

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







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}







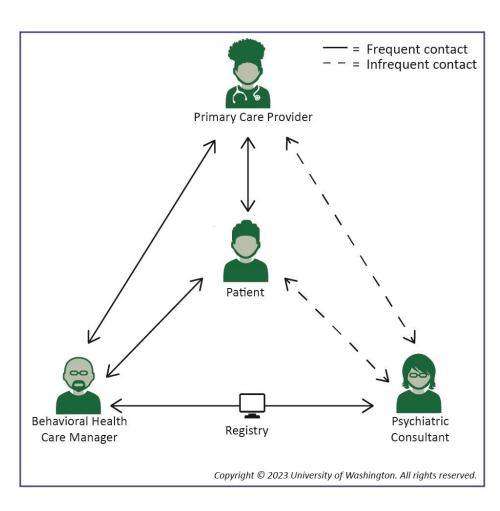


- Psychiatric collaborative care management (CoCM) is a model for treating BH in the context of primary care
- Strong evidence base with over 90 clinical trials across a variety of primary care settings,¹¹ and adoption has become a key policy priority^{12,13}
- Key components:¹¹
 - 1. <u>Team-based Care</u>: Primary care provider, BH care manager, psychiatric consultant
 - 2. <u>Population-focused</u>: universal, preventative screenings and referrals to treatment; patient registries for efficient management
 - 3. <u>Measurement-based</u>: 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 Coch Musc Health 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







Rooted in Implementation Science

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







MUSC Telehealth Center of Excellence

171 Ashley Avenue, Charleston, SC (843) 792-1414

TelehealthCOE.org

Telehealth Centers of Excellence

Implementation Science

Telehealth Toolkit



- Available on COE website: 15, 16
 - https://telehealthcoe.org/wpcontent/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.



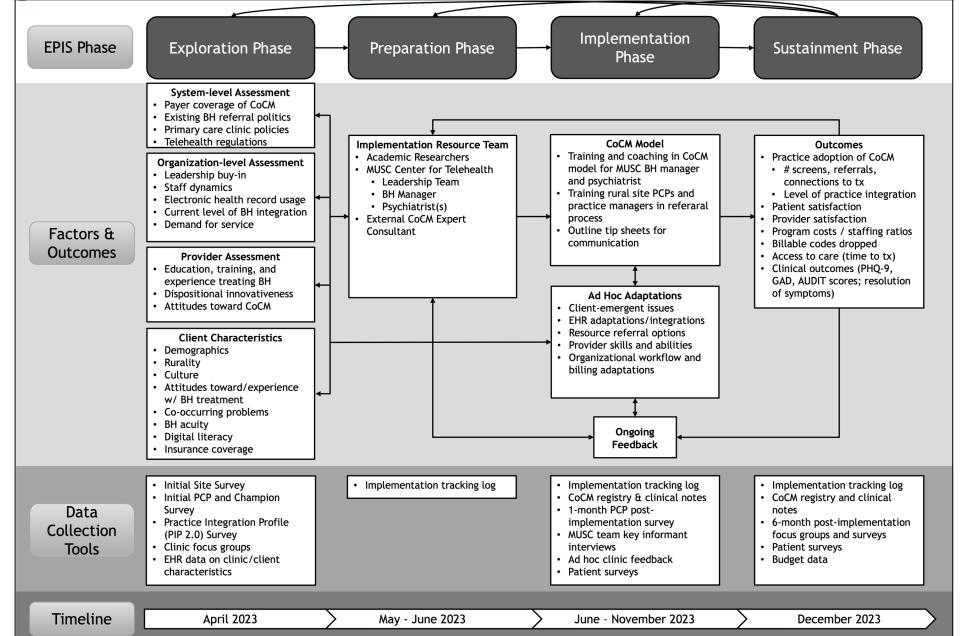
Implementation Science & CoCM

- 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







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

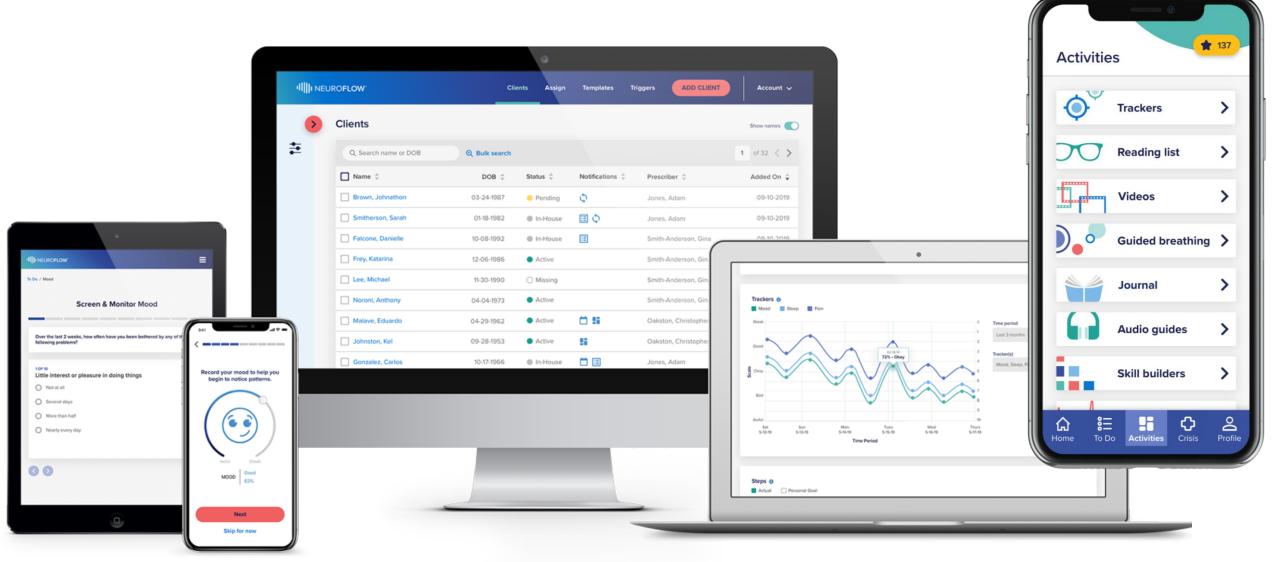
- PCP refers patients to program
 - Initial focus: depression and anxiety disorders
- Enrolled patients complete measurement-driven assessment, triage, and treatment via digital platform (NeuroFlow®) or telephonically with BHCM
- BH care management services include:
 - Brief intervention and care coordination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







NeuroFlow® Partner

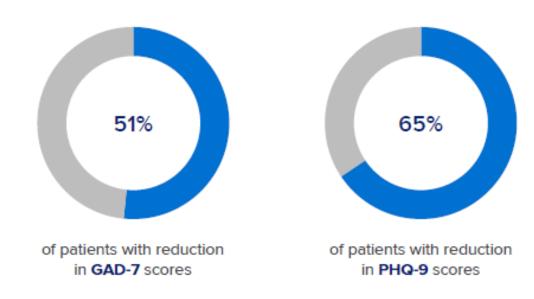




Utilization & Clinical Results

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

SYMPTOM REDUCTION AFTER 8 WEEKS









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







Discussion & Next Steps







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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