Using the Telephone to Engage Collaborative Care Patients

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A Shift

• The phone has historically/traditionally been used for admin tasks or maybe to check in on a high-risk patient.
• The phone is now regarded as an effective means of providing treatment across the patient population, particularly within the Collaborative Care model.

• However...
  • Clinicians aren’t used to it
  • Patients aren’t used to it
  • Practices and organizations aren’t used to it
Why the Phone? Shown to...

- Increase Access
  - Transcends Barriers

- Improve treatment outcomes
  - Early follow-up
  - Frequent contact
  - Routine symptom monitoring
  - Adherence support

- Promote Engagement
  - Persistent Outreach and Flexibility

- Provide Treatment
  - Using evidence-based, brief interventions (yes, over the phone)
What the Research Says

• In studies, patients with early follow-up are less likely to drop out and more likely to improve (Bauer, 2011)

• Patients who have a second contact in less than a week are more likely to take their medications (Bauer, 2011)

• Follow-up contacts (phone or in person) within four weeks of the initial assessment is key to early improvement (Bao, 2015)

• Perinatal period: regular follow-ups with obstetric providers is ideal for frequent and early contact
Evidence

• Systematic Review of multifaceted interventions in depression care (Williams et al., 2007)
  • 20 out of 28 interventions improved depression outcomes
  • 16 of those were delivered primarily or entirely by telephone
• The most commonly used successful intervention features were:
  • Patient education and self-management
  • Monitoring of depressive symptoms and treatment adherence
  • Decision support for medication management
  • A patient registry
  • Supervision of care managers.
Evidence

- For primary care patients beginning antidepressant treatment, a telephone program integrating care management and structured psychotherapy can significantly improve satisfaction and clinical outcomes (Simon et al., 2004)
  - Depression was “Much improved”
    - 80% vs 55%
  - “Very satisfied” with depression treatment
    - 59% vs 29%
  - Higher rates of participation
    - 97% for telephone care management
    - 93% for telephone care management + psychotherapy
The Current Situation

• The telephone offers a flexible, patient-centered approach to provide care.

• Within the Collaborative Care model, the telephone is regarded as a means of treatment delivery.

• Yet, many practices and clinicians are not utilizing the telephone significantly, if at all.

• With all change comes resistance and increasing telephone use presents real barriers.

• These can be overcome with the right approach and strategies.
Barriers

• The Surface Barriers
  • Time
  • Difficulties engaging patients
  • A practice model that prioritizes in-person visits

• The Hidden Barrier
  • Clinician Resistance
    • It’s unfamiliar and uncomfortable
    • A belief that it’s not effective
My Experiences with Telephonic CoCM

• I was uncomfortable when I began using the phone
  • I only used the phone when I absolutely had to
• Fast-Forward: I work with patients primarily or exclusively over the phone
  • Great outcomes
  • Improved engagement
  • Patient satisfaction
• I used to think that patient’s didn’t want it, but I realized the problem was me…
• The fix? Exposure therapy and a shift in Mindset
Meet patients where they are

• The Social Work Maxim
• Literally true with telephonic engagement

• Enhanced Engagement through Flexibility
  • Lunch Break
  • Waiting for Children at Practice
  • At home on couch
  • During action plan execution
I am not here to persuade you that, head to head, telephone is better than in-person.

In a perfect world, there would be no stigma and plenty of clinicians with plenty of availability and no transportation barriers and supervised playgrounds in practices for children and unconditional paid time off for people to attend their appointments and no traffic at all and home visits for people too anxious/depressed to leave the house and everyone would receive in-person psychotherapy sessions at a time that is convenient for them because that is what they prefer.
Treatment only works if the patient is engaged...

Regardless of your feelings about telephone treatment, it’s better to have an engaged patient over the phone, than a disengaged patient in-person.
Kale

Organic?
Cooked?
Consumed.
The Telephone Applied to Treatment

• Discuss phone use with patient at initial contact
  • Emphasize frequent contact in beginning of treatment, as a key component of treatment outcomes
  • Phone contacts are scheduled, just like an appointment

• Explain purpose of phone appointments
  • See how medications are working
  • Assess and monitor symptoms
  • Work on treatment goals
  • Check-in between in-person visits
Clients for Telephonic Engagement

• The telephone offers a versatile and flexible, patient-centered tool within Collaborative Care.

• What clients does this work best with?
  • Missed/cancelled appointment
  • Transportation barriers
  • Decline on-site appointment
  • Childcare barriers
  • Inconsistent attendance/scheduling conflicts
  • Physical injury/limited mobility/chronic pain
  • Scaling back service use due to depression remission
  • Brief check-ins between scheduled appointments
Incorporating the Phone

• Gather multiple phone numbers and ask about best times to call
• Discuss use of phone as a treatment option
  • Not just a back-up!
• Incorporate telephonic contacts into treatment planning
• Always confirm follow-up contact before ending session
• Use no-show appointments and cancellations for telephone outreach
Making it work

• Block a time in schedule for calls: 1-2 hours
  • Assume 20-30 minutes per call
  • Schedule call time with patient within blocked time
• Leverage time from no-shows/cancellations
• Mail or provide PHQ-9/GAD-7 screeners for ease of use over phone
  • Patients can complete it ahead of time
  • Walk through it together
• Mail or provide psychoeducational materials or worksheets
Sample Telephone Contact Outline

- Ask patient if this is still a convenient time to talk
- Set agenda
- Administer PHQ-9/GAD-7 and review scores
- Review action plan from previous contact
- Check medication adherence and response
- Provide brief, goal-oriented talk treatment intervention
- Identify goal and create action plan
- Schedule follow-up appointment
Telephonic Evidence-based Intervention

- Collaborative Care, as a treatment model, is evidence-based
  - Telephone utilization is a fundamental part of the Collaborative Care model
  - This is widely recognized

- Within the Collaborative Care Model, we can provide support and evidence-based interventions (also by phone)
  - Symptom Monitoring
  - Medication Management
  - Talk Treatment
    - Look at the processes involved in Behavioral Activation, Motivational Interviewing, Cognitive Behavioral Therapy, Problem-solving Treatment, and Interpersonal Psychotherapy.
    - The treatment is applied through talking, which is also what we do over the phone.
Telephonic Interventions

• Easy & Effective
  • Motivational Interviewing
  • Behavioral Activation

• Get Creative
  • Cognitive Behavioral Therapy
  • Problem Solving Treatment
  • Helpful to have initial and/or periodic in-person time

• Medication Management
  • Tracking symptoms
  • Assessing response
  • Identifying Side Effects
  • Improving Adherence
Evidence

• “This study confirmed that T-CBT produces significantly lower attrition rates compared with face-to-face CBT among depressed primary care patients” (Mohr et al., 2012)
  • Overcome barriers
  • Overcome patient ambivalence
  • Increase adherence
    • Mainly during initial engagement period
What about rapport?

• Rapport is profoundly important, but not dependent on in-person interaction
• Rapport is developed by fostering a caring connection through the desire to understand and support.

What about non-verbal communication?

• A large part of communication is non-verbal.
• A great deal of extra information is conveyed over the phone (vocal inflection, patterns of speech/thought, cadence)
• Drop-in PCP office visits or collaborative with care team
• It’s better to not have some non-verbal information, than to not have any information because the patient is not engaged in care.
References


