Communication about shared clients between Primary Care and CBO

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## Care Partners Sites

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>CBO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Center of San Diego</td>
<td>Serving Seniors</td>
</tr>
<tr>
<td>Social Action Community Health Systems</td>
<td>El Sol Neighborhood Education Center</td>
</tr>
<tr>
<td>Petaluma Health Center</td>
<td>Sonoma County Health Services Department</td>
</tr>
<tr>
<td>Lifelong Medical Care: Over 60 Clinic</td>
<td>St. Mary’s Center</td>
</tr>
<tr>
<td>UCSF Center for Geriatric Care and Housecalls</td>
<td>Institute on Aging</td>
</tr>
<tr>
<td>USC Dept. of Family Medicine and Eisner Pediatrics and Family Medicine</td>
<td>St. Barnabas Senior Services</td>
</tr>
<tr>
<td>McClellan Outpatient Clinic</td>
<td>N/A</td>
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</tbody>
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Similarities Across Sites

• 3 involve senior centers as community partners
  – FHCSD – Serving Seniors
  – Lifelong Medical – St. Mary’s Center
  – USC – St. Barnabas Senior Services

• 3 – 4 involve home visits
  – SACHS – El Sol Neighborhood Education Center
  – Petaluma Health Center – Sonoma County HSD
  – UCSF – IOA
  – Possibly also FHCSD – Serving Seniors
## Original Innovation

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Partners</th>
<th>Approach</th>
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</thead>
<tbody>
<tr>
<td>FHC of San Diego</td>
<td>Serving Seniors</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>
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<tr>
<td>El Sol</td>
<td>SACHS</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>
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<tr>
<td>Sonoma County HSD</td>
<td>Petaluma Health Ctr</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>St. Mary’s</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>UCSF</td>
<td>Home-based screening, psychotherapy, and primary care services</td>
</tr>
<tr>
<td>USC</td>
<td>St. Barnabas</td>
<td>Screening and bi-directional referral of patients to each organizations services via CBO senior center liaison</td>
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What have we tried?
What works?
What doesn’t work well?
What have we learned?
LifeLong / St. Mary’s Center
Communication: What have we tried?

• Both LifeLong and St. Mary’s Center have currently tried:
  
  – Weekly team meetings
    • These meetings allow us to stay up-to-date regarding patients as well as ideas that as a team we feel will improve our workflow
  
  – Involvement of additional case managers from SMC and LifeLong to assist with screenings, outreach and patient engagement in services
  
  – Teaming up on tabling and offering services for depression care
    • Provides patients with face-to-face interaction with both SMC and LifeLong staff
Communication: What works?

• Weekly team meetings work well for our team.
  – We are not only able to communicate frequently with one another regarding patient care, but we are also able to coordinate new strategies and ideas to outreach and provide information to patients regarding depression care.
Communication: What doesn’t work well?

• What could work better:
  – Deliberate focus on patients who are not showing improvement alongside focus on recruitment strategies
  – More communication between sites regarding conflicting information from patients
    • Administering more holistic care and ensure that the patient is improving
Communication: What have we learned?

- Patients tend to give more information regarding their depression and circumstance during therapy sessions and less when being contacted by SMC staff
  - Possibly due to lack of built relationships
  - Tends to interfere with care if patients don’t share major concerns with each staff member
    - This makes it important to foster trusting relationships with patients
  - An increase in the frequency of patient contacts/therapy sessions may help patients feel more engaged in treatment
FHCSD / Serving Seniors
Communication: What have we tried?

• Primary source of communication:
  – Weekly phone consultations
  – Via email/phone/in person
    • To discuss/review client cases

• Share resources between sites FHCSD and Serving Seniors provide warm connections between both sites
  – Facilitating linkage to care
    • Identifying site point of contact
    • Assisting with transportation
Communication: What works?

- **Weekly communication** (Teleconference/Email)
  - Care Managers meet prior to weekly psychiatric consult to review/highlight cases

- **Warm Connections**
  - Introducing client(s) to organization, having someone to meet/greet client, provide overview of services

- **Identifying new resources/program at either sites**
Communication: What doesn’t work well?

• Scheduling set times to meet via teleconference
  – Conflict in schedules
  – Multiple changes in meeting times
  – Provider out, therefore, unable to reschedule meetings
Communication: What have we learned?

• Flexibility!
  – In mode of communication (telephone, email, in-person)
  – Rescheduling meetings
  – Reducing number of meetings
  – Structuring weekly consults to be more time efficient
El Sol / SACHS
Communication: What have we tried?

- **CALLS:** WE HAVE A WEEKLY PHONE CALLS WITH THE PSYCHIATRIC CONSULTANT.

- **EMAILS:** SHARING NEW PATIENT INFORMATION AND PATIENT FOLLOW-UP.

- **MEETINGS:** WE HAVE MEETINGS EVERY 2 WEEKS WITH MEMBERS OF SACHS.
Communication: What works?

- THE WEEKLY CALLS WITH THE PSYCHIATRIC CONSULTANT IN ORDER TO EXCHANGE INFORMATION REGARDING THE PATIENTS AND TO GIVE UPDATES ON WHAT IS WORKING.
Communication: What doesn’t work well?

• **MEETINGS:** NOT HAVING EVERYONE INVOLVED IN CARE PARTNERS PRESENT AT THE MEETINGS.

• **INTERNAL COMMUNICATION:** NOT EVERYONE INVOLVED IN CARE PARTNERS WAS AWARE OF EVERYTHING THAT WAS GOING ON WITH PATIENTS.
Communication: What have we learned?

• EVERYONE INVOLVED IN THE CARE OF THE PATIENTS SHOULD BE PRESENT AT THE MEETINGS AND HAVE OPEN AND CONSTANT COMMUNICATION WITH EACH OTHER.
USC – Eisner / St. Barnabas
Communication: What have we tried?

- Emails
- Telephone
- In person (weekly team meetings)
- CMTS
Communication: What works?

• Emailing each other throughout the week for updates
• Weekly team meetings
• Having CBO care manager travel to the clinic to introduce the CBO
• NextGen/ EHR: Sending messages regarding patient care between CM, providers and pcps
• CMTS
Communication: What doesn’t work well?

• Phone calls to CBO at times. Having reception unaware of the team members or patients in BALLAD

• Some team members are part-time employees and communication can sometimes be more difficult since they are not available every day
Communication: What have we learned?

- Informing staff at CBO of BALLAD and providing them with a list of team members and patients
- The importance of having an interdisciplinary team meeting to exchange important patient information
Sonoma County HSD / Petaluma Health Center
Communication: What have we tried?

- Introduction to program included: presentation to medical providers, mental health team, team manager meetings, informal contacts, team huddles, MDT meetings, warm handoffs, Huddle TV, and Sonoma County Adult and Aging staff meeting.
- Program postcard developed and used as a marketing tool.
- Program information was presented on Spanish TV and Spanish Radio.
- Participated at Community Health Fair in Petaluma.
- Scheduled meetings between care managers.
- Communication through eCW, Medical Records, to providers and care managers.
- Initially offering therapy to patients.
- CBO CM’s access to county services potentially helpful to patients (IHSS, Case Management Programs, MediCal workers).
- CCM providing therapy for identified patients in the program.
- CCM being integrated into a team at Rohnert Park (RP).
Communication: What works?

• Access to PHC’s eCW (Medical Records) for CBO and CCM supports communication between care managers and providers (exchange of messages with PCP, Psychiatrist, other providers and access to patient medical records).

• Ongoing review of patient’s needs and care manager’s action items.

• Consistency of MDT meetings (first weekly; now every other week).

• Maintaining minutes of MDT meetings. This supports follow through and accountability.

• Frequent communication between care managers and medical/mental health staff.

• CBO and CCM housed at Petaluma Health Center.

• CBO and CCM sharing of office space.

• Development of program referral process within PHC/RP.

• Ongoing assessment of patient’s needs and appropriate services. Therapy considered only one of many options, not initially offered.
Communication: What doesn’t work well?

• Many IT issues involved in making collaboration work for CBO (delayed the ability to access medical records but was resolved by internet access with the use of a county laptop at PHC).
• CCM and CBO streamlining the duplication of notes in the eCW and CMTS.
• Integration of other PHC mental health providers to the treatment team.
• Dual role issues between CCM and CBO presented a challenge regarding responsibilities and best practice.
• Meetings and trainings as part of the grant have been a time challenge for care managers.
• Office space availability to meet with patients continues to be a challenge.
Communication: What have we learned?

- It takes a lot of dedicated people to make the collaboration work! (MA’s, Team Managers, Administration, Finance, IT, schedulers, facilities)
- Roles need to be clearly defined between the CCM and the CBO to avoid duplication of work. For example, it was helpful to assign patients to a Lead CM to ensure successful tracking of patient contact.
- The lead is identified based on assessment of patient needs, language, and fair distribution of responsibilities. This supports collaboration and successful patient treatment.
- CCM can best provide therapeutic services rather than psychotherapy. Therapeutic services to include depression education, behavioral activation, behavior specific focus, and problem solving focus.
- Patients be referred to mental health providers for psychotherapy.
- It has worked better to refer patients who want psychotherapy to other mental health providers than the CCM given the short nature of the program.
- The importance of ongoing communication/presentation about the program due to the changing nature of the health field and staff.
- Always checking with a patient regarding their medication.
Communication: What have we tried?

- Access to Electronic Medical Record
- Weekly Collaborative Care Team Meetings
- Provision of Simple Fax Referral Form with PHQ-9
- Quarterly Presentation at UCSF Staff Meetings
- Weekly UCGC In-Person Pickup of Referrals
- Weekly UCGC Fax of Client Updates
- Distributed Contact Sheet to Team Members
- Established Emergency Protocols Across Organizations
Communication: What works?

- **Access to Electronic Medical Record**
  - Our Psychiatric Consultant is a member of UCSF and is able to enter recommendations directly into UCSF’s EMR
  - Read-only access to EMR allows Care Managers to see medications, PCP appointments, Case Management notes, and review whether Psychiatric Consultation Notes were implemented
Communication: What works?

- **Weekly Collaborative Care Team Meetings**
  - One hour with Dial-in Option
  - UCSF Principal PCP, other PCPs, MA, & LCSWs invited
  - Psychiatrist Consult present
  - IOA Team present
  - Once a month, confirmed attendance of one PCP with focus on their clients for the hour
Communication: What works?

- Quarterly Presentation at UCSF Staff Meetings
  - 1 Page Program Description
  - Enrollment Spreadsheet showing Progress in PHQ-9 Scores
  - 2-3 Case Progress Summaries with PHQ-9 Graphs
Communication:
What didn’t work well?

- Weekly UCGC In-Person Check-in
  - In-Person Check-In started after schedule conflict for UCGC MA with Collaborative Care Team Meeting.
  - Weekly Fax of Client Updates Is Current Solution
Communication: What may not work well?

- Weekly Fax of Client Updates
  - Changes in Enrollment Status
  - Last Care Manager Appointment
  - Last PHQ-9 Score
  - Last Psychiatric Note
  - Recently Implemented; Time intensive for Program Manager and Care Managers; Unclear yet if Helpful
Communication: What have we learned?

• UCSF experiencing reduction in workload from patient participation resulting in less need for medical care, but UCSF workload is still a barrier to screening and identifying further referrals

• Further IOA effort is directed at identifying, crafting, and providing solutions to get around UCSF workload barriers to screening and referral