South Carolina Office of Rural Health

Collaborative Care Plans
November 2016

Michele Stanek, MHS, PCMH-CCE
SC Office of Rural Health
USC School of Medicine
Healthcare Delivery System

Guiding Principles set forth in IOM’s Crossing the Quality Chasm for the healthcare system:

- Safety
- Patient-Centeredness
- Efficiency
- Equity
- Timeliness
- Effectiveness
Triple Aim for Healthcare Improvement

Improve the experience of care, improve the health of populations, and lower the per-capita cost of care.
Transformation

Transformational Change is needed within healthcare; key drivers of quality chasm and rising healthcare costs include:

- Fragmented Care
- Poor communication between patient and care team & across settings
Care Plan

...coordinated plan of evidence-based, integrated clinical care activities that are patient-specific and are agreed upon by the patient, caregivers, and clinician. The care plan is a tool to facilitate communication and shared decision making. Fundamental to the care plan are the conversations that a patient and clinician have regarding the patient’s care...

- IOM, 2013

Care Plan

- Care plan is a tool to:
  - Facilitate communication with patients
  - Promote shared decision-making
  - Increase care coordination & communication across settings
  - Provide path of care
  - Activate patients and promote health
  - Reduce gaps in care
  - Prevent duplication of services...
Care Plan

- Care Plans developed to
  - Meet regulatory requirements
  - Obtain payment
  - Attain recognition or accreditation
  - Promote coordination of care
  - Increase patient safety
  - Facilitate communication
  - Broaden patient needs assessment and support
  - Support care processes and systems of care...
Care Plan

• Challenges of current care plans:
  o Sequential care plans
  o Multiple care plans
  o Competing/conflicting care plans
  o Static document
  o Lack patient-centeredness
  o Illness planning vs. wellness planning
  o Process/service-driven vs. goal-driven
  o Episodic vs. longitudinal
  o Differing regulatory requirements
  o Differing definitions and content by provider types
  o Differing care team composition
Collaborative Care Plan

Care Plan 2.0

- Care plans should synthesize and reconcile multiple plans of care into one blueprint to guide a patient’s care
- Care plans should guide the coordination of care across settings, providers and episodes of care
- Care plans should integrate multiple interventions by multiple providers for multiple conditions
- Care plans should be supported by systems of care and care processes across settings

Collaborative Care Plan

A consensus-driven dynamic plan that represents all of a patient’s and Care Team Members’ prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members, including the patient, to guide the patient’s care. A Care Plan integrates multiple interventions proposed by multiple providers and disciplines for multiple conditions.

-ONC, 2012

Collaborative Care Plan

Collaborative Care Plan

• Universal Components:
  o Health Concerns
  o Goals
  o Risk Factors
  o Instructions
  o Interventions
  o Patient Status/Outcomes
  o Team Members

Discussion

• What are essential elements?
• What are your primary objectives of care plan?
• Who is primary audience?/Who is secondary audience?
• How do you share/involve patient in Care Plan development?
• How do you share Care Plan with other provider organizations/types?
• How can you better engage patients in Care Plan process?
• How can you better integrate and develop Collaborative/Longitudinal Care Plans?