Care Plans

Best Practices for Development and Implementation

Tuesday January 8, 2013
8:00am – 9:00am
Welcome!

Asking Questions

Raise your hand
  - or -
Type into the questions log

Enter your Audio Pin using your telephone
Webinar Agenda

1. Patient-Centered Primary Care Institute (PCPCI)
2. Care Plan Introduction
3. Shared Care Plans for the Pediatric Medical Home
4. Person Centered Care Plans
5. Conclusion & Survey

Q & A
Patient-Centered Primary Care Institute (PCPCI) and Care Plan Introduction

Evan Saulino, MD, PhD
Clinical Advisor
Oregon Health Authority
Patient-Centered Primary Care Home Program
Patient-Centered Primary Care Institute
History and Development

• Launched in 2012 as a public private partnership to advance PCPCH practice transformation
  – Oregon Health Authority
  – Northwest Health Foundation
  – Oregon Health Care Quality Corporation (Quality Corp)

• Broad array of technical assistance for practices at all stages of transformation

• Ongoing mechanism to support practice transformation and quality improvement in Oregon
Learning Collaborative – 2013
- Technical Assistance providers working directly with practices throughout the state

Online Resources
- Website (www.pcpcli.org)
- Webinars
- Online learning modules (coming soon)
- Sign up for newsletter via website
Oregon’s PCPCH Model is defined by six core attributes, each with specific standards and measures:

- **Access to Care** – “Be there when we need you”
- **Accountability** – “Take responsibility for us to receive the best possible health care”
- **Comprehensive Whole Person Care** – “Provide/help us get the health care and information we need”
- **Continuity** – “Be our partner over time in caring for us”
- **Coordination and Integration** – “Help us navigate the system to get the care we need safely and timely manner”
- **Person and Family Centered Care** – “Recognize we are the most important part of the care team, and we our responsible for our overall health and wellness”
• **Current Standards: 5.F.2 Comprehensive Care Planning**

5.F.2 PCPCH demonstrates the ability to identify patients with high-risk environmental or medical factors, including patients with special health care needs, who will benefit from additional care planning. PCPCH demonstrates it can provide these patients and families with a written care plan that includes the following: self management goals; goals of preventive and chronic illness care; action plan for exacerbations of chronic illness (when appropriate); end of life care plans (when appropriate). (Tier 2 – 10 points)
Care Planning PCPCH Standards

• July 2013 Standards: 5.C. Complex Care Coordination

5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness. (Tier 3 – 15 points)
Patient-Centered Care Planning

• Care Plans have shown benefits for patients of all ages:
  – Pediatric – e.g. congenital/developmental conditions, ADHD, asthma
  – Adult – e.g. mental health conditions, COPD, diabetes, cancer, palliative care

• Evidence suggests patient engagement and goal-setting is important to empowerment/outcomes.

• Key to engage multi-disciplinary frontline staff in planning/use to make care plan a “living document”
Medicaid PCPCH Payment Requirements

- “ACA-qualified” patients: work with each patient to develop a person-centered plan within six months of initial participation and revise as needed.

- The care plan must include:
  - self-management
  - preventive and chronic illness care goals
  - action plans for exacerbations of chronic illness
  - end-of-life plans when appropriate
Shared Care Plans: Learnings from the Pediatric Medical Home

PCPCI Webinar – January 8, 2013

RJ Gillespie, MD, MHPE & David Ross, MPH
Context

- The Oregon Pediatric Improvement Partnership and the Oregon Rural Practice-based Research Network have been conducting a learning collaborative with eight practices across the state.

- These 8 practices have been working with the PCPCH standards, but have also kept a focus on broader Medical Home principles.

- Three of five learning sessions completed thus far – focusing on:
  - Identification of CYSHCN
  - Care Coordination
  - Behavioral Health Integration
“Every patient can benefit from a care plan (or medical summary) that includes all pertinent current and historic, medical, and social aspects of a child and family's needs. It also includes key interventions, each partner in care, and contact information. A provider and family may decide together to also create an action plan, which lists imminent next health care steps while detailing who is responsible for each referral, test, evaluation or other follow up.”

From [www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)
Aren’t we already doing Shared Care Plans?

- Key differences between action plan and shared care plan:
  - Action plan is completed by a provider, shared care plan is co-written
  - Action plan has directions, shared care plan has patient-centered elements, most importantly patient goals (and steps to take to get to those goals), and barriers experienced by the patient
  - Shared care plan emphasizes the patient’s central role in managing their own health
Shared Care Plans for CYSHCN

• Developed collaboratively with child and family, incorporates child and family goals
• Effective way to support self-advocacy and self-determination
• Types of care plans
  – Medical summary/transition summary
  – Emergency care plan
  – Working care plan or action plan
  – Individual Health Care Plan for educational setting
Key Elements in Shared Care Plans

- Name, DOB
- Parents/Guardians
- Primary Diagnosis
- Secondary diagnosis(es)
- Original Date of Plan, Updated last
- Main concerns/goals
  - Current plans/actions
  - Person(s) responsible
  - Date to be completed
- Signatures
Shared Care Plans are Patient-Centered

• Include statements that describe the patient in their own words:
  – I want the person working with me to know…
  – The most important information you need to know about me…
  – I have a challenge with…
  – My religion/spirituality does / does not impact my health care…
  – I learn best by…
  – Where I am (concerns)…
  – Where I want to be (goals)…
# Example: Asthma Action Plan

<table>
<thead>
<tr>
<th>Action Zone</th>
<th>Description</th>
<th>Peak Flow Range</th>
<th>Medication Details</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GREEN ZONE</strong></td>
<td>&quot;GO! All clear!&quot;</td>
<td>(80-100% of personal best)</td>
<td>Controller medicine(s)</td>
<td>Take this medicine as needed 10-20 minutes before sports or any other strenuous activity.</td>
</tr>
<tr>
<td><strong>YELLOW ZONE</strong></td>
<td>&quot;Caution...&quot;</td>
<td>(50-79% of personal best)</td>
<td>Reliever medicine(s)</td>
<td>Take these medicines until you talk with your doctor. If your symptoms do not get better and you can’t reach your doctor, go to the emergency room or call 911 immediately.</td>
</tr>
<tr>
<td><strong>RED ZONE</strong></td>
<td>&quot;STOP! Medical Alert!&quot;</td>
<td>(Below 50% of personal best)</td>
<td>Reliever medicine(s)</td>
<td>Call Your Doctor NOW!</td>
</tr>
</tbody>
</table>

**Asthma Action Plan**

I give my permission for this asthma action plan to be used by the following, and for them to share information with each other about my child’s asthma for one year beginning today, so that they can work together to help my child manage her/his asthma. This plan, when signed and dated, may replace the school’s consent to administer medication form, and allows my child’s medicine to be given at school.

- [ ] My child’s school / School health office
- [ ] My child’s clinic / Hospital
- [ ] My child’s day care provider
- [ ] Visiting nurse / Home care agency
- [ ] Insurance case management / Education program

If verbal / telephone consent, signatures of persons taking consent / witnessing:

1. [ ] Parent / guardian signature
   2. [ ] Date

---

**Sample Signature**

Signature: [Signature]

Date: [Date]

---

**Asthma Severity**

- [ ] Mild Intermittent
- [ ] Moderate Persistent
- [ ] Mild Persistent
- [ ] Severe Persistent

**Primary Care Provider**

- [ ] Name
- [ ] Phone

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**Primary Care Clinic**

- [ ] Name
- [ ] Phone

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**No Primary Care Provider**

- [ ] Primary Care Provider Unknown
Food for thought...

Obviously, action plans have an important role, but...how easy would it be to make this into a shared care plan? What simple change can you make (adding to the action plan) to make it a shared care plan?

– Assess patient goals, potential barriers to treatment
– Help patient problem-solve these barriers
– Document these on the plan
What is Self Management Support?

“The systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.”

Institute of Medicine, 2003.
The Five A’s of Self Management Support

• **Assess** patient’s beliefs, behavior and readiness to change
• **Advise** patients by providing specific information about health risks and benefits of change
• **Agree** on collaboratively set goals based on patient’s confidence in their ability to change the behavior
• **Assist** patients with problem-solving by identifying personal barriers, strategies, and support
• **Arrange** a specific follow-up plan
Guidelines for Goal-Setting

• Work collaboratively with the child and family
• Identify goals that are specific and short-term
• Choose goals that are reasonable and achievable
• Start small and build on success
• Provide regular feedback: phone follow-up, email and face-to-face
• Use salient and frequent external rewards
• Goal-setting discussions and follow-up can be conducted by allied office staff
• Identify external supports as needed, e.g., public health nurses, school staff
• Use the Plan-Do-Study-Act or PDSA cycle
Example of Goal-setting worksheet:

My Action Plan

Health Goal I want to work on:

How important is this?

0 1 2 3 4 5 6 7 8 9 10
Not Important  Somewhat  Extremely

What could get in the way of achieving this goal?

Steps I will take to make this change:

1.
2.
3.

How confident am I that I can do this?

0 1 2 3 4 5 6 7 8 9 10
Not confident  Somewhat  Extremely

Additional information I need:
# Child Health Coordination Plan

**Patient Name:** ____________________________  **DOB:** _______________  **Today’s Date:** ____________________________

**Parent/Guardian Name:** ____________________________  **Diagnosis/Health Conditions:** ____________________________

<table>
<thead>
<tr>
<th>Concerns/Issues</th>
<th>Referrals/Goals/Action Plan</th>
<th>Person Responsible</th>
<th>By Date</th>
<th>Action Taken/Outcomes</th>
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______________________________  ________________________________  _________________________
Parent Signature (Plan Reviewed)  Care Coordinator Signature  Date
Example from Oregon: Woodburn Pediatrics Shared Care Plan

Patient Summary & Patient Centered Care Plan - Woodburn Pediatric Clinic
Name: ____________________________
DOB: ____________________________

Pre-visit Phone Call - Date of Contact: ____________________________ Spoke with: ____________________________
☐ English ☐ Spanish

Ongoing Medical Diagnosis:

Family concerns: What do you want the person working with you to know?

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<tr>
<th>Specialists</th>
<th>Next Visit</th>
<th>Up-to-date?</th>
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<tr>
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<td>YES</td>
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<td>Shriner's Referral</td>
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<tr>
<td>Recent Dental visit</td>
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<tr>
<td>Recent Emergency Department visit</td>
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<tr>
<td>Recent hospitalization</td>
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<tr>
<td>Procedures/surgery/planned/hospitalization in next 30 days?</td>
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</tbody>
</table>

Details:

Missed appointments at Woodburn Pediatric Clinic: -- -- -- -- -- NO YES
Missed appointments with specialist: -- -- -- -- -- NO YES

Equipment/Appliances/Assistive Technology/Supplies needed:

Current Medications: Print medication list from EHR. Allergies:
Medications updated in chart? -- -- -- -- -- NO YES

Services:
☐ Physical Therapy
☐ Early Intervention/Special Ed
☐ Occupational Therapy
☐ Counselor
☐ Speech Therapy
☐ LRC in school
☐ IEP in school
☐ Other:

Community Agencies/Resources Involved and/or Referred to:
☐ Department Human Services
☐ Women Intact
☐ Warmest Education Services District
☐ SSI
☐ Family Building Blocks
☐ PCIT (Parent Child Interactive Therapy)
☐ Mental Health
☐ Other:

Care Coordination:
Well child exam up-to-date? -- -- -- -- -- YES NO
Immunizations up-to-date? -- -- -- -- -- YES NO
Difficult with contact or language? -- -- -- -- NO YES

GOALS set in collaboration with patient/family:
Self Management/Chronic Illness care:
Preventive Care:

TO DO:
Child/Parent/Family:

Care Coordinator or Team:

Provider:

Other/Follow up expectations/Referrals:
Implementation Considerations

- Steps to develop care plan templates
  - Process will differ in each practice - involve diverse members of the team - include families in the design!
  - Remember to test changes with small pilots in order to make small discoveries instead of big mistakes
  - Review by external entities and parents has been/will be valuable
  - Practices have used their EMR technologies in various ways
    - Not all started with using/integrating this process with EMR, but most have moved this direction. Drafting and finalizing a template is an important FIRST STEP before considering integration
Example from Oregon: The Children’s Clinic Shared Care Plan

ADD/ADHD Goals and Successes

Goals:
- Take Medication Daily
- Complete Assignments on time
- Turn Assignments in on time
- Increase listening time
- Increase positive behaviors at school (less time in trouble)
- Attend school regularly
- Increase Healthy Meals
- Increase nights without difficulty falling asleep and/or staying asleep
- Other: _____________________________

Successes:
- Taking Medication
- Completing and Turning assignments in on time
- Positive school behaviors
- Regular School Attendance
- Eating Healthy meals regularly
- Regular Sleep
- Other: _____________________________
Solicit Patient Feedback: Small Tests of Change

• For the next five patients that you implement a shared care plan with:
  – Get their feedback as you are reviewing the plan.
  – Call the family 1-2 weeks after implementation and ask…was the shared care plan helpful? Is there something that’s missing?
  – When reviewing patient goals at the next visit, ask the family…was the shared care plan helpful in meeting your goals?
Getting Patients Involved: Bigger Ideas

- Incorporate a patient feedback / suggestion process into your clinic.
- Hold brainstorming sessions with patients and families before developing shared care plans and involve them throughout the development process.
- Appoint patients and families to task forces and work groups to review shared care plans under development.
- Evaluate yourself – From the Patient Perspective – Conduct patient surveys of your own…include questions for CYSHN about the shared care plans.
Key Takeaways:

- Shared care plans are different from action plans in that they:
  - Involve patient goals
  - Barriers, and
  - Steps to achieve goals
- Involve patients/families/youth in the development and implementation of your practice’s shared care plans
- Remember small tests of change lead to big improvements!
Questions? Want more information?

• Contact OPIP
  – opip@ohsu.edu
  – www.oregon-pip.org
Person Centered Care Plans

Jackie Ross
Manager Health Home Support
System – Wide Collaboration

- Multiple Hospital sites had their own Action Plans for patients
- Lack of collaboration between hospital and clinic sites
- PCPCH Certification in the Clinics drove need for Care Plan
- Joint meetings began with hospital sites and hospital / clinic lead
- Focus on “Person Centered” rather than “Provider Centered” plan
What is a Person Centered Care Plan?

### Primary Care
- Medical Summary
- Care Team
- Patient’s Care Goals
- Patient’s Self Management Goals
- Patient’s Barriers to Care
- Action Plan for Behavior Management (as needed)
- Initiated by RN or PCP
- Updated by any clinic staff member

### Emergency Department
- Medical Action Plan for exacerbation of chronic disease
- ED Staff treatment plan
- Initiated by RN Case Manager in collaboration w/ PCP or with input from Case Conference Committee if patient does not have a PCP.
- Highlighted in Red located at bottom of care plan
Implementation

- Develop Smartphrase for EMR
- Agree on location of documentation
- Relocate Care Coordination Section of “Snapshot” for Primary Care

Person Centered Care Plan

Last updated by: Provider: Test Name, MD 1/26/2012
Original author: Kelley Auran, DO

Medical summary: Amber is a 29 year old female with a traumatic brain injury, and stage liver disease due to hepatitis C, chronic abdominal pain and depression, history of methamphetamine abuse. She frequently presents to the ED and PCP office with abdominal pain and requests narcotics. She is being treated for hepatitis C and having side effects of severe depression and suicidal ideation due to treatment medications. She is on narcotic agreement for chronic opioid therapy with PCP and has had consultation and intervention with pain management. She's declined mental health referrals.

Care team:
- Patient Care Team:
  - Baugh, Stephen F, MD as PCP - General (Internal Medicine 2017)
  - Williams, Sally E, MD as Consulting Provider (Infectious Disease)
  - Kelli Godfrey as Social Worker/Care Manager
- Personal support team: husband Bobby 503-555-1212, mother Jane 503-555-1313, narcotics anonymous sponsor, Jill 360-555-9898
- Surrogate decision maker, husband and mother

Amber's care goals (chronic and preventive):
1. “I don’t want to be in pain. I want to enjoy life and do things with my daughter, like play soccer.” Discussed realistic pain reduction and functional ability.
2. “I hate the ER, I don’t want to go there.” Discussed appropriate ER use, try to call PCP office first.
3. “I don’t want to use meth anymore. I’m clean now, I want to stay that way.” Discussed calling narcotics anonymous sponsor and reasons to stay sober.

Amber’s self management tools:
1. When in severe pain, first try ‘break through’ pain medication and wait 30 minutes, then it’s not helping call PCP office - Dr Baugh 503-555-7777. Only go to ED if PCP agrees you need emergency treatment. ED will not give you pain medication for your chronic pain.
2. To help stay sober, call your NA sponsor, Jill 360-555-9898

Amber's barriers to care:
- Substance abuse/chemical dependency: history meth use, now sober since 01/2012
- Other: traumatic brain injury limits cognitive function

Action plan for behavior management:
If yelling and threatening clinic/ED staff, calmly tell Amber you will leave her alone for a few minutes so she can calm down. Provide a quiet non-stimulating (no electronics) environment. Offer a phone so she can call her husband, mother or NA sponsor.

ED Action Plan (Medical action plan for acute exacerbation of chronic illness):
- PCP recommended ED treatment plan: Do not give Amber pain meds for her chronic pain. Treat her for new problems as needed. Call clinic for follow up appt and call clinic care manager to let her know about the ED visit.

ED staff treatment plan: Do not engage Amber in threatening language. If she is alone, call her husband or mother and they will come to ED for support and transport her home. If no ride, give her a taxi voucher due to her brain injury she can’t navigate public transport. If she requests pain medication for chronic abdominal pain, discuss this care plan and she needs to see PCP.
Next Steps

- Ongoing monthly meetings to revise PCCP
- Develop an educational “primer” for all staff
- Apply for Legacy Quality Award as a collaborative team
Thank you!
jaross@lhs.org
Closing

• Please fill out the survey after this presentation – you can send us additional questions

• Webinar materials can be retrieved from our website, www.pcpci.org

• Additional questions?
  – info@pcpci.org

THANK YOU!