Care Partners Team

Laura Rath, MSG
Archstone Foundation
Senior Program Officer

Jürgen Unützer, MD, MPH, MA
University of Washington
Investigator, Care Partners

Ladson Hinton, MD
University of California, Davis
Investigator, Care Partners

Theresa Hoeft, PhD
University of Washington
Investigator, Care Partners

Stuart Henderson, PhD
University of California, Davis
Evaluator, Care Partners

Ashley Heald, MA
University of Washington
Project Manager, Care Partners

Heather Wilcox, BA
University of Washington
Project Assistant, Care Partners
Outline

• Grant management
• Introduction to the learning community
  – Overview of program
  – Group introductions
• How to build these innovations
  – Care Partners website
  – Prelaunch Checklist
  – Implementation and Innovation Guide
• Evaluation expectations
## Archstone Foundation Quarterly Reporting Schedule

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1, 2015</td>
<td>Year One, 1st Quarter Progress Report</td>
</tr>
<tr>
<td>February 1, 2016</td>
<td>Year One, 2nd Quarter Progress Report</td>
</tr>
<tr>
<td>May 1, 2016</td>
<td>Year One, 3rd Quarter Progress Report</td>
</tr>
<tr>
<td>August 1, 2016</td>
<td>Year One, 4th Quarter Progress Report</td>
</tr>
<tr>
<td>September 1, 2016</td>
<td>Year One Evaluation Report</td>
</tr>
<tr>
<td>November 1, 2016</td>
<td>Year Two, 1st Quarter Progress Report</td>
</tr>
<tr>
<td>February 1, 2017</td>
<td>Year Two, 2nd Quarter Progress Report</td>
</tr>
<tr>
<td>May 1, 2017</td>
<td>Year Two, 3rd Quarter Progress Report</td>
</tr>
<tr>
<td>August 1, 2017</td>
<td>Year Two, 4th Quarter Progress Report</td>
</tr>
<tr>
<td>September 1, 2017</td>
<td>Final Evaluation Report</td>
</tr>
</tbody>
</table>
# Archstone Foundation Payment Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2015</td>
<td>Year One, First 90%</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>Year Two, First 90% - contingent</td>
</tr>
<tr>
<td>September 15, 2016</td>
<td>Year One, Final 10% - contingent</td>
</tr>
<tr>
<td>September 15, 2017</td>
<td>Year Two, Final 10% - contingent</td>
</tr>
</tbody>
</table>
Budget Revision Requests

• Generally, the Archstone Foundation is able to accommodate changes to the project budget as approved by the Board of Directors
• To request a budget revision, please contact Laura Rath at lrath@archstone.org for the budget revision template (or visit www.archstone.org)
• Provide a brief narrative of the rationale for the change(s) being requested
• Please do not implement budget changes until approved by the foundation
No-Cost Time Extension

• If there are costs savings at the end of the two-year project period, the program may request a no-cost time extension to use the remaining funds toward the goals of the project (as a reminder, 100 patients should still receive treatment during the two-year project period)

• Evaluation reports will still be due on schedule to assist the Care Partners team in completing the multi-site evaluation

• The final payment will be released once all of the grant funds have been expended and the final reports have been submitted and approved by the foundation
Questions
Collaborative Care Model

Primary Care Practice with Mental Health Care Manager

Outcome Measures
Treatment Protocols
Population Registry
Psychiatric Consultation
Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care

- Evidence-based Collaborative Care for older adults with depression in primary care
- Plus
  - Community-based organizations (CBOs) and/or
  - Family
## Task Sharing Matrix

<table>
<thead>
<tr>
<th>Collaborative Care Task Matrix - CBO, Primary Care Clinic, and Family</th>
<th>Collaborative Care Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will do these tasks? Please mark an 'X' below where appropriate. Multiple people/organizations may be involved in performing the same task so it's OK to mark multiple 'X's in the same row. Note: Most but not all tasks need to be performed by anyone.</td>
<td></td>
</tr>
<tr>
<td>Identify and Engage Patients with Depression in Care</td>
<td></td>
</tr>
<tr>
<td>Task 1. Identify people who may need help</td>
<td></td>
</tr>
<tr>
<td>Task 2. Screen for depression</td>
<td></td>
</tr>
<tr>
<td>Initiate and Provide Treatment for Depression</td>
<td></td>
</tr>
<tr>
<td>Task 3. Gather information to support a clinical assessment</td>
<td>X</td>
</tr>
<tr>
<td>Task 4. Diagnose depression</td>
<td>X</td>
</tr>
<tr>
<td>Task 5. Educate patient and family (as appropriate) about depression</td>
<td>X</td>
</tr>
<tr>
<td>Task 6. Educate patient and family (as appropriate) about treatment options</td>
<td>X</td>
</tr>
<tr>
<td>Task 7. Engage patient and family (as appropriate) in Collaborative Care for depression</td>
<td>X</td>
</tr>
<tr>
<td>Task 8. Develop and initiate a treatment / care plan</td>
<td>X</td>
</tr>
<tr>
<td>Task 9. Prescribe antidepressant medication if indicated</td>
<td>X</td>
</tr>
<tr>
<td>Task 10. Educate patient about medications &amp; other treatment side effects</td>
<td>X</td>
</tr>
<tr>
<td>Task 11. Facilitate patient self-management support and behavioral interventions for all patients regardless of treatment modality</td>
<td>X</td>
</tr>
<tr>
<td>Task 12. Provide evidence-based psychotherapy (e.g., Problem-Solving Treatment, CBT, IPT), if indicated</td>
<td>X</td>
</tr>
<tr>
<td>Task 13. Provide case management or refer to social and other support services (e.g., housing, food assistance)</td>
<td>X</td>
</tr>
<tr>
<td>Task 14. Provide or refer to specialty mental health services outside primary care, if indicated</td>
<td>X</td>
</tr>
<tr>
<td>Track Processes of Care and Clinical Outcomes</td>
<td></td>
</tr>
<tr>
<td>Task 15. Track treatment outcomes using a registry (e.g. symptoms with measurement tool such as the PHQ-9, outcome of referrals and other treatments)</td>
<td>X</td>
</tr>
<tr>
<td>Task 16. Track delivery of care management support (e.g. follow-up calls to patients, clinic appointments, case reviews by psychiatric consultant, referrals)</td>
<td>X</td>
</tr>
<tr>
<td>Task 17. Reach out to patients not engaging in treatment</td>
<td>X</td>
</tr>
<tr>
<td>Adjust Treatment if Patients are Not Responding</td>
<td></td>
</tr>
<tr>
<td>Task 18. Regularly check treatment response and cue providers for possible changes in treatment, if needed</td>
<td>X</td>
</tr>
<tr>
<td>Task 19. Participate in regular (weekly) case review to identify patients who are not improving and provide treatment recommendations</td>
<td>X</td>
</tr>
<tr>
<td>Task 20. Ensure treatment recommendations get to provider and are enacted</td>
<td>X</td>
</tr>
<tr>
<td>Provide Administrative Support and Program Supervision</td>
<td></td>
</tr>
<tr>
<td>Task 21. Provide program support (e.g., scheduling, resources)</td>
<td>X</td>
</tr>
<tr>
<td>Task 22. Provide program supervision</td>
<td>X</td>
</tr>
</tbody>
</table>

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Congratulations grant awardees
## Location of Awardees

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>CBO</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Center of San Diego</td>
<td>Serving Seniors</td>
<td>San Diego</td>
</tr>
<tr>
<td>Social Action Community Health Systems</td>
<td>El Sol Neighborhood Education Center</td>
<td>San Bernardino</td>
</tr>
<tr>
<td>Petaluma Health Center</td>
<td>Sonoma County Health Services Department</td>
<td>Petaluma</td>
</tr>
<tr>
<td>Lifelong Medical Care</td>
<td>St. Mary’s Center</td>
<td>Oakland</td>
</tr>
<tr>
<td>UCSF Center for Geriatric Care and Housecalls</td>
<td>Institute on Aging</td>
<td>San Francisco</td>
</tr>
<tr>
<td>USC Dept. of Family Medicine and Eisner Pediatrics and Family Medicine</td>
<td>St. Barnabas Senior Services</td>
<td>Los Angeles</td>
</tr>
<tr>
<td>McClellan Outpatient Clinic</td>
<td>N/A</td>
<td>Sacramento</td>
</tr>
</tbody>
</table>

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# Primary Awardees

<table>
<thead>
<tr>
<th>Grantee</th>
<th>CBO</th>
<th>Family</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHC of San Diego</td>
<td>✓</td>
<td></td>
<td>CBO senior center engaging clients in depression care at CBO and PCC while facilitating connections to PCC which is approximately 4 blocks away</td>
</tr>
<tr>
<td>El Sol</td>
<td>✓</td>
<td></td>
<td>CHWs to link and support culturally and linguistically appropriate care at CBO and PCC, as well as through home visits and out in the community</td>
</tr>
<tr>
<td>Sonoma County HSD</td>
<td>✓</td>
<td></td>
<td>Embedding social worker from HSD in PCC who will do home visits, facilitate telemedicine/telepsychiatry, and incorporate HSD experience with Healthy IDEAS</td>
</tr>
<tr>
<td>Lifelong</td>
<td>✓</td>
<td></td>
<td>Bi-directional referral of PCC patients and senior center clients to each organization’s services</td>
</tr>
<tr>
<td>Institute on Aging</td>
<td>✓</td>
<td></td>
<td>Home-based screening, psychotherapy, and primary care services</td>
</tr>
<tr>
<td>USC</td>
<td>✓</td>
<td>✓</td>
<td>Screening and bi-directional referral of patients to each organizations services via CBO senior center liaison</td>
</tr>
<tr>
<td>McClellan Outpatient Clinic</td>
<td>✓</td>
<td></td>
<td>Family involvement in depression management. This site is already awarded via the UC Davis subcontract.</td>
</tr>
</tbody>
</table>
Commitment

• 100 patients served over 2 year grant with minimum of 25 patients in year 1
• For family partnerships, 100 patients will have a family partner engaged in care
• CBO and/or family engaged in treatment with primary care clinic (PCC)
  – At least 3 service contacts each with the CBO and/or family (dependent on the partnership) and PCC
• 3 or more PHQ-9 measurements
Questions
CARE PARTNERS LEARNING COMMUNITY GROUP INTRODUCTIONS
Family Health Centers of San Diego: Downtown Family Health Center at Connections

The Primary Care Clinic
Downtown Family Health Center at Connections (DTFHC) resides in the heart of downtown San Diego – home to many of San Diego’s lowest-income seniors – and is co-located within a multi-service residential community designed to help homeless individuals move into permanent housing.

The CBO
Serving Seniors is an independent non-profit focused on improving the health and wellbeing of San Diego’s low-income seniors through the provision of essential services such as food, healthcare, housing, and social services.

The Innovation
Our partnership with Serving Seniors will allow FHCSD to create a medical neighborhood to enhance primary and mental healthcare for downtown seniors with depression.
El Sol Neighborhood Educational Center

The Primary Care Clinic

Founded in 1991, El Sol serves the educational needs of San Bernardino and Riverside community members. Utilizing the Community Health Worker model, El Sol provides an array of culturally and linguistically competent community-based services, focused on promoting and maintaining the well-being of vulnerable communities.

The CBO

SAC Health System is a Federally Qualified Health Center Look-Alike, Teaching Health Center Graduate Medical Education programs providing primary care, behavioral health, dental, well woman, pediatric, family medicine and community resources to the residents of the Inland Empire.
El Sol Neighborhood Educational Center

The Innovation

Providing a strong link between SAC Health System, the community-based health center, and the patient, El Sol, through their Community Health Worker program, the San Bernardino: Depression in Late Life Collaborative, will provide an innovative approach in improving health outcomes for individuals at-risk for or suffering from depression in the Inland Empire region.
Sonoma County Human Services Department, Adult & Aging Services Division

The Primary Care Clinic

Petaluma Health Center (PHC) is the principal safety net health care provider in southern Sonoma County. It serves approximately 23,000 patients a year (mostly low-income), with services ranging from primary care to mental health treatment and even dentistry for children.

The CBO

The Sonoma County Human Services Department, Adult & Aging Services Division (A&A) serves as the county safety net provider of senior services. The Division provides protective services, in-home care assessment, and case management services to older adults and people with disabilities throughout Sonoma County.

The Innovation

A&A will embed a social worker with responsibility for home visits and care coordination into the clinic treatment team at PHC. The assessment and care plan developed by this home visiting Care Coordinator will help inform the treatment team and ensure that the patient’s community needs are considered when developing a plan to treat his/her depression.
LifeLong Medical Care: Over 60 Health Center

The Primary Care Clinic
The LifeLong Over 60 Health Center is a leader in the delivery of integrated health and social services for the elderly.

The CBO
St. Mary’s Center is a community of hope, justice and healing, serving at-risk elders and preschoolers in the heart of Oakland.

The Innovation
FQHC and CBO will both identify older adults with depression, jointly offer a range of clinical and non-clinical services when depression is identified, and track outcomes so nobody falls through the cracks.
Institute on Aging

The Primary Care Clinic
UCSF Housecalls and Center for Geriatric Care serve San Francisco’s homebound elders who are in need of home-based primary care, and who face difficulty in regularly receiving clinic-based services.

Meredith Greene, MD  Karyn Skultety, PhD  Helen Kao, MD
Institute on Aging

The CBO

The Institute on Aging (IOA) has a long history of creating innovative mental health services for seniors and adults with disabilities, including the integration of behavioral health screening in existing IOA care management programs, a 24-hour suicide prevention and intervention hotline called the Friendship Line, home-based psychotherapy, and a psychology training program.

The Innovation

With UCSF’s primary care providers and IOA’s mental health clinicians having extensive experience in providing home-based services, this collaboration is an innovative model for serving isolated, homebound older adults struggling with depression.
USC-Eisner Family Medicine Center at California Hospital

The Primary Care Clinic

Located in Downtown Los Angeles, Eisner Pediatric and Family Medical Center is a Federally Qualified Health Center dedicated to providing comprehensive, high-quality healthcare for all ages. USC-Eisner Family Medicine Center at California Hospital, also an FQHC, is the primary residency clinic for the California Hospital/USC Family Medicine Residency Program, and a medical home within the Eisner system for patients of all ages.

Camilo Zaks, MD – PI
Sandra Avila, MD – CoPI
USC-Eisner Family Medicine Center at California Hospital

The CBO

St. Barnabas Senior Services (SBSS) is a dynamic non-profit senior service agency dedicated to ensuring that older adults have the right to age with dignity by providing comprehensive and innovative programs that promote healthy aging, prolong independence, and enhance the well-being of more than 18,000 older adults each year.

The Innovation

Our innovation will be to coordinate between the two PCP sites and SBSS for training friends or family members to be Caregivers who will participate in evaluating, treating and advocating for their older adult with depression.

John Kotick, JD – CoPI
VA McClellan Outpatient Clinic

The Primary Care Clinic
VA McClellan is an outpatient clinic in the Sacramento area that serves over 9000 veterans, the majority of whom are age 65 and above, that is developing integrated mental health and primary care services for veterans.

The Innovation
The key innovation of the VA McClellan site is to engage family members in older veterans’ depression care, including task-sharing related to psychoeducation, self-management (i.e. adherence, symptom monitoring), behavioral activation, and participation in primary care visits.

Angela Araneta, PhD – Care Manager and Co-investigator
Questions
Current Care Partners website:
http://uwaims.org/archstone/
New Care Partners website:
https://aims.uw.edu/care-partners/
New Care Partners website: https://aims.uw.edu/care-partners/
New Care Partners website: https://aims.uw.edu/care-partners/
New Care Partners website: https://aims.uw.edu/care-partners/

PRE-LAUNCH CHECKLIST

The Implementation and Planning Pre-launch Checklist (Word version) was developed to help guide your organizations through the implementation of Collaborative Care. As you plan and perform each of the activities below, please check off each one as it occurs and provide narrative responses where indicated in your Implementation and Innovation Guide.

Step 1. Lay the Foundation (June/July)

Introduction

- Kick off webinar and orientation to Step 1. Lay the Foundation: Monday, June 15, 2015, 3:00-4:30pm
- Agenda: Introductions, grant management, Collaborative Care training plan, and evaluation plan
- For details on how to join, visit the Care Partners website: http://uwaims.org/archstone
- For team members that have yet to be hired, start hiring process as soon as possible. New hires will need to complete relevant pre-launch activities and be familiar with the project prior to the 2-day training in September
- Sample job descriptions for care managers and psychiatric consultants can be found here:
- Project leads schedule 30-minute, weekly check-in call with Ashley Heald to begin in June after the Kickoff Webinar (Schedule through carepartners@uw.edu)
Implementation and Planning Pre-Launch Checklist

Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care

This tool was developed to help guide your organizations through the implementation of Collaborative Care. As you plan and perform each of the activities below, please check off each one as it occurs and provide narrative responses where indicated in your Implementation and Innovation Guide (coming soon).

1. Lay the Foundation - JUNE - JULY

☐ Kick off webinar and orientation to Step 1. Lay the Foundation: Monday, June 15, 2015, 3:00-4:30pm
  - Agenda: introductions, grant management, Collaborative Care training plan, and evaluation plan
  - For details on how to join, visit the Care Partners website: http://uwaims.org/archstone/
    - Note: we are currently building a new site for this project and you will be redirected to it from the above link once it is ready

☐ For team members that have yet to be hired, start hiring process as soon as possible.
  New hires will need to complete relevant pre-launch activities and be familiar with the project prior to the 2-day training in September
  - Sample job descriptions for care managers and psychiatric consultants can be
Implementation and Innovation Guide

Care Partners: Bridging Families, Clinics, and Communities to Advance Late-Life Depression Care

This guide was developed to provide a framework for you to document both the implementation of Collaborative Care at your organizations and the innovative intervention developed through the sharing of Collaborative Care tasks between primary care and community partners.

Over time, this guide will tell the story of your unique implementation of Collaborative Care and innovation in late-life depression care. Content within the guide may then be useful for several audiences: 1) aid in the development of your quarterly and annual progress reports for the Archstone Foundation, 2) serve as training manuals for new staff, and 3) may be used by other organizations wishing to replicate your model of care in the future.

As you plan and perform each of the activities in the Pre-launch Checklist, please insert documents and provide narrative responses where indicated in this guide.

1. Lay the Foundation

A crucial first step in implementing Collaborative Care is understanding how it will fundamentally change your practice. It is a new way of doing medicine and requires an openness to creating a new vision.
June - mid July activities

• June 15th Kickoff Webinar
• Start hiring process for other Care Partners team members, if applicable
• Schedule weekly 30-minute check-in with Ashley Heald (carepartners@uw.edu)
• Identify team members who will commit to participating in activities like 2-day training, attending webinars and coaching calls, etc.
• Watch Introduction to Collaborative Care module in the Learning Community Site (~1 hour)
  – Access from the main Care Partners website
• Create a vision statement for your implementation and innovation
  – Details in Pre-Launch Checklist
• July 15th Workflow Development Orientation Webinar
Learning Community Site

Welcome to the Care Partners Learning Community Site!

The learning modules below include presentations, handouts, links and practical templates that are available to print and use as part of a Collaborative Care team.

Module 1 - Introduction to Collaborative Care
This module gives a brief introduction to Collaborative Care and then delves into team structure and the roles and tasks of Collaborative Care including identifying and engaging patients, patient assessment, initiation of treatment, follow-up and tracking outcomes, and relapse prevention.
Questions
Evaluation Process

1. Planning
2. Gathering Data
3. Reporting and Sharing Lessons Learned

4. Evaluation Process

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Evaluation Aims

1. To examine how the **intervention was experienced** by key stakeholders, including 1) depressed older adults, 2) family members, and 3) staff at primary care clinics and community-based organizations.

2. To describe the **interventions and their implementation across sites**, including challenges and lessons learned.

3. To identify **changes in multidimensional care networks** involving 1) patients, 2) family members, and 3) staff at primary care clinics and community-based agencies.

4. To evaluate the **outcome of the interventions** at the level of 1) patients and families and 2) participating organizations. What worked and didn't work? For whom and under what conditions did the intervention produce positive outcomes?

5. To describe the **development and evolution of the overall initiative**. What is the emerging and projected impact of the overall initiative on late life depression care locally and nationally.
<table>
<thead>
<tr>
<th>Gathering Data</th>
<th>Source? For what aim?</th>
</tr>
</thead>
</table>
| **CMTS data (quantitative)** | • Staff  
  • Patient outcomes data from registry |
| **Interviews** | • Patients, staff  
  • Experience, implementation, network |
| **Focus groups** | • Staff  
  • Experience, implementation, initiative |
| **Site observations** | • Clinics and CBOs  
  • Experience, implementation, network |
| **Document analysis** | • Proposals and annual reports  
  • Outcomes, implementation, initiative |
# Evaluation Activities and Schedule

<table>
<thead>
<tr>
<th>Data collection</th>
<th>Who</th>
<th>Collection Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre-grant Jan 2015 - June 2015</td>
</tr>
<tr>
<td>CMTS data</td>
<td>depressed older adults (n=700)</td>
<td>X</td>
</tr>
<tr>
<td>Site observations</td>
<td>7 sites</td>
<td>X</td>
</tr>
<tr>
<td>Key informant interviews</td>
<td>4 -6 key informants at each site</td>
<td>X</td>
</tr>
<tr>
<td>Focus groups</td>
<td>leaders and staff</td>
<td>X</td>
</tr>
<tr>
<td>Interviews with patients</td>
<td>sample of patients &amp; family (n=50-70)</td>
<td>X</td>
</tr>
<tr>
<td>Documents</td>
<td>Application, APRs, regular calls</td>
<td>X</td>
</tr>
</tbody>
</table>
Questions
Thank you