Implementation Guide: Integrated Team Documentation

TEAM UP Protocol

Routine documentation of visits for each integrated care team member (primary care providers [PCPs], behavioral health clinicians [BHCs], community health workers/family partners [CHW/FPs]) is a core component of the TEAM UP Model™. The TEAM UP Center Integrated Team Documentation requirements have the explicit goal of standardizing documentation among each care team member, reducing documentation burden, contributing to data reporting requirements, and improving the overall quality of care delivered to patients.

The TEAM UP Center's Integrated Team Documentation is ensured through the utilization of documentation templates, called Behavioral Health (BH) Plans, that have been uniquely designed for each care team member. Each role-specific BH Plan is embedded within a practice's electronic medical record (EMR). Each BH Plan is organized around three core elements that should be documented for any visit within pediatric practice: Assessment/Identification, Action(s) Taken, and Plan of Care. Regardless of care team role or reason for visit, the BH Plan should be completed at every visit encounter within a given practice. Importantly, the BH Plans are not meant to replace all documentation requirements outlined by your practice's documentation standards/requirements, but rather simplify and standardize documentation pertaining to behavioral health. Further, practices are encouraged to maintain current documentation requirements.

The following Implementation Guide was developed to provide a brief context for BH Plan utilization as well as information to assist a practice in implementing BH Plan, integrated team-related documentation protocol.

Background and Rationale

The TEAM UP Center's integrated team documentation protocol was developed with collaborating pediatric practices over an eight-year period with deliberate attention to feasibility. Beyond the standardization of documentation practice, the BH Plans are meant to accomplish the following goals:

- Provide a mechanism to easily obtain data on BH identification, treatment discussion, and care planning
- Advance clinical care and decision support
- Enable the use of corrective feedback loops and quality improvement initiatives
- Promote team collaboration and interprofessional communication
- Improve care management
- Reduce documentation burden
- ~~Such protocol was informed by an existing evidence-base centering the importance of standardized documentation within EMRs and an identified need to easily obtain data on~~

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~~behavioral health identification and treatment discussion/discussions within primary care settings.~~

~~EMR templates provide a standardized and systematic way of documenting and tracking patient care, while simultaneously offering insight into provider assessment and decision making that allows for corrective feedback loops and quality control (Weed, 1997). As outlined by the American Medical Informatics Association, clinical data capture and documentation enhance a care team's overall effectiveness and productivity through enabling team collaboration, ensuring care process management, and advancing clinical decision support (Cusack et al., 2013). Structured and consistent documentation maintains high quality patient care through supporting team communication and coordination.~~

~~EMR templates and/or standardized data elements have been explored within the behavioral health integration (BHI) settings to capture behavioral health information related to screenings, referrals, treatment, and follow-up information (Cifuentes et al., 2015 Segel et al., 2022; Godoy et al, 2017; Zerden et al., 2021). However, documentation practices vary based on the professional background of the care provider (i.e., PCPs vs. BHCs vs. CHW/FPs), which can disrupt care coordination/communication (Segal et al., 2022; Zerden et al., 2021). EMRs equipped with structured data elements standardizes documentation practices for each care provider role and improved care coordination (Segal et al., 2022; Zerden et al., 2021). EMR templates and structured data elements also improve chart review processes and data pulling procedures that are essential to quality and care improvements initiatives (Hatchimonji et al., 2022; Segal et al., 2022; Zerden et al., 2021). Collectively, EMR templates (i.e., BH Plans) in the TEAM UP Model ensures a team-based, collaborative care approach that improves the lives of children and families.~~

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Development and continued use of the BH Plans were informed by an existing evidence base outlining the importance of standardized documentation templates in integrated behavioral health settings (Cifuentes et al., 2015 Segel et al., 2022; Godoy et al, 2017; Zerden et al., 2021). For more information on the rationale and research behind TEAM UP's Integrated Team Documentation protocol, please see our ___.

EMR Considerations

At the onset of your involvement with the TEAM UP Center, it is critical that your practice identify an IT analyst that can work closely with the clinical care team members, TEAM UP Center Evaluation Team, and Relevant to incorporate each of the BH Plans into your practice's EMR. Your practice will be provided with copies of each of the BH Plans to ensure accurate visualization and understanding of the BH Plan functionality. Importantly, there is minor branching at the end of each BH Plan that is necessary accurate BH Plan completion, which has been difficult for practices to incorporate in their BH Plan builds in the past. Below you will find linked versions of the most current version of the BH Plans:

- PCP BH Plan

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- BHC BH Plan
- CHW BH Plan

In our work with previous practices, there are few considerations that are key to successful implementation of the BH Plans within your practice's EMR, which are outlined below.

1. **Create each BH Plan so that it can be pulled for data collection at the item-level (e.g., each question and response on the BH plan should correlate to its own variable in data collection).**
   Previous practices have had success with correctly pulling the BH Plan data by creating a series of Smart Lists for each question and response. Variables should be created as outlined in the Evaluation Data Dictionary. For example, Question 1 on the PCP BH Plan ("Was a behavioral health or developmental (BH/D) topic discussed or addressed at this visit?"), requires the creation of three separate variables:
   - PCPBHPlanQ1A – indicates that the response "No" was selected (value of 1) or not selected (value of 999) when Q1 on the PCP BH Plan is completed for a given encounter
   - PCPBHPlanQ1B – indicates whether the response "Yes – typical social/emotional development and anticipatory guidance provided" was selected (value of 1) or not selected (value of 999) when Q1 on the PCP BH Plan is completed for a given encounter
   - PCPBHPlanQ1C – indicates whether the response "Yes – Issues addressed/discussed" was selected (value of 1) or not selected (value of 999) when Q1 on the PCP BH Plan is completed for a given encounter

   Smart Lists have been identified as way to both easily embed the BH Plans within the EMR but also in the subsequent pull of each of these unique variables. However, in order to appropriately pull this information from the Smart Lists created, there will need to be Smart Data Elements that are associated with each Smart List.

2. **The Location of the BH Plans should make sense within the EMR's note template structure and align with documentation workflows.**
   Previous practices have faced challenges when the BH Plan is placed in a location that is counterintuitive to documentation standards for each provider type (i.e. PCPs vs. BHCs vs. CHW/FPs). The BH Plans should be incorporated into each care provider's note template. However, within the note template there are a variety of locations to place the BH Plans. In a previous practice, PCPs had difficulty completing their BH Plan because it was placed within the "Screening Instrument" section of the note template. We encourage the IT Analyst to speak to each of the appropriate clinical staff members to ensure appropriate placement of the BH Plans within a care provider's note template.

3. **Hard-stop functionality should be implemented to ensure BH Plan completion.**
   Previous TEAM UP Center practices have had success in ensuring the completion of the BH Plans when there is a hard-stop functionality in place. In these instances, the care provider is unable to close the note until the BH Plan is completed. We have seen the most push-back on this among the PCPs, given that behavioral health is not always discussed during

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an encounter. However, the current iteration of the PCP BH Plan has a one-click, easy-out option within the first question for encounters where BH was not discussed.

Clinical Implementation Considerations

Behavioral Health Plan Descriptions

Primary Care Provider (PCP) BH Plan

The PCP BH Plan should be completed by a PCP attending to a patient during a medical visit. The PCP BH Plan is completed at every pediatric medical visit, including well child visits, sick visits, and follow-up visits – regardless of whether or not there were BH or developmental issues identified and/or addressed at the visit, and regardless of the reason for the visit. Implementation consideration for the construction and utilization of the PCP BH Plan can be found in the EMR Programming Guide. Materials were developed to train PCPs on the Plan, with Clinical Champions and Project Managers helping to lead training and quality improvement efforts ("5.0 Supporting Documents").

There are three core elements within the PCP BH Plan:

1. Assessment/Identification – Documentation of behavioral health or developmental concern(s) identified during the visit and further specification of the concern
2. Actions Taken – Actions completed during the visit that range from psychoeducation to medication prescription
3. Plan of Care – Identification of the intended care plan including who on the care team, if any, should be involved in the patient's subsequent care and any referrals completed

Behavioral Health Clinician (BHC) BH Plan

The BHC BH Plan should be completed by all BHCs seeing patients within the Pediatrics (and sometimes Family Medicine) Department as part of their standard documentation practice. The BHC BH Plan should be completed for all encounters (e.g., in person, phone, virtual) between a BHC and a patient, family member, or collateral, regardless of the need identified or addressed, or the reason for the encounter. The BHC BH Plan should not be completed if the BHC does not have direct contact with an individual (i.e., leaving a voicemail or sending a text). Implementation considerations for the construction and utilization of the BHC BH Plan can be found in EMR Programming Guide. Materials were developed to train BHCs on the Plan, with Clinical Champions and Project Managers helping to lead training and quality improvement efforts ("5.0 Supporting Documents").

There are three core elements within the BHC BH Plan:

1. Assessment/Identification – Documentation of the reason for the visit, whether the visit was a warm handoff, and further specification of the concern
2. Actions Taken – Documentation of therapeutic intervention used at the visit and secondary screening instruments used

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Screen shots of templates
Biref description of each template
Evaluation Reccoemndations

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Need section for Implementing the Plans Clinically; could look at updated Universal Newborn Touch that charlotte just finished.
Could consider: Workflow development, staffing and personnel, protocol, documentation and tracking,

EMR functionality, EMR Placement
Clinical Implementation (How to train and orient staff at outset and throughout project)

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3. Plan of Care – Identification of the intended care plan including who on the care team, if any, should be involved in the patient's subsequent care and any referrals completed

Community Health Worker/Family Partner (CHW/FP) BH Plan

The CHW/FP BH Plan should be completed by all CHW/FPs seeing patients within the Pediatrics (and sometimes Family Medicine) Department as part of their standard documentation. The CHW/FP BH Plan should be 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. The CHW/FP BH Plan should not be completed when the CHW/FP does not have direct contact with an individual (i.e., leaving a voicemail or sending a text). Implementation consideration for the construction and utilization of the CHW/FP BH Plan can be found in the EMR Programming Guide. Materials were developed to train CHW/FPs on the Plan, with Clinical Champions and Project Managers helping to lead training and quality improvement efforts ("5.0 Supporting Documents").

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There are three core elements within the CHW/FP BH Plan:

1. Assessment/Identification – Documentation of the reason for the visit, whether the visit was a warm handoff, further specification of the concern, type of contact, and length of visit
2. Actions Taken – Documentation of strategies used at the visit
3. Plan of Care – Identification of the intended care plan including who on the care team, if any, should be involved in the patient's subsequent care and any referrals completed

Initial Training

Upon initial involvement of the TEAM UP Center, we encourage the project leadership team at your practice to complete a comprehensive review of each version of the BH Plans. A review of the BH Plans will be completed with your practice's leadership team and a member of the TEAM UP Center team to address any and all questions. The purpose of this is to gain initial comfortability and use of the BH Plans in documentation processes. Over the course of the six-month planning period in your initial engagement with the TEAM UP Center and implementation of the TEAM UP Model™, your practice will first be asked to build each of the BH Plans in your EMR. At this same time, the TEAM UP Center asks that the clinical leadership/project management team prioritize the implementation of all three BH Plans.

Beyond the TEAM UP Center team, your practice leadership can use the BH Plan Training Guides to facilitate the understanding and learning of the BH Plans. A training Guide has been developed for each of the care team roles (PCPs, BHCs, CHW/FPs) and are meant to help facilitate understanding and utility of each BH Plan. You can find the Training Guides linked below:

- PCP BH Plan Training Guide
- BHC BH Plan Training Guide
- CHW BH Plan Training Guide

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Based on our learnings from previous practices and the knowledge that staff-turnover is inevitable, it is critical that each newly added member of the care team (PCPs, BHCs, and/or CHW/FPs) are adequately trained in the use of the BH Plans. We encourage the leadership team at your practice

to complete this training. However, the TEAM UP Center staff can be available to assist in the process where appropriate. In addition, we have found that ongoing review of data obtained from the BH Plans (which should be available within your Relevant Implementation Dashboard) is helpful in addressing issues with BH Plan completion and/or any concerns with how the integrated team are completing the BH Plans. The TEAM UP Center Implementation Team will regularly assess BH Plan completion and utilization in various forums to ensure appropriate integrated team documentation.

Workflow Development

Based on prior work with practices, BH Plan completion is best ensured when there is a well-developed workflow for when the BH Plan should be completed. Further, a workflow should be developed for BH Plan completion for each role of the integrated team (PCPs, BHCs, CHW/FPs). Successful BH Plan Completion Workflows should include the following components:

- When the BH Plan should be opened within EMR
- When and how should the BH Plan be pulled into the note template
- When the BH Plan should be completed
- Review of the BH Plan prior to submission

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-Plans need to be filled out at every visit (phone call or in-person)
-Integrated into every note template for the core roles
-Plans should be sequenced in a way that makes sense for documentation practice (i.e., not in screening tab); able to complete at the conclusion of the visit
-Hard stop
-Population into the note

Serve as a cross-check to how it should have been built/described in the EMR Guide.

Resources

Links to all relevant resources – first TU developed, then anything external that is noteworthy

References

Formal references section for anything that needs citing within document