Implementing Telehealth-enabled Psychiatric Collaborative Care (CoCM) in Rural South Carolina

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Learning Objectives

- Understand the key components of the CoCM model.
- Identify barriers and facilitators of to implementing CoCM in rural areas.
- Describe how telehealth can be used to enhance the CoCM model and aid its implementation in rural communities.

Background

11TH Annual Telehealth Summit of South Carolina
December 4 - 6, 2023
Hyatt Regency Greenville
Greenville, South Carolina

U.S. Behavioral Health

- Mental illness and substance use disorders are highly prevalent in the United States.
  - 1 in 5 adults and 1 in 6 youth experience mental illness each year.[1]
  - 13.9% of U.S. adults meet the criteria for alcohol use disorder and 3.9% for another drug use disorder.[2]
  - Acuity has only worsened since pandemic.[3]
- High costs of healthcare associated with not addressing behavioral health (BH)[4,5]
  - Treatment for medical conditions among individuals with BH disorders is 2.8-6.2 times higher than the costs for those without BH disorders.[4]
  - Although patients with BH disorders account for more than half of all healthcare spending, only 4.4% of these costs are actually for BH services.[4]

Rural Behavioral Health

- Rural individuals experience similar rates of BH disorders yet severely lack access to adequate treatment.[1]
- Fewer BH providers working in rural areas as compared to rest of country.[6,7]
- Limited access to BH services likely contributes to higher suicide rates among rural Americans (nearly 2x that of urban Americans).[8]
- Most rural residents receive BH services in the context of primary care.[9,10]

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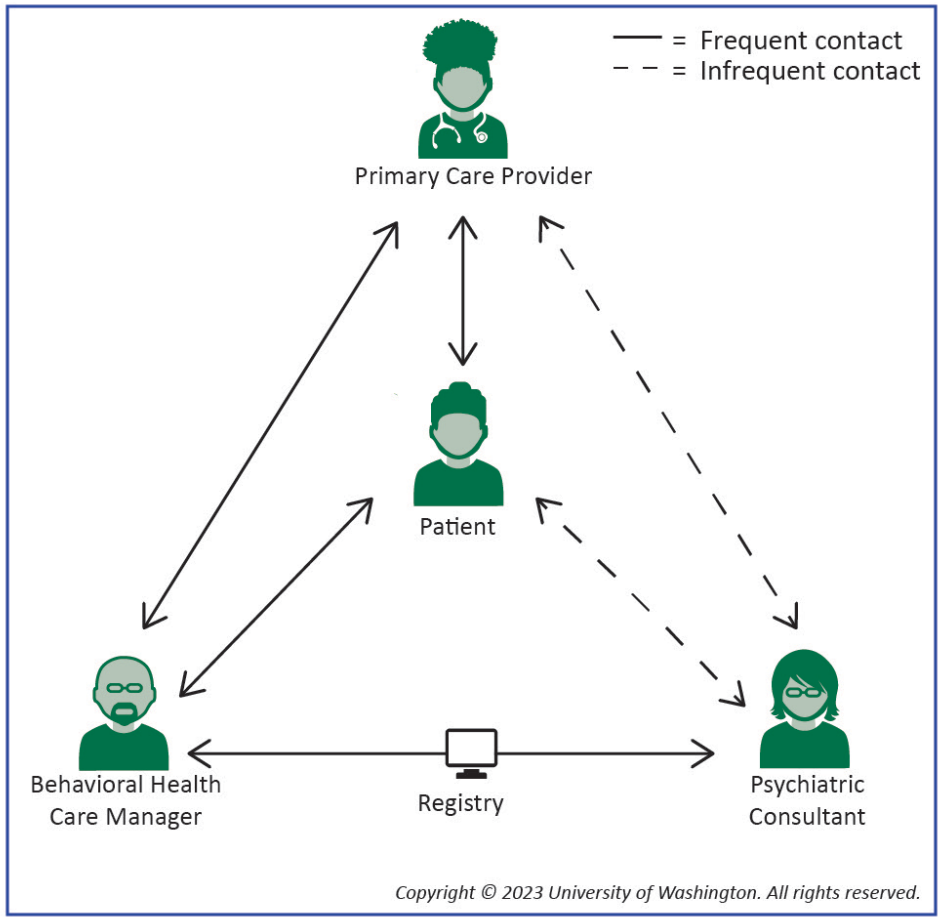
Psychiatric Collaborative Care Model (CoCM)

- Psychiatric collaborative care management (CoCM) is a model for treating BH in the context of primary care
- Strong evidence base with over 90 clinical trials across a variety of primary care settings,[11] and adoption has become a key policy priority[12,13]
- Key components:[11]
  1. Team-based Care: Primary care provider, BH care manager, psychiatric consultant
  2. Population-focused: universal, preventative screenings and referrals to treatment; patient registries for efficient management
  3. Measurement-based: Regularly administered, validated BH assessments to monitor progress toward to reach treatment goals

CoCM Model - Staffing



- Behavioral Health Care Manager (BHCM)
  - Develops treatment plans
  - Provides brief intervention & care coordination
  - Powers the program and does bulk of work
- Psychiatric consultant
  - Meets weekly with BHCM to review complex cases and patients not improving to advise on treatment strategies
  - Available for direct consult with primary care provider (PCP) or patient as needed
- PCP:
  - Prescribe meds to patient based on psychiatrist recommendations

CoCM in Rural Communities

- CoCM has great potential for rural BH given its efficient use of limited BH resources, ability to be conducted via telehealth, and focus on primary care.
- Implementation has proved difficult:
  - Limited availability for BH workforce.
  - Limited training and implementation resources for rural contexts.
  - Financial constraints for small practices to hire own BH care manager.

MUSC Telehealth-enabled CoCM Pilot

- Funded using HRSA's Telehealth Center of Excellence
- Develop and pilot a telehealth-enabled CoCM model in 4 rural, MUSC regional health network sites.
- Funding to hire BH care manager (1.0 FTE) & psychiatric consultant (0.05FTE), and to support mixed methods, implementation science evaluation
- Aims:
  - Determine ideal CoCM program model & implementation strategies to aid uptake.
  - Identify initial barriers and facilitators to implementation of telehealth-enabled CoCM pilot among the 4 rural clinics.

Methods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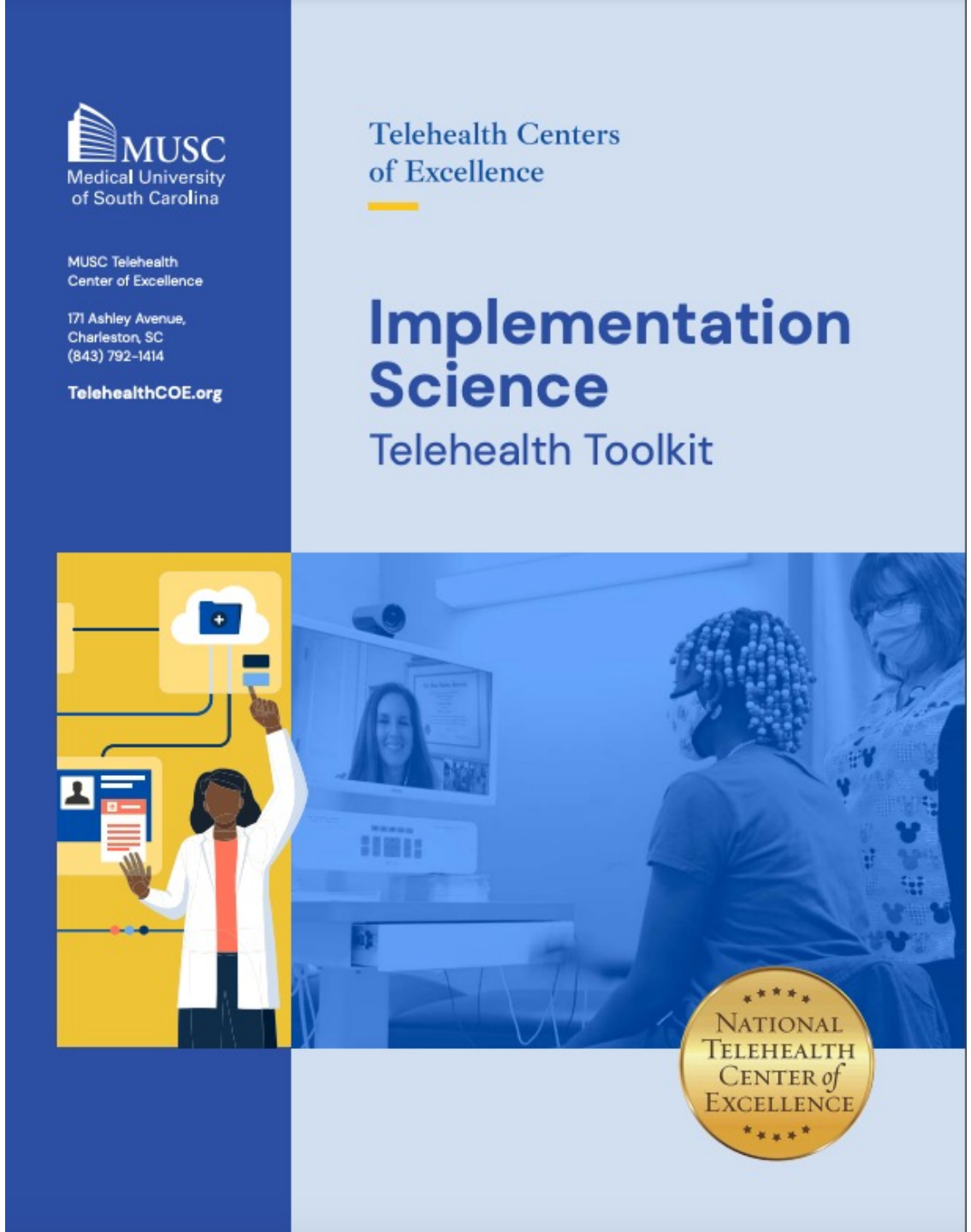
Rooted in Implementation Science

- Implementation science deploys diverse study methods to support the uptake of evidence-based treatments into routine practice.[14]



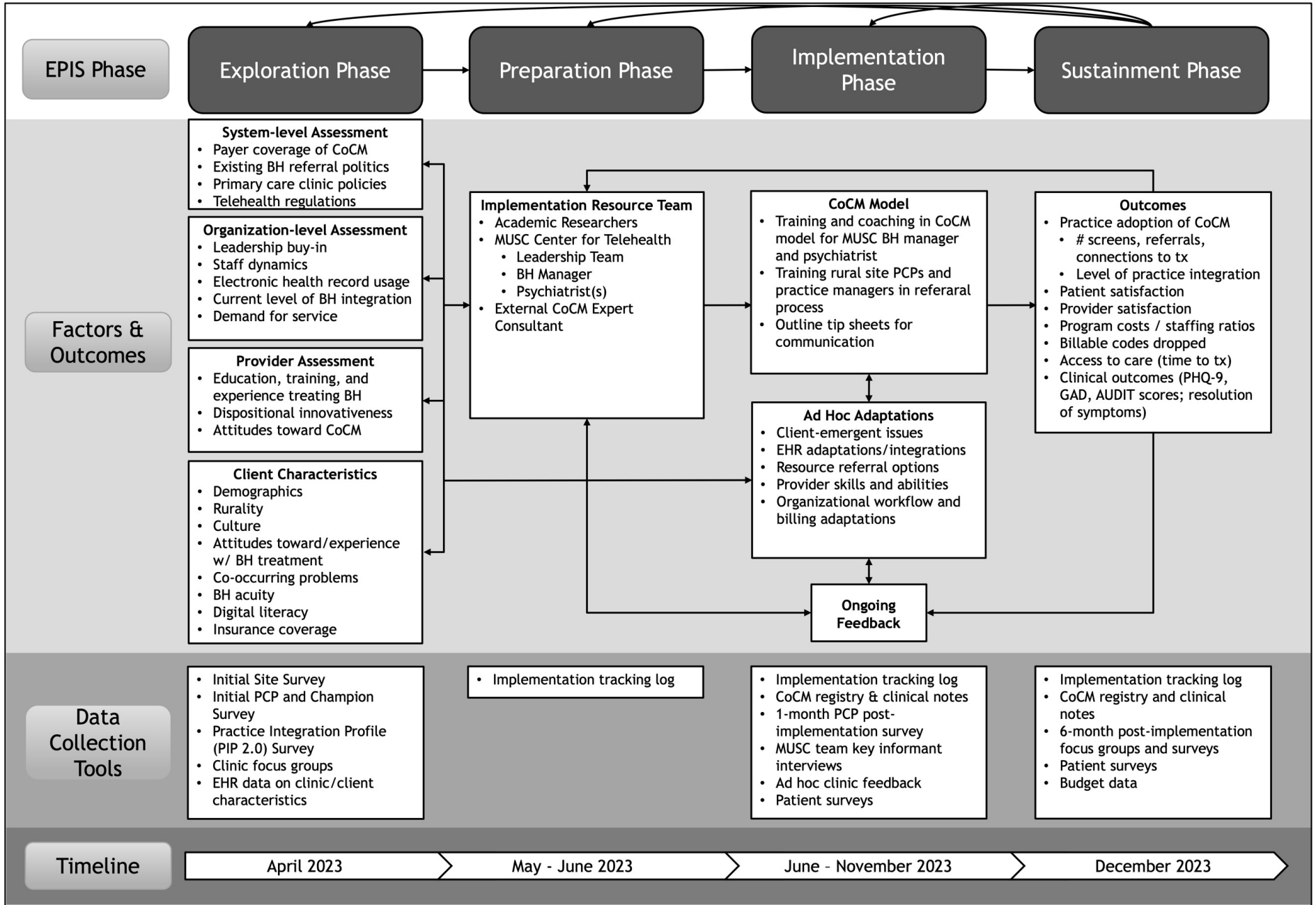
- Available on COE website:[15, 16]
  - https://telehealthcoe.org/wp-content/uploads/2023/07/MUSC-COE-Implementation-Science-Telehealth-Toolkit.pdf

- Johnson EE, Kruis R, Verdin R, Wells E, Ford DW, Sterba KR. Development of an Implementation Science Telehealth Toolkit to Promote Research Capacity in Evaluation of Telehealth Programs. *Telemed Rep.* 2023 Oct 4;4(1):286-291. doi: 10.1089/tmr.2023.0039. PMID: 37817872; PMCID: PMC10561742.

Implementation Science & CoCM

- Very few IS studies however have examined specific factors related to CoCM rollout in rural primary care. [17, 18]
- Even fewer have focused on telehealth-enabled CoCM.[19]
- Model for this research:
  - Aarons' Dynamic Adaption Process (DAP)[20] model based on his EPIS (Exploration, Preparation, Implementation, Sustainment)[21] model

Dynamic Adaptation Process Model



Results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Initial Needs Assessment

- Conducted 4 focus groups and administered surveys to PCPs and practice managers (n=13)
- Top barrier to meeting BH needs:
  - Lack of BH providers for referrals. Most indicated >8 weeks for psych referral.
- Other commonly cited barriers:
  - Adequate time, financial resources, space/staff for behavioral health resources.

Initial Needs Assessment

- Strong interest in program and seen as greatly needed.
- Obtained detailed information on implementation including:
  - Referral methods
  - Handouts for patients
  - Methods for communication with PCPs
  - Types of patient referrals

Pilot Process

- PCP refers patients to program
  - Initial focus: depression and anxiety disorders
- Enrolled patients complete measurement-driven assessment, triage, and treatment via digital platform (NeuroFlow®) or telephonically with BHCM
- BH care management services include:
  - Brief intervention and care coordination
  - Psych review with BHCM
- Information sharing facilitated via EHR
- Monthly reports available for documenting treatment plan, assessment scores, and time spent (for billing)

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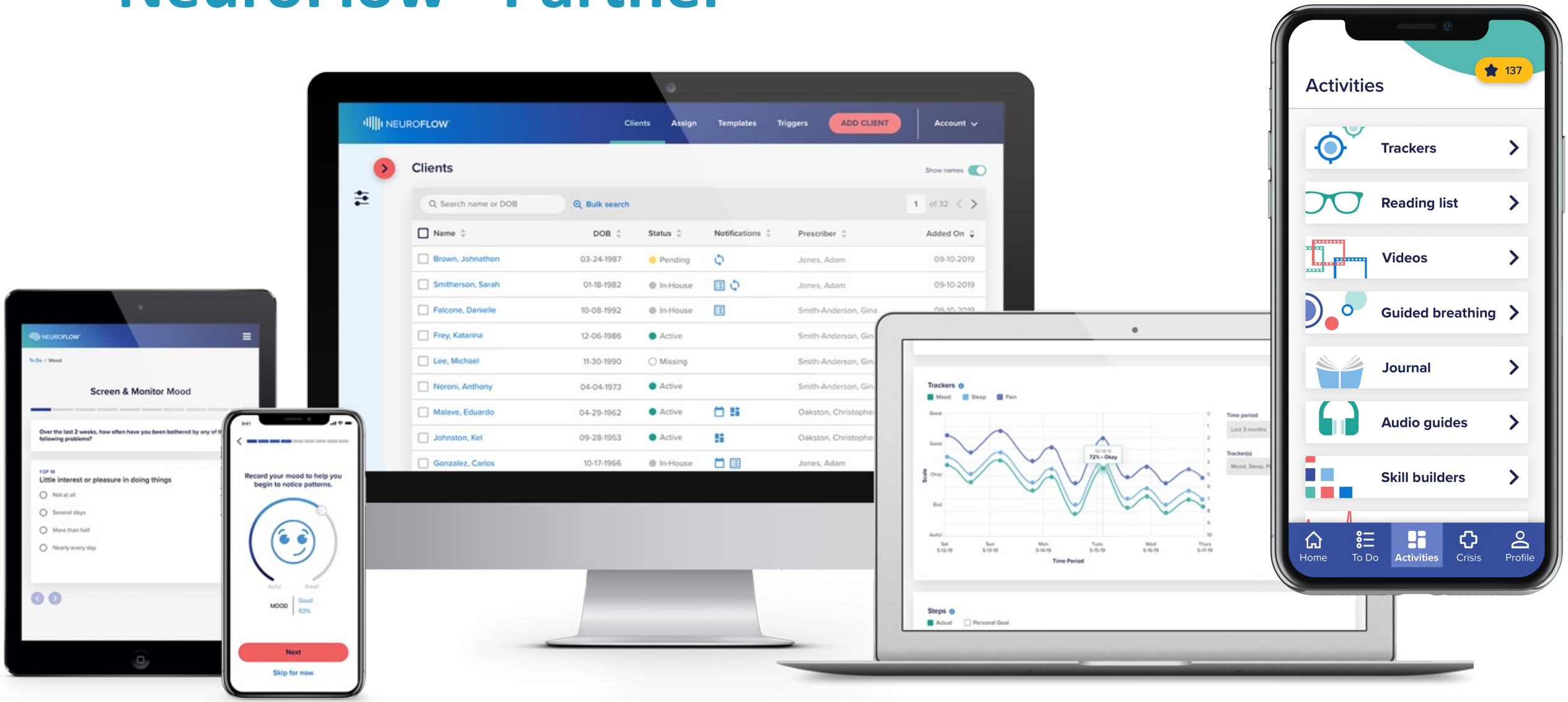
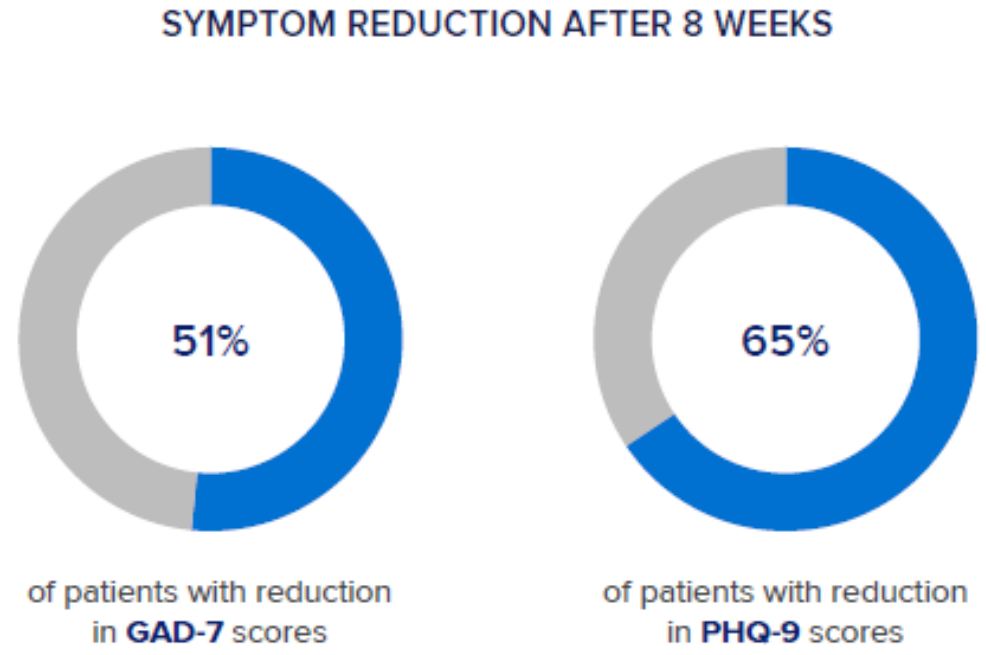


Utilization & Clinical Results

- 130+ referrals since go-live (June 2023)
- 53 enrollments
  - only 3 lost to contact
- 42 medication recommendations based on psych review



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Post-launch Qualitative Feedback

- What aspects have been most helpful from the program?

"Please continue to offer the service. I believe patients are very satisfied. I am happy with the feedback/ notes / recommendations from Miss Candace."

"Ease of sending referrals and great communication from Candace."

"The notes that I receive after a patient is referred to keep up with their progress and recommendations from psychiatry have been the most helpful."

"Being able to quickly connect patients with a counselor."

- Received helpful feedback re: closing out referral process and working with practice referral specialists

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Discussion & Next Steps

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Discussion

- Telehealth-enabled CoCM is feasible for supporting rural practice participation in CoCM
- Providers and patients alike find the service extremely beneficial, especially given shortage of psychiatrists and other BH specialists
- Further examination of financial sustainability and business models are needed.
  - All major payers pay for CoCM with the exception of SC Medicaid
  - Advocacy to support sustainable payment may be necessary
- Examination of feasibility beyond pilot is necessary.

Next steps

- More formal analysis and write-up of findings, looking at both implementation and clinical outcomes
- Pilot to scale to 20 MUSC sites in early 2024 (including peds)
- Examination of opportunities to extend this partnership/model to non-MUSC affiliated sites
  - Need to address contracting, billing, and information sharing challenges
- Other use cases: school-based BH; perinatal BH

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