • Use of interventions is documented	• Assess BHCM knowledge and skill • Provide training in new skills or booster sessions • Ask psychiatric consultant to recommend brief interventions, when appropriate • Review documentation expectations and EHR templates
Caseload is full and BHCM cannot accept new patients	• Quarterly caseload review meeting with BHCM and clinical supervisor • Treatment intensified at 8-12 weeks if no improvement • Triage patients when needed	• Engage in routine caseload review meetings • Identify patients for triage or relapse prevention • Review whether program referrals have been clinically appropriate • Review whether BHCM FTE needs to be altered
Core team members not actively engaged in the program	• BHCM, psychiatric consultant, treating providers, clinical supervisor, and program manager are engaged (e.g., attend meetings, complete designated tasks)	• Encourage staff involvement; dedicate staff time • Consider soft skills for BHCM hiring • Encourage team sharing of success stories at wider staff meetings

Program introductions not "warm"	• All staff deliver warm handoffs • Initial and ongoing patient engagement rates remain high	• Retrain the COCM program pitch; include positive patient feedback