



## IMPROVEMENT BRIEF

### Tri-State Children's Health Improvement Consortium (T-CHIC)

#### Shared Care Plans

#### **T-CHIC:**

*The Tri-state Children's Health Improvement Consortium (T-CHIC) is an alliance between the Medicaid/CHIP programs of Alaska, Oregon, and West Virginia formed with the goal of markedly improving children's health care quality. T-CHIC aims to drive continuous quality improvement in child health care by: 1) Improving children's health and health care quality measurement; 2) Integrating Health Information Technology (HIT) systems; and 3) Developing the best models of health care delivery for children and their families. Each participating state will learn what works best for improving children's health in their own state and across T-CHIC.*

#### **PURPOSE OF THIS BRIEF**

- To provide a definition of Shared Care Plans that practices can use in operationalizing systems and strategies to implement them.
- To provide an overview of key elements of a Shared Care Plan.
- To provide key lessons and implementation considerations for practices working on quality improvement projects related to shared care plans.
- To provide examples of innovative methods used by practices within the T-CHIC learning collaborative community to develop and implement shared care plans.

#### **T-CHIC MEDICAL HOME PRIORITY**

- Every patient can benefit from a care plan that includes all of the pertinent elements described in this brief.
- There are key differences between an Action Plan and a Shared Care Plan.
- Shared Care Plans are especially effective when done collaboratively with families of children with special health needs as a way to support self advocacy and self- determination.
- Therefore, a T-CHIC priority area for practices is the development of intentional processes for the design and implementation of Shared Care Plans for care coordination.

## SHARED CARE PLANS: A DEFINITION

*“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. If needed, emergency plans provide explicit instructions for prepared actions to be taken by the family, other caregivers or teachers, and all health care professional”* [-medicalhomeinfo.org](http://www.medicalhomeinfo.org)

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

## KEY ELEMENTS OF A SHARED CARE PLAN

The key elements in a shared care plan include:

- Primary diagnosis
- Secondary diagnoses
- Main concerns / goals, including
  - Current plans / actions (including goals for self-management, preventive care, and chronic illness care)
  - Person(s) responsible
  - Date to complete goals
- Specialists and other community resources involved in the patient’s care
- An action plan for exacerbations of illness, including how to contact the relevant provider / clinic
- Resources for self-education
- Signatures<sup>1</sup>

Ideally, the shared care plan 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)...

### 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*

<sup>1</sup> We need to be sure to reference Bob’s presentation / care coordination toolkit as some of these come from his slides specifically.

- Where I want to be (goals)...

Shared care plans are living documents that evolve as a patient's disease process progresses or improves, as goals are met, or as new barriers are encountered. They should be updated regularly to ensure accuracy and relevance to patients.

### SHARED CARE PLANS AND ACTION PLANS: KEY DIFFERENCES

- 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

### OVERVIEW OF CONSIDERATIONS FOR PRACTICE-BASED IMPLEMENTATION OF SHARED CARE PLANS

#### Ideas for obtaining patient feedback on shared care plans:

- *For the next five patients that you implement a shared care plan:*
  - 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?*
- *Conduct patient satisfaction surveys of your own...include questions for CYSHN about the shared care plans.*
- *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.*

#### **Involve Families in the Creation of Your Practice's Shared Care Plan**

This effort is focused on creating a document to help patients manage their care, so it is important that it meets all their needs:

Patient-centered domains to document on Shared Care Plans:

- Agreed upon goals from the appointment
- Next steps in care:
  - What needs to be done before my next appointment
  - Whose responsibility is it to get it done
- How to obtain care
  - Best way to contact my doctor or nurse
  - What to do if I need care after hours
- Date(s) of next appointments

#### **Translation Issues**

Since most Shared Care Plans are embedded in the EMR, language translation capabilities are limited. It is important to involve families that English is not their primary language to find out what the most important fields to be translated are. This can help save a practice time, since it may reduce the number of fields that are translated.

- Important fields to consider for translation:
  - Goals
  - Patient Concerns
  - To-do's

### **Start With a Small Population**

When implementing Shared Care Plans, follow the quality improvement principles of small tests of change to ensure that the Shared Care Plan meets the needs of families and providers before spreading it to all Children and Youth with Special Health Care Needs. Practices who have implemented on a broad population have quickly felt overwhelmed by the number of care plans that need to be developed. Starting with a small subset of CYSHCN (such as a single diagnosis) to ensure workflow problems are addressed before wide scale implementation may alleviate this problem. Start with a certain diagnosis, potentially a diagnosis that already has natural touches with their care team so they are easy to get in contact with. For example, if you routinely speak with patients with ADHD or asthma by phone for monthly medication refills, discussing goals and barriers during these calls may be a small test of change that is easier to implement,

Alternatively, you may consider piloting shared care plans with a single provider in the practice who can serve as a practice champion to work out problems with practice workflow before spreading to other providers in the practice.

### **Use your EHR to Facilitate SCP Development**

It is important to plan for how your EHR will facilitate developing Shared Care Plans for the population of CYSHCN. This includes developing a general template for creating Shared Care Plans, ensuring translation of SCP into the patient's language of choice, and developing systems for tracking and updating the SCP within the medical record.

How to use the EMR to help stream line Shared Care Plans

- Use of Care Alerts
- Drop Downs for Goal Setting
- Adding decision support for diagnosis
- Using the problem list diagnosis code to track CYSHCN – can map this to patients that have a SCP in the chart

### **Make a plan to Integrate the Input of Specialists**

Unless the PCP and the specialist are on the same EHR system and can share documents this can be very challenging. In addition, mental health specialists have a lot of HIPPA concerns when it comes to sharing back information to the PCP creating another barrier in a truly comprehensive shared care plan. In order to make the plan as useful as possible, it is important to establish communication streams with known specialists to incorporate as much about patients care as possible. Things to consider when you work on a communication/sharing strategy:

- How to triage/when to refer to different specialist
- How will you know when your patient has been seen
- What do the specialists want to know when they are referred at patient (patient history, labs, medications etc)
- At what time interval (how quickly) can you we get notes back
  - What will be shared in these notes: diagnosis, medication changes, etc.

**PRACTICE VIGNETTES:**

**Spotlight from Oregon:** Eight primary care practices in Oregon are participating in the *Enhancing Child Health in Oregon (ECHO)* Learning Collaborative. Shared Care Plans have been discussed at Learning Sessions and on Calls/Webinars. Below is a highlight of quality improvement interventions practices implemented around the development and use of Shared Care Plans.

**The Children's Clinic**

**Prior to T-CHIC/ECHO:** The Children's Clinic was not working on developing Shared Care Plans prior to joining the ECHO Learning Collaborative.

**After Starting T-CHIC/ECHO:** As a part of Oregon's medical home initiative which provides enhanced reimbursement for specific ACA diagnosis, the program requires the practice to create a Shared Care Plan for each patient with the ACA diagnosis. The Shared Care Plan is required to include goals, "to-do's" and success as well as other relevant patient information as well as how to contact the practice/their care team. Since the Children's Clinic has such a large patient panel, they decided to start with a single diagnosis for enhanced reimbursement– they began with Attention Deficit Hyperactive Disorder (ADHD).

Knowing that it is important not to add additional burden on to the Primary Care Providers during a visit, the Children's Clinic explored other ways to get "touches" to these patients and include this additional requirement into their already standardized workflow. In their practices it is customary to have monthly med checks with their ADHD patients. Normally the advice nurses call this panel of patients to make sure that the medications are still working well for the patient, check on side effects and ask other routine medication follow up questions – it was identified that since the nurses already have monthly contact with these patients it would be easy to add additional questions to help create a Shared Care Plan.

In another attempt to help build this addition into their workflow, the Children's Clinic updated their EHR template for the ADHD med checks to include: consent into the medical home program (another requirement of the program), goals and successes. The 'goals' and 'successes' options offer drop down menus to help the nurses facilitate the call, but there is also an "other" option which allows the nurses to type a custom response depending on the patients needs.

Examples of the pre-populated '**goals**' for ADHD include:

- Take medications daily
- Complete assignments on time
- Turn assignments in on time
- Increase listening time
- Increase positive behavior at school (less time in trouble)
- Attend school regularly
- Increase healthy meals
- Increase nights without difficulty falling asleep and/or staying asleep

Examples of the pre-populated '**successes**' for ADHD include:

- Taking medication
- Completing and turning assignments in on time
- Positive school behavior
- Regular school attendance
- Eating healthy meals regularly
- Regular sleep

Once the goals and successes are created the nurses are able to print a Care Plan for the patient using this information and their Clinical Summaries used for Meaningful Use. Thus far the Children's Clinic has been very successful at completing the Shared Care Plans for this patient population and they plan to expand this workflow to other diagnosis (including asthma and autism) once they complete the Shared Care Plans for their ADHD population.



## Woodburn Pediatrics



**Prior to T-CHIC/ECHO:** Woodburn Pediatrics (WPC) was not working on developing Shared Care Plans, nor were they working towards Meaningful Use – which can be a helpful transition prior to joining the ECHO Learning Collaborative. Additionally, Shared Care Plans have been identified as one of the harder medical home components for a practice to meaningfully achieve.

**After Starting T-CHIC/ECHO:** After beginning to identify complex children with special health care needs to establish their newly hired Care Coordinator's patient panel (the panel was developed by using provider gestalt to recall the most complex and time intensive patients) the practice decided to initiate pre-visit planning for these patients.

### The Pre-visit Planning Form included:

- Patient demographics (including language, contact and time of contact)
- Ongoing medical diagnosis
- Medication
- Family concerns
- Specialists (next visits and if their appointments were up to date)
- Referrals
- Services
- Community agencies involved in care

To begin, the Care Coordinator is calling her patient panel before the child's next well-child appointment to complete the pre-visit form. Their EHR is able to pre-populate the demographic information, medical diagnosis and medications, but the other fields require the Care Coordinator to do a manual chart review. It has been documented that starting Shared Care Plans for patients is the hardest/most time intensive, but as long as they are regularly updated based on the patients needs then they should require less time to maintain. The chart reviews were taking about an hour to complete per patient, however it is important to note that she was doing these forms for her most complex patients who often had multiple specialists, referrals and services involved in their care.

Once Oregon's medical home initiative decided to mandate Shared Care Plans for enhanced reimbursement, WPC worked to transition their Pre-Visit Planning form to a Shared Care Plan. To do this they added the fields: "to-do's" for the child/parent/family, care coordinator, provider and other

follow up expectations. They also added goals, which the PCP works to create with the patient during the visit and is followed up with by the Care Coordinator as needed.

The first barrier on noted from this practice on Shared Care Plan completion was that this document is created in English (largely due to EHR capabilities) however a majority of their practice is made up of Spanish speaking families. To make these documents useful/meaningful their Care Coordinator translates the to- do's, goals and concerns into Spanish. It was determined that the Care Coordinator would translate only these fields based on a focus group that the practice had when creating this document. After these fields are added and/or translated, the Care Plan is mailed to the patient. Another barrier WPC encountered was that currently their EHR is unable to save this document in a way that can be easily manipulated/updated by multiple people, so they have to save it as a document and copy and paste into a new document to update and re-save with the date to make sure everyone is using the most current version.

At WPC, Shared Care Plans are still being trialed for a relatively small patient population (less than 100 patients with complex Special Health Care Needs), but these will be the hardest/ most time intensive to complete. Providers at WPC have expressed the benefit of having Shared Care Plans done for these patients, as they clearly articulate goals and next steps to make sure that appointments run smoothly, but they also allow families to express their concerns in the appointments – some of which the PCP may not have known about. Once they complete care plans for this population, WPC plans to add more patients to the Care Coordination panel based on ACA diagnosis. It has been determined that Autism patients will be the next group to get added to the panel and to get Shared Care Plans.



**Spotlight from West Virginia:** Ten primary care sites are participating in the TCHIC project. Below is a highlight of a quality improvement intervention implemented to better identify children for care coordination needs.

### Arbor Medical Associates



Two of the largest pediatric practices in Elkins, WV merged to become Arbor Medical Associates in October 2009. Since then the organization has again merged but this time to be a part of an FQHC. Elkins is a rural city in Randolph County WV with its biggest industry being tourism for skiing. There are 6 providers in this practice.

**Prior to T-CHIC:** Before beginning the T-CHIC project Arbor Medical was utilizing action plans in an attempt to assist children in their population that was at or above the 85 percentile in the body mass index. The children were prescribed a nutritional plan and an exercise regimen. The parents were given instructions to assist the children with the plan. The providers and the team re-visited the process to determine what wasn't working...which was bringing in patients and giving them a plan to follow. A "diet" without saying the word and then telling them how many minutes a day they should "exercise" without saying that word as well.

**After the T-CHIC project:** The team decided (the providers, the dietician, and the care coordinator) that they would attempt to involve the patient and the family with a new plan that would be individualized per patient. Shared care plans were to be implemented for each patient identified as being in the 85% on the BMI chart and above. The patients were scheduled for a visit with a provider to discuss the health issues involved with elevated BMI. The patients had a consult with a dietician and labs were performed to determine if there were any underlying conditions for the elevated BMI before the process of creating a shared care plan was established.

The parents, child, and care coordinator came up with a plan that fit the child. Questions were addressed to assist in creating that individualized plan that would allow more buy-in from the patient and family. What foods do they like? What can we remove from the diet? What sports, outdoor activities, or other active things do they like? The care coordinator was able to get sponsorships through the YMCA for some of the children that were not able to afford it otherwise. The patients/families were provided with a list of free sports to get involved in and all the contact numbers. Educational materials were introduced for the parents choose from including "healthy plate", "weight watchers for kids", "NO sugar added", a drink/beverage handout that the parents were able to read and understand that explained how many hidden calories there are in drinks (including juice and whole milk).

A series of follow up visits were scheduled with the patients/families. The first visit was set for 3 months after the care plan was developed. That timeframe proved to be too long to wait for the first

follow up. The parents were frustrated and the patients were bored without seeing results for that long. The schedule was changed to 30, 60, 90 days then every 90 following that series. This was a HUGE improvement. The patients were seeing the results sooner and the parents were getting the encouragement they needed.

The BMI percentages for all patients, of all providers have fallen across the board since shared care plans were implemented.

