



Identification and Evidence-Based Interventions for Treating Anxiety and Depression Community of Practice

Patient-Centered Care Planning

February 14, 2023

2:00–3:30 p.m.

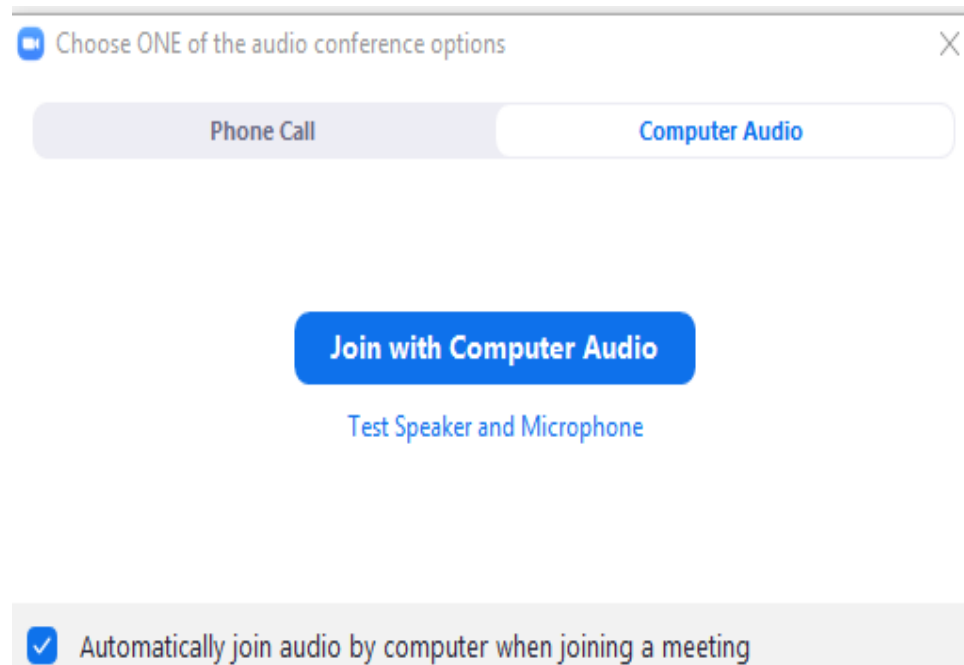
Vision: Healthy Communities, Healthy People



Connecting to Audio

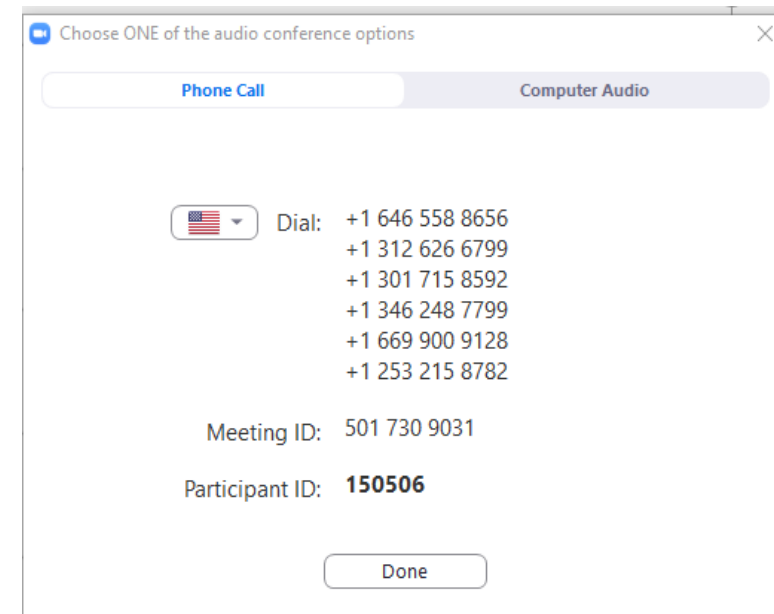
By computer:

- Click **Join with Computer Audio**.



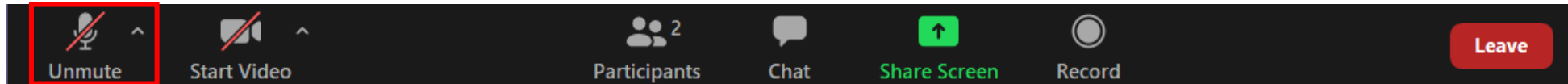
By phone:

- Click the **Phone Call** tab, dial a listed phone number, and enter **Meeting ID** and **Participant ID**.

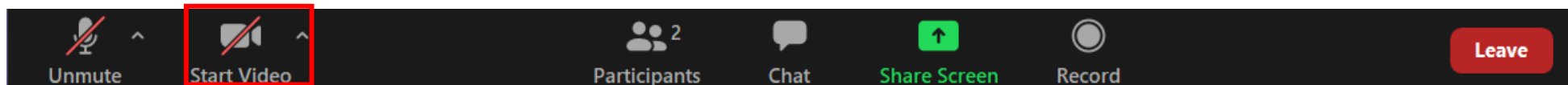


Zoom Participation

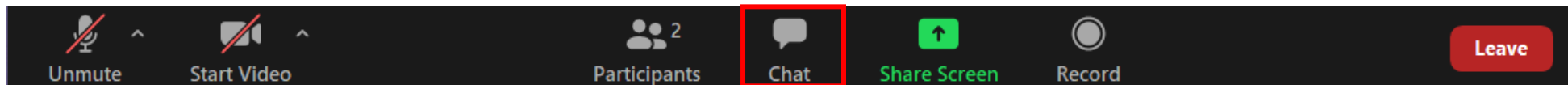
- You will begin muted. To **unmute/mute**, click the **microphone** icon located at the bottom left of your Zoom window.



- We encourage everyone to keep their video enabled. Click **Start Video** to join by webcam.



- To ask a question using the **Chat** feature, click the **Chat** icon located at the bottom center of your Zoom window.



Continuing Education

- We will be offering **1.5 CE credit per session** attended, for a maximum of 12 CEs for participation in all 8 CoP sessions.
- You **must** complete the Health Center Satisfaction Assessment after **each** session for which you plan on receiving CEs.
- **CE credits will be distributed for all sessions at the conclusion of the CoP.**



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Session 3 Facilitators



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JBS International, Inc. (JBS)



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BHTA Technical Expert Lead
JBS International, Inc. (JBS)

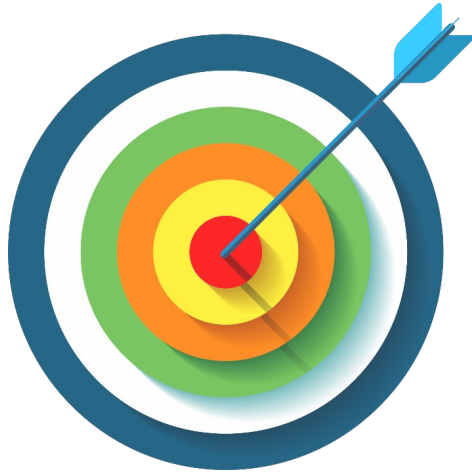
Participant Locations



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Objectives



Source: iStock

Participants of today's CoP Session 3 will

1. Define patient engagement in care planning,
2. Contextualize care plan strategies,
3. Align care with patient values and culture, and
4. Negotiate patient-relevant goals.

Patient-Centered Care

THE 4 C'S OF PATIENT CENTERED CARE



Values – Preferences – Traditions – Shared Decision-Making – Accessibility – Socioeconomic Conditions¹.

Develop a Partnership Through Shared Purpose

- **Create a shared vision, mission, goal(s), and objectives**
 - **Vision:** Communicates the ideal conditions for the patient if the problem was resolved.
 - **Mission:** Describes what the partnership is going to do and why it's going to do it.
 - ✓ Mission statements are concise and outcome oriented.
 - **Goal(s):** Action-oriented statements that describe the outcomes the partnership hopes to achieve.
 - **Objectives:** Specific strategies and tasks that will be used to reach one's goals. Use SMART format:
 - ✓ Specific
 - ✓ Measurable
 - ✓ Achievable
 - ✓ Realistic
 - ✓ Timed (has a target date or timetable)



Image: publicdomainvectors.org

Intervention Strategies in Integrated Care

- **Care Team Collaboration**
 - Trusted family members/significant others
 - Other supportive connections, such as friends, peers, social workers, community resources (food, literacy, \$ assistance)
- **Brief Therapy Best Practices (discussed more in later sessions)**
 - Provided by behavioral health care manager
 - Behavioral activation
 - Cognitive behavioral therapy-primary care
 - Problem solving therapy².



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Negotiating Treatment Priorities

Interpersonal

- Communication among care team
- Knowing the patient's values, beliefs, abilities, preferences
- Importance of all team members present

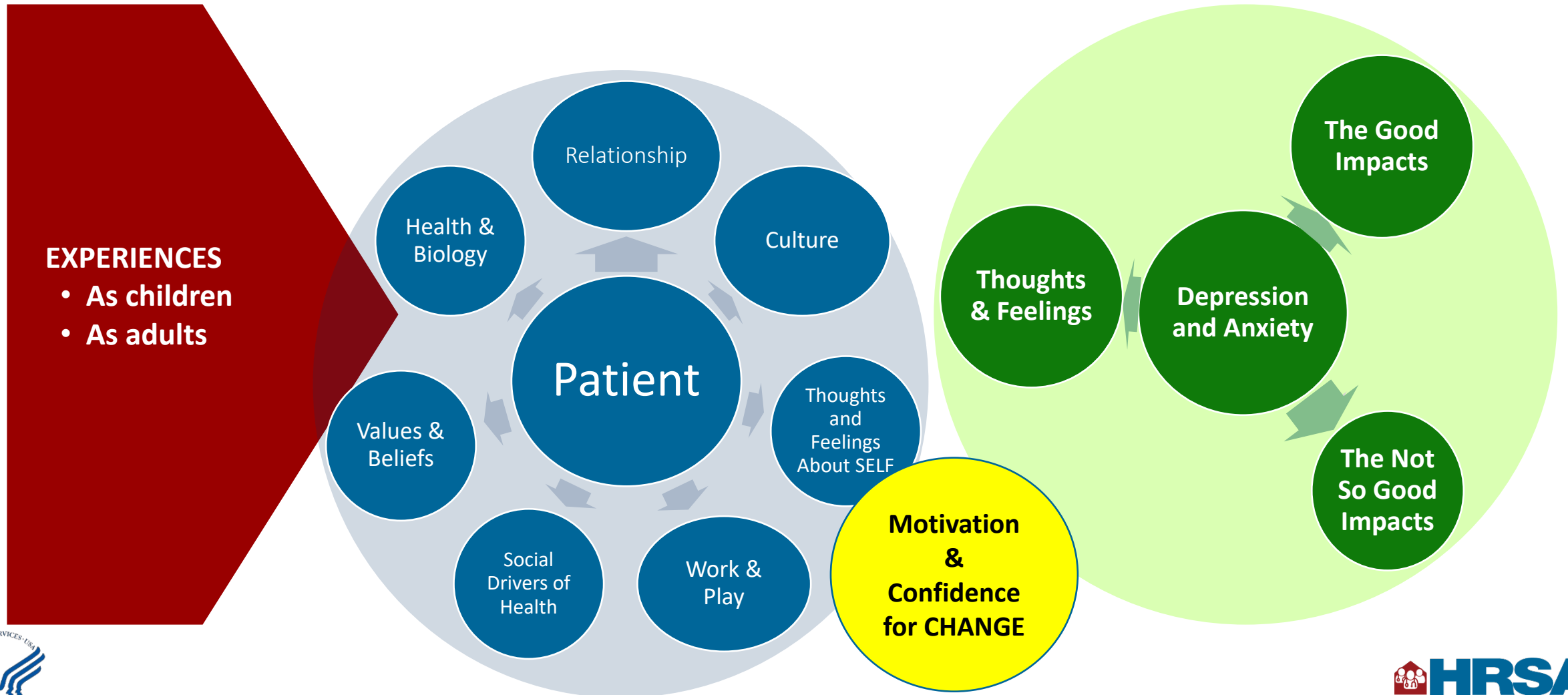
Clinical

- Shared decision-making using best practices and self-management
- Coordination and continuity among all center staff and providers
- Types of visits available

Systemic

- Physical environment is calm and welcoming
- Access to care: ease in making appts, wait times
- Information technology (IT) supports collaborative care planning; coordinated, consistent, efficient ³.

Contextual Understanding of Personal Experience of Anxiety and Depression



Patient-Centered Care Plan

Be specific regarding strategies and tasks that will be used to reach one's goals.

SMART Format

Specific

Measurable

Achievable

Realistic

Time-limited

Cecilia will write in her journal once weekly for the next 90 days.



Sample Change Plans

Prescription for Change

Date: _____


Action Plan


1. _____
2. _____
3. _____

Signature: _____

Witnessed by: _____

Please call ___/___-___ on _____
to let us know if this plan is working for you.

 SMART Recovery®
Life beyond addiction

 CHANGE-PLAN
WORKSHEET

Changes I want to make:

How important is it to me to make these changes? (1-10 scale)

How confident am I that I can make these changes? (1-10 scale)

The most important reasons I want to make these changes are:

The steps I plan to take in changing are:

How other people can help me (person; kind of help):
the Setting Goals for Change Exercise or the Change Plan Worksheet

I will know my plan is working when:

Some things that could interfere with my plan are:

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Sample Change Plan

Basic Care Plan Example

Person-Centered Care Plan

Risk Level: (*High, Moderate, Low*)

Last updated by: (*dot s*)

Original Author: (*dot s*)

Medical Summary:

Patient Care Team: (*dot*) *patientcareteam to pull in all team members*

Personal Support Team:
(*Include community contacts, caseworkers, therapists, etc here, primary caregiver/contact information goes here.*)

Patient's care goals (chronic and preventive):
(*Patient's personal goals for care goes here*)

Patient's self management tools:
(*patient education, groups, referrals go here*)

Patient's barriers to care/goals:
(*psychosocial and other risk factors go here*)

Team Goals: (chronic and preventive):

(continued on next slide)

Sample Change Plan (continued)

Basic Care Plan Example

Sample Plan:

Risk Level: High

Last updated by: XXX XXX, RN 1/16/2013

Original Author: XXX XXXX, MD 11/11/2012

Medical Summary: Cindy is a 48 y/o single mother of two children, Johnny 13 and Amelia 9. Cindy has diabetes, high blood pressure, and knee pain. She is 85 lbs over her desired weight. She has a past history of alcohol and methamphetamine use but clean and sober for 13 years. Her diabetes and hypertension are under poor control and it is difficult to persuade her to get needed lab work and show up for office visits.

Care Team:

Personal Support Team: Boyfriend Joe 503-222-2222, Mother Carol 971-333-3333, AA sponsor Kim, 503-111-1111

(continued from previous slide)

Sample Change Plan (continued)

Basic Care Plan Example

Patient's Care Goals (chronic and preventive)

1. "I would like to eat better so I can lose some weight"
2. "I need some help in managing all the stress I'm under with money and the kids"

Patient's Self Management Tools:

1. Call TOPS (Take Off Pounds Sensibly) 503-444-4444 for a support group near your home
2. Meet with Diabetes Education for refresher on nutrition and diet 503-214-9999
3. Meet with our clinic behavioral coach, Dr Jones, about your high blood pressure and stress

Patient's barriers to care:

1. Has to take 2 buses to get to clinic for lab and office visits
2. Boyfriend is overweight and resists making changes in family food choices

Team Goals

1. Cindy will come in for office visit and lab work at least twice a year
2. Cindy will sign up for MyChart and use the diabetes self care to keep team posted on her blood sugar and blood pressure.

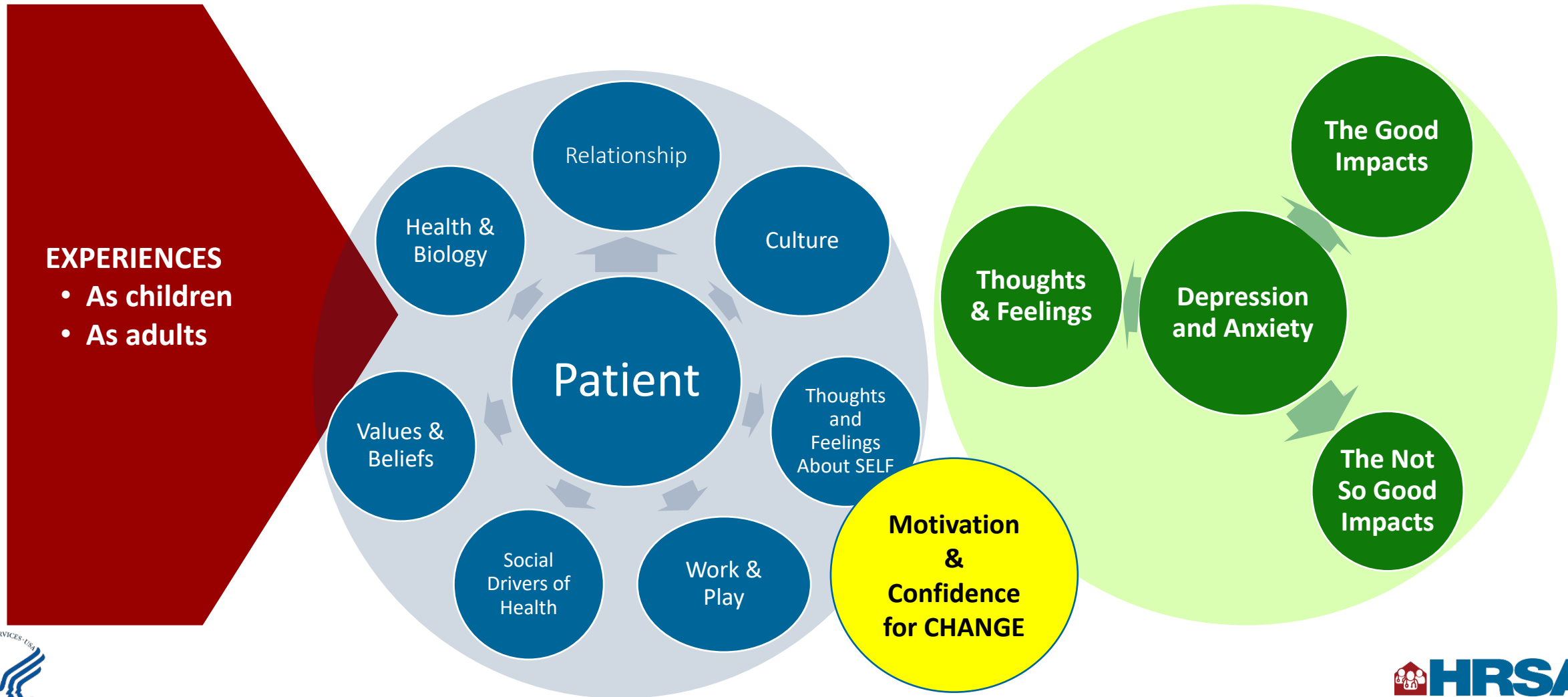
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Breakout Session: Cecilia's Care Plan



Source: iStock

Contextual Understanding of Your Person and Their Experience of Anxiety and Depression



Debrief: Cecilia's Care Plan

A patient-centered care plan includes patient priorities (values), health center priorities, incremental strategies, available resources.

Care Plan

Demographic Info – Care Team – Duration – Summary – Broad Goal(s) – Objectives – F/U

Goal #1: Cecilia will feel less sad and worried about how she is doing as a wife and mother.

Objectives:

Person(s) Responsible:

Review Date:

Progress to Date:



Q & A



A Collective Summary of Today's Session

Objectives

- Define Patient Engagement in care planning
- Contextualize care plan strategies
- Align care with patient values and culture
- Negotiate patient-relevant goals

❖ What worked well today? Opportunities?

❖ Topics for further discussion



Next Steps

Participate in Post-Session Office Hours

- Stay after each session to discuss the material presented, or
- Attend Office Hours: Friday the same week as CoP, 1:00-2:00 p.m. ET

Schedule One-to-One Coaching Session

- Facilitators will be contacting each CoP participant individually.
- Participants will engage in a 60-minute one-to-one coaching session with the facilitator to refine desired outcomes from participation.

BPHC-BH TA Portal

<https://bphc-ta.jbsinternational.com/>

- Request TA
- Access Learning Management System (LMS) modules
- Learn more about BH TA options
 - One-on-One Coaching
 - E-learning Webinars
 - Virtual Site Visits to Improve Outcomes
 - Integration of Oral and Behavioral Health
 - Virtual Brown Bag Sessions



BPHC-BH TA
Bureau of Primary Health Care Behavioral Health Technical Assistance

Event Calendar | About Us | Contact Us

Home | Technical Assistance Resources | Request Technical Assistance | Learning Management System

Welcome to the BPHC-BH TA Resource Portal!

The Bureau of Primary Health Care (BPHC) Behavioral Health (BH) Technical Assistance (TA) portal is designed to meet the specific needs of HRSA health centers and shall focus on both mental health and substance use disorders (referred to jointly as “behavioral health”), with an emphasis on the opioid epidemic.

Learn About BH TA Options

- One-on-One Coaching
- E-learning Webinars
- Intensive TA for Practice Change
- Join a Community of Practice (CoP)
- Integration of Oral Health and Behavioral Health Virtual Learning Collaborative
- Virtual Brown Bag Lunches



Coming in February and March

Micro-Webinar (30 minutes)

WEBINAR

2/15/2023, 12:30–1:00 PM ET, *“Addressing Racial and Ethnic Disparities in Pediatric Mental Health in an Integrated Care Setting”*

REGISTER: <https://bphc-ta.jbsinternational.com/event-calendar/addressing-racial-and-ethnic-disparities-pediatric-mental-health-integrated-care>

LEARNING COLLABORATIVE (Oral Health and Behavioral Health Integration)

3/8/2023, 1:00 – 2:30 PM ET *“Tobacco, Vaping, and Cannabis: Implications for Patients” - Didactic Session*

REGISTER: <https://us06web.zoom.us/meeting/register/tZAuceyorTkrHta9eDN58p3T71uq8ADHnrGJ>

3/9/2023, 1:00 – 2:00 PM ET *“Tobacco, Vaping, and Cannabis: Implications for Patients” - Discussion Session*

REGISTER: <https://us06web.zoom.us/meeting/register/tZAldeqtrz8sGNZQxw9gAZetrVXrC2lElZQe>



Continuing Education & Satisfaction Assessment

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- You **must** complete the Health Center Satisfaction Assessment after **each** session for which you plan on receiving CEs.
 - Follow the link in the chat
 - Use the link in the follow-up message from Alchemer (Survey Monkey)
- **CE credits will be distributed within 2 weeks after the session**



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Session 3: Individual Factors Affecting Engagement, Resilience, and Well-Being

Thursday, February 16, 2023

Vision: Healthy Communities, Healthy People





Thank You!

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Vision: Healthy Communities, Healthy People



Endnotes

1. Health Leads Patient-Centered Care: Elements, Benefits And Examples - <https://healthleadsusa.org/resources/patient-centered-care-elements-benefits-and-examples/>
2. AIMS Center COLLABORATIVE CARE - <https://aims.uw.edu/collaborative-care?msclkid=dc639558a6d911eca67279913db6a1e6>
3. A Framework for Making Patient-Centered Care Front and Center - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3442762/>
4. Patient Centered Care Plan - <https://www.aafp.org/dam/brand/aafp/pubs/fpm/issues/2015/0100/p7-rt1.pdf>
5. Care Plans - An Overview of Key Elements of a Care Plan - <https://www.ctc-ri.org/sites/default/files/uploads/CTC%20NCM%20Care%20Plans%202020FEB18%20-%20FINAL.pdf>



References

- American Academy of Family Physicians. (n.d.). *Patient-centered care plan*. <https://www.aafp.org/dam/brand/aafp/pubs/fpm/issues/2015/0100/p7-rt1.pdf>
- Care Transformation Collaborative Rhode Island. (n.d.). *Care plans: An overview of key elements of a care plan*. <https://www.ctc-ri.org/sites/default/files/uploads/CTC%20NCM%20Care%20Plans%202020FEB18%20-%20FINAL.pdf>
- Greene, S. M., Tuzzio, L., & Cherkin, D. (2012). A framework for making patient-centered care front and center. *The Permanente Journal*, 16(3), 49–53. <https://doi.org/10.7812%2Ftpp%2F12-025>
- Health Leads. (2018, November 11). *Patient-centered care: Elements, benefits and examples*. <https://healthleadsusa.org/resources/patient-centered-care-elements-benefits-and-examples/>
- University of Washington AIMS Center. (n.d.). *Collaborative care*. <https://aims.uw.edu/collaborative-care?msclkid=dc639558a6d911eca67279913db6a1e6>

