

CARE PLUS NJ, INC.

Describing the process of assessing, planning, providing and monitoring comprehensive integrated services through a case illustration.

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VICE PRESIDENT CLINICAL SERVICE

Incorporated in 1978, CPNJ is a private non-profit community based organization which serves Northern New Jersey.

We specialize in providing recovery focused mental health and substance abuse outpatient services to adults and children.

We also provide embedded primary care, numerous child welfare services and Work First NJ service.

We are Joint Commission Accredited and are licensed by the NJ Department of Human Services, Division of Mental Health and Addiction Service and NJ Department of Health and Senior Services.

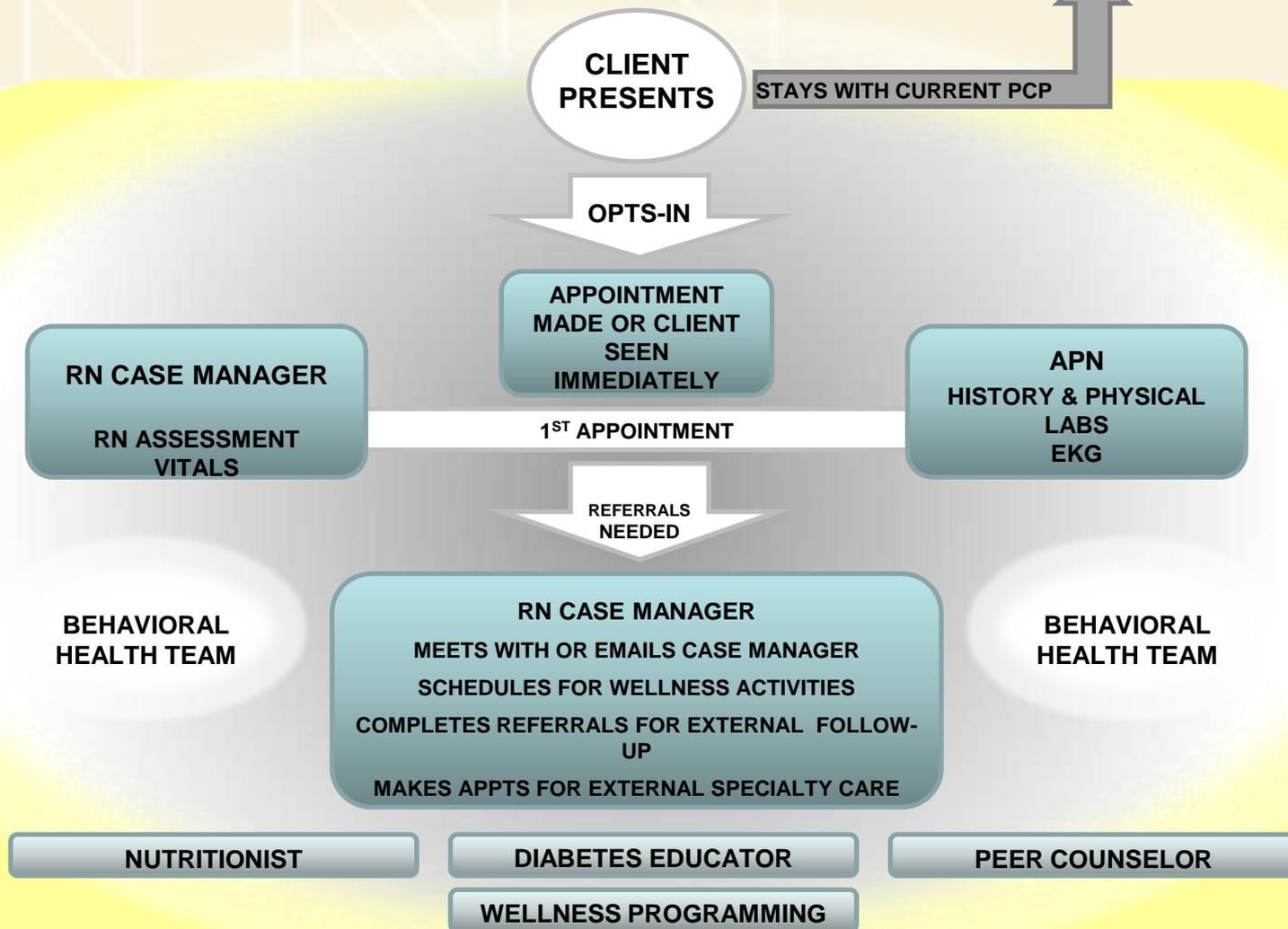
Our Model

- Bi-Directional and Embedded Care
 - Primary care within the mental health center
 - Mental health care within the primary care center.
- Integrated and Multidisciplinary Treatment Team
 - Wellness Services are a Central Component
- Focus On:
 - Nutrition
 - Exercise
 - Stress Reduction

Team Roles

- Nurse Care Manager/Liaison
- Advance Practice Nurse
- Collaborating Primary Care Physician
- Psychiatrist
- Case Manager
- Clinician
- Peer Counselor
- Certified Diabetes Educator
- Nutritionist
- Dentist
- Podiatrist





Treatment Planning

- Data is gathered from all providers involved-- this currently occurs through internal structured emails as frequently as daily.
 - Partial Care Staff report on program involvement, group attendance and consumer participation and pre-vocational progress.
 - Residential Services report on self care, AA meeting attendance, OA meeting attendance any treatment plan related responses.

Treatment Planning

- Primary Care reports on physical health response and health data outcomes
- Psychiatric prescribers report on any changes in mental status and current medications and response.
- Ultimate goal: One integrated treatment plan

Progress Monitoring (H indicators and other health conditions)

- Reviewed by Primary Care Team
- Shared with Behavioral Health Staff PRN
- These indicators are reviewed as they come in
- The information is accessed in multiple forms.
- Labs are reviewed with consumers upon receipt. Abnormal results are planned for with the client and staff upon receipt.

Communication

- Hallways
- Formal and informal meetings
- Phone Calls
- Internal Email
- EMR
- Pharmacy
- Family

Our Client

This is a 37 year old, single, Hispanic male who has never married. He has been hospitalized psychiatrically many times. His last hospitalization was at the county hospital and lasted one year.

He lives in a 24 your group home having become homeless after having been asked to leave the family home 4 years ago.

Reports his mother and sister had been verbally abusive and understands that his ETOH addiction also was a barrier to returning home.

He struggles with intermittent auditory hallucinations.

History of suicidal ideation.

Low Frustration Tolerance. When he became frustrated in the past he would report the urge to drink.

He historically likes to please people and recently gave his sister a large amount of money.

Borderline IQ. Attended special education classes and completed high school

Struggles with Bipolar Affective Disorder Mixed, Unspecified

He has a positive history of having worked as a custodian and returning to work is a future goal for him.

He is motivated to socialize with others.

Physical Health

Sleep Apnea

Asthma

Hypertension

Obesity

Unable to walk down the hall without becoming out of breath, perspiring and needing to sit down

Our Client

- Lab results are shared upon receipt. His response is often – “did I do good?” or “I feel sad”.
- Staff explain results in a way that he understands and reinforces change.
- Other team members work to encourage and motivate him. Initially we had his case manager in the exercise room to run a group as he became comfortable.
 - He now exercises 5 days per week for one hour.

Our Client

- AA meetings
 - Client initially was isolative in meetings. This being a focus of his plan, staff in all areas cajoled, encouraged and supported him to speak up in groups which he felt more comfortable in during the day.
 - Our Client is now a “greater” at AA meetings.
 - He is now avoiding meetings which serve bagels and other treats to support his weight loss.

Our Client

- Healthy Living
 - Sobriety, Exercise, Diet
 - RAND data collection showed us what clients were utilizing what type of groups. This information had not been captured in a sort able format previously.
 - We were now able to identify groups which we could encourage client to attend and reward his attendance.
 - He now feels confident enough to attend OA groups

Section H Data for Our Client

Initial Weight/BMI	308 / 51.2
Latest Weight/BMI	262 / 42.6
Initial Blood Pressure	150/88
Latest Blood Pressure	108/74
Initial Total Cholesterol	197
Latest Total Cholesterol	143
Initial Triglyceride	181
Latest Triglyceride	72

Initial LDL	128
Latest LDL	97
Initial HDL	33
Latest HDL	33
Initial HgBA1c	6.8
Latest HgBA1c	6.1

Goal #1 - Domain: LIVING*(Choose from Living, Learning, Working & Social)***Date Established: 7.10.12****Goal Statement:** [redacted] has had a life long struggle with obesity. Consumer is currently working with his treatment team to regain a normal weight, establish a healthy lifestyle and reduce his medical conditions. The area of focus under this domain will be nutrition, food preparation, weight management, and overall insight into his physical health.**Step 1:** *(must be measurable)* Mr. [redacted] will lose 2-3 lbs per week.**Set Date: 07.10.12****Target Date: 1.10.13****Completion Date:****Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Staff, Jamie Cook MA/MHW will provide consumer with daily support in meal preparation in accordance to his diet restrictions and monitor consumer's weight loss with daily Medifast journal review.**Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Staff, Jamie Cook MA/MHW will provide consumer with partial care groups, including Weight Management and Medical Integration exercise groups, to reduce overall weight.**Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Medical staff, including diabetic educator, dietician and Kathleen Boyle RN, will meet with consumer as needed for support in his weight loss goal.**Step 2:** *(must be measurable)* Mr. Velarde will follow his Medifast diet daily**Set Date: 07.10.12****Target Date: 1.10.13****Completion Date:****Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Staff, Jamie Cook MA/MHW will assist consumer with weekly food shopping and meal planning according to diet restrictions.**Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Medical staff, including diabetic educator, dietician and Kathleen Boyle RN, will meet with consumer as needed for education on the Medifast diet.**Service Provided:** *(incl responsible staff, duration, frequency and clinical focus)* Staff, Jamie Cook MA/MHW will provide

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Planning: Individualized Integrated Care Plan

A. Primary care services:

- Frequency

Seen by NP average of 2 times/month

Works out in the Gym daily for one hour

Meets with Nutritionist 2 x's per month

- Focus of service

Weight, Diet, Exercise, Healthy Lifestyle

Planning: Individualized Care Plan

B. Behavioral health service

- Frequency
Attends Partial Care 5 days per week
- Provider(s)
Sees a psychiatric prescriber monthly
- Focus of treatment
Mood, Diet, Exercise, Maintaining a Healthy Lifestyle.

Planning: Individualized Care Plan

C. Wellness Activities/services

- Frequency

In a given week, along with exercising in the gym he attends the following groups:

Stress Management

Illness Self Management

Recover Activities

- Provider(s)

MHW's, Nutritionist, or Other program staff

Optional

How has the individualized assessment, planning, service delivery and monitoring process influenced organizational policy decisions?