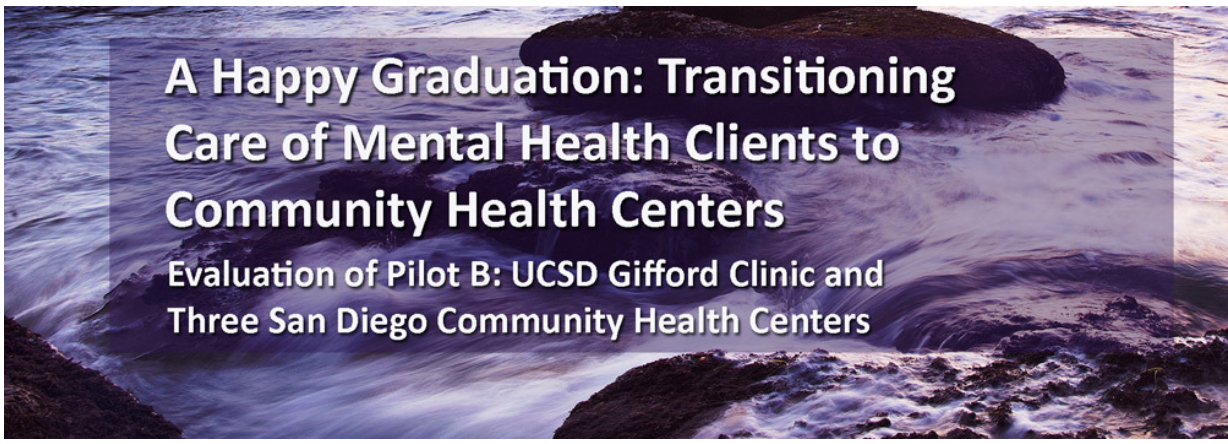

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FUNDED BY
Blue Shield of California Foundation
Safety Net Integration 2014: Advancing Primary Care and Behavioral Health Integration through Community Collaboration

September 2015

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The purpose of this report is to describe the evaluation of a pilot to test a cross-system integration strategy in Central San Diego. The Council of Community Clinics received funding for the pilot from the **Blue Shield of California Foundation** through an initiative entitled, *"Safety Net Integration 2014: Advancing Primary Care and Behavioral Health Integration through Community Collaboration."* The grant program aimed to support communities engaged in, or seeking to engage in, collaborative activities to improve systems-level primary care and behavioral health integration. The one-year project period began July 1, 2014, and the CCC received a budget-neutral grant extension through August 31, 2015.

> "It has been amazing to have a point of contact at primary care sites and has aided overall communication and efficiency between clinics for other needs as well."
>
> ~ Gifford Clinic Staff

One of the contract award's six key grant objectives was to pilot two cross-system integration strategies in San Diego County. The goal of Pilot A, which took place in North County San Diego, was to provide shared treatment and care coordination to clients who were seen simultaneously at a specialty mental health clinic and a community health center. The Pilot A evaluation is described in a separate report. **The pilot evaluation described here, also referred to as Pilot B, was designed to test a model of transitioning mostly long-term clients of the UCSD Gifford Clinic, a specialty mental health clinic, to community health centers who would provide them with integrated behavioral health and primary care services.**

The opportunity was presented to clients as a "graduation" because the client no longer needed the intensive services they had been receiving at Gifford Clinic. Instead, their specialty mental health provider linked them with one of three federally qualified health centers (FQHCs) where they would receive primary care, therapy, and medication management. The participating community health centers were:

Family Health Centers of San Diego
La Maestra Community Health Center
San Diego Family Care

Gifford Clinic. The Gifford Clinic is an outpatient mental health service funded by the County of San Diego Behavioral Health Services division and administered through the Department of Psychiatry at the UCSD School of Medicine. The clinic serves individuals with serious mental illness, as well as those with concurrent substance use and mental health disorders. Clients are either uninsured or covered by Medi-Cal. For those meeting criteria for specialty mental health services, Gifford Clinic offers psychiatric assessment and medication management; psychosocial assessment and customized treatment planning; and individual and group psychotherapy.

EVALUATION APPROACH

Because this was a pilot project, the main objective of the evaluation was to determine whether the transition process could be effective and well received by patients and agencies alike. The grantee was particularly interested in determining whether the transition visit(s) taking place at Gifford Clinic would support the client as they changed mental health providers. The specific evaluation questions were as follows:

> "I am happy with all of the variety of things I can get done at the clinic."
>
> ~ Client

1. Would providers and clients be receptive to the change?
2. Would the client complete at least one visit at the community health center?
3. What were the most successful and challenging aspects of the project?

DATA SOURCES

The evaluation consultant worked with CCC project staff to collect both quantitative and qualitative data:

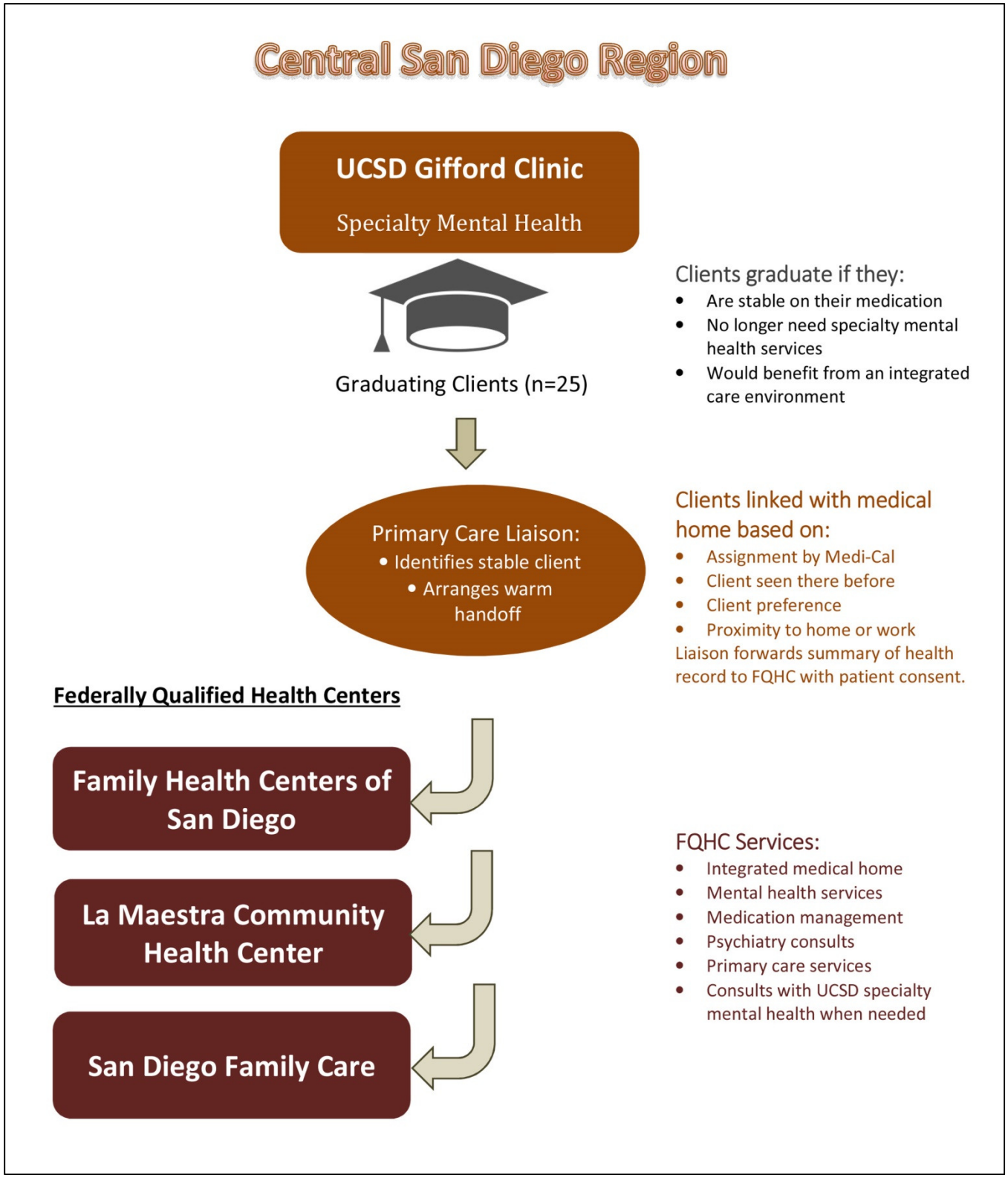
Client Profile Report: Gifford Clinic generated a report that showed standard information for the 25 participating clients, including age, length of time at Gifford Clinic, diagnosis, and whether the transition was successful. To protect privacy, client names were not used but rather replaced with unique numerical identifiers.

Post-Pilot Staff Survey: The purpose of this survey was to give the participating staff from the FQHCs and Gifford Clinic an opportunity to provide feedback on certain aspects of the project, such as whether there was a clear and successful referral protocol, whether clients were receptive to transferring, whether the FQHCs received a patient summary from Gifford Clinic, and the strengths and weaknesses of the pilot. The core survey consisted of 6 items. The clinic behavioral health staff answered three additional questions and the Gifford Clinic staff answered two additional questions. The survey took place in August 2015.

Client Interviews: The Gifford Clinic primary care liaison interviewed the clients that transferred their care to the health center to find out if they had completed an appointment, to learn about what health goals they might be working on at the FQHC, and to answer any additional questions they might have. The liaison interviewed 16 out of 25 total clients.

A pictorial overview of the project is shown in **Figure 1**.

Figure 1: Overview of Pilot B, Care Transition



DESCRIPTION OF TRANSITION PROCESS

The transition process consisted of identifying clients who were ready to "graduate" to a primary care setting, gaining their agreement to participate, facilitating a meeting between the client and the community clinic liaison, scheduling the appointment at the health center, and following up with the client to see if they successfully completed the appointment or needed further assistance. Each of these steps will be described in more detail below.

> *"This is a great concept; patients responded and adapted very well. This helps to avoid patients falling through the cracks by ensuring continuity of care."*
>
> *~ Clinic Behavioral Health Staff*

1. **Identify eligible clients.** Gifford Clinic staff identified individuals who demonstrated stability in their psychiatric condition and appeared ready to transition to primary care for integrated primary care and mental health services. Clients had to meet the following eligibility criteria in order to participate in the pilot:

    - Have a stable medication regimen for at least six months.
    - Not be receiving intra-muscular psychotropic medications.
    - Have a good record of keeping their appointment with their psychiatrist and/or nurse for medication management services.
    - Be able to function as a "medication management only" individual at the specialty mental health program without the need for intensive services for at least 6 months.
    - Have a score of at least 5 (and clinically stable) out of a possible 8 on the Milestones of Recovery Scale (MORS). MORS is a one-page, single score assessment that provides a snapshot of an individual's progress toward recovery by evaluating their risk, engagement, and skills and supports.
    - Have a stable living arrangement.
    - Have Medi-Cal coverage.

2. **Meet with the identified individual to discuss participating in the pilot and transitioning their care to a community health center**. The Gifford Clinic primary care liaison met with the individual to discuss the possibility of transitioning to a primary care setting for ongoing treatment. The conversation included the following (see detailed talking points in **Attachment 1**):

    - The reasons the Gifford Center staff feel the individual is ready to "graduate," and the value of continuing care at a community clinic in order to address additional health conditions.
    - Helping the client select an FQHC and describing the available services. Sometimes the client had already been established with the health center, or selected one that was close to their work or home. The client ultimately decided which clinic to transition to, whether Family Health Centers of San Diego, La Maestra Community Health Center, or San Diego Family Care.

- Assurance that Gifford Center would remain available to the individual should their services be needed in the future.

> "Longstanding clients were often more open to transferring than anticipated if the conversation was tailored to them as individuals."
>
> ~ Gifford Clinic Staff

3. **Obtain necessary consents.** The client signed a consent to participate in this pilot (**Attachment 2**) and authorization to release the protected health information to their selected community health center (**Attachment 3**). The following information was faxed to the receiving community health center:
   - Most recent behavioral health assessment or most recent behavioral health update
   - Psychiatric assessment
   - Information about the medication regime over the last six months, history of keeping appointments, stability over the last 6 months, current living arrangement and insurance status

4. **Schedule 1-2 transition visits between FQHC staff and client at Gifford Clinic**. The primary care liaison, who in most cases was also a therapist, scheduled appointment times with FQHC staff to meet the transitioning client at Gifford Clinic. These meetings typically took place at the beginning or end of the day when the FQHC staff person was on their way to or leaving from work. The three reasons for the transition appointments were to 1) give the client an opportunity to meet someone from the FQHC; 2) allow the FQHC staff explained what to expect in the community health center environment, size of facility, more crowded waiting rooms, and longer wait times; and 3) confirm that the individual seemed like a good candidate to transition care.

5. **Schedule client's first appointment with the FQHC primary care provider**. In most cases the client met the FQHC staff liaison/therapist at the clinic. They talked further about what to expect, then together walked to the front desk and scheduled the appointment with the primary care provider. At Family Health Centers of San Diego, for example, they scheduled the patient first to see a therapist at the site of their choice. After this appointment, the therapist helped the client schedule the appointment with a PCP for medication management.

6. **Have a follow-up conversation with client**. The Gifford Clinic primary care liaison attempted to speak with each client within one week of the client's first scheduled primary care appointment to ask how the visit went. The Follow-Up Conversation Documentation Tool is included in **Attachment 4**.

To ensure the individual was comfortable with their care transition, the Gifford Center psychiatrists remained available for consultation to the FQHC providers who took over responsibility for medication management. In addition, transitioning individuals were not "closed out" of Gifford Clinic services for at least 120 days, and clients were allowed to continue to attend groups. If the client found the transition was not a good fit, Gifford Clinic agreed to an expedited re-entry process.

FINDINGS

Almost every client was satisfied with their transition to the community health center, even if it was a little difficult leaving the therapist or psychiatrist they had been seeing at Gifford Clinic. As shown in the **Client Profile** report, 20 out of the 25 individuals participating in this pilot (80%) completed an appointment at the community health center (see **Figure 1**). Two clients had no appointment or were a "no show," two clients could not be reached and therefore their status was unknown, and only one client opted out of the pilot completely. In addition:

- Clients ranged in age from 30-69 years old, with an average age of 49.
- The length of time at Gifford Clinic ranged from 2 months to 17 years, with an average of 5.6 years.

Most clients went to the clinic to which they had previously been assigned by Medi-Cal, with the larger clinics receiving more clients. As shown in **Figure 2**, the distribution of clients was evenly split between Family Health Centers of San Diego and La Maestra Community Health Center with 11 each. San Diego Family Care, the smaller of the community health centers, received 3 clients.

Figure 1

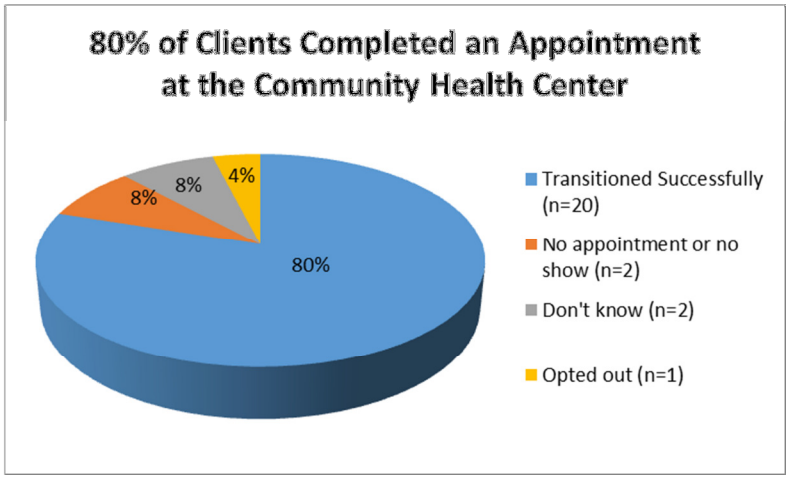
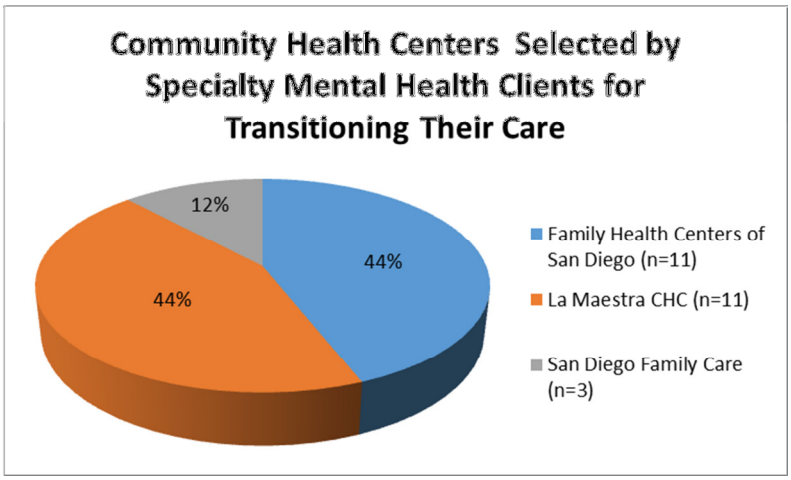


Figure 2



POST-PILOT SURVEY – PROVIDER PERSPECTIVE

Six FQHC behavioral health staff and two Gifford Clinic staff completed the post-pilot survey in August 2015. All respondents agreed or strongly agreed that there was a clear referral process put into place for graduating clients. Seven out of eight (87.5%) agreed or strongly agreed that clients were appropriate candidates to transfer their care from the specialty mental health clinic to a community health center, and that clients were receptive to being transferred. With the exception of one person, all felt that a summary of the patient's medical record was transferred successfully to the community health center. A similar proportion of clinic behavioral health providers felt they continued the patient's behavioral health care without interruption, linked the patient with primary care services, and didn't feel the patients were being dumped. Gifford Clinic, with only two respondents, strongly agreed or were neutral as to whether they thought clients would continue to receive good care at the clinic. Both agreed or strongly agreed that health center staff would make their clients feel welcome. See **Table 1** for Post-Pilot Staff Survey Results.

Table 1: Post-Pilot Staff Survey Results

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
All Respondents (n=8)					
1. There was a very clear referral protocol put into place for referring "graduating" clients from specialty mental health to a community health center				12.5%	87.5%
2. Clients were appropriate candidates to transfer from specialty mental health to a community health center.			12.5%	12.5%	75.0%
3. Clients were receptive to being transferred from specialty mental health to a community health center.			12.5%	50.0%	37.5%
4. A summary of the patient's medical record (history, diagnosis, treatment plan, medication list) was transferred from specialty mental health to the community health center.		12.5%		37.5%	50%
Clinic Behavioral Health Staff (n=6)					
5. We were able to continue the patient's behavioral health care uninterrupted.			16.7%	50.0%	33.3%
6. We were able to link the patient with primary care services				16.7%	83.3%
7. I didn't feel patients were being "dumped"			16.7%	16.7%	50%
UCSD Gifford Clinic Providers (n=2)					
5. I felt confident that our graduating patients would continue to get good behavioral health care at the health center			50%		50%
6. I felt confident that the health center staff would make our patients feel welcome.				50%	50%

STRENGTHS

When providers were asked to select the **most successful aspects** of the pilot (see **Table 2**), the statement receiving the highest score was, "**we gained a referral contact at the other agency**." This item had an average rating of 5.75 – much higher than the next three items which were, **"we learned more about the services at the other agency**" (3.50 average rating); "**clients expressed they were satisfied with the change**" (3.25); and "**it increased access to specialty mental health services at UCSD Gifford for people with higher need,**" meaning the transitioning of patients opened up slots for new patients to be enrolled at Gifford Clinic.

Table 2: The Most Successful Aspects of the Pilot – Each Respondent Chose Their Top 3 (n=8)

Possible Successes	Total points	Average rating*
We gained a referral contact at the other agency.	46	5.75
We learned more about the services at the other agency.	28	3.50
Clients expressed they were satisfied with the change.	26	3.25
It increased access to specialty mental health services at UCSD Gifford for people with higher need.	26	3.25
The transfer process was relatively smooth.	22	2.75
A summary of the patient's medical record was usually provided.	14	1.75
Health centers have the level of staff needed to care for seriously mentally ill individuals.	6	.75
Other (please specify)	0	0.00

* Average rating = total points divided by number of respondents.

"It was a great experience to have the time to collaborate."

"Wonderful project! I wish we had one for children's mental health!"

~ FQHC Behavioral Health Providers

CHALLENGES

Providers reported that the **most challenging aspect** of the project (see **Table 3**) was that **"clients did not want to change providers"** (3.43 average rating). Some respondents also felt that health centers do not have enough staff to care for seriously mentally ill individuals (2.71). Other challenges written in to the "other" option were that a client did not have enough medication prior to being transferred; it was difficult to find time for meetings; and not all health center staff were open to treating serious mental illness. Although the scores were relatively low on these items, these comments exposed some of the other difficulties that emerged in the process from the providers' perspective.

A Gifford Clinic provider noted the importance of using PCPs that are supportive of providing services to clients who have graduated from a specialty mental health setting. She felt that it still takes commitment on the part of the provider, and that only someone who has agreed to these types of integrated services should care for these new patients. She said, *"Sometimes we would see someone who had been transferred successfully come back because a new PCP was assigned after the original transfer and not as willing to care for the client's mental health needs."* She also felt it was important for a Gifford Center staff contact to offer continuing support to clients after the transfer process has occurred, as well as to the PCP and mental health providers.

Table 3: The Most Challenging Aspects of the Pilot – Each Respondent Chose Their Top 3 (n=7)

Possible challenges	Total Points	Average rating
Clients did not want to change providers.	24	3.43
Health centers do not have enough staff to care for seriously mentally ill individuals.	19	2.71
A summary of the patient's medical record was not regularly provided.	14	2.00
Clients really were not ready to be transferred out of specialty mental health.	13	1.86
Other: *"Client did not have sufficient meds prior to transition"*	7	1.00
Other: *"Finding time for meetings"*	6	0.86
Other: *"Some but not all health center staff open to treating serious mental illness"*	6	0.86
The process for transferring the client was not smooth.	5	0.71
Clients expressed they were not satisfied with the change.	5	0.71
Other: (Not specified)	5	0.71

Ranked 1st = 7 points; 2nd = 6 points; 3rd = 5 points

CLIENT INTERVIEWS

The Gifford Clinic primary care liaison attempted to reach all 25 participants by phone for a standardized "Follow-Up Conversation," in which she would ask seven pre-determined questions and document their answers. She also added any additional explanations the clients offered. After the interview, the questioner recorded the clinic to which the client transferred, and the services they were using. She also assessed whether she felt the client's medical concerns were being addressed, and whether or not the client was engaged. The liaison successfully connected with 16 participants (64%), and their responses are summarized in **Table 4**. Client quotes about the positive aspects of the project are provided in **Figure 3**.

> *"You guys made it pretty easy to switch clinics. It's more convenient to get everything done over there. Dr. Gordon takes good care of me – always checks on my mental and physical health."*
>
> *~ Client*

The liaison observed that 100% of clients were engaged in the process and having their medical concerns addressed. In addition:

- 100% of clients reported they had completed an appointment at the community health center.
- 100% said their visit was "good" – the top rating.
- 94% had another appointment scheduled.
- 81% were working on health goals at the clinic.
- 15 out of 16 clients interviewed were using primary care services, 11 were using psychiatry services, 7 were seeing a therapist, and 2 were using medication monitoring services but did not specify the type of provider.

Although some clients had already been going to the clinic, some were there for the very first time. Clients reported they were working on losing weight, heart health, asthma management, cholesterol levels, foot pain, getting his/her thyroid in check, quitting smoking, adjusting medication to manage sleep, managing diabetes, monitoring drinking, and monitoring psychiatric medication. Considering the challenge of assuring that clients with serious mental illness are getting the health care they need, this is an impressive list!

Table 4: Participant Responses to the Follow-Up Conversation Questions (n=16)

Client Questions	No	Yes	Examples of Explanations
1. Have you been to the clinic?	0%	100%	
2. Was it what you expected?	13%	88%	• I was expecting much less. • Very good, caring environment; surprised by the 1.5 hour wait time. • Better than I thought. • I've been going there a long time. I knew what to expect.
3. Do you have any goals you are working on at the clinic?	19%	81%	• Losing weight • Cataract surgery • Monitoring a heart condition • Cholesterol levels; right foot pain • Asthma management • Quitting smoking • Thyroid care • Managing diabetes
4. Are you planning to return?	6%	94%	
5. Do you have another appointment scheduled?	6%	94%	
6. Would you like help making an appointment?	94%	6%	
	Poor or OK	**Good**	
7. How was your visit?	0%	100%	• Very Impressed • MD was busy but she got everything done. • I knew everything about the place. The primary care liaison did a really good job. • Polite staff. The doctor and I get along great.
Interviewer Assessment	**No**	**Yes**	
1. What services are they using?			• 15 clients are using primary care • 11 clients are using psychiatry services • 7 clients are using mental health or therapy services • 2 clients mentioned they are using medication monitoring services but did not specify type of provider.
2. Are the client's medical concerns being addressed?	0%	100%	
3. Is the client engaged?	0%	100%	

STRENGTHS

Generally speaking, clients were pleased by the transition to the community health center setting, mainly because they appreciated the ***assistance*** they received in doing so. A couple people mentioned how much they valued meeting the clinic point of contact before their first visit, and already knowing someone who worked at the health center. Generally speaking, participants were impressed with the clinic facilities, as well as the caring, competent services they received. A few people mentioned it was more convenient to get both their physical and mental health needs taken care of at the same location. They were comforted knowing they could return to Gifford Clinic if they needed to.

CHALLENGES

The biggest challenge mentioned was excessive wait times for scheduled appointments, for example with this client who said, *"Long wait time to see MD was a major pain. I had a 3:30 appointment but wasn't seen until 5:00."* One participant said, *"It all seems to take longer to get what I need than at Gifford."* One person felt there was a lack of communication by the PCP, but the Gifford Clinic primary care liaison intervened to help resolve the outstanding questions.

Figure 3: In Their Own Words: Successes Mentioned During Client Interviews

I am impressed by the facilities and level of care.

I am sentimental about leaving Gifford Clinic but feel I am in good hands with La Maestra.

"It was very helpful to get to know the primary care clinic contact at Gifford and then to get to see her over at San Diego Family Care."

It's nice to know I can come back to Gifford if things get bad.

"I did like how well prepared I felt by the fact that someone from Family Health Centers came to Gifford and got me set up to switch. It helped me feel less anxious."

I have been seeing a PCP at the clinic for many years. It has been beneficial to transition my psychiatric care – I feel more comfortable in this familiar setting.

"I am happy with all of the variety of things I can get done at the clinic."

DISCUSSION

Overall, the majority of Gifford Clinic clients successfully transitioned their care, mainly because of the attention they received during the transition visits. The clinic liaison explained what to expect, and identified possible challenges the clients might face, such as more crowded waiting areas and longer wait times. They also gave the client their phone number so the client could call if they had questions or became frustrated. Clients were well equipped for the transition, and expressed that they were satisfied with the change.

The project was also successful because community health centers were involved in the planning from the beginning, and their input was incorporated into the program design. In addition, the project transferred clients to the clinics at a reasonable rate – about 1-2 per week, rather than transferring all clients at once. This also contributed to the success of the project by not overwhelming the clinic and primary care providers with an influx of new clients all at once.

In response to the first evaluation question, **whether or not providers and clients would be receptive to the change,** the answer for the most part is that they were. Although providers reported that the most challenging part of the project was that clients would not want to transfer where they received care, ***clients overwhelmingly reported satisfaction with the change***. One Gifford Clinic respondent was "neutral" on whether she *"felt confident that our graduating patients would continue to get good behavioral health care at the health center."* It may be helpful to query that person and find out what it would take to increase her level of confidence. The goal would be for all providers to be highly confident that their clients would receive good behavioral health care at the health center.

On the question of **whether or not the client would complete at least one visit at the community health center**, the answer was in the affirmative as 80% - 20 out of 25 clients – completed at least one appointment. This success may be attributed to the warm handoff that was created between Gifford Clinic and the community health centers. Although it was time consuming for the clinic points of contact to go to Gifford Center to meet clients, it was well worth the investment because the transfer of care was successful.

On the third question – **the most successful and challenging aspects of the project** – they have been documented in detail in this report. One of the most successful aspects of the pilot was that each agency gained a referral contact at the other agency. In addition, most clients completed their first appointment, and clients were overwhelmingly satisfied with the experience. One of the most challenging parts of the process was the concern on the part of providers that health centers do not have enough staff to care for seriously mentally ill individuals. This may be an area worth exploring in the future to see if the concern is warranted, and to be able to articulate why or why not. In addition, some work may be needed in streamlining the transfer process in terms of being sure the receiving clinic has all of the necessary paperwork and background information about the client.

CONCLUSION

Indeed for most Gifford Clinic clients it was a happy graduation to transition their care to the community health center where they could receive integrated primary care and behavioral health services. While there were concerns, such as wait times, the experience overall was positive. This is in large part because the clinic point of contact met the client first at Gifford Clinic to explain what to expect at the FQHC.

If the opportunity becomes available to extend the evaluation, it would be useful to explore a few areas. First, it would be important to get feedback from the health center's primary care providers, psychiatrist, and therapists as to whether the client was a good candidate for the transition, and whether the clinician thought it was effective. In addition, it would be useful to check back with the client after six months or a year to review their health care utilization, to see if they continued to address their health goals, to identify any measurable successes (such as decreases in hemoglobin A1c for diabetics), and to determine if their psychiatric/medication needs were met at the health center.

Finally, it would also be useful to hear from the clients that did ***not*** complete an appointment at the health center. Why didn't they complete the appointment, and what were their concerns? Were clients who were already patients at the health center more likely to be satisfied with their transition and to stick with it? Answers to these questions would also shed some light on further areas for improvement, and give clues as to how to further solidify the program.

ATTACHMENTS

ATTACHMENT 1: TALKING POINTS

- The transition should be termed a “graduation”.
- Congratulate the client on his or her success.
- Remind the client that the transition to primary care was one of the goals of treatment from the beginning of treatment and an indication that the client has made significant progress.
- Inform the client of the advantages he or she will now have in being able to get both primary and behavioral healthcare in one setting (list any relevant examples).
- Let the client know having regular access to primary care is important because primary healthcare is often be ignored when significant behavioral health issues are present
- Reassure the client that staff at Gifford will monitor the client’s successful transition and continue to be available to the client for support thorough the process.
- Inform the client that in the unlikely event that the client should need specialty mental health care again, Gifford will be available to the client.

ATTACHMENT 2: CONSENT TO PARTICIPATE IN THE PILOT

CLIENT/PATIENT		
LAST NAME: Click to enter name.	FIRST NAME: Click to enter name.	MIDDLE INITIAL: enter here.
ADDRESS: Click to enter address.	CITY/STATE: Click here to enter.	ZIP CODE: enter text.
TELEPHONE NUMBER: Click to enter here.	SSN: Click here to enter text.	DATE OF BIRTH: enter here.
Purpose of Pilot: I understand the purpose of the Blue Shield Transition Visit Pilot is ***to facilitate the successful transition of individuals a specialty mental health center to a community health center to receive both primary care and ongoing behavioral health services.*** I understand this transition will involve communication and sharing of records between Gifford Clinic,		
Right to Revoke: I understand that I have the right to revoke this consent at any time. I understand if I revoke this consent I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this consent.		
Expiration: Unless otherwise revoked, this consent will expire on the following date, event, or condition: If I do not specify an expiration date, event or condition, this consent will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.		
CONSENT OF INDIVIDUAL		
SIGNATURE:	DATE: Click here to date.	
By signing above I consent to participate in the Blue Shield Shared Treatment Planning Pilot.		
VALIDATE SIGNATURE		
SIGNATURE OF STAFF PERSON:	DATE: Click to enter date.	

ATTACHMENT 3: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

THE FOLLOWING ORGANIZATIONS ARE AUTHORIZED TO RELEASE and/or RECEIVE INFORMATON:

☐ UCSD/Gifford Clinic ☐ Council of Community Clinics	☐ Family Health Centers of San Diego ☐ La Maestra Community Health Center ☐ San Diego Family Care

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ Most recent Behavioral Health Assessment or most recent Behavioral Health Update
☐ Psychiatric assessment
☐ Information about medication regime over the last six months, history of keeping appointments, stability over the last six months, current living arrangement and insurance status

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax: I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: I understand I have authorized the disclosure of my health information and California law generally prohibits recipients of my health information from re-disclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

VALIDATE IDENTIFICATION ☐

SIGNATURE OF STAFF PERSON:	DATE:

ATTACHMENT 4: FOLLOW-UP CONVERSATION DOCUMENTATION TOOL

Client Number: _____ Date: _____ Date of PC Appt. _____

1. Have you been to the clinic?
   ☐ Yes ☐ No [If **No**, skip to # 9]

2. How was your visit?
   ☐ Good ☐ OK ☐ Poor Details: _____

3. Was it what you expected?
   ☐ Yes ☐ No Explanation: _____

4. Do you have any goals you are working at the community health center?
   ☐ Yes ☐ No Explanation: _____

5. [*If answered* 'OK' *or* 'Poor' *#2*] What are your concerns?
   Explanation: _____

6. Are you planning to return?
   ☐ Yes ☐ No [If **No**, skip to #9] Explanation: _____

7. [*If answered* 'Yes' *above*] Do you have another appointment scheduled?
   ☐ Yes ☐ No Explanation: _____

8. [*If answered* 'Yes' *#7*] Can I call you after the appointment to see how it went?
   ☐ Yes ☐ No Explanation: _____

9. [*If answered* '**No**' *#1 or #6*] Why not?
   ☐ Fear of New provider/clinic ☐ Transportation ☐ Client does not feel visit is necessary ☐ Other_____

10. Would you like help making an appointment?
    ☐ Yes ☐ No Explanation: _____

11. Is there something else I can do to help resolve the situation?
    ☐ Requested another transition meeting at Gifford ☐ N/A ☐ Other_____

For reviewer to complete (*not for interview with client*):

1. Where did the client go for care?
   ☐ Clinic ☐ Hospital/ER ☐ Has not yet be seen for primary care ☐ Returned to Gifford

2. What services are they using?

3. Are the clients' medical concerns being addressed? ☐ Yes ☐ No

4. Is the client engaged? ☐ Yes ☐ No

Narrative: