Enhanced case management in depression care workflows: lessons from primary care partnerships with community-based organizations

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BACKGROUND
Late-life depression is a pressing public health concern among an aging U.S. population facing increasing chronic health concerns (Jeste 1999). Many older adults lack access to depression treatment or receive ineffective care (Frederick 2007).

Collaborative care (CC) is an evidence-based model that treats depression in primary care using a team approach involving the patient’s primary care provider, a psychiatric consultant, and a care manager, who provides regular follow-up and monitoring until symptoms improve (Unützer 2002).

In 2014, six California primary care clinics were funded to adapt and implement enhanced CC programs with community-based organizations (CBO) partners. One site also involved family more actively in depression care. Several programs added case managers to the CC care team to connect patients with needed local resources.

This research assessed the approaches and lessons of integrating case managers more actively into CC to inform workflow developments for a new cohort of sites funded in 2018 to engage in similar work.

METHODS
Qualitative data was collected through focus groups (n=10) and key informant interviews (n=24) with 3-4 representatives from each site (i.e., care managers, case managers, physicians, project leads). Qualitative thematic analysis utilizing NVivo software identified major themes related to implementation and case management.

Quantitative data was tracked in a care management tracking system (CMTS) that guides depression care for care managers and psychiatric consultants at each site. CMTS includes process of care and depression symptom outcomes.

FINDINGS
Case Management Approaches:
• All 6 sites incorporated a dedicated case manager in the depression care team or worked with social workers more generally
• Clinic and/or CBO staff offered case management
• Some sites offering case management also offered home visits as a part of the depression care program – Sites 2, 4 and 5

Qualitative Findings:
Case managers were integrated to a varying degree into the depression care teams at each site ranging from limited integration to a CBO case manager sharing an office and caseload with the clinic care manager.

1. Slicing: One site relied on EHR referrals for coordination with case managers (Site 3)
   “Well, (CHW supervisor) was connected to the project, ‘cause she’s a lead social worker. So, she participated and did some administrative work, you know? And the others (social workers) were not connected to the program.” (Site 3)

2. Collaborating: Four sites integrated case managers more into the depression care team (Sites 1 and 4-6)
   “So, we met weekly, either in person or by phone. The whole team would discuss specific patients. And, so, for instance, if there was a client or a patient that needed to follow up with some case management stuff, the care manager, the therapist, would let me know. And I would make sure that those issues that they had observed during their home visit would be addressed” (Site 4)

Some sites enhanced case management through home visits and use of larger community networks

1. Home Visits: Three sites enhanced case management by adding home visits (Sites 2, 4 and 5)
   “he was in constant need, particularly around his, like, either PG&E bill or his food stamp services being recertified. Med-Cal, Social Security. And, and, so, the – he would bring up these issues during his one-hour session with the therapist, and the therapist would immediately tell me, these are the things that came up. Can you please assist with this? I would immediately go to his home, go over all the documentation that he was concerned about, and we would – and we were able to solve this.” (Site 4)
   “to but have her continue to do those home visits, or have someone of the same (unintelligible) skills or go out in the community, it’s gonna be very instrumental. To be successful. Yeah, Yeah.” (Site 5)

2. Networks: One site embedded case management in their network of resources and relationships to enhance referrals (Sites 5 and 6)
   “I’ve been working at the county and know a lot of people at the county. Maybe easier to access certain services.” (Site 5)

Strategies to share patients were sometimes based on differing levels of patient need
   “we would discuss what, you know, what’s going on with the patient, what are the primary needs. And if the needs were primarily home and community, then (CBO home visiting care manager) would be the … Lead Care Manager. So she was – even though she might still be involved with that particular patient … If that was not the case then, you know, either I would be the Lead Care Manager, or someone she would, and I was the Lead Care Manager for all the Spanish speaking.” (Site 5)

Findings from CMTS:
• Sites struggled with engaging patients eligible for and interested in care from both the clinic and CBO
• One site with a large multiservice organization (Area Agency on Aging) as CBO partner had the highest level of engagement in the program (Site 5)
• Home visits ranged from 0% (Site 6) – 74.0% (Site 4) of the site’s total visits
• Clinic visits ranged from 5.2% (Site 4) – 77.3% (Site 1) of the site’s total visits
• Case management referrals in CMTS give a glimpse at the breadth of linkages offered to patients

CONCLUSIONS
• Sites differed in their level of integrating case managers into the depression care team
• Including the case manager in the weekly case review enhanced team communication and follow-up on patients needs
• CBOs can enhance case management through offering home visits which clinics often do not prioritize with clinic resources
• Large well-established CBOs can pull on networks of resources and relationships to enhance the potential for successful referrals

IMPLICATIONS FOR PRACTICE
• Some clinic systems prefer to employ case managers in house though working with CBO partners can enhance case management approaches
• Findings will inform new sites in cohort 2 as they develop depression care workflow processes between clinic and community partners
• Findings could inform future developments of cohort 1 workflows as well (e.g., as Site 2 looks for future clinic partners)
• Community-clinic partnerships (i.e., Accountable Communities of Health) can learn from strengths CBOs bring to case management

REFERENCES
Jeste et al. (1999) Conservative statement on the upcoming crisis in geriatric mental health: research agenda for the next two decades. Arch Gen Psychiatry, 56:848

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