BHICCI

Core Competencies, Chapter 8

Subject: Shared Care Planning

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Definition and Why Shared Care Planning is Important to Integrated Complex Care

Shared care planning is grounded in the practice of shared decision-making among patients and their care team. Shared care planning develops shared accountability to address key health/treatment goals and facilitates communication with the patient/client and across his/her care team, including any specialty providers. Effective shared care planning builds health literacy and activation through actively supporting patients to be involved in identifying problems and treatment needs, as well as self-management goals. This is especially critical for patients/clients who have complex medical and behavioral health conditions.

Shared care planning includes the following components: identification of members of the care team, specification of health problems/concerns, agreements re: goals and planned actions among patient and providers, and may include a medication list. The shared care plan is serves as a tool that focuses care management and treatment on short-term client/provider care objectives. Especially when clients have multiple complex conditions, it is critical that members of the care team have access to the same information and can build upon the shared care plan. Team members must act in coordination toward a common care management and clinical goals in order to provide integrated and high quality care.

Example

Mrs. Ramos meets with her care manager to develop a Shared Care Plan. She is not sleeping well, is worried about her medications side effects, and is having trouble remembering to take her medications. She also worried about her husband's recent job loss and potential loss of their apartment. The care manager helps Mrs. Ramos develop three personal health goals for the next month that are recorded in her shared care plan:

1. Sleep more restfully.
2. Get in better control of her diabetes and take her medications regularly.
3. Hang on to her apartment.

The plan was further detailed to include steps that the patients and care manager will take to be successful, along with deciding on a method for measuring success for each personal goal. The care plan was entered into the patient's electronic medical records and electronically forwarded to both the primary care provider and the endocrinologist. At a follow up appointment, the care manager saw that both the primary care provider and the endocrinologist noted the care plan – which enabled each to adjust care efficiently based on the patient's personal care goals. The care manager was pleased to see that her efforts resulted in a better focus and unification around the patient's goal statements.

Narrative Description

A shared care plan documents the patient's health goals, self-care commitments, and the steps that the care manager will take to assist the patient in addressing his/her needs. A shared care plan meant to be READ by all member of a complex care team, including (or especially) the treating primary care provider and any specialist(s) involved with the patient. The shared care plan is written "in the client's voice" whenever possible – which means using the client's actual stated words. When optimally crafted, it can also serve as a take-home handout to the client provided to the Client to guide his/her self-management. A shared care plan results from the discipline of care planning. Effective shared care planning utilizes the skills of shared decision-making, motivational interviewing, and engagement skills. Shared care planning assists patients in understanding how they can take steps themselves toward self-care/self-management. The plan describes how the patient can achieve better treatment engagement, adherence and

outcomes. Thus, the process of care planning is often itself therapeutic (too often clinicians mistake shared care planning as a mere "paperwork exercise" – whereas in reality it can be one of the more impactful activities in care management. Shared care plans are also meant to communicate and promote shared accountability and consistency across the health care team in addressing each patient/client's health goals. The share care plan facilitates communication between the patient/client and across his/her care team. According to the AHRQ Integration Academy the North Star of Share Care Planning is: "Patients are routinely part of creating care plans and making decisions. All members of the integrated care team have access to the care plan and practice in accord with it."

A shared care plan should thus be a patient centered/patient driven expression of key needs/problems, specific treatment/health goals that reflect patient's priorities as well as the care team's critical health concerns. As patients make progress, the plan needs to be updated: An effective shared care plan is generally established for no more than a 3-month period (longer shared care plans tend to be filed away and forgotten).

Well-written shared care plans support measurement based care by specifying how progress in achieving goals targets will be measured. During each contact, the provider/team member should check in with the patient on goals stated in the shared care plan inclusive of health, behavioral health and self-management goals. The shared care plan makes and excellent reference document for case consultations, morning huddles, and caseload reviews.

Characteristics/Components of a shared care plan:

- Developed by the Care Manager in collaboration with the patient/client
- The Shared care plan is written in "plain language" that is literacy level sensitive and in patient's words to the extent possible
- Includes patient's statement of problems (or needs).
- Medical diagnosis or condition being addressed.
- 1 – 5 Personal wellness goals (wellness includes medical, behavioral, personal, lifestyle, social, and other social wellness determinants. All goal statement should be achievable.
- Identifies intermediate objectives for assessing progress in meeting goal and/or identifies a method for measuring success.
- Identifies specific steps or actions to be carried out by patient and healthcare team
- Indicates who is involved in the patient's care/care team--including specialty providers, and family or other natural supports.
- Updated frequently enough to stay accurate and useful.
- A shared care plan is NOT a compilation of (detailed) treatment plans from each provider or an annual plan to meet Medicaid/Medicare audit standards

Available Resources

1. Agency for Healthcare Research and Quality Integration Academy, Develop A Shared Care Plan, https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan
2. My Total Health Plan: Avery, Bataille, Urada, http://www.cibhs.org/sites/main/files/file-attachments/ccc-shared_care_planning.pdf
3. Shared Care Plans: A Reference Guide, HealthTeamWorks, http://www.healthteamworks.org/wpcontent/uploads/2016/05/Shared_Care_Plans_Reference_Guide.pdf
4. Patient Centered Primary Care Institute (Examples of Shared Care Plans) http://ww.pcpci.org/sites/default/files/resources/Shared%20Care%20Plans_0.pdf

BHICCI Plan for Learning / Teaching / Coaching

- Agency Leadership, primary care providers, care managers, and Clinic Staff READ the materials presented in Core Competency 8 - Shared Care Planning, and discuss with the practice coach.

- PARTICIPATE OR VIEW Web-training or In-Person Presentation: Review of basics of shared care planning – developed by Jen Clancy Consulting team.

How will Competence in this area be Measured?

Following completion/verification of the above learning/teaching/coaching plan, each clinician will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician's competency in each of the following by:

1. Case discussion of 3 or more complex care patients, or
2. Chart review of 5 or more patients, or
3. Direct observation of clinician interaction and conversation with patients/clients and other departments.

COMPETENCY AREA	EVIDENCED BY:	SUPERVISOR'S RATING*
Care Planning skills are utilized.	• Communicates clearly with customers who do not speak English fluently • Explains wellness issues clearly and succinctly • Demonstrates a willingness to hear others out before reaching a decision • Evidenced by: Effective empathy conveyance • Reliance on open ended questions in interactions with patient/clients • Consistent use of, reflective listening in interactions with patients/clients • Regular and effective use of normalizing and affirming with patients/clients • Utilizes some form of evidence based care planning: such as shared decision making, motivational interviewing, or problem solving therapy.	1 2 3 4 5
Development of care plans.	• Care plans will contain health goals that are achievable and maximize patient voice. • Care plans contain identified structured measures or measurable objectives. • Action steps and accountability for both client/patient and caregiver are clearly specified in the plan. • Care plans document progress in achieving personal goals.	1 2 3 4 5
"Person First" documentation is employed.	• Evidenced by the absence of 'condition first' language in documentation and verbal discussion, avoiding words such as 'addict', 'diabetic', 'high utilizer', etc. • Avoidance of high judgment words verbally and in writing, such as 'non-compliance', 'lying' 'manipulative' and 'drug seeking' • Identifying whose perspective is being shared in writing and in documentation, to avoid perspectives being prioritized as 'truth' (instead of 'patient	1 2 3 4 5
Care Plans are Shared	• Care plans are entered into the Medical Record for viewing by team members. • Care plan is electronically forwarded to key clinical members (such as PCP, specialists). • Care plan is forwarded to "outside" care providers with ROI and as clinically appropriate.	1 2 3 4 5

*1= Excellent results with no need for prompting or support.
3 = good results and/or required some prompting or support.
5 = required much support and/or was unable to complete necessary skills.