CHW/FP Behavioral Health Plan Training Guide

Disseminated 07/12/2021

TEAM UP FOR CHILDREN

Transforming and
Expanding
Access to
Mental Health Care in

Urban
Pediatrics

BOSTON MEDICAL CENTER

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FOR CHILDREN

INTRODUCTION

Purpose and Overview

What is the CHW/FP Behavioral Health Plan?

- The CHW/FP Behavioral Health Plan (aka CHW/FP BH Plan) is a documentation template developed as part of the TEAM UP pediatric behavioral health integration model and incorporated within your health center's EMR.

What is the purpose of the CHW/FP BH Plan?

- The CHW/FP BH Plan documents in a standardized way the goals identified, interventions delivered, and plan of care for all services delivered by CHW/FPs in the integrated environment. Data from the CHW/FP BH Plan will be included in TEAM UP data sets and incorporated into evaluation and quality improvement metrics to better understand care delivered by CHW/FPs and patterns in BH service delivery.

Completion Guidelines

Who completes the CHW/FP BH Plan?

- All CHW/FPs seeing patients within the Pediatrics (and sometimes Family Medicine) Department should complete the CHW/FP BH Plan as part of their standard documentation.

When is the CHW/FP BH Plan completed?

- The CHW/FP BH Plan is completed for all encounters (in person, phone, or virtual) between a CHW/FP and a patient, family member, school, or other service provider, regardless of the need identified or addressed, or the reason for the encounter. Do not fill the plan out when you do not have direct contact with an individual (i.e. leaving a voicemail or sending a text).

Core Elements

The CHW/FP BH Plan documents the following core elements:

1. The reason for the encounter
2. The type of contact, i.e., in-person, virtual or phone, other
3. The goals identified by the patient/family during the encounter
4. The actual interventions utilized or delivered during the encounter
5. The total time spent on the encounter
6. The treatment plan following completion of the encounter, i.e., next steps identified to support patient/family

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DOCUMENTING ELEMENTS OF THE ENCOUNTER

Documenting Elements of the Encounter

These questions document specific components of the encounter.

Follow the prompt to complete each questions by checking either all that apply or checking one. All questions should be answered.

Reason for Contact/Referral

Reason for CHW/FP contact/referral (check ALL that apply):

- ❑ Assistance completing a screening tool (SWYC, PSC, etc.)
- ❑ Universal touch/healthy parenting support
- ❑ Request from patient/family
- ❑ Request from PCP
- ❑ Request from BHC
- ❑ Request for support from other (specify in free text)
- ❑ Follow up on existing issue/referral
- ❑ Free text to provide more detail if necessary (specify)

Type of Contact

Type of contact (check ALL that apply):

- ❑ In-person visit in clinic
- ❑ In-person visit in home
- ❑ In person visit other (specify in free text)
- ❑ Telephone call with patient or family
- ❑ Virtual visit with patient or family
- ❑ Virtual visit with other (specify in free text)
- ❑ Telephone call with EI provider
- ❑ Telephone call with school
- ❑ Telephone call with off-site provider or specialist
- ❑ Telephone call with other (specify in free text)
- ❑ Text
- ❑ Email or patient portal
- ❑ Mailed letter
- ❑ Fax

Goals Identified by Family

Goals identified by family (check ALL that apply):

- ❑ Material needs support
- ❑ Care coordination/navigation to:
  - EI
  - IEP or school-based services
  - CBHI
  - Outpatient counseling
  - Autism or developmental delay evaluation
  - Other (specify in free text)
- ❑ Support to complete ADHD evaluation
- ❑ Support to access parent group or support
- ❑ None
- ❑ Free text to provide more detail if necessary (specify)

Interventions Utilized

Interventions utilized in this visit (check ALL that apply):

- ❑ Material needs support for:
  - Housing resources
  - Food resources
  - Other community-based resources
  - Other (specify in free text)
- ❑ Care coordination/navigation to:
  - EI
  - IEP or school-based services
  - CBHI
  - Outpatient counseling
  - Autism or developmental delay evaluation
  - Other (specify in free text)
- ❑ Support to complete screening tool
- ❑ Support to complete ADHD evaluation
- ❑ Parenting support
- ❑ Financial counseling
- ❑ Support for insurance enrollment/re-enrollment
- ❑ Outreach to engage patient/family in care
- ❑ Introduce BRANCH
- ❑ Free text to provide more detail if necessary (specify)

Length of Contact

Length of contact (check ONE):

- ❑ 5 minutes or less
- ❑ 6-15 minutes
- ❑ 16-30 minutes
- ❑ 31-45 minutes
- ❑ 46-60 minutes
- ❑ 61-90 minutes
- ❑ Over 90 minutes (specify total time in minutes in free text)

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DOCUMENTING TREATMENT PLAN FOLLOWING ENCOUNTER

Documenting Treatment Plan Following Encounter

This section focuses on the treatment plan following this encounter.

The first question asks what the treatment plan is following your encounter; depending on that answer, you may go on to answer a few additional questions.

Treatment Plan

Treatment plan following this visit (check ALL that apply):

- ❑ New/additional services needed
- ❑ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

Treatment Plan

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Treatment plan following this visit (check ALL that apply):

✖ New/additional services needed

❑ Continue with current services (defined

❑ Further services offered but declined

❑ Issue resolved; routine follow up

Type(s) of new/additional service(s) (check ALL that apply):

❑ Continue with CHW/FP support

❑ PCP follow-up

❑ Integrated BHC follow-up

❑ Other care team member follow-up
(specify which care team member in free text field)

❑ On-site specialty services

❑ Off-site services

What was the identified need or concern which led to referral for new/additional services?

❑ Free text (specify need or concern in free text field)

When new or additional services are needed, answer the following two questions to describe those services.

Treatment Plan

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Treatment plan following this visit (check ALL that apply):

- ❑ New/additional services needed
- ✖ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

When continuing with current services, answer the following question to describe the services the patient already receives.

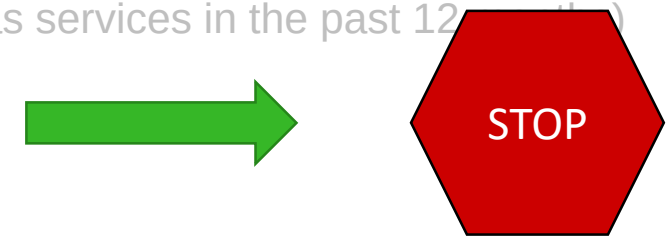
The patient already receives (check ALL that apply):

- ❑ PCP management
- ❑ Integrated BH services
- ❑ On-site (non-integrated) BH services
- ❑ Other on-site services (care management, etc.)
- ❑ Off-site BH services
- ❑ EI, IEP, 504 Plan (established)
- ❑ CBHI/IHT

Treatment Plan

Treatment plan following this visit (check ALL that apply):

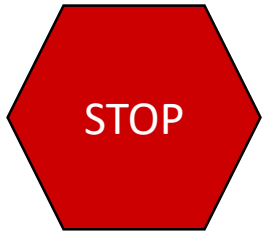
- ❑ New/additional services needed
- ❑ Continue with current services (defined as services in the past 12 months)
- ☒ Further services offered but declined
- ❑ Issue resolved; routine follow up



Treatment Plan

Treatment plan following this visit (check ALL that apply):

- ❑ New/additional services needed
- ❑ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ✖ Issue resolved; routine follow up



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SCENARIOS

Scenario #1

A child's mother mentions to their BHC that they are experiencing food instability, so the BHC refers them to the CHW/FP. The CHW/FP meets with the family by Zoom to learn more about their needs and goals. They spend about 45 minutes and the CHW/FP shares information about accessing food through the local food pantry. As a next step, they set up another meeting to complete a SNAP application together.

Reason for CHW/FP contact/referral (check ALL that apply):

- ❑ Assistance completing a screening tool (SWYC, PSC, etc.)
- ❑ Universal touch/healthy parenting support
- ❑ Request from patient/family
- ❑ Request from PCP
- ✖ Request from BHC

Type of contact (check ALL that apply):

- ❑ In-person visit in clinic
- ❑ In-person visit in home
- ❑ In person visit other (specify in free text)
- ❑ Telephone call with patient or family
- ✖ Virtual visit with patient or family

**Options shown here are just an excerpt from the full list of options*

Scenario #1

A child's mother mentions to their BHC that they are experiencing food instability, so the BHC refers them to the CHW/FP. The CHW/FP meets with the family by Zoom to learn more about their needs and goals. They spend about 45 minutes and the CHW/FP shares information about accessing food through the local food pantry. As a next step, they set up another meeting to complete a SNAP application together.

Goals identified by family (check ALL that apply):

- [x] Material needs support
- [ ] Care coordination/navigation to:
  - EI
  - IEP or school-based services
  - CBHI
  - Outpatient counseling
  - Autism or developmental delay evaluation
  - Other (specify in free text)
- [ ] Support to complete ADHD evaluation

Interventions utilized in this visit (check ALL that apply):

- [ ] Material needs support for:
  - [ ] Housing resources
  - [ ] Food resources
  - [x] Other community-based resources
  - [ ] Other (specify in free text)

**Options shown here are just an excerpt from the full list of options*

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Length of contact (<u>check ONE</u>):

- ❑ 5 minutes or less
- ❑ 6-15 minutes
- ❑ 16-30 minutes
- ✖ 31-45 minutes
- ❑ 46-60 minutes

Scenario #1

A child's mother mentions to their BHC that they are experiencing food instability, so the BHC refers them to the CHW/FP. The CHW/FP meets with the family by Zoom to learn more about their needs and goals. They spend about 45 minutes and the CHW/FP shares information about accessing food through the local food pantry. As a next step, they set up another meeting to complete a SNAP application together.

Type(s) of new/additional service(s) (check ALL that apply):

- ✖ Continue with CHW/FP support
- ❑ PCP follow-up
- ❑ Integrated BHC follow-up
- ❑ Other care team member follow-up (specify which care team member in free text field)
- ❑ On-site specialty services
- ❑ Off-site services

Treatment plan following this visit (check ALL that apply):

- ✖ New/additional services needed
- ❑ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

What was the identified need or concern which led to referral for new/additional services?

- ✖ Free text (specify need or concern in free text field ***Food insecurity***

Scenario #2

The CHW/FP calls 2 yo patient's parent the day ahead of the scheduled WCC to complete the SWYC. They complete the screener together in about 13 minutes and the CHW/FP notes that the parent indicated experiencing food insecurity and plans to follow up on this issue.

Reason for CHW/FP contact/referral (check ALL that apply):

- [x] Assistance completing a screening tool (SWYC, PSC, etc.)
- [ ] Universal touch/healthy parenting support
- [ ] Request from patient/family
- [ ] Request from PCP
- [ ] Request from BHC

Type of contact (check ALL that apply):

- [ ] In-person visit in clinic
- [ ] In-person visit in home
- [ ] In person visit other (specify in free text)
- [x] Telephone call with patient or family
- [ ] Virtual visit with patient or family

**Options shown here are just an excerpt from the full list of options*

Scenario #2

The CHW/FP calls 2 yo patient's parent the day ahead of the scheduled WCC to complete the SWYC. They complete the screener together in about 13 minutes and the CHW/FP notes that the parent indicated experiencing food insecurity and plans to follow up on this issue.

Goals identified by family (check ALL that apply):

- ❑ Support to complete ADHD evaluation
- ❑ Support to access parent group or support
- ✖ None
- ❑ Free text to provide more detail if necessary (specify)

Interventions utilized in this visit (check ALL that apply):

- ❑ Support to complete screening tool
- ✖ Support to complete ADHD evaluation
- ❑ Parenting support
- ❑ Financial counseling
- ❑ Support for insurance enrollment/re-enrollment
- ❑ Outreach to engage patient/family in care

**Options shown here are just an excerpt from the full list of options*

Scenario #2

The CHW/FP calls 2 yo patient's parent the day ahead of the scheduled WCC to complete the SWYC. They complete the screener together in about 13 minutes and the CHW/FP notes that the parent indicated experiencing food insecurity and plans to follow up on this issue.

Length of contact (check ONE):
- ❑ 5 minutes or less
- ✖ 6-15 minutes
- ❑ 16-30 minutes
- ❑ 31-45 minutes
- ❑ 46-60 minutes

Treatment plan following this visit (check ALL that apply):
- ✖ New/additional services needed
- ❑ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

Scenario #2

The CHW/FP calls 2 yo patient's parent the day ahead of the scheduled WCC to complete the SWYC. They complete the screener together in about 13 minutes and the CHW/FP notes that the parent indicated experiencing food insecurity and plans to follow up on this issue.

Type(s) of new/additional service(s) (<u>check ALL that apply</u>):

- ✖ Continue with CHW/FP support
- ❑ PCP follow-up
- ❑ Integrated BHC follow-up
- ❑ Other care team member follow-up

(specify which care team member in free text field)

- ❑ On-site specialty services
- ❑ Off-site services

What was the identified need or concern which led to referral for new/additional services?

- ✖ Free text (specify need or concern in free text field ***Food insecurity***

Scenario #3

A CHW/FP calls to follow up with a family a week after a referral was made to early intervention services to see if they have been able to connect with the EI intake coordinator to schedule the initial appointment. The parent indicates that they have scheduled the initial appointment but mentions feeling a lot of stress about the child's behavior. The CHW/FP spends roughly 25 minutes providing psychoeducation about coping strategies and parenting supports, explains the EI process, and introduces BRANCH as another potential support for the family. The parent agrees to connect with the BHC to learn more about BRANCH.

Reason for CHW/FP contact/referral (check ALL that apply):

- ❑ Request from PCP
- ❑ Request from BHC
- ❑ Request for support from other (specify in free text)
- ✖ Follow up on existing issue/referral

Type of contact (check ALL that apply):

- ❑ In-person visit in clinic
- ❑ In-person visit in home
- ❑ In person visit other (specify in free text)
- ✖ Telephone call with patient or family
- ❑ Virtual visit with patient or family

**Options shown here are just an excerpt from the full list of options*

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Goals identified by family (check ALL that

- ❑ Care coordination/navigation to:
  - ✖ EI
  - ❑ IEP or school-based services
  - ❑ CBHI
  - ❑ Outpatient counseling
  - ❑ Autism or developmental delay e
  - ❑ Other (specify in free text)
- ❑ Support to complete ADHD evaluation
- ✖ Support to access parent group or supp

Interventions utilized in this visit (check ALL that apply):

- ❑ Material needs support
- ❑ Care coordination/navigation to:
  - ✖ EI
  - ❑ IEP or school-based services
  - ❑ CBHI
  - ❑ Outpatient counseling
  - ❑ Autism or developmental delay evaluation
  - ❑ Other (specify in free text)
- ✖ Parenting support
- ❑ Financial counseling
- ❑ Support for insurance enrollment/re-enrollment
- ❑ Outreach to engage patient/family in care
- ✖ Introduce BRANCH

**Options shown here are just an excerpt from the full list of options*

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A CHW/FP calls to follow up with a family a week after a referral was made to early intervention services to see if they have been able to connect with the EI intake coordinator to schedule the initial appointment. The parent indicates that they have scheduled the initial appointment but mentions feeling a lot of stress about the child's behavior. The CHW/FP spends roughly 25 minutes providing psychoeducation about coping strategies and parenting supports, explains the EI process, and introduces BRANCH as another potential support for the family. The parent agrees to connect with the BHC to learn more about BRANCH.

Length of contact (<u>check ONE</u>):

- ❑ 5 minutes or less
- ❑ 6-15 minutes
- ✖ 16-30 minutes
- ❑ 31-45 minutes
- ❑ 46-60 minutes

Scenario #3

A CHW/FP calls to follow up with a family a week after a referral was made to early intervention services to see if they have been able to connect with the EI intake coordinator to schedule the initial appointment. The parent indicates that they have scheduled the initial appointment but mentions feeling a lot of stress about the child's behavior. The CHW/FP spends roughly 25 minutes providing psychoeducation about coping strategies and parenting supports, explains the EI process, and introduces BRANCH as another potential support for the family. The parent agrees to connect with the BHC to learn more about BRANCH.

Treatment plan following this visit (check ALL apply):

- ☒ New/additional services needed
- ☒ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

Type(s) of new/additional service(s) (check ALL that apply):

- ❑ Continue with CHW/FP support
- ❑ PCP follow-up
- ☒ Integrated BHC follow-up
- ❑ Other care team member follow-up (specify which care team member in free text field)
- ❑ On-site specialty services
- ❑ O

What was the identified need or concern which led to referral for new/additional services?

- ☒ Free text (specify need or concern in free text field **Parental stress and concern over child's behavior**

Scenario #3

A CHW/FP calls to follow up with a family a week after a referral was made to early intervention services to see if they have been able to connect with the EI intake coordinator to schedule the initial appointment. The parent indicates that they have scheduled the initial appointment but mentions feeling a lot of stress about the child's behavior. The CHW/FP spends roughly 25 minutes providing psychoeducation about coping strategies and parenting supports, explains the EI process, and introduces BRANCH as another potential support for the family. The parent agrees to connect with the BHC to learn more about BRANCH.

Treatment plan following this visit (check ALL that apply):

- ✖ New/additional services needed
- ✖ Continue with current services (defined as services in the past 12 months)
- ❑ Further services offered but declined
- ❑ Issue resolved; routine follow up

The patient already receive (check ALL that apply):

- ❑ PCP management
- ❑ Integrated BH services
- ❑ On-site (non-integrated) BH services
- ❑ Other on-site services (care management, etc.)
- ❑ Off-site BH services
- ✖ EI, IEP, 504 Plan (established)
- ❑ CBHI/IHT

Scenario #4

The CHW/FP meets with the parent during the 2-month WCC for a newborn touch. The CHW/FP introduces the integrated team, shares some resources on newborn development, and asks the parent how they are coping with a new baby at home. The parent shares that they are tired but in good spirits with lots of support from live-in grandparents and say they do not need any extra support at the moment. They spend about 5 minutes talking and then say goodbye.

Reason for CHW/FP contact/referral (check ALL that apply):

- ❑ Assistance completing a screening tool (SWYC, PSC, etc.)
- ✖ Universal touch/healthy parenting support
- ❑ Request from BHC
- ❑ Request from patient/family
- ❑ Request from PCP

Type of contact (check ALL that apply):

- ✖ In-person visit in clinic
- ❑ In-person visit in home
- ❑ In person visit other (specify in free text)
- ❑ Telephone call with patient or family
- ❑ Virtual visit with patient or family

**Options shown here are just an excerpt from the full list of options*

Scenario #4

TEAM UP FOR CHILDREN

The CHW/FP meets with the parent during the 2-month WCC for a newborn touch. The CHW/FP introduces the integrated team, shares some resources on newborn development, and asks the parent how they are coping with a new baby at home. The parent shares that they are tired but in good spirits with lots of support from live-in grandparents and say they do not need any extra support at the moment. They spend about 5 minutes talking and then say goodbye.

Goals identified by family (check ALL that

- ❑ Care coordination/navigation to:
  - ❑ EI
  - ❑ IEP or school-based services
  - ❑ CBHI
  - ❑ Outpatient counseling
  - ❑ Autism or developmental delay
  - ❑ Other (specify in free text)
- ❑ Support to complete ADHD evaluation
- ❑ Support to access parent group or sup
- ✖ None

Interventions utilized in this visit (check ALL that apply):

- ❑ Material needs support
- ❑ Care coordination/navigation to:
  - ❑ EI
  - ❑ IEP or school-based services
  - ❑ CBHI
  - ❑ Outpatient counseling
  - ❑ Autism or developmental delay evaluation
  - ❑ Other (specify in free text)
- ✖ Parenting support
- ❑ Financial counseling
- ❑ Support for insurance enrollment/re-enrollment
- ❑ Outreach to engage patient/family in care
- ❑ Introduce BRANCH

**Options shown here are just an excerpt from the full list of options*

Scenario #4

The FP meets with the parent during the 2-month WCC for a newborn touch. The FP introduces the integrated team, shares some resources on newborn development, and asks the parent how they are coping with a new baby at home. The parent shares that they are tired but in good spirits with lots of support from live-in grandparents and say they do not need any extra support at the moment. They spend about 5 minutes talking and then say goodbye.

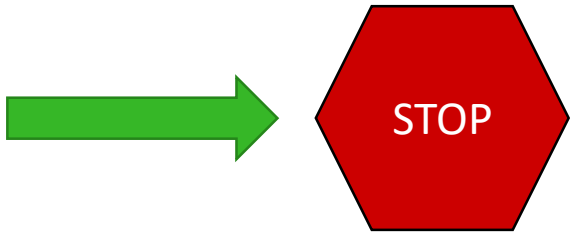
Length of contact (check ONE):

- [x] 5 minutes or less
- [ ] 6-15 minutes
- [ ] 16-30 minutes
- [ ] 31-45 minutes
- [ ] 46-60 minutes

**Options shown here are just an excerpt from the full list of options*

Treatment plan following this visit (check ALL that apply):

- [ ] New/additional services needed
- [ ] Continue with current services (defined as services in the past 12 months)
- [x] Further services offered but declined
- [ ] Issue resolved; routine follow up



Questions

The CHW/FP BH Plan was developed in partnership by TEAM UP Implementation and Evaluation teams at BMC and participating community health centers.

For questions regarding the CHW/FP BH Plan, please contact:

[INSERT NAME OF CHC CONTACT]

Charlotte Vieira

TEAM UP Implementation Manager

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Funding Acknowledgment

TEAM UP FOR CHILDREN

All activities within the TEAM UP for Children initiative are made possible through the contributions of the TEAM UP partners. Funding for the TEAM UP for Children initiative is provided by the Richard and Susan Smith Family Foundation and The Klarman Family Foundation.

Codman Square Health Center

THE DIMOCK CENTER

LOWELL COMMUNITY HEALTH CENTER

Brockton Neighborhood Health Center

DotHouse Health
We keep you well

Greater New Bedford Community Health Center

SOUTH BOSTON COMMUNITY HEALTH CENTER

RICHARD AND SUSAN Smith Family Foundation

BOSTON MEDICAL CENTER

BOSTON UNIVERSITY

THE KLARMAN FAMILY FOUNDATION


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