Integrated Care Plans: Theory & Practice

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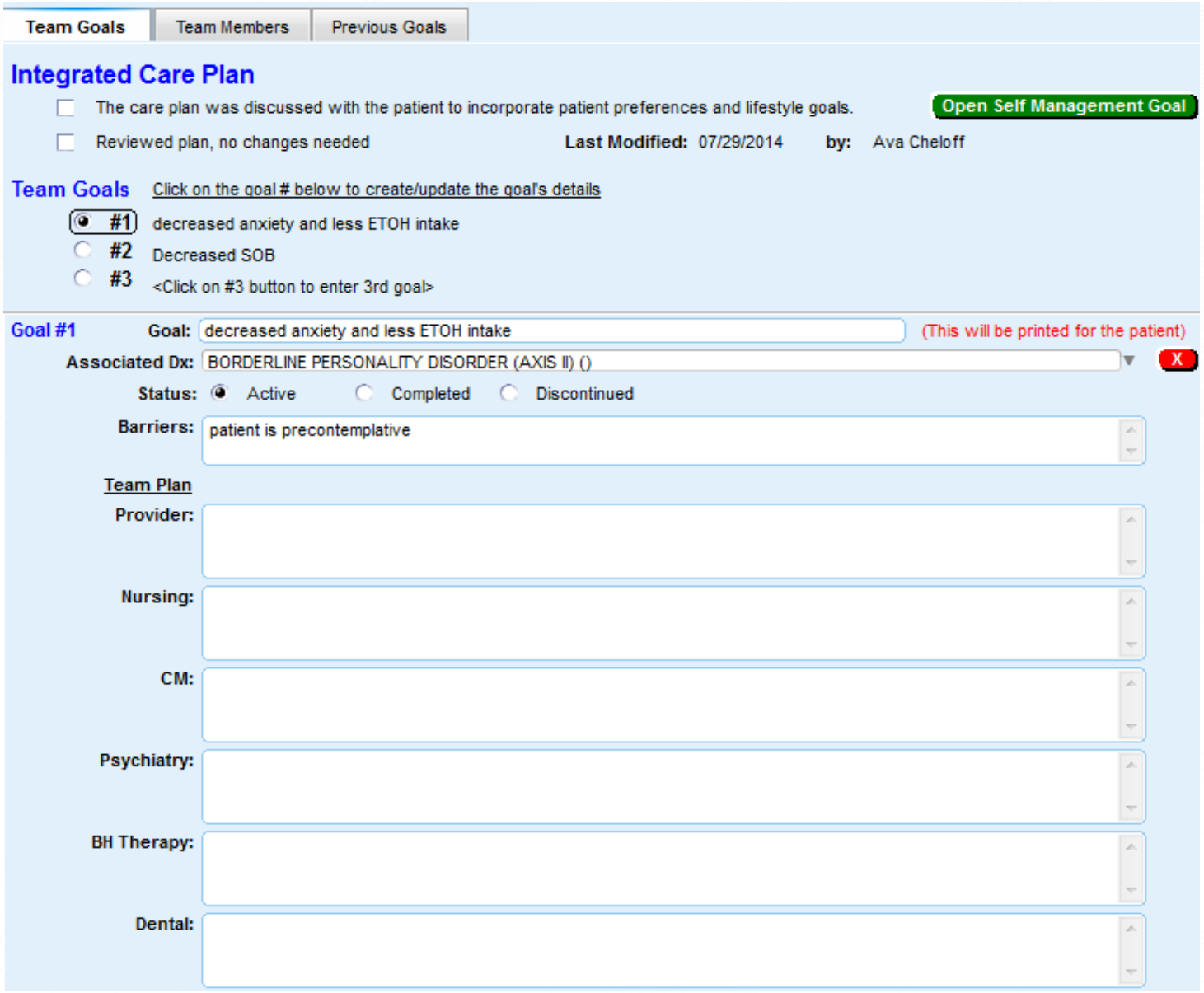
Boston Health Care for the Homeless Program

May 2015

Theory & Practice

- Theory
  - Concise snapshot of current priorities of team, across disciplines
  - Intent is to better coordinate care among ALL providers
  - Dynamic document – while overarching goals may persist, specific plans may change frequently
- Practice
  - Culture shift, takes time
  - Emphasize empowerment of all team members to change plans
  - Case conferencing is the best mechanism for generating a plan
  - Make it front and center – don't bury it in the note


Team Goals
Team Members
Previous Goals
Integrated Care Plan
The care plan was discussed with the patient to incorporate patient preferences and lifestyle goals.
Open Self Management Goal
Reviewed plan, no changes needed
Last Modified: 07/29/2014
by: Ava Cheloff
Team Goals
Click on the goal # below to create/update the goal's details
#1 decreased anxiety and less ETOH intake
#2 Decreased SOB
#3 <Click on #3 button to enter 3rd goal>
Goal #1
Goal: decreased anxiety and less ETOH intake
(This will be printed for the patient)
Associated Dx: BORDERLINE PERSONALITY DISORDER (AXIS II) ()
X
Status: Active Completed Discontinued
Barriers: patient is precontemplative
Team Plan
Provider:
Nursing:
CM:
Psychiatry:
BH Therapy:
Dental:

Team Goals | **Team Members** | Previous Goals

This plan is a concise snapshot of current patient priorities across disciplines. Its intent is to better coordinate care among all providers, including behavioral health, primary care, nursing, case management and oral health.

This document should be viewed as dynamic – while overarching goals may persist, specific objectives and plans are likely to change frequently over time.

To update a name, click the role button and then highlight the name:

○ RN ○ Psych ○ Therapist ◉ Dentist ○ CM

Primary Care Team: Red Team
PCP: Jennifer K Brody MD
Clinical Care Mgr (RN): Margaret R Marini RN
Psychiatry: Karen M Henley MD
Therapist:
Dentist: Mary Colleen Anderson DDS
Case Manager:

<Clear name>
Anderson DDS, Mary Colleen
Dental, JYP
Filzer DDS, Alan L
Ricci DDS, Thomas M
Wang DMD, Yi

The SPARK Center at Boston Medical Center

Therapeutic childcare in a multidisciplinary team environment working in conjunction with primary and specialty care providers.

Making community connections.

Referral to feedback

SPARK children

- Medical issues such as VLBW infants, hypoxic brain injury, seizure disorders, respiratory problems, FTT, CP, ASD, cardiac defects, HIV, sickle cell, TBI
- Emotional/behavioral challenges: Impaired self regulation, neglect, physical and/or sexual abuse, parental loss, DV, trauma
- Have complex, overlapping challenges
- Have needs that can't be met in other settings
- Are at highest risk for abuse/neglect
- Live in poverty

SPARK Team

- Educators - provide therapeutic, developmentally appropriate classrooms for content and social skills.
- EI Coordinator - provides assessment, referrals, transitions to public school
- Psychology clinicians - provide individual, family and group therapy, educational testing, home visits, development of care plans
- Nurses - provide assessment, health education, direct care, care coordination, adherence support, emergency triage

Care Plans

Community and home

- Respect for family values, priorities and cultures.
- Value each discipline's contribution.
- Create communication plan for follow up.

Moving on to school

- Parental letter to request evaluation.
- Testing happens at SPARK with appropriate input.
- SPARK staff attends IEP meeting.
- Contact with school staff as needed.

Protecting Privacy

- Privacy policies consistent with BMC.
- HIPAA and permission forms signed on admission and updated each September.
- All staff adhere to yearly employee training updates related to confidentiality.

Case Study

Nursing

- Nutrition
- Gather medical data
- Classroom assistance

Behavioral Health

- Assessment
- Behavioral intervention plan
- Classroom assistance

Education

- Small therapeutic classroom
- 1:1 ratio
- Assessment (education and social)

DCF/Foster parent

- Team meetings
- Buy-in on “the plan”
- Communication

THE SPARK CENTER

Integrating Care: From Evidence to Operations

Second Annual Statewide Forum on Integration

Integrating Care: From Evidence to Operations

Second Annual Statewide Forum on Integration

The SPARK Center
255 River St.
Mattapan, MA 02126
Phone: 617-414-2050
Fax : 617-534-2057
www.bmc.org/SPARK

Supporting **P**arents **A**nd **R**esilient **K**ids

Patient Progress Report

Case Review Date :_____

Child:_____ **Current Age:** _____

DOB:_____ **Date of Enrollment:**_____

Nursing and Early Intervention:

___Provider Initials

Developmental/Classroom:

___Provider Initials

Behavioral Health:

___Provider Initials

Family/Other:

___Provider Initials

Assessment:

Plan:

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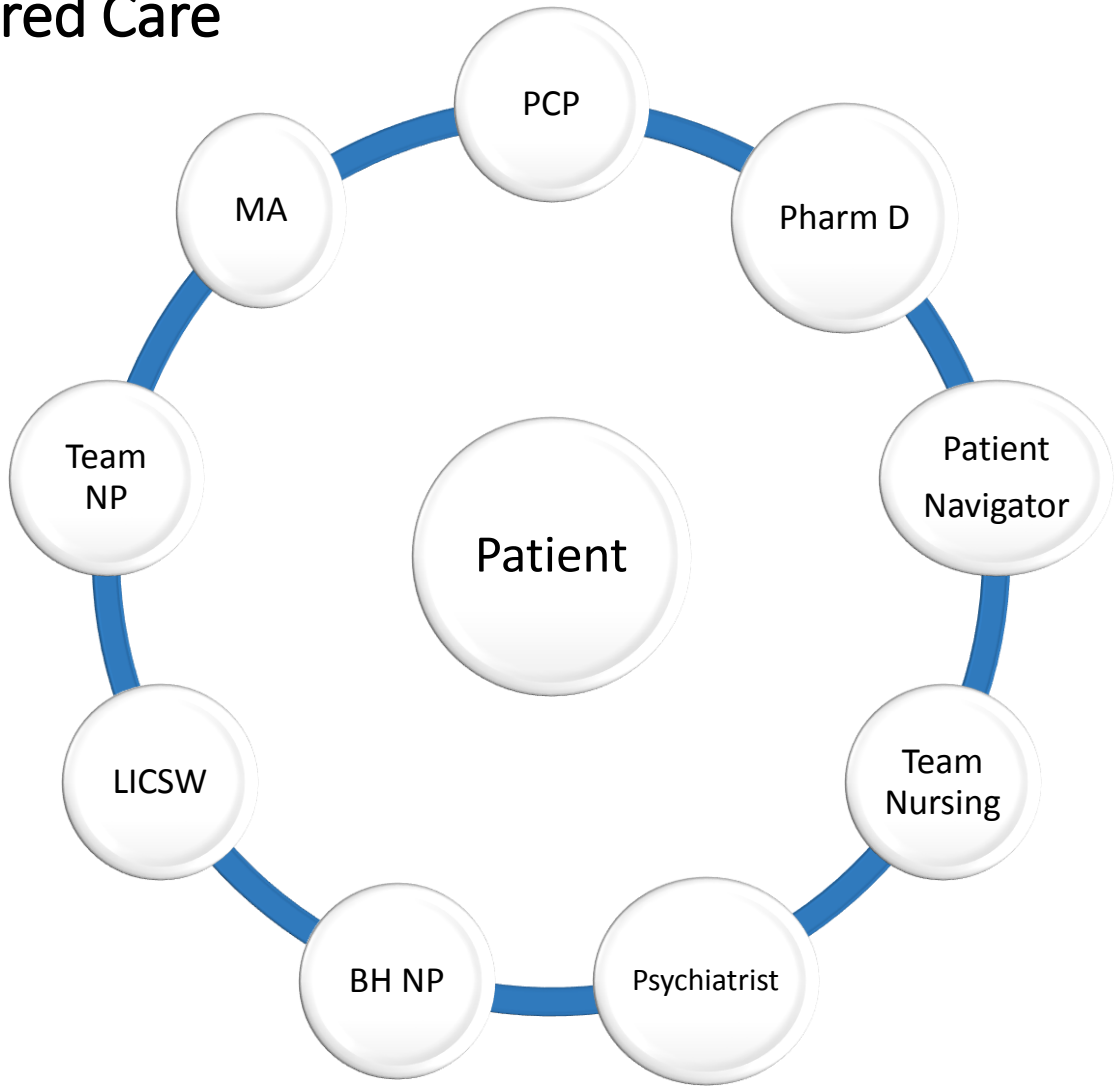
Behavioral Health Care Management

Family Medicine Center at Boston Medical Center

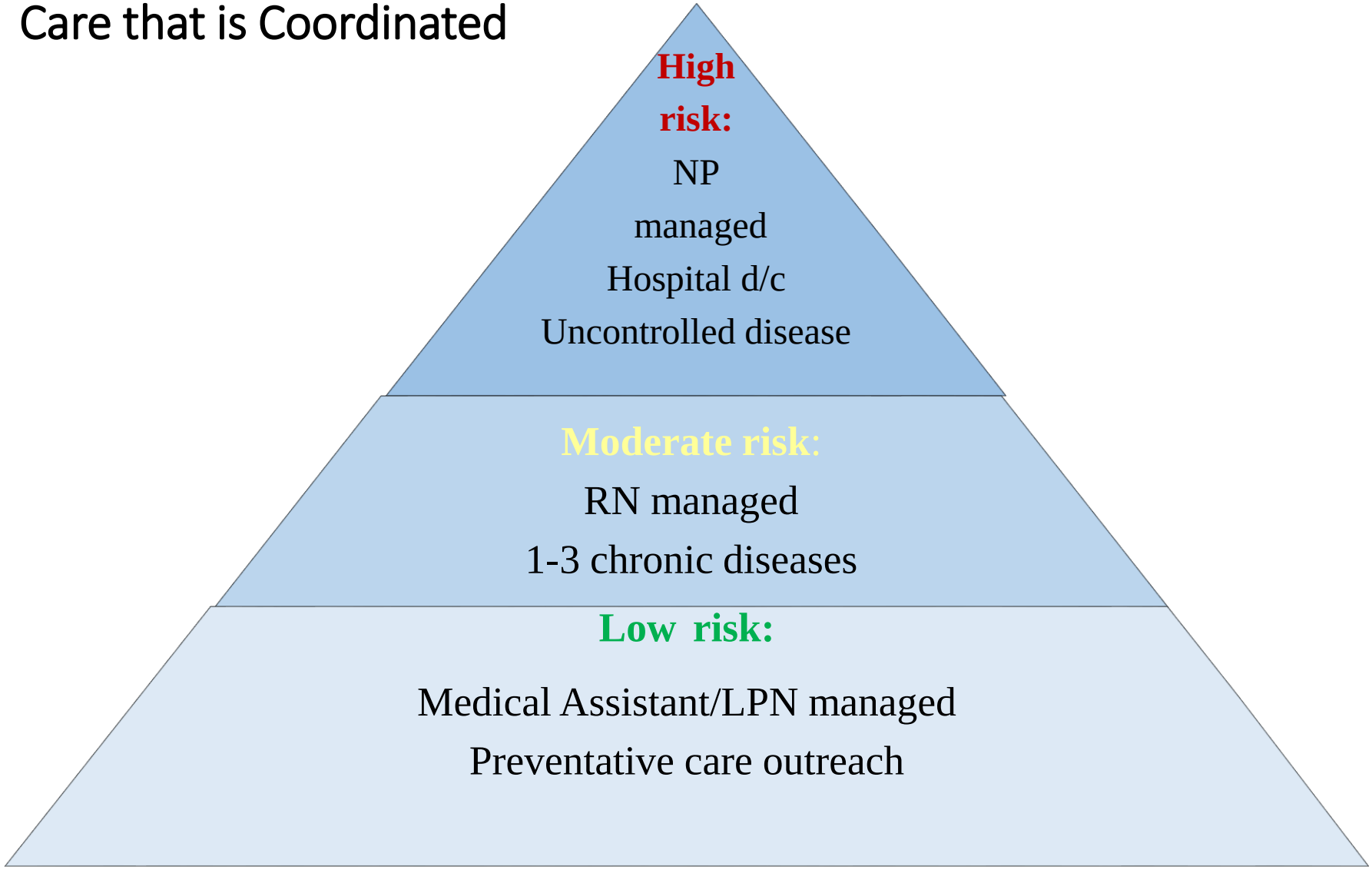
Alysa N. Veidis RN, MSN, FNP-BC

May 12, 2015

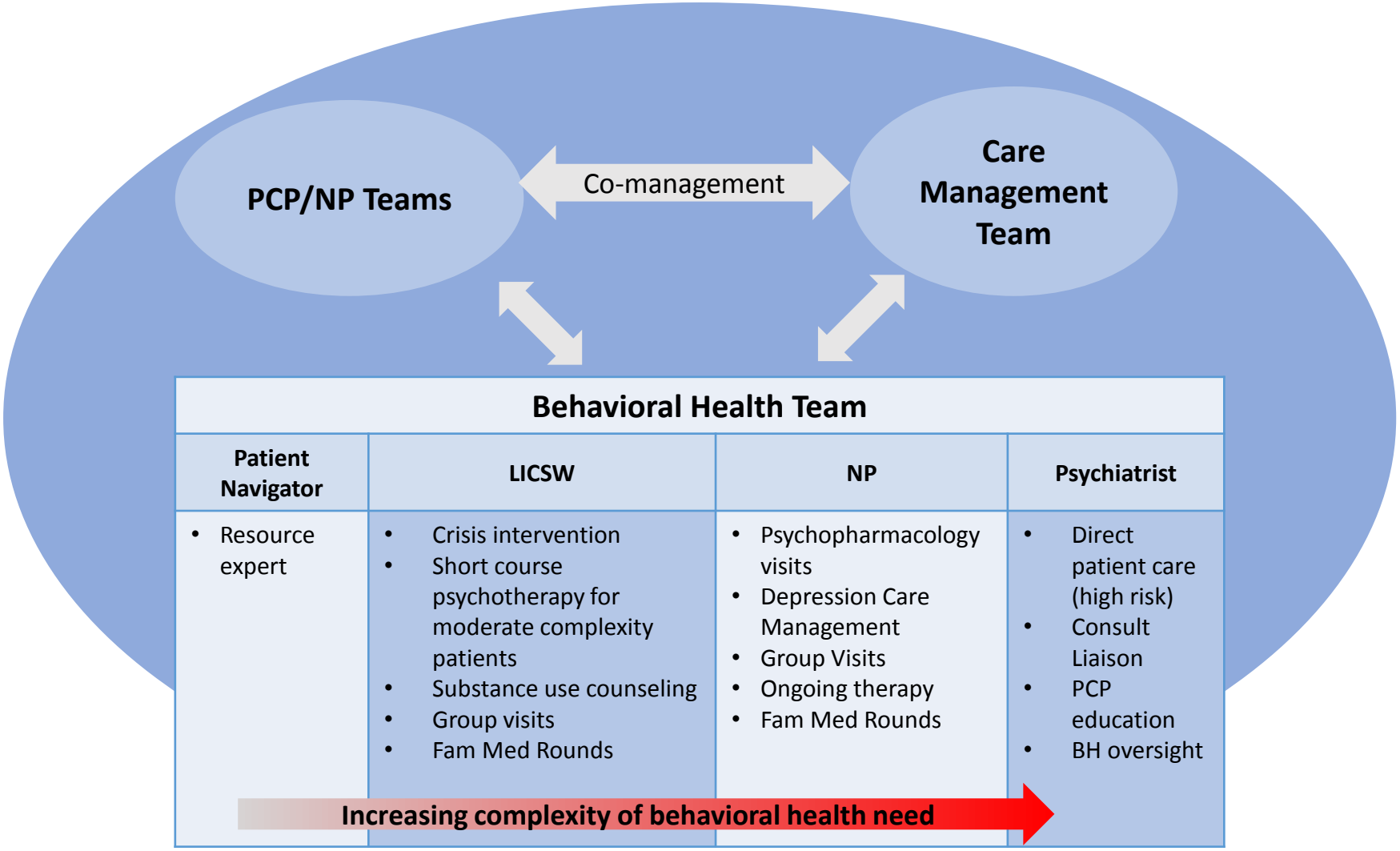
Patient Centered Care



Care that is Coordinated



Integrated Behavioral Health Model

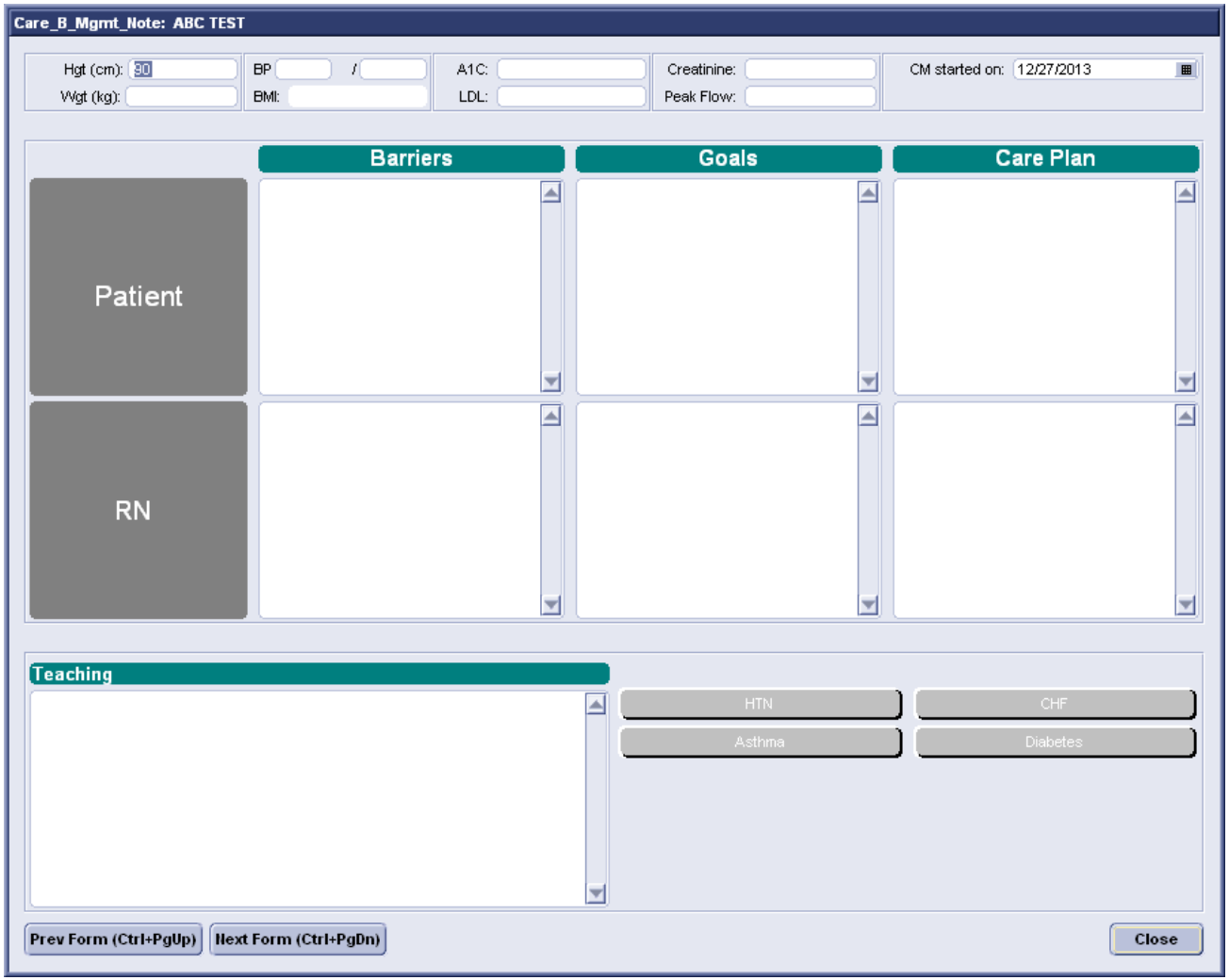


Behavioral Health Team

Patient Navigator	LICSW	NP	Psychiatrist
• Resource expert	• Crisis intervention • Short course psychotherapy for moderate complexity patients • Substance use counseling • Group visits • Fam Med Rounds	• Psychopharmacology visits • Depression Care Management • Group Visits • Ongoing therapy • Fam Med Rounds	• Direct patient care (high risk) • Consult Liaison • PCP education • BH oversight

Increasing complexity of behavioral health need

Care Note


Care_B_Mgmt_Note: ABC TEST
Hgt (cm): 90
Wgt (kg):
BP /
BMI:
A1C:
LDL:
Creatinine:
Peak Flow:
CM started on: 12/27/2013
Barriers
Goals
Care Plan
Patient
RN
Teaching
HTN
CHF
Asthma
Diabetes
Prev Form (Ctrl+PgUp)
Next Form (Ctrl+PgDn)
Close

EMR Communication between LICSW and PCP

Doc ID: **291**
From: **Odell MD (2193), Christine**
Date Sent: **04/20/2015**
Time Sent: **2:20 PM**
Priority: **Normal**
Comments

Properties: **Clinical Summary (MHLTH) at FAMYACC4 on 04/16/2015 3:39 PM by Abbie (LICSW) Duger**

Pt returns for individual therapy-45 min session, pt arrives on time for session. Pt reports that her mood has been "up and down". Pt reports that she wants to leave her current living situation, but unsure of when she wants to leave. SW and pt discuss going into a shelter and pt requests the number for a shelter in the Lynn area.
Pt discusses times when she used to be more succesful-describes times when she used to be the 'head' of a group home, used to make meals, manage tasks. Pt reports that she wants to get back to that life. This SW and pt discuss barriers to her being happier/more successful/cutting toxic people out of her life. Pt reports that she wants to live on her own and wants to make good choices for herself.
Pt to continue attending the Depression Group Visit, will return in 1 week for individual therapy and mood management.

Electronically Signed by Abbie (LICSW) Duger on 04/16/2015 at 3:39 PM

Electronically Signed by Christine Odell MD (2193) on 04/20/2015 at 8:16 AM

Communication- multi-pronged approach

Mode of Communication	Detail
✓ **Warm Hand -Offs**	Daily and unscheduled
✓ **Curbsides/ Pages**	Ad- hoc and daily
✓ **EMR**	Progress Notes, and messaging in Centricity with security lock
✓ **All staff meeting**	Weekly Brief Updates and periodic agenda focus
✓ **Monthly Team Rounds**	Monthly Flash Rounds
✓ **Huddle**	Daily update on BH team schedule and availability

Concrete How To's

Worth It:
1. Lay the Groundwork ("measure twice and cut once")
2. Don't underestimate the power of cross-departmental collaboration
3. Understand Behavioral Health Provider skill sets
4. Strategically place BH providers in the clinic (between exam rooms)
5. Understand billing and volume implications
6. Train , train and train some more
7. Communication and organization is KEY – you cannot over communicate!
8. Involve all levels of staff
9. Start small and spread
10. Decide on measures of success early