# SHARED CARE PLANS

## ECHO MONTHLY CALL- AUGUST 9, 2012

Oregon Pediatric Improvement Partnership

*ECHO is a project of the Tri-State Children's Health Improvement Consortium (T-CHIC) & Supported by the Oregon Health Authority*

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# Goals for today's call

- By the end of this call, participants will be able to:
  - Recognize the importance of and need for shared care plans as a cornerstone of care coordination and self management support in the medical home
  - Understand strengths and opportunities related to shared care plans across the collaborative
  - Demonstrate an improved understanding of the critical elements of a shared care plan
  - Recognize important next steps in the design and implementation of shared care plans in practice

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# Shared Care Plans and Self-Management Support

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# Shared Care Plans…Background

- "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

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# 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

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# 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

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# 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

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

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# PCPCH Standards:
# 5.F: Comprehensive Care Planning

- Use of a standardized, written care plan for high risk patients or certain conditions (e.g. asthma or diabetes) that contains the **following required elements**:
  - self management goals (e.g. diet or exercise goals, goals for self-testing or medication list with times of administration)
  - goals of preventive care (e.g. recommended immunizations or screening tests)
  - goals of chronic illness care (e.g. target blood sugar, weight or other health goal)
  - action plans for self-management during exacerbations of chronic illness (e.g. written asthma action plan or sliding scale insulin instructions)
  - goals for completing POLST form or advanced directive (if appropriate)

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# Medicaid Waiver for ACA Payments: Person-Centered Plan

- Defined as the plan that shall be developed by the PCPCH and reflect the client and family/caregiver preferences for:
  - education, recovery and self-management
  - management of care coordination functions
  - Peer supports, support groups and self care programs shall be utilized to increase the client and caregivers knowledge about the client's health and health-care needs.

- The person-centered plan shall be based on the needs and desires of the client including at least the following elements:

  (i) Options for accessing care;

  (ii) Information on care planning and care coordination;

  (iii) Names of other primary care team members when applicable; and

  (iv) Information on ways the team member participates in this care coordination

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# Example: Asthma Action Plan

Primary Care Provider Name _____ Phone _____

Primary Care Clinic Name _____ Phone _____

☐ No Primary Care Provider ☐ Primary Care Provider Unknown

**ASTHMA SEVERITY (Check one):**
☐ Mild Intermittent ☐ Moderate Persistent
☐ Mild Persistent ☐ Severe Persistent

N1748

**ASTHMA ACTION PLAN**

## GREEN ZONE
"GO! All clear!"

Peak Flow Range:

_____ to _____
(80-100% of personal best)

- Breathing is easy
- Can play, work, and sleep without asthma symptoms

**When you are in the GREEN ZONE, take the following controller medicine(s) every day.**

| *Controller* medicines | How much to take | When to take it |
|---|---|---|
| | | |
| | | |
| | | |

Spacer used: ☐ *Optichamber:* ☐with mask ☐without mask

| Medicine | How much to take | *Take this medicine as needed 10-20 minutes before sports or any other strenuous activity.* |
|---|---|---|
| | | |

☐ Student may carry and use this medicine at school after approval by the School Nurse

## YELLOW ZONE
"Caution..."

Peak Flow Range:

_____ to _____
(50-79% of personal best)

- Wake up at night

- Cough & wheeze

- Chest is tight

**When you are in the YELLOW ZONE, keep taking your GREEN ZONE controller medicine(s) every day and add the following reliever medicine(s) to help keep the asthma episode from getting worse.**

| *Reliever* medicine | How much to take | When to take it |
|---|---|---|
| | | |
| | | |

***If you are in the YELLOW ZONE for more than 12-24 hours, call your doctor.***
***If your breathing symptoms get worse, call your doctor.***

☐ Student may carry and use this medicine at school after approval by the School Nurse

## RED ZONE
"STOP! Medical Alert!"

Peak Flow Range:

_____ to _____
(Below 50% of personal best)

- Medicine is not helping
- Breathing is hard and fast
- Can't walk
- Can't talk well
- Ribs show
- Nose opens wide to breathe

**When you are in the RED ZONE, start taking your RED ZONE medicine(s) and *Call Your Doctor NOW!***
- **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.***

| *Reliever* medicines | How much to take | When to take it |
|---|---|---|
| | | |
| | | |

This asthma action plan is good for one year beginning: _____ MD/NP/PA signature _____

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 _____ ☐ My child's emergency _____
☐ Insurance case management / Education program _____

*If verbal / telephone consent, signatures of persons taking consent / witnessing:* Parent / guardian signature _____

1) _____ 2) _____ Date _____

Name _____ MR# _____ Birthdate _____ (Address sticker / Label)

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# 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

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# 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.

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# Self Management Support

- Empower and prepare patients to manage their health and health care.
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.
- Organize internal and community resources to provide ongoing self-management support to patients.

From the Chronic Care Model, www.improvingchroniccare.org

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# 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

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# 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

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# Example 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:**

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# CHILD HEALTH COORDINATION PLAN

**PATIENT NAME:** _____ **DOB:** _____ **TODAY'S DATE:** _____

**PARENT/GUARDIAN NAME:** _____ **DIAGNOSIS/HEALTH CONDITIONS:** _____

| CONCERNS/ISSUES | REFERRALS/GOALS/ACTION PLAN | PERSON RESPONSIBLE | BY DATE | ACTION TAKEN/OUTCOMES |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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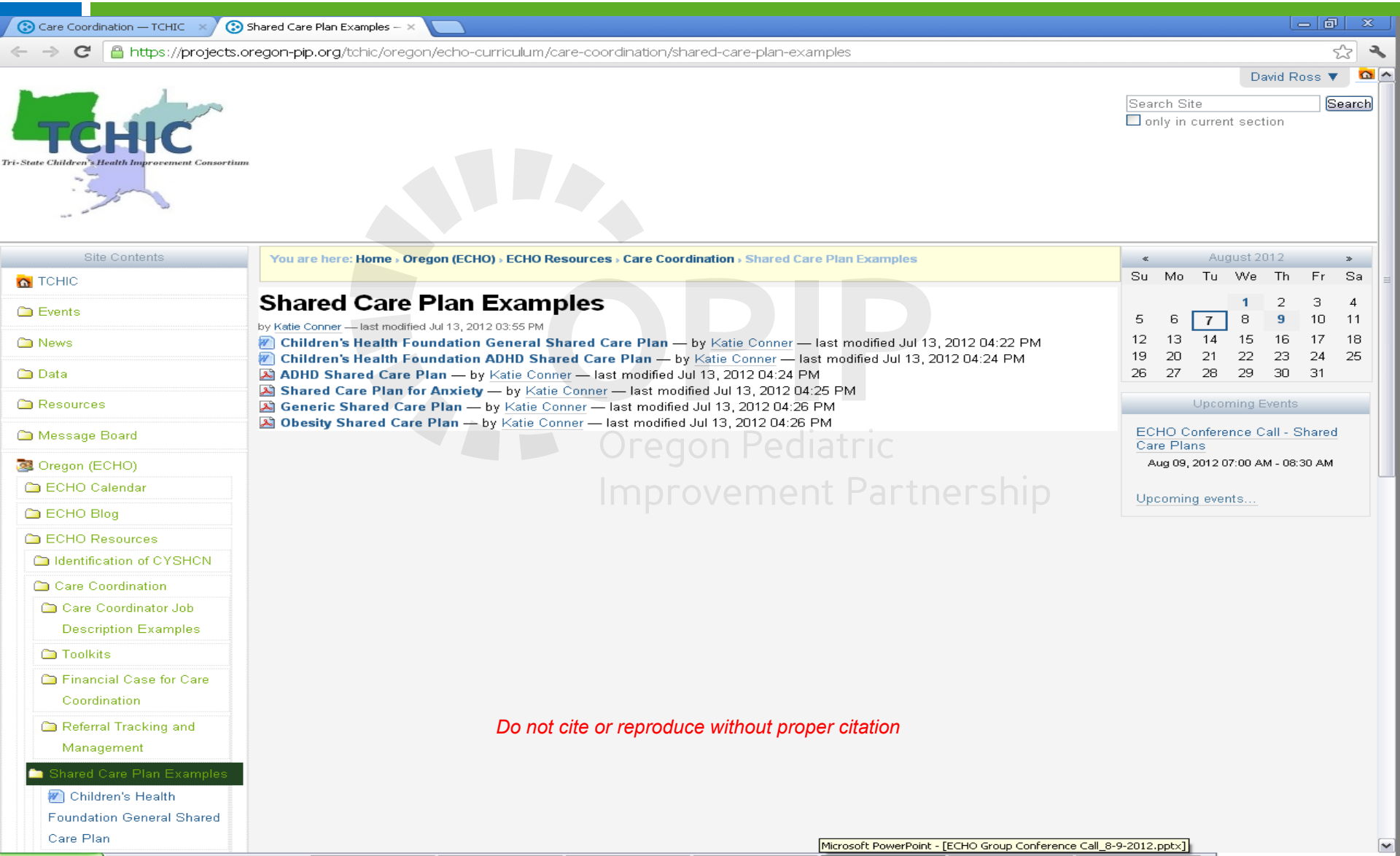
_____ _____

**Parent Signature (Plan Reviewed)** **Care Coordinator Signature** **Date**

# Other Examples on QI Teamspace

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# Involving Patients In Developing Shared Care Plans

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# Solicit Patient Feedback: Small Tests of Change

- 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?

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# Getting Patients Involved: Bigger Ideas

- 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.

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# Need Help Identifying / Recruiting Patients?

- Technical Assistance available from our partners in OCCYSHN
  - Oregon Family to Family Health Information Center: http://www.oregonfamilytofamily.org/
- www.medicalhomeinfo.org also has some resources / suggestions

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# Discussion

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# Discussion

- *Where is your practice at in the development and implementation of shared care plans?*
- *What challenges are you facing, and what questions do you have for the group?*
- *What is your plan moving forward?*

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# Summary

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# Key Takeaways

- Shared care plans are different from action plans in that they involve patient goals, barriers, and steps to achieve goals
- Consider elements of shared care plans required by PCPCH and ACA
- Involve patients in the development and implementation of your practice's shared care plans
- Remember small tests of change lead to big improvements!

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