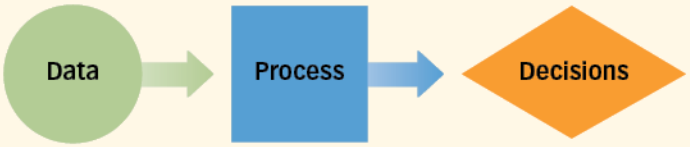
WORKFLOW 101:

Care Planning



Organization Name _____ Date _____

Why is Care Planning important component of Care Management and Care Coordination?

- Care planning is a detailed approach to care and customized to an individual patient's needs
- Care Planning Enhances 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
- Care plans are called for when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions
- A care plan can be developed for anyone (healthy or sick) with pre-visit, visit and post-visit activities being assigned to the right team member, allowing that person to work to the top of his or her license (i.e., a nurse might conduct med rec, but a health coach can do self-management support (SMS))

Who in the practice or organization is tasked with Care Planning and completing a Care Plan?

- Doctors, NP, RN, SW can all contribute as a multi-disciplinary team to the care plan
- Complex patients requiring care management – care planning is often performed by a nurse who focuses on patients with the highest risk for health deterioration and/or poor outcomes
  - For less complex patients; social workers, behavioral health specialists and other members of the multidisciplinary care team can support the care plan
  - A care plan can be developed for anyone (healthy or sick) with pre-visit, visit and post-visit activities being assigned to the right team member, allowing that person to work to the top of his or her license (i.e., a nurse might conduct med rec, but a health coach can do self-management support (SMS))

Who will most benefit from care planning?

- Complex Care Patients
- High-risk patients due to (related to) chronic conditions
- Patients at risk for readmission
- Non Adherent/Non-Compliant Patients
- Patient with socio economic issues
  - Limited access to care
  - Unable to afford medication
  - No care givers or family to help

What tasks need to be assigned have an effective Care Planning?

- Multi-disciplinary team in place and appropriately licensed
- Create Care Planning Templates for Chronic Conditions
- Population Identification
- Risk Stratification of Population
- Identify High-Risk Patients and Risk Factors
- Identify Disease Burden
- List of patients who would benefit from care planning interventions
- Outreach programs to address chronic illness, open gaps in care
- Metrics to monitor and modify goals

When will assigned activities take place?

- Day and time for report review
- Care plan/SMS plan creation with patient and review
- When to educate patients? Scheduled appointment/proactive phone call
- How soon after ER/Inpatient discharge to begin calling patient and to get patient in for appointment

Where will assigned activities take place?

- Dedicated time and space to manage review of reports, patient calls and education