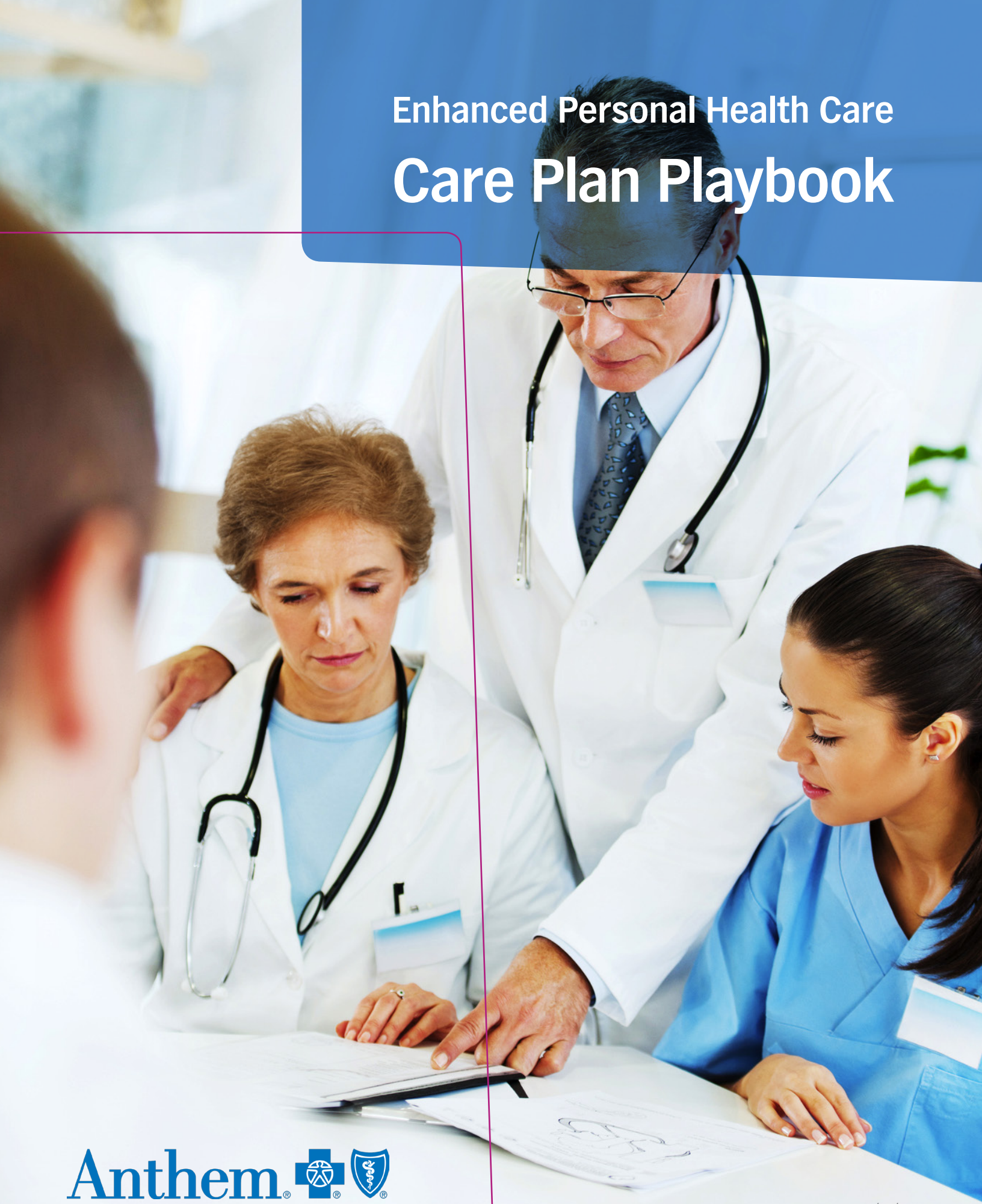
Enhanced Personal Health Care

Care Plan Playbook



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What is a Care Plan?

A care plan is a detailed approach to care that is 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.
- Use patient health records and available EPHC reports to identify patients who can benefit from a care plan.

A care plan template can be reviewed on Anthem.com:

Providers ➡ Select Your State ➡ Enhanced Personal Health Care Program ➡ Provider Toolkit ➡ Care Planning

Care Planning Step-by-Step

1. Identify patients at risk for poor health care outcomes such as not meeting treatment goals for chronic conditions or avoidable emergency room utilization, inpatient admission or readmission.

   This can be done during an interview, physical examination, obtaining a health history, reviewing diagnostic data, or reports that identify your high-risk population and those with gaps in care.

   The illustration below describes the two primary groups of patients who can benefit from care plans.

Members with recent inpatient visits

A care plan will allow providers to assess and minimize risk for readmission.

Members with chronic disease

A care plan will help providers identify and adhere to evidence-based care, supporting better quality of care along with a decrease in overall utilization and cost.

2. During a patient assessment, use assessment domains and data from our longitudinal patient record to guide questions and focus on potential areas of concern. (See Appendix 1 and 2 for 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. (See Appendix 3 for examples.)

Actionable Information for Care Planning

As an Enhanced Personal Health Care participant, you will have access to a broad range of patient information through our EPHC reports.

Our EPHC reports are designed to be intuitive and useful, supporting your efforts on the most pertinent data about a given patient's health, allowing you to focus on chronically ill, at-risk patients that can benefit the most from care management interventions.

Patient360 (P360), our longitudinal patient record, is embedded into our EPHC reports and is available as a standalone tool.

EPHC reporting will detail your patient population's

- Prospective risk score, helping you identify patients at high-risk for future health care complications
- Emergency room utilization
- Inpatient utilization
- Risk for inpatient readmissions
- Gaps in care

In addition to EPHC reports, you can identify patients who may benefit from care management by screening for those who:

- Are not meeting treatment goals
- 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 comorbid medical and behavioral health conditions

Appendices

Appendix 1: Assessment Domains

Below is a suggested listing of assessment domains/functional areas to guide goal formation and related elements that support the identification of goals and interventions.

Domain 1: Informed Choices

Element 1	Life planning documents: DPOA, living will, health care proxy
Element 2	Aggressive vs. palliative care–hospice

Domain 2: Functional Status and Safety

Element 1	Personal safety plans: child proofing, home safety, fall prevention
Element 2	Level of independence and functional deficits
Element 3	Maximum functional status and 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 or 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 and drug Use
Element 5	Depression screening
Element 6	Play and other stress management techniques

Domain 6: Barriers to care/impact to treatment plan

Element 1	Cultural and language barriers
Element 2	Community resource availability
Element 3	Communication impediments: hearing and vision loss, low literacy

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	Coordination with specialists and other providers

Appendix 2: Examples of Assessment Domains

Domain 1: Informed Choices

Element 1	Does the patient have a living will, power of attorney, or health care proxy? If so, obtain copies for provider records. If not, assess providing information to patient to be educated on documents.
Element 2	If condition warrants, assess and educate patient on hospice services vs. palliative care

Domain 2: Functional Status and Safety

Element 1	Are there safety concerns identified such as home safety and fall precautions? Does the home have scatter rugs, stairs, or other barriers to mobility at home? If children are in the home, is the home child-proofed?
Element 2	Is the patient independent, or dependent on assistance for daily function? If the patient shows some deficits, what are they, and are they barriers to meeting goals?
Element 3	What is the patient's goal for function, if impaired?
Element 4	Assess the patient's psychosocial concerns. Is cognitive function age appropriate? What is the highest level of education the patient completed? Is the patient able to read and write?
Element 5	Does the patient need caregiver resources and involvement? Is the patient able to provide care for himself or herself? If not, who is assisting the patient with care and appointments?

Domain 3: Condition Management

Element 1	Care Gaps
Element 2	Is the patient following the recommended plan of care prescribed by the provider based on disease process or health issues identified?
Element 2	If applicable, review discharge instructions with the patient. Ask about activity level, knowledge of adverse signs and symptoms related to patient's condition, any home care and DME needed.
Element 3	Does the patient understand what to report to the provider concerning health conditions? Does the patient understand when to call the provider and seek medical care?
Element 4	Is the patient in pain? Ask the patient to rate pain on pain scale, address medications for pain relief and options if pain is not being relieved with current regimen.

Domain 4: Medication Management

Element 1	Obtain a list of over-the-counter and prescription medications that the patient is taking. If available, check your pharmacy portal to confirm medications. Does the patient understand why he/she is taking each medication? Are any of the medications new or different from previous medications? Are any medications missing? Does the patient ever forget to take medications? Is the patient careless about taking medications? When the patient feels better, does he or she stop taking medication? Does the patient understand the long-term benefit of the medication? Does the patient forget to fill medications on time?
Element 2	Is the patient getting medications filled at multiple locations and prescribed by multiple providers? If more than six medications prescribed, evaluate medications to look for possible duplication.
Element 3	Ensure that the patient understands and can verbalize potential side effects to monitor and report any adverse effects to the provider. Is the patient experiencing any unusual reaction after taking medication?
Element 4	Potential barriers include not getting medication filled appropriately, financial difficulties, location or transportation issues. Does the patient need resources to address those barriers?

Domain 5: Prevention/Lifestyle

Element 1	Is the patient on any specific type of diet? What is the patient's BMI and nutritional status?
Element 2	Does the patient smoke? If so, is he/she interested in smoking cessation information?
Element 3	Review age-appropriate annual preventive care items such as mammograms, Pap smears, colon exams, rectal exams, prostate exams. Has patient received flu shot and is the patient up-to-date on immunizations?
Element 4	Does the patient use alcohol or drugs on a regular basis? If so, consider management of this. Has the patient used alcohol or drugs at any time?
Element 5	During the past month, has the patient been bothered by feeling down, depressed, or hopeless? During the past month, has the patient 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 patient relieve stress? Does the patient participate in stress-relieving activities, i.e. exercise, deep breathing, relaxation? For a child, does the child act out in play?

Domain 6: Barriers to Care/Impact to Treatment Plan

Element 1	Are there cultural issues that will affect the patient's health our outcome of health? Are there any religious or ethnicity practices/issues that will potentially affect health or treatment?
Element 2	Does the patient have access to community resources? Are there needs to connect the patient with resources? What access does the patient have to a computer and other avenues for linking with resources?
Element 3	What is the patient's primary spoken language? Are there any hearing, vision, or sensory problems? Is the patient able to read and write? Evaluate communication barriers such as visual or hearing aids.

Domain 7: Transitions of Care/Access to Care

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

Appendix 3: 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

- Problem statement with an action plan that is measurable, obtainable, and important to the patient
- What is highest priority for the patient?
- Identify what the patient wants to have happen or accomplish, when to have it completed, and how you as the primary care provider will know that it is done
- Assess 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)
- Intervention(s):
  - The steps that are needed to be taken to assist the patient to reach the goal(s)
    - Each 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
- 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 at high-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 EPHC 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 A1C (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 A1C 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

Appendix 4: Care Planning Resources

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.

Complex Care Management Toolkit

This 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.

Resources from Anthem.com

Enhanced Personal Health Care providers have access to a trove of practice transformation guidance:

- The Enhanced Personal Health Care Provider Toolkit Care Planning section includes a care plan template and related resources
  - Follow this path to the Provider toolkit:

    Providers ➡ Select Your State ➡ Enhanced Personal Health Care Program ➡ Provider Toolkit
- Our Learning Collaborative e-Catalog includes several recorded webinars related to care planning and chronic disease
  - Follow this path to the e-Catalog:

    Providers ➡ Select Your State ➡ Enhanced Personal Health Care Program ➡ Collaborative Learning Opportunities

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