

Care Plans

An Overview of Key Elements of a Care Plan

Definition

Care plans are written documents that help empower patients with complex conditions to better manage their own care.

These plans are meant to be written collaboratively with the patient and family, and incorporate the patient's and family's goals, preferences for care, and action plans for exacerbations of condition(s).

In collaboration with the family, the development of a care plan also helps to identify potential barriers to care, and helps the patient or family problem-solve ways to overcome these barriers.

Describe the patient in their own words

Care plans should include statements that describe the patient in their own words, such as:

- 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 not impact my health care...
- I learn best by...
- Where I am (concerns)...
- Where I want to be (goals)...

NCQA-PCMH CM 04 (Core): Person- Centered Care Plan

- The practice has a process for consistent development of care plans for the patients identified for care management
- The practice involves the patient in the plan's development, which includes discussions about goals
- The practice updates the care plan at relevant visits
 - Relevant visit addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal

<h1 style="text-align: center;">NCQA-PCMH</h1> <h2 style="text-align: center;">Person-Centered Care Plans</h2>	* Core ✓ Credit
Develop Care Plans for patients identified for Care Management	*
Care Plan Elements:	
Problem list	*
Expected outcome/prognosis	*
Treatment goals	*
Medication management/medication reconciliation	*
Schedule to review and revise plan	*
Provides written care plan to patient/family/caregiver	*
Documents patient preferences and functional/lifestyle goals	✓
Identifies and discussess potential barriers to goals	✓
Self-management plan	✓
Care plan integrated and accessible across settings of care	✓

**NCQA-PCMH
CM 05 (Core):
Provides
Written Care
Plan to
Patient/Family**

The care plan may be printed and given to the patient/family/caregiver or made available electronically

**NCQA-PCMH
CM 06 (Credit):
Patient
Preferences
and Goals**

Functional/lifestyle goals can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan.

Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.

Guidelines for Goal Setting

- Work collaboratively with the patient/child and family
- Identify goals that are specific, measurable, and time bound (documented target completion date)
- Start small and build on success
- Provide regular feedback: phone follow-up, email, and face-to-face
- Goal-setting discussions and follow-up can be conducted by care team members
- Identify external supports as needed, e.g. school nurses, community programs, family members

**NCQA-PCMH
CM 07 (Credit):
Patient
Barriers to
Goals**

Addressing barriers supports successful completion of the goals stated in the care plan.

Barriers may include physical, emotional or social barriers.

**NCQA-PCMH
CM 08 (Credit):
Self-
Management
Plans**

Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers to meeting care-plan goals.

BCBSRI

- Working to develop a framework for successful care management, drawing from NCOA standards and other evidence-based best practices
- Patient goals should be S.M.A.R.T.
 - Specific: Well defined, clear, and unambiguous
 - Measurable: With specific criteria that measure patients progress towards the accomplishment of the goal
 - Achievable: Attainable and not impossible to achieve
 - Realistic: Within reach, realistic, and relevant to patients functional/lifestyle
 - Timely: With a clearly defined timeline, including a starting date and a target date
- Interventions and goals should be prioritized based on specific patient assessment and identified needs

RIPCPC

- Aligns with NCQA-PCMH Standards and best practices

G-Learn

- Document level of care Low, Mod or High.
- Consider templates for levels of care and which team member may be the lead of the case based on level.
- Roles and responsibilities of each team member to determine using each team member to the top of their license and creating standards of care.
- Create EMR templates protocols to capture important information and standardize care. This document should be sent to team members including the patient's medical neighborhood.
- Have resources referrals built into EMR for quick reference and documentation

G-Learn

- History of Present Illness (Patient History)
 - Story of the patient's current, main problems in a "who, what, when, where, why" format
 - Personal and Family Data pertinent to the case
- Pertinent Medical History
 - List of the patient's medical condition affecting the current care.
 - If they have chronic conditions, what is the patient's understanding of those conditions?
 - Are they compliant to their treatment regimens?
 - Have they had any acute episodes recently?
 - Social Needs
 - Are they a smoker? Alcohol? Drug use?
 - Employment
 - How would you describe their lifestyle?
 - What is their support system like?

G-Learn

- Pertinent Medical History (Con't)
 - Medications
 - What are their current medications?
 - Are they taking them correctly?
 - Can they afford the medications prescribed?
- Objective Observations
 - What observations were gathered after speaking with the patient in person or on the phone?
 - Did you participate in a family meeting? What were you able to observe about the relationships

G-Learn

- Identified Care Gaps/ Needs
 - Have you identified barriers to care? Gaps in care? If there are any, how will you handle them?
 - Who will you collaborate with from the medical neighborhood in order to provide the patient with the best possible care?
 - Have you learned about the patient's personal habits, likes and dislikes, daily routines, baselines?
 - Are there any acute needs to be addressed with the Care Team?
 - Are there any emergent needs to be addressed with the PCP or ED?

G-Learn

- Resources put in place
 - What are the signs and symptoms this patient should report to you or their PCP immediately?
 - What educational materials are you sending home with the patient?
 - Are there any community services you can set up for this patient?
 - Will they need any home medical equipment?
 - What findings should you escalate and to whom?

Basic Care Plan Example

Person-Centered Care Plan

Risk Level: (*High, Moderate, Low*)

Last updated by: (*dot s*)

Original Author: (*dot s*)

Medical Summary:

Patient Care Team: (*dot*)*patientcareteam to pull in all team members*

Personal Support Team:

(*Include community contacts, caseworkers, therapists, etc here, primary caregiver/contact information goes here.*)

Patient's care goals (chronic and preventive):

(*Patient's personal goals for care goes here*)

Patient's self management tools:

(*patient education, groups, referrals go here*)

Patient's barriers to care/goals:

(*psychosocial and other risk factors go here*)

Team Goals: (chronic and preventive):

Basic Care Plan Example

Sample Plan:

Risk Level: High

Last updated by: XXX XXX, RN 1/16/2013

Original Author: XXX XXXX, MD 11/11/2012

Medical Summary: Cindy is a 48 y/o single mother of two children, Johnny 13 and Amelia 9. Cindy has diabetes , high blood pressure, and knee pain. She is 85 lbs over her desired weight . She has a past history of alcohol and methamphetamine use but clean and sober for 13 years. Her diabetes and hypertension are under poor control and it is difficult to persuade her to get needed lab work and show up for office visits.

Care Team:

Personal Support Team: Boyfriend Joe 503-222-2222, Mother Carol 971-333-3333, AA sponsor Kim, 503-111-1111

Basic Care Plan Example

Patient's Care Goals (chronic and preventive)

1. "I would like to eat better so I can lose some weight"
2. "I need some help in managing all the stress I'm under with money and the kids"

Patient's Self Management Tools:

1. Call TOPS (Take Off Pounds Sensibly) 503-444-4444 for a support group near your home
2. Meet with Diabetes Education for refresher on nutrition and diet 503-214-9999
3. Meet with our clinic behavioral coach, Dr Jones, about your high blood pressure and stress

Patient's barriers to care:

1. Has to take 2 buses to get to clinic for lab and office visits
2. Boyfriend is overweight and resists making changes in family food choices

Team Goals

1. Cindy will come in for office visit and lab work at least twice a year
2. Cindy will sign up for MyChart and use the diabetes self care to keep team posted on her blood sugar and blood pressure.

Thank You!

