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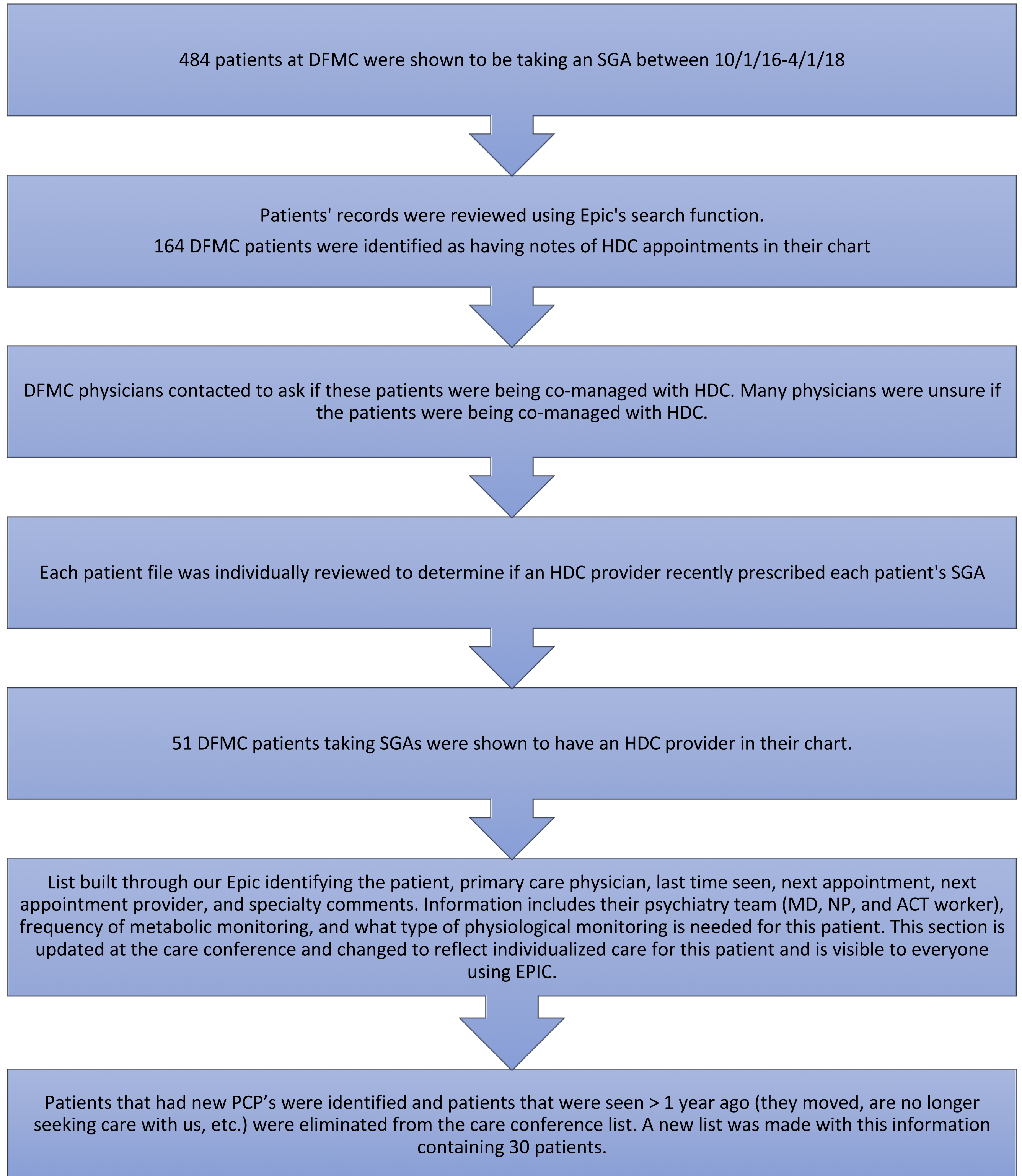
Supplemental Material 1: Care Conference Patient List Identification



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Supplemental Material 2:
Family Medicine Resident Preparation for HDC/DFMC Care Coordination Conference

The DFMC and the Human Development Center have joined together to improve patient care through holding a monthly care coordination meeting where we discuss the current treatment plans of shared patients. Specifically, we are looking at our shared patients who are being prescribed second generation antipsychotics by HDC and who receive their primary medical with DFMC. This document will outline what happens at each care conference and what your role will be.

Attendees:
From HDC:
Clinical pharmacist
Psychiatrist and Medical Director
Nurse Care Coordinator or Assertive Community Treatment Nurse when available
From DFMC:
PharmD Resident
Family Medicine Physician Faculty
Nurse Care Coordinator
Behavioral Health Faculty
Project evaluator from the College of Pharmacy
Pharmacy students occasionally

The purpose of the care conference is to discuss 2-3 patients in a coordinated way. You, the DFMC Resident, will start by giving a brief (3-5 minute) presentation of the patient including current health status, overview of recent visits or hospitalizations, and any known social concerns. The PharmD resident will discuss his/her recent medication reconciliation. The nurse care coordinator will discuss recent labs for monitoring of SGA's and any that need to be completed. The HDC clinicians will discuss pertinent information from their agency. As a group we will also clean up the problem list as it pertains to mental health diagnoses so both agencies are in agreement. The Family Medicine Physician Faculty leads the meetings and guides us through the discussion.

The conference happens in the Coffee Creek Conference Room (next to the Program Director's office) starting promptly at 1:00 and ending at 2:15. Please be on time.

Resident Responsibilities:

1. Brief chart review of each patient (especially the Pharm.D. resident's medication reconciliation note). The RN Care Coordinator will send you an in-basket message with the names and MRN's of the patients to be presented.
2. Prepare the brief presentation of the patient including current health status, overview of recent visits or hospitalizations, and any known social concerns.
3. During the care conference we have the Epic chart open and you will oversee navigation.
4. At the conclusion of the conference you will write a progress note on each patient discussed using the .DFMCHDCCARECOORDINATION dot phrase. It is fairly simple and straight forward. You are given 20 mins at the end of the meeting before your next scheduled patient to complete the documentation or do concurrent documentation.
5. Please also complete the paper survey provided to you at the end of the conference and return to the Behavioral Health Faculty or Nurse Care Coordinator.
6. You will also receive an email from the project coordinator that afternoon or the next day with a brief survey to complete. It will take you less than 5 minutes.

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Supplemental Material 3: Care Conference Template Agenda

Behavioral Health Faculty will keep time on phone [Goal = 15 minutes/patient]

Care Team Brief Introductions: state name and role (Family Medicine Faculty Facilitates - 5 min)

Present Patient Case & overall impression of status; prioritize list of known needs (Family Medicine Resident)

Medication reconciliation/updates (Pharmacy Resident)

Clinical data - Therapeutic Goals - met?

Clinical data - Monitoring Goals - met?

Discuss any social determinants impacting patient

Shared care planning

Referrals

Follow-up plan

Documentation in EHR (Family Medicine Resident)

[fax med list/visit note/labs to HDC afterward]

Follow up with patient (appropriate team member)

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Supplemental Material 4: “Completed Care Conference Note” Duluth Family Medicine Clinic / HDC Care Coordination Conference Electronic Health Record Documentation Template

@TD@

Present: [automatically inserts clinicians present at care conference] ***

Start Time: ***

End Time: ***

@NAME@
@AGE@
@SEX@

@NAME@ is being discussed today for treatment evaluation for the current diagnosis of ***, future plan management and care coordination between their mental health clinic (HDC) and their primary care clinic (DFMC).

Problem list has been reconciled {YES/NO 200010}

@PROB@

Current medications have been reconciled {YES/NO 200010}
@CMED@

HBA1C every 1 year and every 6 months if diabetic: @LASTHBA1c@
LDL every 1 year @LASTLDL@
Liver Function Testing every 1 year @LASTLFT@
BMP every 1 year @BMP@
EKG every 1 year @EKG@

Last appointment date: ***
Next appointment date: ***

Overall impression of status (known needs including psychosocial): ***

Follow up plan: ***

@ME@

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Supplemental Material 5: Family Medicine Resident Post-Care Conference Survey

The purpose of this survey is to gather your perceptions of what you learned from the **care conference experience**.

1. I am a *(circle one)*:
   PGY1
   PGY2
   PGY3

2. I *understand* all of the elements (biological, psychological, social) that must be considered to provide holistic patient care.

   Before the care conference:

1	2	3	4	5
Not at all				*Completely*

   After the care conference:

1	2	3	4	5
Not at all				*Completely*

3. I am *confident* conducting medication safety monitoring (i.e. knowing what and when to monitor) for my patients taking second-generation antipsychotics (e.g. lipids, A1C, ECG).

   Before the care conference:

1	2	3	4	5
Not at all				*Completely*

   After the care conference:

1	2	3	4	5
Not at all				*Completely*

4. My *understanding* of the roles that each of the team members can play in the care of complex patients like the ones presented in the care conference was/is:

Before the care conference:

1	2	3	4	5
Minimal				*Excellent*

After the care conference:

1	2	3	4	5
Minimal				*Excellent*

5. The care conference helped me develop a more comprehensive patient-centered care plan for my patient(s).

1	2	3	4	5
Strongly disagree				*Strongly agree*

6. Which professionals contributed to the development of the treatment plan for the patients discussed at the care conference?

7. I plan to engage with an interprofessional team in care of my future patients

1	2	3	4	5
Strongly disagree				*Strongly agree*

If agree, with whom, and how so?

If disagree, why not?

8. The most helpful part of the care conference was:

9. The care conference experience could be improved by:

*Please give your completed survey to [nurse care coordinator] (or leave on keyboard if not available).

Thank you for your feedback. If you have additional ideas or feedback, please contact [primary author/investigator]

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Supplemental Material 6: Post-Care Conference Quality Improvement Survey (electronic, sent by email)

What went well? [free text]

What should we do differently next time? [free text]

Name [free text]

Site [list of options to select response]

Role [list of options to select response]

Date of Care Conference [list of options to select response]