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
Shared Care Plans and Self-Management Support

ECHO Monthly Call- Shared Care Plans

A project of the Tri-State Children's Health Improvement Consortium

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“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.
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

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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)...

Do not cite or reproduce without proper citation
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)

*Do not cite or reproduce without proper citation*
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
Example: Asthma Action Plan

GREEN ZONE
“GO! All clear!”
Peak Flow Range:

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

- Medication
- How much to take
- When to take it

YELLOW ZONE
“Caution...”
Peak Flow Range:

- Wake up at night
- Cough & wheeze
- Chest is tight

- Medication
- How much to take
- When to take it

RED ZONE
“STOP! Medical Alert!”
Peak Flow Range:

- Medication is not helping
- Breathing is hard and fast
- Can’t walk
- Can’t talk well
- Rib’s show
- Nose opens wide to breathe

- Medication
- How much to take
- When to take it

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 medication to be given at school.

[Signatures and details]

Date:
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

Do not cite or reproduce without proper citation
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.

Do not cite or reproduce without proper citation
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

Do not cite or reproduce without proper citation
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

*Do not cite or reproduce without proper citation*
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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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>
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<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
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?

Do not cite or reproduce without proper citation
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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ECHO Monthly Call- Shared Care Plans
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
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?
Summary
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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