Care Planning and Integrative Medicine

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Traditional Treatment

- Mental Illness is treated separately from physical Illness
- 15% of Patients with mental Illness are treated
- 85% poorly treated or untreated
- Result of fragmented care:
    - Persistent physical and mental illness
    - Disability
    - High health care service cost

Key Elements of Clinical Integration

- Collaboration is systematic
- Integration can be bi-directional
- Care is trans-disciplinary
- Care is holistic

Making the Case for Integration: Reviewing the Facts

- Demonstrated efficacy in improving health outcomes in multiple populations
  - Chronically Ill
  - Mentally Ill
  - Individuals with Co-morbid conditions
    - Study Involving 417 patients with co-occurring depression and diabetes across 18 primary care clinics
    - Those receiving care in an integrated, care management model showed increase in exercise, decrease in depression score, decrease in hemoglobin A1C[1]
- Increased patient satisfaction with services

The Spectrum of Integration

Coordinated Care	Co-Located Care	Integrated Care
• Stepped Care • Clinicians and services are located at different sites • Each individual clinician has separate treatment plans • Routine exchanges of info between separate treatment providers	• Stepped Care • Central Location: Service specialties located in the same facility • Enhanced formal and informal communication (face-to-face, phone) • Consultations between differing specialists	• Stepped Care • Central Location: Service specialties and physicians located within CNS • All services are guided by the same treatment guidelines, systems, and principles of CNS • Treatment Team: One treatment plan between all specialists for one patient • All treatment team clinicians to track patient progress

The Care Manager

Works with patients and their family/caregiver. Providing:

- Case management
- Care coordination
- Resource management

Not integrative

Results:

- Patients dissatisfaction
- medication errors
- Patient safety concerns
- Miscommunication
- Duplication of resources

Assessing Health Risks and Health Needs

	Historical	Current	Future Vulnerability
Biological Domain	1. Chronicity 2. Diagnostic dilemma	1. Symptom severity impairment 2. Diagnostic challenge	Complications and life threats
Psychological Domain	1. Barriers to coping 2. Mental health history 3. Cognitive development 4. Adverse developmental events	1. Resistance to treatment 2. Mental health symptoms	Learning/mental health threats
Social Domain	1. Employment and leisure 2. Relationships	1. Residential Stability 2. Support system 3. Community participation	Family/school/ social system vulnerability
Health System Domain	1. Access to care 2. Treatment experience	1. Getting needed services 2. Coordination of care	Health system impediments

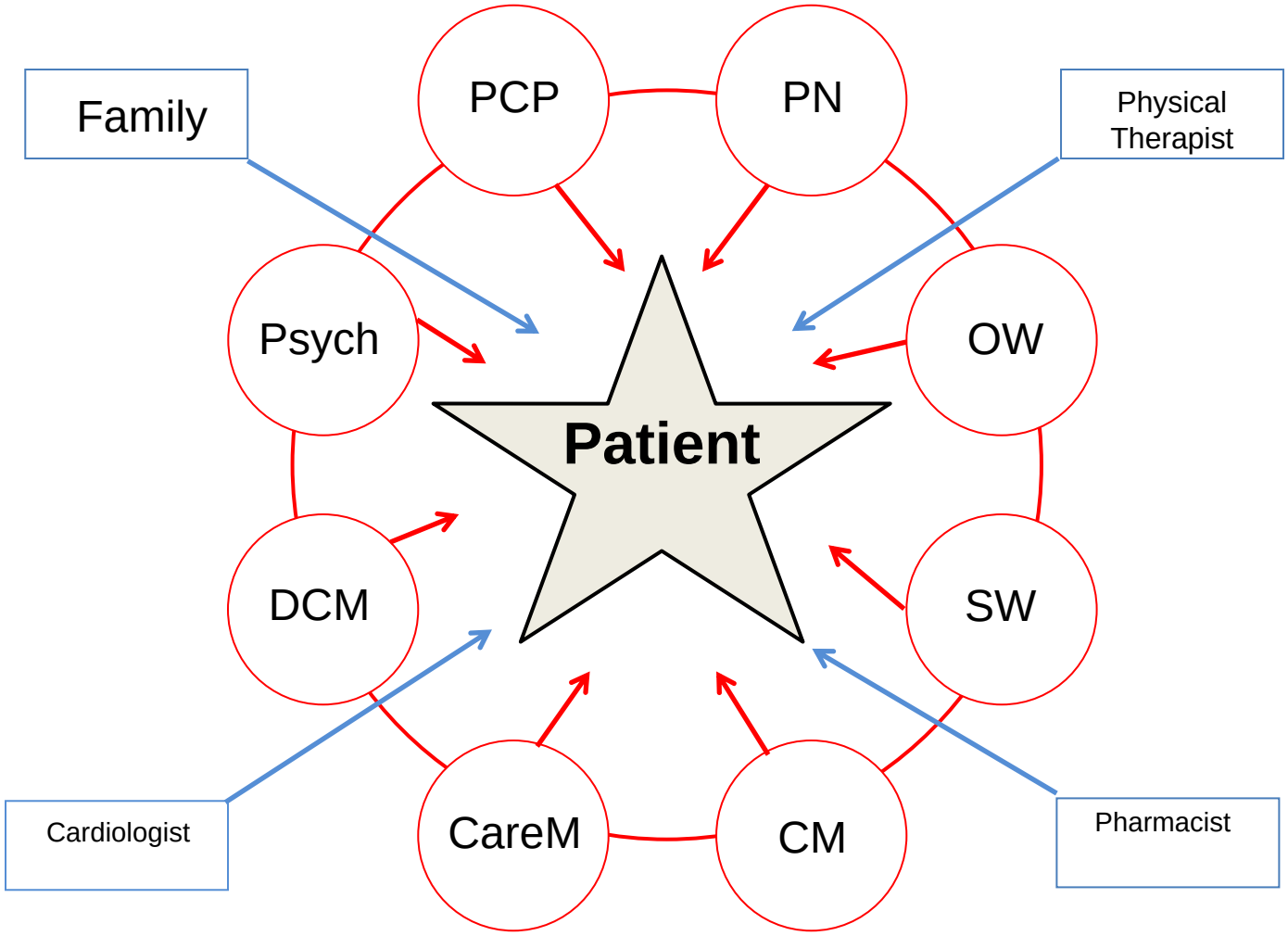
Care Plan

Definition

- Care plan – an individualized document developed **by the patient** and members of their team

    * members can be within your agency and outside of your agency

What does a patient centered care plan look like?


Family
PCP
PN
Physical Therapist
Psych
Patient
OW
DCM
SW
Cardiologist
CareM
CM
Pharmacist
Agency team members
Outside of Agency

What does a care plan function?

A lot like football!