Patient-Centered Primary Care

# Care Plan Development

A care plan is a detailed approach to care customized to an individual patient's needs. Care plans are called for when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions.

This guide is meant to serve as a reference for providers who are new to the care planning process.

## Building a Care Plan

Care plans include, but are not limited to, the following:

- Prioritized goals for a patient's health status
- Established timeframes for reevaluation
- Resources that might benefit the patient, including a recommendation as to the appropriate level of care
- Planning for continuity of care, including assistance making the transition from one care setting to another
- Collaborative approaches to health, including family participation

## Guiding Principles

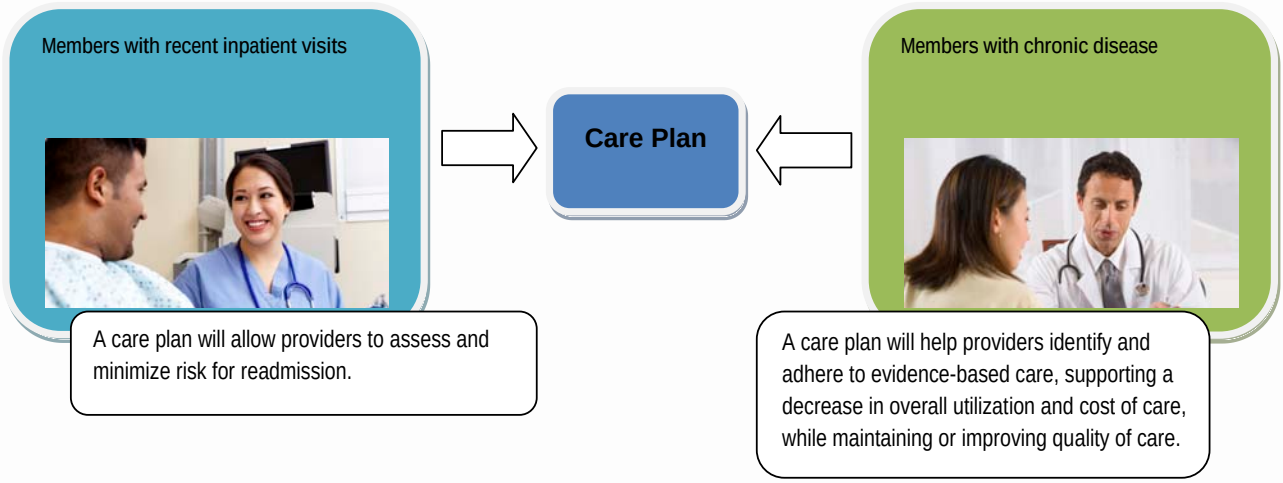
- A care plan should enhance the patient's treatment plan by providing a list of identified health conditions or problems with a corresponding prioritized list of interventions to meet the patient's goals. Standard assessment domains are used as a basis for this list of problems and corresponding goals.

- There is no single template that must be followed for creating a care plan, but there are critical elements that should be included. The format will vary based on the provider's charting process and electronic capabilities. The care plan format should fit into the provider's current workflow and should not require duplicative documentation. (Refer to the provider toolkit for sample care plans).

## A Systematic Approach to Care Planning: A step-by-step guide

1. Identify a patient with complex health needs who is at high risk for readmission or an adverse medical event. This can be done during an interview, physical examination, obtaining a health history, reviewing diagnostic data, or our reports such as the Hot Spotter report, inpatient authorization report or Care Opportunity reports. (See illustration below for more information about which patients can benefit from care plans).
2. During a patient assessment, use assessment domains and Member Medical History Plus (MMH+) data to guide questions and focus on potential areas of concern. (Click here for more information about assessment domains).
3. Identify which of the patient's conditions or health concerns place him or her at the highest health risk. Review the domains for guidance on problems identified.
4. Create Goals for Care that address education around, patient support, and treatment for the conditions or problems already identified in the care plan. Place goals in order of priority. (Click here for more information on goal development and examples of goals.)

## Identifying those most in need of care management support




We will give you a list of your high-risk patients within the various reports, which will include:

1. Patients who have had an acute inpatient admission and who are at risk for readmission within the next 90 days, according to our predictive modeling. Predictive modeling incorporates claims data, utilization data, and specific care gaps into algorithm logic.
2. Patients with one of five chronic conditions: heart disease; diabetes; hypertension; asthma, or chronic obstructive pulmonary disease (COPD).

We recognize that you will have additional opportunities to identify other high-risk members based on your own unique experience with, and knowledge of, your patients.

Patients who can benefit from care management include patients who:

- Have chronic conditions
- Are receiving treatment from multiple specialists
- Have complex treatment and management plans
- Are impacted by psycho-social concerns
- Have been diagnosed with multiple chronic conditions
- Are dealing with co-morbid medical and behavioral health conditions.

# Appendix 1: Assessment Domains

Below is a suggested listing of assessment domains/functional areas to help guide goal formation and related elements that support the identification of goals and interventions. **Click here to see examples of information for assessment domains (Appendix 4).**

| **Domain 1** | **Informed Choices** |
|---|---|
| Element 1 | Life Planning documents ( DPOA, Living Will, Healthcare Proxy) |
| Element 2 | Aggressive vs. palliative care--Hospice |
| **Domain 2** | **Functional Status and Safety** |
| Element 1 | Personal Safety Plan (child proof/home safety/fall prevention). |
| Element 2 | Level of independence /functional deficits |
| Element 3 | Maximum functional status / functional status goal |
| Element 4 | Cognitive function |
| Element 5 | Support/caregiver resources and involvement |
| **Domain 3** | **Condition Management** |
| Element 1 | Care Gaps |
| Element 2 | Understanding of Self Management Plan |
| Element 2 | Understanding of Condition Specific Action Plan/Monitoring Plan |
| Element 3 | Understanding of Condition "Red Alerts" |
| Element 4 | Pain Management |
| **Domain 4** | **Medication Management** |
| Element 1 | Medication reconciliation |
| Element 2 | Polypharmacy |
| Element 3 | Side effects |
| Element 4 | Barriers to adherence |
| **Domain 5** | **Prevention/ Lifestyle** |
| Element 1 | Nutrition/ Dietary Plan/ BMI |
| Element 2 | Smoking Status |
| Element 3 | Preventive Care/ Screenings/Immunizations/Flu Shot |
| Element 4 | Alcohol / Drug Use |
| Element 5 | Depression Screening |
| Element 6 | Play/Stress Management Techniques |
| **Domain 6** | **Barriers to Care/Impact to Treatment Plan** |
| Element 1 | Cultural/language barriers |
| Element 2 | Community Resource Availability |
| Element 3 | Communication Impediments (Hearing/Vision Loss, unable to read, etc.) |
| **Domain 7** | **Transitions Of Care/Access To Care** |
| Element 1 | Care Transition Plan |
| Element 2 | Participating Provider Network |
| Element 3 | Optimal Site of Service |
| Element 4 | Specialists / other provider coordination |

# Appendix 2: Goal Development

## SMART Goals:

**Specific:** The goal should be specific to the patient's situation and focused on one desired outcome.

**Measurable**: The goal must be a measurable, evidence-based outcome.

**Achievable:** The goal must be reasonably achievable based on patient's condition

**Relevant:** The goal must be individualized to the patient, based on stated needs, desires, and assessment findings

**Time Specific:** Goals need to include a target date that is achievable.

## Goal Concepts:

1. Problem statement with an action plan that is measurable, obtainable, and important to the patient.
2. What is highest priority for the patient?
3. Identify what the patient wants to happen/do, when to have it completed, and how you will as the PCP know that it is done.
4. Barrier(s): Any factor that can limit the patient from achieving the goals set forth in the care plan (i.e., lack of transportation, financial issues, social issues, lack of knowledge.
5. Intervention(s): The steps that need to be taken to assist the patient to reach the goal(s):
   - Intervention must be prioritized and customized for each patient to resolve the issue/problem that will have the highest impact on patient's health status
   - Continuous reprioritization of the care/interventions for the patient must occur based on the most recent interactions and new information from clinician.
6. Evaluation: Ongoing review and revision of the care plan until goals or met. This may include development of new goals.

## Goal Setting Example 1: A recent inpatient visit

*Patient was noted to have a high risk of readmission due to a recent discharge from the hospital post-op hip fracture. The patient was placed on an anticoagulant post operatively. During the assessment, the provider noted that the patient stopped taking the medication due to side effects and had symptoms of anxiety and depression.*

1. **Identify a patient with the highest risk for a readmission to the hospital:**
   - Recent surgery for hip fracture

2. **Identify problems**

   Medication Management (Domain)
   - Side effects (Element); patient is not adherent with anticoagulant therapy post operatively
   - Anxiety and Depression

3. **Create Goals for Care**

   **Priority Goal 1**: Patient will be compliant with anticoagulant therapy as evidenced by taking medication as prescribed by (Date targeted).

   **Priority Goal 2:** Patient will start SSRI and in conjunction will start counseling session due to home stressors as evidenced by taking medication as prescribed and making/attending appointment with counselor and have decrease in feelings of anxiety/depression and improved coping mechanisms by (Date targeted).

**Priority Goal 3:** Patient will not have a readmission due medication compliance as evidenced by no readmissions in a three month period by (Target date).

4. **Identify barrier(s) to goal obtainment:** Barriers include lack of knowledge about medication and the importance of taking medication. Other barriers can be lack of finances or transportation concerns.

5. **Intervention(s)**
   - Prioritization of the care/intervention
   - Discuss importance of the medication
   - Discuss the side effects with the patient

6. **Evaluation:** Follow-up appointment scheduled in two weeks.

## Goal Setting Example 2: Multiple Gaps in Care

*The provider notes that a female patient with diabetes and hyperlipidemia is past due on several labs and annual exams. This was noted on the practice's Care Opportunity report.*

1. **Identify a patient with gaps in care:**
   - Patient noted to have gaps in care that included an overdue in Lipid testing (patient on cholesterol medication), overdue in Hgb AIC (diabetic patient), and overdue Pap smear.

2. **Identify problems**

   Overdue on several screenings and lab work
   - Patient is controlled diabetic

3. **Create Goals of the Care**

   **Priority Goal 1:** Patient will have Lipid panel and Hgb AIC completed within one week as evidenced by having lab completed and results obtained by PCP.

   **Priority Goal 2:** Patient will have pap-smear done within one month as evidenced by having test completed and results reviewed by PCP.

4. **Identify barrier(s) to goal obtainment:** Barriers include lack of transportation to lab. Patient will ask a family member take her to lab.

5. **Intervention(s)**
   - Prioritization of the care/intervention
   - Discuss importance of lab results
   - Discuss importance of annual preventative follow-up

6. **Evaluation:** Follow-up appointment scheduled in two weeks.

# Appendix 3: Resources to Guide Practices in Care Plan Development

### Partnering in Self-Management Support: A Toolkit for Clinicians

Self-management support is the care and encouragement provided to people with chronic conditions and their families or caregivers to help them understand their central role in managing their illness, making informed decisions about care, and engaging in healthy behaviors.

*New Health Partnerships, a national program of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement; May 2009.*

Available at http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx

### Complex Care Management Toolkit

The following document is a guide to improving and implementing a complex care management program for individuals with multiple chronic conditions, limited functional status, and psychosocial needs, who account for a disproportionate share of health care costs and utilization. This toolkit summarizes ideas to improve an existing complex care program, or implement a new one. In the document, there are links to numerous resources and tools that you can adapt as you build or test changes for your program.

You can access this document on our provider webpage at this link: Complex Care Management Toolkit

### Guide to Four Pillars of Post-Discharge Care and Readmission Reduction

Eric Coleman, MD, MPH, is Professor of Medicine and Head of the Division of Health Care Policy and Research at the University of Colorado Anschutz Medical Campus. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care "hand-offs". The following grid is a guide to Coleman's four pillars. These include medication reconciliation, follow-up care, any red flags and self care concerns, and communication issues. This document provides a one page detailed explanation of each pillar, which are important in reducing hospital admissions. For more information about the Care Transitions Program and additional resources, you can visit http://www.caretransitions.org/.

**A Guide to the Four Pillars of Post-Discharge Care and Readmission Reduction**

| Medication Reconciliation | Follow-Up/ Usual Source of Care | Red Flags/Self Care | Communications |
|---|---|---|---|
| ◦ Compare list of medications pre-admission & post discharge—assist patient in resolving all discrepancies<br>◦ Educate patient on indication for use | Ideally follow-up appointment should be made before discharge | Patient/Caregiver received and understands discharge instructions | Encourage patient to bring discharge instructions to primary care provider (PCP) |
| ◦ Look for omissions<br>◦ Look for drug class duplicates<br>◦ Look for changes in drug formulations such as long acting to short acting medications | Identify date & time of follow-up appointment as well as provider name | Instructions should cover:<br>◦ Diet<br>◦ Activity<br>◦ Medications<br>◦ Wound Care<br>◦ Follow-up appointment<br>◦ Diagnostic tests pending | Encourage patient to make PCP aware of:<br>◦ pending diagnostic testing results<br>◦ changes to medication regimen<br>◦ abnormal diagnostic testing results |

| Medication Reconciliation | Follow-Up/ Usual Source of Care | Red Flags/Self Care | Communications |
|---|---|---|---|
| Be especially alert when the patient is taking >5 medications, several prescribing physicians or using several pharmacies | Contact patient 2 to 3 days after the follow-up appointment to see if it was kept and assess changes in plan of care, meds, etc | Post operative patients should know symptoms of infection:<br>• Redness<br>• Swelling<br>• Red Streaks<br>• Increasing pain<br>• Drainage from wound<br>• Fever | • Provide reinforcement of plan of care and utilize teach back methods to support patient's understanding<br>• Encourage patient self-management actions<br>• Encourage patient to involve caregivers in their plan of care<br>• Provide appropriate community resources<br>• Consider Social Worker referral |
| Every prescribed medication should be linked to a disease or diagnosis | If patient has no usual source of care assist in identifying one and scheduling appointment | Provide education specific to diagnosis/disease including red flags of when to call physician and/or seek care | Assist patient/caregiver in developing questions prior to provider visits |
| Assist in removing barriers | Review attribution reports on Availity or MMH+ to identify physicians member most often sees | Identify if Home Health or Durable Medical Equipment services were ordered and being received | Provide Personal Health Record (PHR) tool and encourage completion |
| • Look for possible drug-drug, drug-food interactions and side effects<br>• Consider Pharmacy Referral(to internal CM program or transformation team pharmacist) | Even if patient has no needs arrange a follow-up call in 5 to 7 days and reassess | Ensure all education or instructions are provided at the patients educational level and in a language they understand | |
| *High Risk Meds; Insulin, Warfarin, Coumadin, Cardiovascular drugs, Inhalers, Antiseizure, Eye, Analgesics, Oral hypoglycemics, Methotrexate, Immunosuppressants* | *Important Tip: People with chronic health conditions and multiple co-morbidities as well as the elderly at the most at risk* | *At discharge patients/ caregivers must take on those activities that were being performed by providers and begin coordinating their own care* | |
| Sample teach back quote: *"I want to be sure I explained your medication correctly. Can you tell me what this medication is for and how you are going to take it?"* | Sample teach back quote: *"It's very important that you see your doctor as soon as you can after a hospital stay. So I encourage you to call your doctor and schedule an appointment right away. Now, sometimes there can be more than one doctor providing you with care and it can be confusing to know who you should follow up with. So, let's talk about which doctor you'll be seeing in follow up to your recent hospital stay."* | Sample teach back quote: *"I would like to be sure I explained the potential reasons you may want to seek care with your Physician. Could you help me understand when you think you may need to seek care from your Physician?"* | Sample teach back quote: *"Having good communications with your Physician is really important, and there may be times that you will have questions for your physician to answer. Let's talk about what some of those questions may be for your next appointment."* |

# Appendix 4: Examples of Assessment Domains

| Domain D1 | Informed Choices (Domain 1) |
|---|---|
| Element 1 | Does member have a living will, Power of Attorney, or Healthcare Proxy? If so, obtain copies for physician records. If not, assess providing information to member to be educated on documents. |
| Element 2 | Assess and educate member on hospice services vs. palliative care (if condition warrants). |
| **Domain D2** | **Functional Status and Safety (Domain 2)** |
| Element 1 | Are there safety concerns identified such as home safety and fall precautions? Does the home have scatter rugs, stairs, have barriers for member to be mobile within home? If children in home, is the home child proofed? |
| Element 2 | Is member independent or dependent on assistance for daily function? If deficits, what are they and are they barriers to meeting goals? |
| Element 3 | Maximum functional status / functional status goal: What is the member's goal for function, if impaired? |
| Element 4 | Assess patient's psycho social concerns? Is cognitive function age appropriate? What is the highest level of education completed for member and are they able to read/write? |
| Element 5 | Does member need caregiver resources and involvement? Is member able to provide care for self, if not, who is the person involved in assisting member with care and appointments? |
| **Domain D3** | **Condition Management (Domain 3)** |
| Element 1 | Care Gaps |
| Element 2 | Is the member following the recommended plan of care prescribed by physician based on disease process or health issues identified? |
| Element 2 | Review of discharge instructions with member (if applicable), activity level, knowledge of adverse signs and symptoms related to member's condition, any home care and DME needed. |
| Element 3 | Does member understand what to report to physician concerning health conditions? Does member understand when to call physician and seek medical care? |
| Element 4 | Is member in pain? Have member rate pain on pain scale, address medications for pain relief and options if pain is not being relieved with current regimen. |
| **Domain D4** | **Medication Management (Domain 4)** |
| Element 1 | Obtain list of medications over-the-counter and prescription medications that member is taking. Check with pharmacy portal (if access available) to confirm medications. Does member understand why taking each medication? Are any of the medications new or different from previous medications? Are any medications missing? Does member ever forget to take medications? Is member careless about taking medications? When member feels better, do they stop taking medication? Does member understand the long-term benefit of the medication? Does member forget to fill medications on-time? |
| Element 2 | Per MMHPlus, are they getting medications filled at multiple locations and prescribed by multiple physicians? If more than 6 medications prescribed, evaluate medications to ensure no duplication of similar medications on list. |
| Element 3 | Member understands and can verbalize potential side effects to monitor and report to physician any adverse effects. Is member experiencing any unusual reaction after taking medication? |
| Element 4 | Potential barriers include not getting medication filled appropriately, financial issues causing member not to get medication filled, location or transportation issues, and does member need resources to assist in reducing the barriers. |

| Domain D5 | Prevention/ Lifestyle (Domain 5) |
|---|---|
| Element 1 | Is member on any specific type of diet? What is member's BMI and nutritional status? |
| Element 2 | Does member smoke? If so, are they interested in smoking cessation information? |
| Element 3 | Review annual preventative care items such as mammograms (age appropriate), pap smears, colon exams, rectal exams, prostate exams. Has member received flu shot and up to date on immunizations? |
| Element 4 | Does member use alcohol or drugs on a regular basis? If so, consider management of this. Or has member used alcohol or drugs at anytime? |
| Element 5 | During the past month, has the member been bothered by feeling down, depressed, or hopeless? During the past month, has the member been bothered by little interest or pleasure in doing things? If yes to these questions, consider behavioral health involvement and further evaluation for depression. |
| Element 6 | How does the member relieve stress? Does the member participate in stress relieving activities, i.e. exercise, deep breathing, relaxation? For a child, does the child act out in play? |
| **Domain D6** | **Barriers to care/impact to treatment plan (Domain 6)** |
| Element 1 | Are there cultural issues that will affect member's health our outcome of health? Are there any religious or heritage practices/issues that will potentially affect health or treatment? |
| Element 2 | Does member have access to community resources? Are there needs to connect member with resources? What access does member have to computer and other avenues for linking with resources? |
| Element 3 | What is members primary language spoken? Are there barriers to hearing, vision, sensory? Is member able to read and write? Evaluate communication barriers such as visual or hearing aids. |
| **Domain D7** | **Transitions Of Care/Access To Care (Domain 7)** |
| Element 1 | Care Transition Plan |
| Element 2 | Participating Provider Network : Are providers in network? |
| Element 3 | Optimal Site of Service |
| Element 4 | Specialists / other provider coordination |