Thompson Region Integrated Case Management Learnings

Family Background:

BIOLOGICAL DAD
- Diagnosed with PTSD
- Biological son 3 years old
- Has sole custody

STEP MOM
- Diagnosed with PTSD
- Biological daughter 6 years old
- Pregnant

3 YEAR OLD CHILD
- Experienced trauma
- Behavioral issues

Family is currently living in a home they cannot afford to rent because dad had to switch jobs.

BIOLOGICAL MOM
- History of substance use
- Does not have custody of biological son

Identification:

PEDIATRICIAN
- Identifies a complex family
- Works with family as three year old is having behavioral issues
- Approaches LAT to support an integrated case management session with family to develop integrated care plan

The Team:

PEDIATRICIAN

ADULT PSYCHIATRIST
- Previously worked with parents

SOCIAL WORKER
Ministry of Child and Family Development

2 FAMILY PHYSICIANS
- Obstetrics
- GP

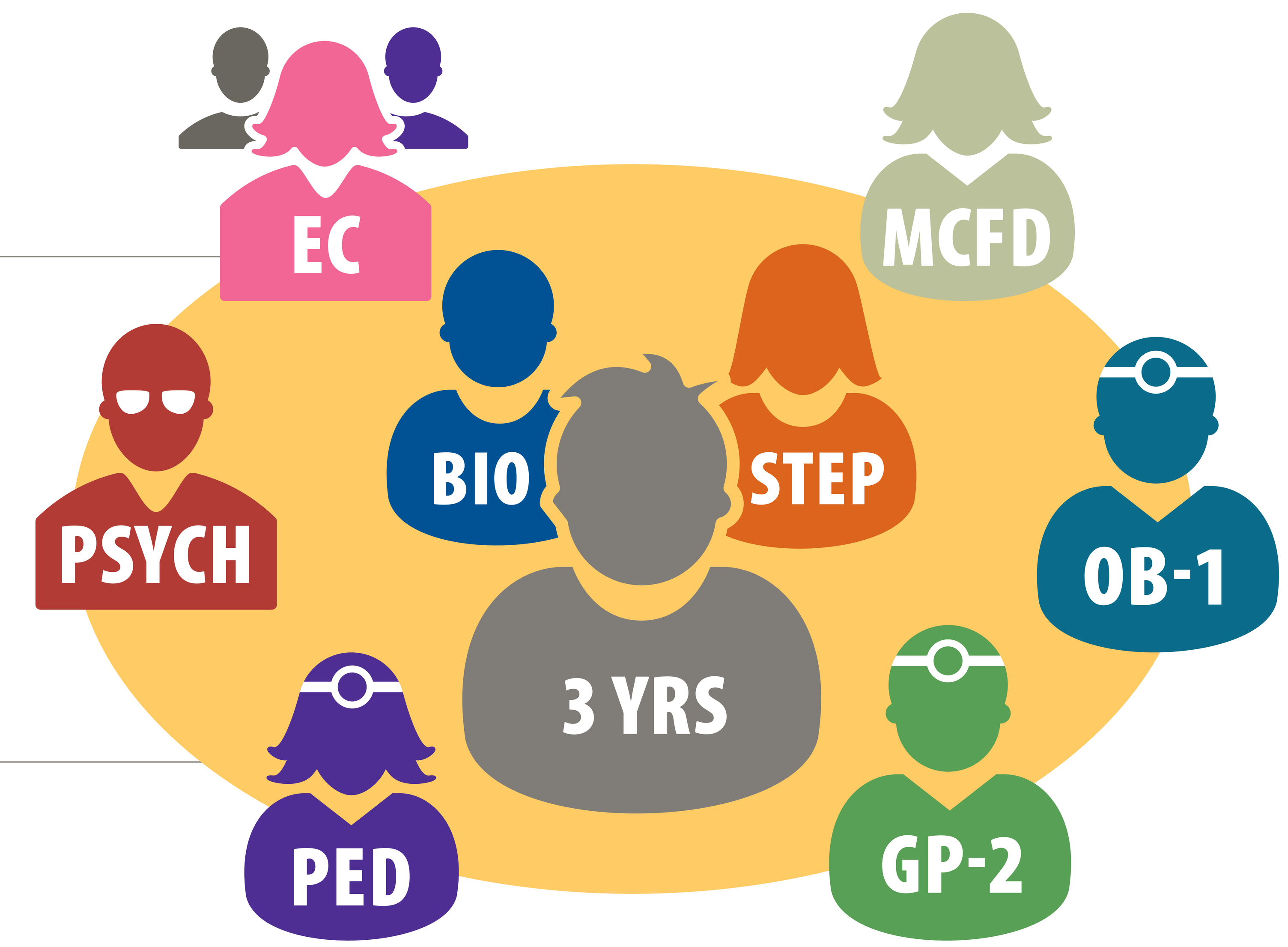
EARLY CONNECTIONS
Interior Community Services

BIO DAD, STEP MOM, 3 YR OLD

Case Management Definition:

A collaborative, client-driven process that supports the clients' achievement of safe, realistic and reasonable goals within a complex health, social and fiscal environments.
(Canadian Standards for Practice for Case Management, 2009)

GOAL:
To provide coordinated wrap around care for a complex family in need



Team Participated in an Integrated Case Management Session November 2015

TEAM MEMBERS	ACTION ITEMS	COMPLETION DEC 2015	COMPLETION JAN 2016
Pediatrician	• Referral for IHCAN Assessment • Connect with Adult Psychiatry • Letter to support child care subsidy • Stay connected with GP (obstetrics) • Continue to support 3 year old	✔ ✔ ✔ ✔ ✔	 ✔ ✔
Adult Psychiatrist	• Continue to provide help for parents		✔
Family Physician #1	• Continue providing obstetrics care, pre and post delivery	✔	✔
Family Physician #2	• Continue to support family	✔	✔
MCFD Social Worker	• Continue to support family • Register family for child care subsidy	✔ ✘	✔ ✔
Interior Community Services	• Regular connection: Weekly home visits with family	✔	✔

OVERALL ACTION ITEMS:
- Pediatrician organized team of professional to support family
- Immediate short term plan in place
- Long term plan discussed with family

CHALLENGES:
- Lack of clarity around roles for case management
- Challenging referral process to services
- Lack of respect for collaborating between professionals
- Historical tensions between organizations
- Action items not being followed through in a timely manner

STRENGTHS:
- Initially increased relationships and trust between providers
- Increased relationships and trust between family and providers
- Health care providers being able to put a face to a name

Family's Current Situation:
- Family moved and living in a home they can afford
- Decreased financial stress
- Increased energy, and commitment to working on adult relationships
- Biological mom is no longer abusing substances and has supervised visits with son
- All three parents taking Circle of Security training
- 3 year old no longer having nightmares

Next Steps:
- Schedule another session with team and family
- Clearly outline roles and responsibilities of the professional team members to each other and to family

Done Differently Next time:
- Clearly identifying the roles of each provider for the family, including the responsibilities of a case manager. The case manager could then follow up with the professionals ensuring action items were completed before the next meeting with the team.

Learnings:
- Any person in the care of a complex family can take steps to pull an integrated case management session together
- The benefits of working together have the possibility to outweigh the cons
- To clearly define roles of each provider, including the responsibilities of a case manager. Case manager is critical for both the youth/family as well as the professionals

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Thompson Region: How to Start an Integrated Case Management Session

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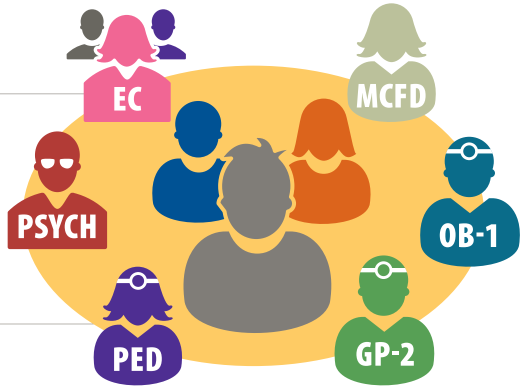

An Integrated Case Management Process:

1. Identify a complex family
2. Assess family's readiness
3. Identify a case manager
4. Case manager approaches appropriate team members
5. Case manager organizes session with family and team
6. Family and team members come together
7. Co-develop wrap around care plan and assign action items
8. Case manager follows up to ensure action items are complete

Thompson Region Division of Family Practice A GPSC initiative

SharedCare Partners for Patients

British Columbia

doctors of bc

BILLING CODES

SGP
Society of General Practitioners of BC

Kamloops - Service Elements and Billing Codes for Mental Health Team

PROVIDER	PATIENT SERVICES					PROVIDER SERVICES																
	Planning Visit	Follow-up				Specialist giving advice to GP				GP requesting advice from Specialist				GP providing advice to allied Provider				GP providing advice to GP or Specialist	Case Conference		
	In-per	In-per	Vid	Tel	Email	In-per	Vid	Tel	Email	In-per	Vid	Tel	Email	In-per	Vid	Tel	Email Fax		In-per	Vid	Tel
Specialist			10003	10003	10006	10002	10002	10002	10005											10004	10004
GP-MRP	14043 Mental Health Planning			14076	14079							14077 14016 14018				13005 if requested	13005 if requested		14077	14077	14077
GP-OB If in maternity network				14076															14077	14077	14077
GP providing consultative expertise to NP about NP'S own patient																14019					
GP with specialty training & working in focussed HA program for (e.g. addictions)				14023												14022		14021 14022			

** In order to access billing fee code hyperlinks, please log into the Society of General Practitioners of BC website at* ***www.sgp.bc.ca*** *June 2016*

For case conference with pediatrician, allied providers and GP- MRP and GP- OB 14077 billable for both the GP OB and the GP FP

- The GP OB could bill up to two sessions on the mom, and the other GP could bill up to 2 sessions on the child.
- If the GP is FP for both mom & dad it would not be appropriate to bill for both for concurrent times, but if meeting > than ½ hr, then the GP could bill the rest of the time as 14077 under the dad.
- If the GP MRP and GP OB case conference with each other about the same patient, each can bill 1 unit of 14077.

Follow up phone calls are 14076 (talking to patient) or 14077 (talking to allied provider or specialist) or 13005 (talking to allied provider when requested), ensuring that the conversations meet the planning elements, time elements and other fee requirements for case conference (14077) or meet the fee requirement for brief advice when requested (13005).

If the patient has had a 14043 mental health planning visit billed by FP, then they can use 14079 to communicate with the patient. Depending on situation, 13005 could be used for some communications, if these patients are considered to be in "community care," and advice from an MSP defined allied provider caring for the patient was requested.

All of the information above should be interpreted in the context of reading the FULL fee details in the SGP Simplified Guide to Fees at www.sgp.bc.ca or other billing reference.