Author’s response to reviews

Title: Costs of implementing and sustaining enhanced collaborative care programs involving community partners

Authors:

Theresa Hoeft (thoeft@uw.edu)
Heather Wilcox (hwilcox@uw.edu)
Ladson Hinton (lwhinton@ucdavis.edu)
Jurgen Unutzer (unutzer@uw.edu)

Version: 1 Date: 14 Mar 2019

Author’s response to reviews:

Response to reviewers:

Reviewer #1: This manuscript reports on the costs of implementation enhanced collaborative care programs for treating depression in primary care with collaborations from community-based organizations. Implementation costs are not usually reported, yet they are crucial to decision making. Therefore, this study contributes to the literature by reporting on a comprehensive costing evaluation of its program, with special focus on the activities and costs associated with the planning phase of implementation.

The concept of sustainment is included in the title of the manuscript and it is mentioned as a distinct phase early in the text. However, this study does not seem to focus on sustainment costs, given (1) that they are not reported separately, and (2) the short time horizon of this study. This needs to be clarified throughout the manuscript. Furthermore, the short time horizon and the limited number of sites with complete data diminish the significance of this manuscript.

We appreciate the reviewer’s support of the collection of implementation costs and welcome the opportunity to share more about how we collected sustainability costs. We were on a relatively short timeframe for collecting the one-month cost of care data that informs sites’ sustainability efforts following the implementation period. We separated out 1) the implementation period – a time of change as the program takes on new patients and improves processes of care – from 2) the steady state period where changes to the workflow are minimal or nonexistent. This later period post-implementation allowed us to get an early analysis on costs to sustain the program from a cost of care perspective. Sites each determined their own dates when programs reached a steady state and few changes were being considered to programs. Sites were interested in understanding costs to operate and sustain their programs as developed. The one-month data collection was designed to give leadership / decision-makers at the organizations more detail on these costs and activities. Given the short timeframe of the grant, these analyses are an early look
at these costs and we will follow-up with sites to collect data again later in the sustainment period. As mentioned in the first paragraph of the discussion we are planning to administer this one-month cost of care data collection again with sites that have continued in the Care Partners program. The template for data collection is a useful tool for assessing sustainability of the program as developed and possible changes that may further its sustainability. Items missing from this template that should also be considered in future data collection on sustainability include continued training costs to boost fidelity to an evidence-based program and training costs for new staff. We added detail on pg. 21 regarding the early nature of this sustainability data collection, potential insights from repeated data collection in longer studies, and possibility of adding training data during the sustainability period in future studies.

Additional Comments:

Page 5, line 104 - Would it be possible to include as an appendix the template for the detailed spreadsheet or what was collected in the spreadsheet? It is unclear whether this level of detail is captured in the Tables.

We have now included an attachment on this detail. Please see Additional File 1. We also referenced this attachment on pg. 6 in the methods.

Page 6, lines 122-123 - this suggests that there were three periods observed in the study (planning, implementation, and sustainment). However, only two were presented in the results (e.g., in Table 3, results are reported by Planning and Implementation Phases only). Can this point be clarified?

We have added detail to Table 4 and the manuscript text to help clarify the three phases. To help clarify we revised Table 4 with a title focused on cost of care to sustain programs. Table 3 separates the planning phase of implementation (i.e., before the patients were recruited) from the implementation stage (i.e., when the patients were enrolled and the programs were still developing through an iterative learning process with support from practice coaches). The sustainment period began when changes had slowed to a minimum or stopped. Each site decided when their period of implementation ended and sustainment period began. We more clearly outlined these periods on pg. 2 in the abstract and pg. 6 in the methods.

Page 8 Results/Site Overview - This section could be improved with a discussion of the scale of operations at each site. Further, it would be interesting to know how implementation costs varied with the size and capacity of each site.

We have added detail about the clinics launching these programs and the primary care networks they sit within to pg. 9 of the manuscript.

However, we are unable to draw connections between the scale of operations at the clinics and implementation costs in part due to the small number of sites in the project but also because grant recipients were at times the community-based organization (CBO) partners. In these scenarios, a strong quality improvement infrastructure at a larger clinic system may not impact
costs of implementation if much of the organization and administrative work is being led by the CBO.

Table 1 - clarify in the title that these are patient demographics.

Tables 2 and 3 - a footnote should be added to explain incomplete data.

Table 3 - it would be useful to add the length/time period for each phase by site.

Thank you for pointing out these areas to improve the tables. These details have been added to Tables 1 - 3.

Reviewer #2: Thank you for submitting your article. Assessing the costs of implementation is useful and important to share. Your edits responding to the comments from your last submission are clear. I have some minor clarifying questions mainly regarding your methodology.

Methods:

-The program was implemented for 2 years but the costs of care were collected for only 1 month of implementation during the sustainment period? Please explain why costs of care were collected only for 1 month after implementation and not during.

We collected cost of care activities in the sustainment period to give the sites feedback on costs to sustain their programs once implemented. Leadership at each site will consider sustainability of the programs as the programs develop but we encourage them to think about the clinical effectiveness of the programs over cost as they implement. We discussed this with other health economists who agreed that it was best to wait until the sites implemented their programs before collecting cost of care data.

The one-month time period was chosen as an adequate period of time to collect costs that might vary throughout the month but also not burden the sites too heavily with data collection. The cost evaluation was funded as a separate study after the sites received their grant awards in July 2015. We wrote in honorariums to encourage and support data collection from the sites for this additional work, but also attempted to make the data collection relevant to the sites at all steps and less cumbersome to encourage site participation. We are planning to repeat the one-month data collection though in our current grant to get another glimpse at the resources needed to support these programs.

-It seems the time/value of the family partners are not included in the costs. Is this correct? If so, please explain why

This is an excellent question and we would really value this data on family care partner time / activities. We focused more on the CBO and clinic provider + staff time at this stage of the grant
given that six of the seven sites involved a CBO, only two involved family, and the site that involved both family and a CBO was the clinic that chose not to complete the cost evaluation (Site 6). The other family site (site not involving a CBO) is also a VA site and we did not feel we could add another data collection element to the IRB at that site without considerable additional effort for the study site. We will plan to collect this data within our current grant which involves one new site working with family care partners funded in July 2018.

-You mention the varying implementation periods for each site (line 128). Could this information be added to Table 3 for each site? Do the hours and costs align with the length of implementation for the sites? This is not mentioned as a reason for why they vary so much across sites.

Reviewer 1 also mentioned this helpful addition to Table 3 and we feel it is greatly enhances the table.

For two sites it is possible that the hours and costs align with the total implementation costs (Sites 2 and 3) as their implementation periods extended past a second in-person meeting and thus included additional travel costs and time spent at the meeting. We see however that some sites spent considerably more hours on activities in the planning phase compared to the implementation phase so do not suspect there is much difference based on length of the implementation period beyond atypical activities such as an additional in-person meeting. Site 3 also had higher costs in the implementation period due to continued planning meetings during the implementation phase as they strategized ways to improve enrollment.

Results

-This sentence could be more clear: Line 182: "Three sites offered a majority of care via home visits through CBO staff from a health education outreach organization…” I suggest something like: Three other sites offered a majority of care via the following: home visit through XX, home visit psychotherapy, and a health and human services agency."

We have updated and clarified the text on pg. 9 to the following below.

“Three other sites offered a majority of care via home visits delivered by: CBO staff from a health education outreach organization (Site 2), an in-home supportive services organization focusing on in-home psychotherapy (Site 4), and a health and human services agency (Site 5).”

-Line 186- Remove "The"

This has been removed.

-In the section starting on line 301 - No explanation is given for why partnerships ended or dissolved.

Both partnerships ended in part due to an unexpectedly low number of shared patients that were using services at both partnering organizations (i.e., CBO and clinic). The programs were not
asking older adults to change primary care providers and thus were relying on participants using services at both organizations or enrolling those at / in contact with the CBO who did not have a primary care home. Each site felt challenged in their attempts to enroll and treat 100 participants (the funder’s expected enrollment goal) which likely strained the partnership. Site 1 transitioned to a program that could outreach to their original partner CBO and many other CBOs through incorporating a clinic case manager position in the depression care team. This was a role now employed by the clinic versus working with case managers at the CBO as a part of the team. Cost of care data was collected for this new iteration of their program. Site 2 ultimately moved to doing collaborative care out in the community interacting with multiple clinics versus working in closer partnership with just one clinic. Their transition to this new program occurred much later / after the cost of care data collection in the first phase of the grant funding. The formal partnership work at these two sites on this grant to implement collaborative care ended though the organizations still work together and collaborate on other projects. We added text on pg. 14 to reflect background on the dissolved partnerships.

-Is low enrollment the norm or specifically for this program? Any reasons for the low enrollment?

The description above about the two sites with partnerships that formally ended hints at some of the main challenges sites faced in enrolling patients across sites. An additional challenge was engaging depressed older adults in care with the CBO if the CBO staff were not coming to their home. We added text on pg. 16 to highlight these reasons.

-Line 368 - would you only report on the sites that continued their community partnerships? The ones that dropped off should be addressed regarding sustainability challenges.

To stay within the Care Partners project and the associated learning community of sites engaging in this innovative work, Site 1 did have to propose a program that still enhanced collaborative care to incorporate community linkages (i.e., to CBO or family). Data collected from Site 1 after the implementation of the new case manager / community outreach position within the depression care team – presented in Table 4 – thus fit within the goals of the Care Partners cost evaluation piece. We incorporated findings from Site 1 as another example of task sharing collaborative care for depression. The cost data collection was geared to help them sustain their new innovative program. We added text on pg. 18 to highlight these sustainability challenges and future sustainability directions for Sites 1 and 2.