Reviewer’s report

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

Version: 0 Date: 06 Jun 2017

Reviewer: Richard Byng

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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.

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. 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. 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.

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. 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.

Line 67, page 4 suggests significant subsequent improvements but doesn't detail what they are.

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.

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.

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.

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.

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.

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. 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.

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. 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.

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.

The discussion section brings up the issue of accessibility on page 419 but, as described above, this is not a focus of the analysis and I think rightly so. 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. 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.
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.

Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Unable to assess

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