Author’s response to reviews

Title: Understanding collaborative care implementation in the Department of Veterans Affairs: Core functions and implementation challenges

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Author’s response to reviews:

Editor Comments:

Thank you for submitting this manuscript, which clearly has some merit. I agree with the reviewers that it could be suitable for publication with some revisions, and encourage you to careful read and directly address their comments. I look forward to receiving and having the opportunity to review the revised version in future.

Reviewer reports:

Mark Williams (Reviewer 1): I appreciate the work that went into this project and the efforts to better understand the reasons collaborative care models develop differently in various settings. Those outside the VA system may assume that within the VA it is simple to standardize care given the VA structure and this type of research clarifies that things are not so simple.
Comments:

1. The title is not very catchy and does not tell the reader what type of research this manuscript describes.

   Thanks for this feedback. We propose the following revised title that more closely describes the purpose of the study.

   Understanding collaborative care implementation in the Department of Veterans Affairs: Core functions and implementation challenges

2. The term 'blended' may not be familiar to many readers. Two references are provided in relationship to the term, both related to work within the VA system. It makes one want to ask more details about the models at each site to understand better there differences and to be able to judge for ourselves that one is simple 'co-location' and one is 'blended'. In the literature the term 'co-location' also implies other things about how the mental health staff are integrated or not into the way patients are managed at that site. It might be more clear to simply describe the sites as collaborative care with on-site care management and collaborative care with either no care management or off-site care management if that applies here (or something like that).

   We appreciate the potential misunderstandings around terminology in this area. Our revision now labels the two sites as care management (CM) and embedded mental health (EMBED). We also clearly specify in both the background and methods that the VA CM site does include embedded mental health staff.

3. Other than a footnote, I had trouble getting a sense about how the CL site's care management service worked. It appears to have been off-site and targeting high risk patients but it is not clear if this service was also available at the blended site and to what extent some of the tasks of care coordination (education, tracking, activation) were being done by these individuals and if they were being done, did staff at the site know about it? Since it appears that two care managers from this telehealth program were interviewed, more details about how this is a part of the story or a limitation in drawing conclusions would be helpful.

   We had debated whether to include this information or not in our paper. The telehealth program is designed for patients with chronic medical illnesses. However, the telehealth program does address mental health symptoms such as depression that may co-occur with medical illnesses. This program is likely present at both sites, but was not discussed at the site with depression care
management, likely because that site has multiple care management options. VA has a range of care management options (e.g., home health care) that were not the focus of this study because they are not designed for depression care management. Given that the footnote is confusing and the longer description is only tangentially relevant to the goals of the study, we have removed references to the telehealth program.

4. Research question one (RQ1) asks what a blended site offers over a co-located site. To answer that question methodologically, it would seem that the researchers would have taken a more open-ended approach in the interviews. However, in the section entitled 'Core Care Management Function', it appears the researchers came prepared with what they felt were the core functions of depression care management before doing the interviews. Perhaps the research question that was really answered was something like 'are core functions of depression care management happening at both sites?'

The reviewer is correct that we first grounded our study in the literature to determine the likely core functions of depression care management. However, we designed the interview guide to first ask participants how they provide depression care before we asked questions that fit our conceptual framework. This allowed participants to talk about depression care using their own language and could have revealed other core functions not expected. We used open coding for this site to identify any other depression care management functions. We did not find any new core functions. We have clarified this process in the methods.

5. Research question two (RQ2) appropriately sets up the question with what the literature says about barriers to implementing a blended collaborative care model. Among the barriers listed is reimbursement. In the VA system is reimbursement a barrier? If so, how did the site with care management get past that? If not, consider highlighting this issue because it may interest the reader who could be biased to think that reimbursement is the main barrier and if that were fixed, care management would happen. In fact, if reimbursement is not an issue in the VA, I would encourage highlighting that fact in the abstract by saying that in two sites where reimbursement options are the same, one has not added a formal care manager and one has done so. With the evidence being strong for the impact of care management, this research asks about barriers to implementation - both to check if the main functions of care coordination are already happening at the site without it (and therefore not needed) and on administrative barriers.
Thank you for this suggestion. Reimbursement is not an issue in VA, and we have included this in both the abstract and methods.

6. In methods - it is confusing to know why snowball sampling was needed for two clinics when the investigators already had an internal VA list and there is limited information on who did the interviews.

We now specify that snowball sampling was used to adjust for unreliability in the VA lists. Such lists are maintained by administrators for their own goals that may only partially overlap with the goals of the research. Thus, the lists were only used to start the snowball process.

It would also be helpful to know about denominators - for example, if 4 primary care clinicians were interviewed at site one, how many primary care clinicians were eligible to be interviewed? Consider using the COREQ checklist as a way to make sure you are covering the main bases of qualitative research reporting.

Thank you for suggesting the COREQ checklist. We have gone through the checklist and added the necessary information to the methods section. Regarding denominators, we do not know the true number of eligible participants. We used snowball sampling to ensure that we had representation from the different relevant roles, but we are unable to provide an accurate denominator aside from the 45 recruitment invitations that we sent out.

7. The sentence right before the quote under 'Getting Care Management on Leaders' Agendas' (lines 383 and 384) is confusing. What does 'frequent press' mean?

We have clarified this as “frequent inquiries by the media and government representatives”

8. The sentence just before the discussion about barriers appearing to be administrative rather than provider or patient driven may be overreaching without any questions being asked of patients.

We have omitted the phrase “patient-driven barriers” to establishing care management.
9. The first line of the discussion should be more clear for a reader in regards to what to do. How does one pay specific attention to structural and role clarity’?

Thanks for pointing this out. We have reworded the first sentence to be clear about what the study indicates needs to be integrated - program structure (e.g., dissemination of program knowledge), interpersonal relationships (e.g., trust), and communication systems (e.g., computer alerts).

10. On line 435 and 436 the authors mention that co-located sites feel that care management would lessen a provider workload. While I believe that may have been said by respondents in the co-location sites, I had trouble locating proof of that in the quotes.

This is a valid point. We had interpreted quotations like that of the physician’s assistant (p. 15) to indicate that provider workload would be lessened. We have, however, revised our language to more accurately reflect the data presented in the results section. That is, rather than reducing workload, care management would allow more attention to and follow-up on patient concerns.

11. The quotes were helpful.

    Thank you, we are glad that the quotes were informative.

12. In the first line of the discussion, one wonders what 'specific attention to structural and role clarity' would look like? Would it be more helpful to say that monitoring of key functions of care management - education, activation, and tracking of outcomes in all sites might better identify if a site has figured out how to do that without formally hiring a care manager? There are scales for activation and perhaps ways of using the electronic record to assess numbers of contacts of depressed patients after treatment initiation.

Thank you for this suggestion. We have added the following sentence to our paragraph on interpreting study results: Sites could regularly measure patients’ perceptions of education, activation, and monitoring in order to determine the need for either stronger support from embedded mental health staff or justify the need for investment in a depression care management program.
Richard Byng (Reviewer 2): Review of BMC health service research

This is a potentially important paper about an area of health services delivery, namely collaborative care, for what is called depression. Much has been written about collaborative care in its various forms, as well as its basis in the chronic disease model, and there are trials showing its moderate effect size in different forms. This paper focuses on the delivery of collaborative care and the care management component of that. It could benefit from a more precise analysis of the literature of collaborative care and care management, from further clarity about the methods and potentially further analysis, and some more detailed description within the results section.

1. Perhaps the most important issue to improve on is the clarity and precision of language with respect to collaborative care and care management. Collaborative care has been defined in a number of different ways and for that reason it might be helpful to use one of the standard definitions as a starting point.

Thank you for this suggestion. We have drawn from a Cochrane Review to define Collaborative Care.

2. Within collaborative care, the background literature appears to use collaborative care and care management interchangeably and it might be more helpful for the authors to decide that they are looking at collaborative care, as in the title, rather than care management, but that the focus is on the care management function.

We appreciate the potential for misunderstanding here. Our revised background and title now more clearly indicate that the care management function of the Collaborative Care Model is the focus of this paper. Specifically, our revision now labels the two sites as care management (CM) and embedded mental health (EMBED). We also clearly specify in both the background and methods that the VA CM site does include embedded mental health staff, which is not a standard implementation of the Collaborative Care Model.

My reading of the paper is that the key question is whether care management functions, i.e. those functions carried out by non-professional staff (engaging with individuals, following them up,
ensuring some level of education), but also involving some clinical issues such as goal-setting and supporting individuals to achieve those goals, should be carried out by separate individuals - care managers - who are not normally mental health professionals and are dedicated to these functions, or whether these functions can be embedded within the work of co-located mental health professionals and/or primary care clinicians or administrators. I appreciate that I may have misunderstood the function of the paper but I think that the methods employed and the situation of having two different versions of collaborative care, one with and one without a dedicated care manager, and an analysis of the pros and cons of these different models in achieving the functions of care management has the potential to add both clarity and new knowledge to the literature.

Thank you, your reading of the paper is consistent with our intentions. We hope that our revision makes this even clearer.

Considering the background in detail, the paper starts with quite an emphasis on improving access with a rationale that having some form of primary care mental health function, i.e. collaborative care, within primary care will improve access. This is clearly an important objective of collaborative care but is not really addressed within the rest of the paper, as a direct consequence.

We agree that access is not the focus of this paper, and have removed these references.

It may be more important to elaborate some of the tensions that appear to be there within the discussion, particularly issues such as whether or not to have multiple individuals involved in the care of an individual with specialist functions, versus one individual taking on multiple functions in order to reduce confusion, handover, etc., which can be costly to the system.

You are completely correct. Upon review, we recognize a bias in our discussion where we are implicitly favoring the care management program. However, you are completely correct that our data suggests that the care management program may introduce additional challenges. We have revised the first paragraph of the discussion and now take a more balanced approach.

Line 67, page 4 suggests significant subsequent improvements but doesn't detail what they are.
We have removed this statement as the improvements to the model since 2008 are not the focus of this paper. This paper focuses on the current implementations of integrated mental health care.

Line 77 starts what is an important paragraph around the core care management functions but, as above, appears to confuse and conflate care management and collaborative care, whereas the main function of the paper will be to bring out what might be care management functions from the wider collaborative care model.

Thank you for pointing out this confusion. We have heavily revised our presentation of the collaborative care model to more clearly indicate how depression care management is the key innovation that we will be studying.

The research questions are reasonable, although I would personally also ask in question 1 the converse ie whether there are any advantages of a co-located, rather than blended, model and indeed it appears that there are potentially some.

You are entirely correct. It was not our intention to ignore the possible advantages to an embedded model. We have added to the background a discussion of the possibility that a dedicated care manager may be unnecessary.

Within the methods, data collection is really clear and the distinction between description of the interview guide is helpful, particularly showing how all participants were asked about the functions of care management, lines 156-158. The coding is well-described. In the analysis, it is helpful to have the difference between descriptive and analytic themes; a really good example is provided for descriptive themes which were effectively coded from prior theory, whereas it appears the analytic themes are developed bottom-up but intent on understanding casual issues as to whether blended or co-located had a better chance of achieving key outcomes. It would be helpful to have examples of how these were carried out.

Thanks for this suggestion. We provided the following example: For example, descriptive themes regarding staffing were reported in each site, but the BLEND site discussed how to hire the best care managers, whereas the CL site discussed barriers to hiring.
For me, this is also a potential area of weakness in that a thematic analysis was chosen to look at causal issues without an overarching theory as to causation being embedded within the analytic process. Similarly, with respect to implementation, another tactic could have been to use one of the frameworks of implementation, such as normalisation or process theory, to guide the analysis.

We share the reviewer’s perspective here. In general, we agree that it is important to use conceptual frameworks when studying implementation in order to ensure that all of the relevant concepts were covered. However, in this particular study we chose to gather more information about the care management process to better understand differences in how the programs were structured (RQ1) rather than focusing primarily on the implementation challenges (RQ2). We did find that the implementation challenges were interesting and potentially informative to administrators who may be planning to implement collaborative care and so we decided to include data from both research questions in this paper. However, this was not the primary purpose of the study.

Table 2 illustrates one of the issues related to description of what collaborative care is in that it's not clear whether there is therapy per se being offered. Personally, I think it would be helpful to actually unpack this issue which I think goes to the heart of one of the problems of collaborative care, in that practitioners can be therapeutic without giving real therapy, can support people with setting goals, etc., and that this can blend into formal motivational interviewing. Again, there are questions as to whether that is therapy or not; either processes can be therapeutic in guiding goals and can also be therapeutic in creating engagement and relationships which are potentially valued above the generation of goals. The quote on 205 suggests that being listened to and taken an interest in is a key outcome for patients according to the practitioners involved, and yet this is not seen as a core component of collaborative care or indeed the care management function.

We see the reviewers point and agree that this is an interesting issue. Unfortunately, the current study does not have the data needed to explore the patient-experienced outcomes of collaborative care. We have noted in the limitations that we didn’t speak to patients, and therefore it’s possible that patients may experience depression care management in ways that aren’t captured by staff perspectives.

The quote on line 220 is certainly interesting and could point to the work needed to be done by practitioners in overcoming what is seen by the patient in this case as an imposition of yet another interference. Given what we know about the burden created by healthcare (as well as
disease), it is worth considering the potential harms of collaborative care of a patient having to engage with a doctor, psychiatrist, and then a further care manager.

Burden associated with high levels of outreach and care could be a potential downside of collaborative care, but is not a theme that emerged in this study. Our interpretation of the quote referenced above was that the patient was overwhelmed and agreeing to let the care manager call back was agreeing to help that he was not getting elsewhere. This was interpreted as a positive interaction overall.

We agree that research evaluating negative effects of applying collaborative care could be informative. This was not the focus of this study, and no clear negative effects emerged from the data. We have, however added a comment about the value of future research in evaluating potential negative effects of collaborative care to the discussion section.

The section on patient education involves another quote from the Chief of mental health, who is perhaps over-quoted and my interpretation of it is that the practitioners are reiterating care management philosophy a little uncritically, but perhaps I am over-interpreting this quote.

We have replaced this quote with another patient education quote. Three different informants discussed the importance of patient education to the care management program.

The section on care management functions at the CL site, line 264, is important. I am not convinced about the word 'nominally' on line 266. I think that while the practitioners are not clear they can always succeed, I think they are providing elements of it and the reason for not doing perhaps what they could do is a resource one.

We agree that the term nominally does undervalue the care management functions that may be provided by some primary care and embedded mental health staff, and have removed it. We also have expanded the discussion regarding the care management functions provided by embedded mental health staff.
One of the interesting aspects for me was line 322 where primary care providers are shown to be confused by mental health programmes. I think this is a point that is worth drawing out and, rather than seeing it as a weakness of primary care providers, some reflection on the collaborative care process could be made and the collaborative care or care management process could be improved by having greater clarity as to how the various players and the different roles can achieve outcomes for patients.

We agree. We have added the following: “This suggests an important system-level deficiency in support for integrated mental health. Education of individual primary care physicians is challenging in general, and the effectiveness is further limited by high workload and turnover.”

Line 340, the quote demonstrates a lack of trust in the whole process and, given the only moderate effect size of collaborative care, and the fact that some clinicians may have witnessed problems of the implementation of collaborative care, should not be ignored as again being seen as a problem of the primary care clinician. The quote in line 358 provides a very good rationale for why distrust may exist, in that the implementation of collaborative care is not fitting into the routine of the primary care professional, who has a very real concern about the insertion of both systems and another individual into the care of people with complex problems. Importantly, line 440, the authors recognise some of the implementation problems of primary care physicians for perhaps good reasons, not fully accepting the collaborative care model.

Thank you for identifying these important points. To avoid misinterpretations, we now emphasize that the section about trust identifies system-level and team-level weaknesses, rather than provider-level weaknesses.

In terms of limitations, it could be emphasised further that patients were not involved in the study and also there are no quantitative measures of process which could have been helpful context for interpretation of the study, even such things as how big a population the coverage for the two settings there was and how many practitioners there are from different groups.

This is a good point. We have added this to our limitations section.
Note: typo on line 494 with an incomplete sentence. Also, the conclusion line 492-494, I am not absolutely convinced that that is the main conclusion, similarly, the sentence 498-500.

Thanks for pointing out the typo. We have also revised the conclusion to be more balanced and fully represent the diverse perspectives of our participants.