Health and Social Care Systems Integration: Sharing Care

Speakers

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Speakers

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Sharing care - from the medical provider's perspective

Mike Klinkman

We have a model for this approach

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Collaborative Care for Patients with Depression and Chronic Illnesses

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Original Investigation FREE

November 27, 2006

Collaborative Care for Depression
A Cumulative Meta-analysis and Review of Longer-term Outcomes

Simon Gilbody, MBChB, MRCPsych, DPhil; Peter Bower, PhD; Janine Fletcher, MSc; et al
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Arch Intern Med. 2006;166(21):2314-2321. doi:10.1001/archinte.166.21.2314

Long-Term Clinical Outcomes of Care Management for Chronically Depressed Primary Care Patients: A Report From the Depression in Primary Care Project

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ABSTRACT

PURPOSE Recent studies examining depression disease management report improvements in short-term outcomes, but less is known about whether improvements are sustainable over time. This study evaluated the sustained clinical effectiveness of low-intensity depression disease management in chronically depressed patients.

METHODS The Depression in Primary Care (DPC) intervention was introduced in 5 primary care practices in the University of Michigan Health System, with 5 matched practices selected as control sites. Clinicians were free to refer none, some, or all of their depressed patients at their discretion. Core clinical outcomes of remission and serial change in Patient Health Questionnaire (PHQ-8) scores for

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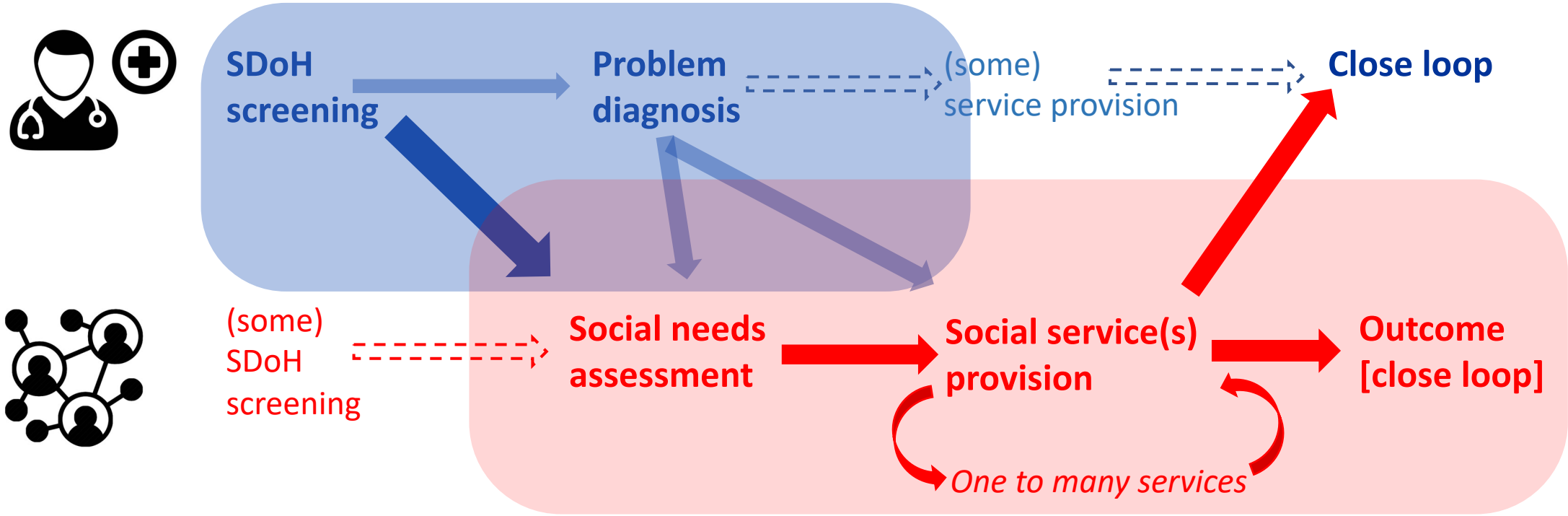
Shared care:

Complementary workflows of medical and social care providers



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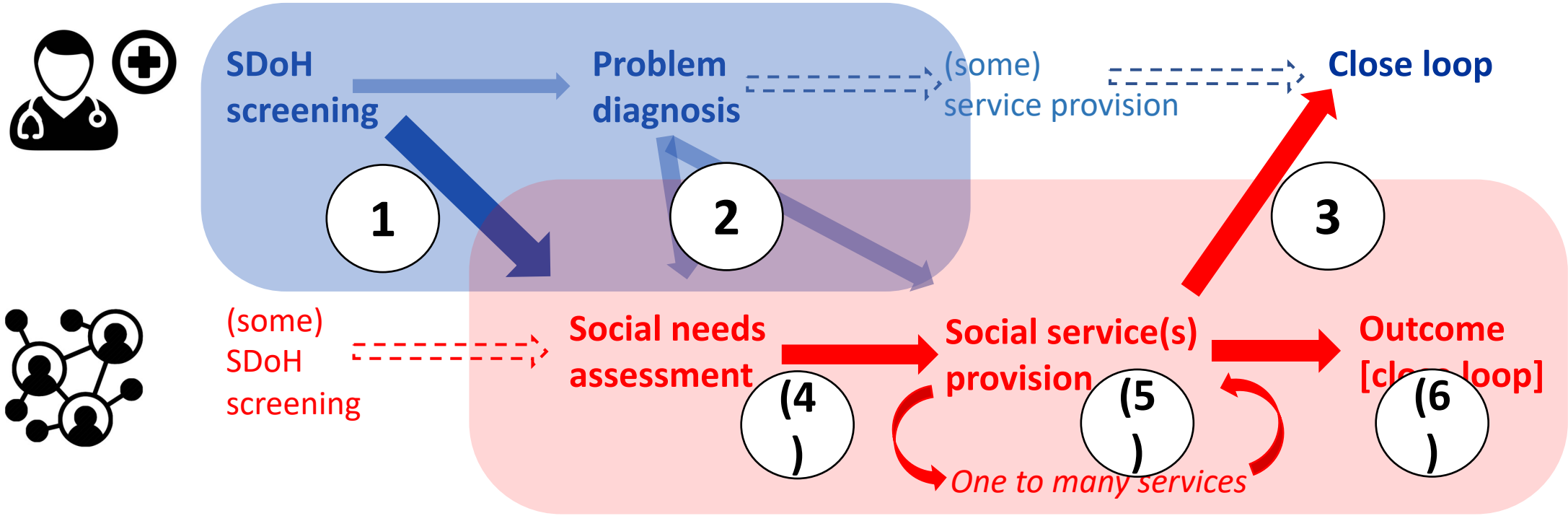
Shared care:

When, what, and how do we need to communicate?



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What do we need to communicate?
Referrals (#s 1, 2, 3)

FROM MEDICAL PROVIDER:

- Identity and demographics
- Screening results
- (Possible) social care problems
- Relevant medical information
- What are we requesting?
  - *Specific service or intervention?*
  - *Assessment only?*
  - *Social care coordination assistance?*
  - *Contracted service?*
- Any important context to share
- Requested status updates

FROM SOCIAL CARE PROVIDER:

- Accept or decline? (with reasons)
- Recommend a different provider?
- Additional information needed?
- Confirmed active social care problems
- (Possible) social care plan
- (Possible) status updates
- Resolution (closed loop)

What else might we need to communicate?
Care plan, status updates, outcomes (#s 4, 5, 6)

FROM SOCIAL CARE: all optional

- Confirmed active social problems?
- Care plan?
- (Periodic) status updates?
- Specific services/interventions provided?
- Outcome measure(s)?
  - *met needs?*
  - *general outcome/ function?*
  - *self-sufficiency?*
  - *Satisfaction with care?*
  - *next steps /recommendations for the medical provider?*

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How can we best connect to communicate?
Simple, interoperable messages

HL7 workgroups have captured many (most?) of the specs needed, but FHIR is not yet widely implemented, even in medical settings

- FHIR Clinical Care IG STU 2.2
  - Available at https://build.fhir.org/ig/HL7/fhir-sdoh-clinicalcare/
- Standardized referral messages as initial phase of work
  - Ex: MiHIN Interoperable Referral message in pilot testing
- Vendor-specific solutions for local implementation (EHR +/- SHARP)
  - Interoperability and FHIR capability not certain, many are bespoke
- Solutions for #4,5 and 6 will require social care co-design work
- ***The patient/client/caregiver perspective is still missing!***

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