# **Integrated Plan of Care**

Patient: Jean JohnsonDOB:12/12/0000Age: 45 yoLanguage: EnglishSex: FemaleGender: Female

**Emergency Contact**: Matt Johnson **Relationship**: Husband **Phone**: (555) 555-5555

Primary Care Physician: Dr. Norman Bell

**CARE TEAM MEMBERS:** 

Nursing: Elaine Reynolds Behavioral Health: Lesley Manson Pharmacy/Pharmacist: XYZ Pharmacy / Marianna VanDeMewre

| Problem | Fatigue             | Overweight                      | Medication List: | HTN Prescribed Medication |
|---------|---------------------|---------------------------------|------------------|---------------------------|
| List:   | Hypertension (HTN)  | Poor Adherence to medication    |                  | Herbs                     |
|         | High Blood Pressure | History of elevated blood sugar |                  | Vitamins                  |

## PRESENTING CONCERNS:

| Patient Report: Strengths      |  | :   | Barriers:   |  |
|--------------------------------|--|---|---|--|
| "tired," "mad" she children, c |  | hurch support, husband supportive,  | history of depression, eats when she is bored, office |  |
| can't play with kids           |  | nd, history of successful weight loss   | supplies unlimited candy, carbs, and sodas for        |  |
|                                | through nutrition management and exercise, |   | office food, medication adherence limitations to      |  |
|                                | medication                                 | n adherent 5xweek with HTN medication   | 5xweek  |  |
| Shared Goal:                   |  | Outcomes:   |   |  |
| "I would like to play wi       |  | After 2 month of integrated plan of care, pt to report improved mood through depression       |   |  |
| for at least 20 minutes        | a day                                      | screening results or start of depression mgmt plan, increased self report of described energy |   |  |
| without stopping."             |  | levels and playtime with children, improved daily blood glucose levels, improvement on        |   |  |
| Review: 2 months               |  | adherence as evidenced by screening tool  |   |  |

#### **PROGRESS:**

| Care Team     | Progress   | Date of    |
|---------------|--|------------|
| Provider      |  | Service    |
| PCP:          | Walking 10 minutes 3xweek; medication adherent 6 days a week                                 | 08/15/0000 |
| Norman Bell   |  |            |
| BH:           | Completed depression screening tool/No evidence; motivational enhancement; walking 15 08/20/ |            |
| Lesley Manson | minutes 3xweek; Play with kids 10 min, daily with a 5 minute break; eating protein for       |            |
|               | breakfast  |            |
| Nursing:      | Walking 20 minutes 3xweek; Play with kids 20 min, daily with a 5 minute break; developed     |            |
| Elaine        | snack alternatives for work place; Medication adherence 7xweek; reported improved mood and   |            |
| Reynolds      | energy; knee hurting during walking, unclear etiology, history of injury, referral to OT and |            |
|               | nutritionist as needed; reviewed blood sugar monitoring and provided log                     |            |
| Specialty:    | Completed OT intake, practiced strengthening exercises and activity modification; 3xweek     | 09/20/0000 |
| OT/ Sue Dahl  | exercises  |            |

## REFERRALS:

| Referral          | Date Referred |
|-------------------|---------------|
| Nutritionist      | 9/15/0000     |
| OT                | 9/15/0000     |
| Diabetes Educator |               |

# INTERVENTIONS:

| Supports:               | Patient Directed:        | Care Team:   |
|-------------------------|--------------------------|--|
| Husband will set        | Pt will identify list of | Nurse will fill medication administration box and practice blood sugar         |
| reminders for           | activities she enjoys    | monitoring/glucometer and use of log. She will follow up within the week       |
| medication adherence    | doing with her kids      | regarding assessing adherence and problem solving. Behavioral health will      |
| and schedule a cooking  | and begin to             | review stress response relationship to diabetes and hypertension and complete  |
| class to learn about a  | schedule play            | more formal mental health evaluation/screening to incorporate short term       |
| diabetes menu; husband  | activities; request      | objectives related and medication review. Primary Care prescribes oral         |
| will be invited to next | healthier snacks and     | medication for improved diabetes control/lower blood glucose levels. Care team |
| care team meeting for   | choices at work          | rotating follow up calls for daily monitoring first week and then 2x week      |
| inclusion               |                          | regarding objectives. Adherence screening tool.                                |
|                         |                          |  |