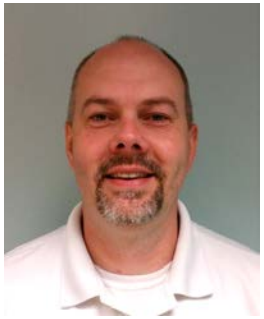
SIM PCMH Initiative Affinity Groups

Shared Care Planning: What and How?

August 3rd, 2017

Michigan Care Management Resource Center
Affinity Group Support Staff

Marie Beisel, Introductions



Scott Johnson - Group Facilitator

Lauren Yaroch - Questions

Judy Avie – Participant Facilitator

SIM PCMH Affinity Groups

The care manager and coordinator affinity group facilitates networking and promising practice sharing across the state. This group is open to all Initiative care managers and coordinators offering an opportunity for peer to peer learning. Collaboratively, care managers and care coordinators will identify areas of interest, topic focus, and prioritize challenges. Outcomes include:

- "What works"
- "What has been tried and does not work"
- Shared learning
- Identification of best practices
- Identify educational needs

Care Manager and Coordinator Learning Credits

One hour of SIM PCMH Longitudinal Learning Credit will be earned per each hour of participation in the Affinity Groups.

- Participants must register with their complete information to earn credit, anonymous participants will not earn Learning Credits.
- To obtain Longitudinal Learning Credit participants must join sessions “live” (in real-time).

Instructions for Obtaining a Certificate of Completion

To receive a certificate of completion for the “Care Manager and Care Coordinator Shared Care Planning: What and How?” Affinity group

1. Attend and participate in the entire Affinity Group
2. Check inbox for email from MiCMRC for “SIM Affinity group Evaluation”
3. Follow instructions in the e-mail: Attest to completing the Affinity Group, complete the evaluation and submit. This step generates an email to you containing the certificate of completion

For technical assistance please e-mail:

micmrc-requests@med.umich.edu

Care Manager & Care Coordinator Participant Commitment:

Attendees participating in a variety of ways during the interactive virtual meeting

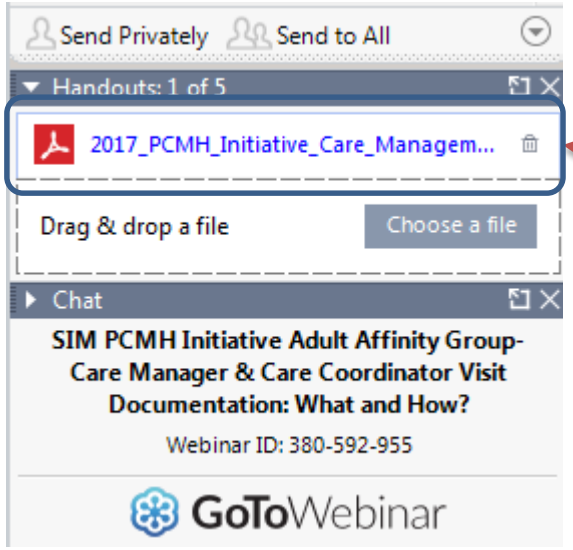
- Posting questions, verbally sharing experiences and lessons learned, responding to polls
- Completion of post meeting evaluation
- Attendee contact information will be shared with the group to promote networking
  - Example: in addition to the contact information, sharing information such as area of expertise
- Completion of a brief survey to identify future high priority Affinity Group meeting topics.

Housekeeping: Webinar Toolbar Features

Collapse Toolbar

Raise Your Hand

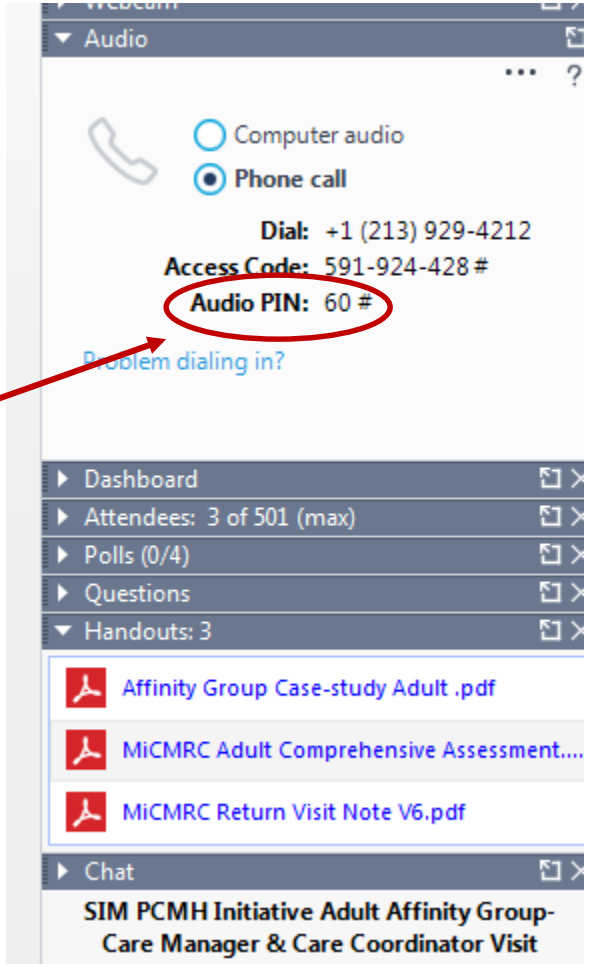
Ask a Question



Access PDF Versions of documents

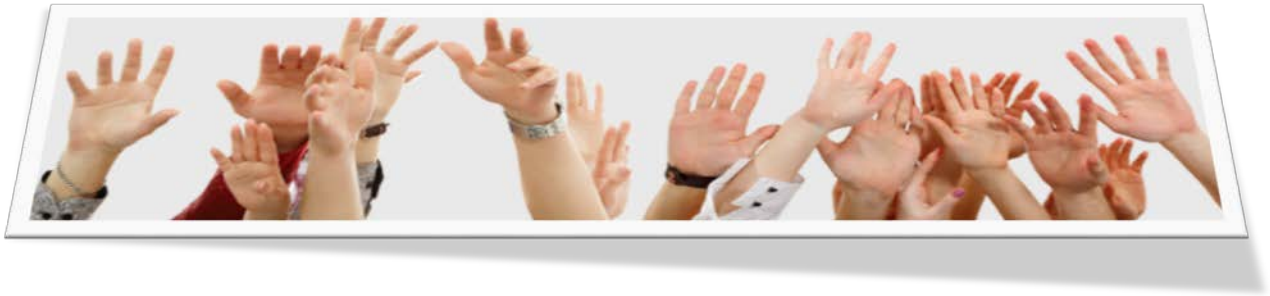
Use question box at any time for your questions and we will try to answer during session.

If you did not enter your audio pin when first dialing in please input it now to allow for unmuting of your phone



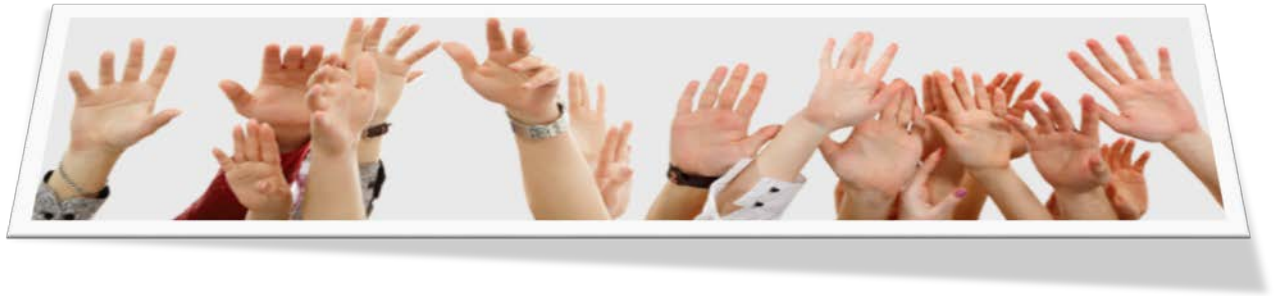
- How long have you been in care management, less than 1 year, 2 to 3 years, 4 or more

- Provide one question you would like to get answered about shared care planning – type into question box



- Raise your hand if you find shared care planning challenging

- Raise your hand if you would like to share a specific challenge with shared care planning



- Raise your hand if you have found a solution or had success in the challenges mentioned

Let’s pause a moment to address any questions or comments

Agenda

- Discuss the key differences in Care Management and Care Coordinator roles, and how this affects care planning

- Discuss shared care planning definition, purpose and elements

Key roles of the Care Manager

- **Complete comprehensive assessment** of patient's health conditions, treatments, behaviors, risks, supports resources, values, preferences and overall service needs. This can be done in coordination with other members of the care team
- **Develop comprehensive, individualized care plans**; coordinate services required to implement the plan; provide continuous patient monitoring to assess the efficacy of the plan; periodically re-evaluate and adapt the plan, as necessary
- **Ensure patients have timely and coordinated access** to medically appropriate levels of health and support services and continuity of care
- **Provide a range of client-centered services** that link patients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible
- **Conduct medication reconciliation**
- **Promote patient's and family caregiver's active engagement in self-care**
- Coordinate and communicates with all professionals engaged in a patient's care, especially during transitions from the hospital
- Assist with advance directives, palliative care, hospice and other end-of-life care coordination

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Key Roles of the Care Coordinator

- **Jointly creates and manage the individualized plan of care** with the patient/family, care team and community based organizations, that outlines the patient's current and longstanding needs and goals for care and addresses coordination needs and gaps in care
- **Contribute to ongoing maintenance**, which includes monitoring, following up and responding to changes in the patient's individualized plan of care
- **Support self-management goals** to promote patient health
- Align resources with patient and population needs
- Demonstrate administrative skills to organize, evaluate, and present information clearly both verbally and in written communication; **maintain documentation according to practice specifications**
- **Demonstrate knowledge about community resources** by providing information on the availability of and, if necessary, coordinate these services that may help support patients' health and wellness or meet their care goals

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SIM PCMH General Requirements

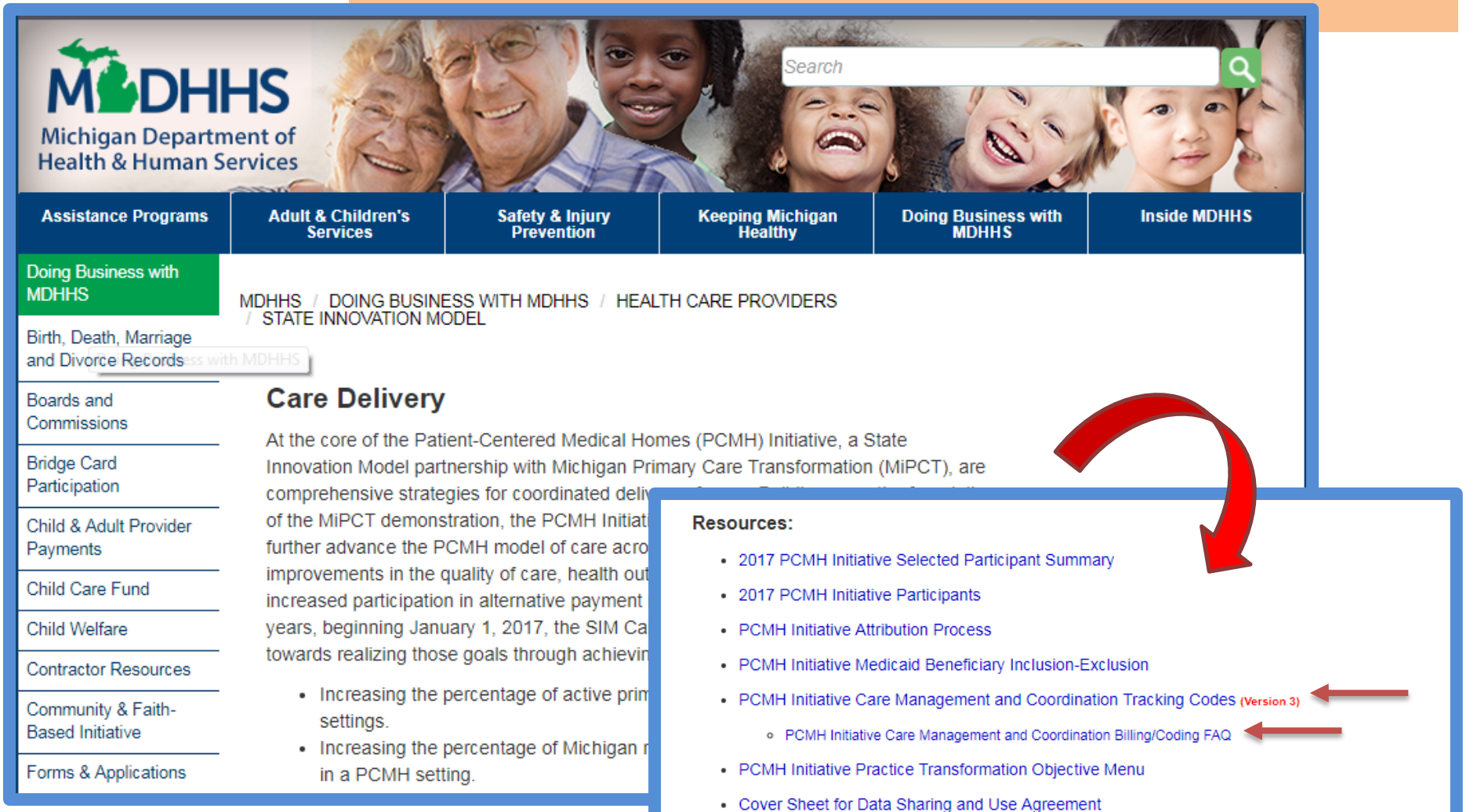
For the purposes of the PCMH Initiative, care management and coordination services are “the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively.”

- It includes services such as (but it not limited to):
  - Comprehensive assessment of the patient’s medical, functional, and psychosocial needs
  - System-based approaches to ensure timely receipt of all recommended preventive care services
  - Medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications
  - Management of care transitions between and among health care providers and settings, including referrals to other providers, follow-up after emergency department visits, and discharges from inpatient settings
  - Coordination of care with and linkages to home and community-based service providers. o (The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.)

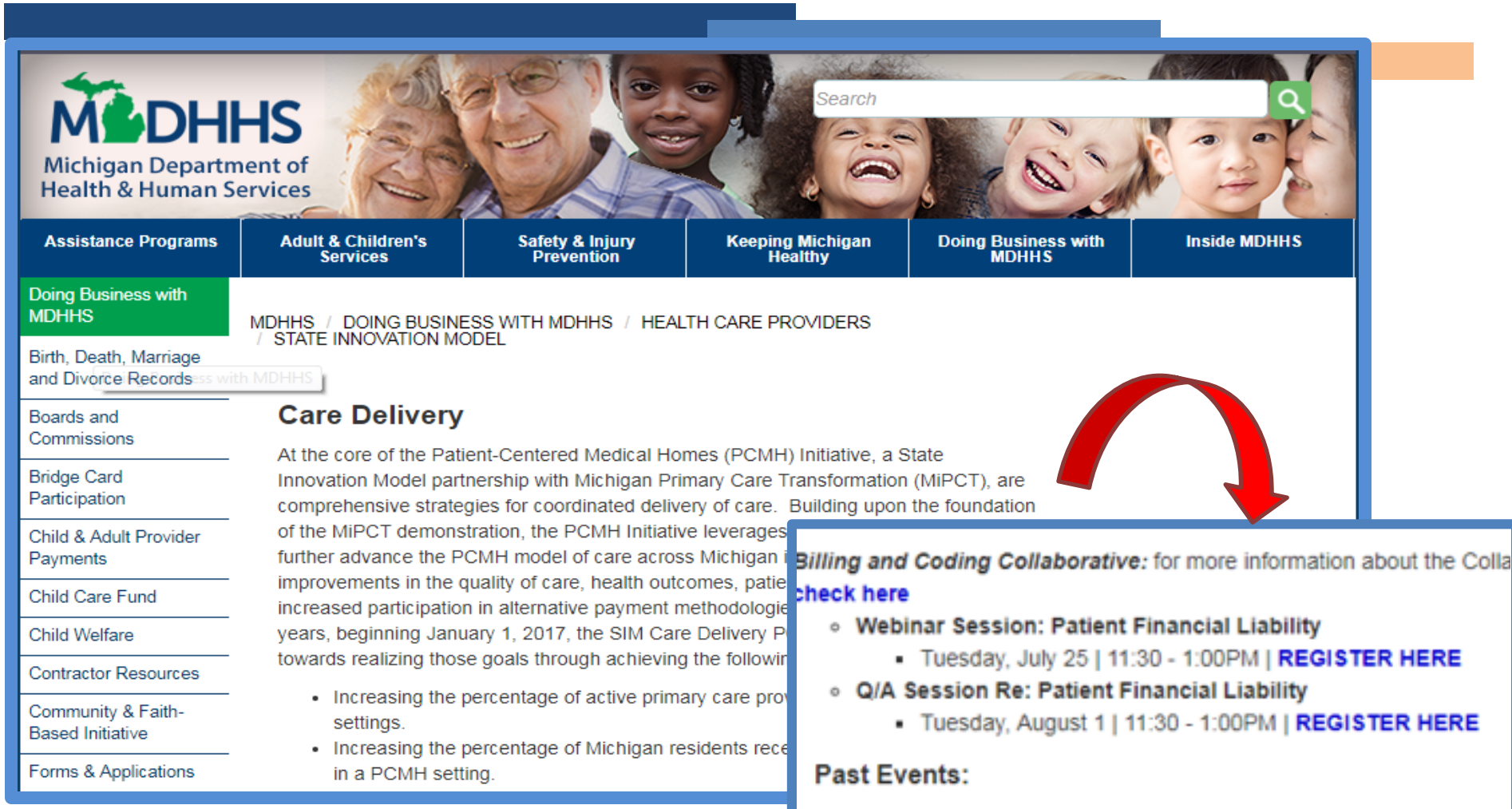
SIM PCMH General Requirements

- All care management services provided by a participating provider and reported using the tracking codes above should be documented in an electronic care management and coordination documentation tool accessible to all members of a care team

- The tool must be either a component of an EHR, or able to communicate with an EHR, to ensure pertinent care management and coordination information is visible to care team members at the point of care



For more information on Affinity groups, care manager and care coordinator roles and requirements, tracking codes, and the SIM PCMH Initiative go to: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76092_77452---,00.html



SIM PCMH Billing and Coding Collaborative

To support SIM PCMH Initiative practices and POs in understanding G and CPT care management and coordination code requirements for Medicare patients, as well as care management and tracking codes for Medicaid patients. The collaborative will: ☐Support participants in Billing/Coding related issues for Care Management (CM) / Care Coordination (CC) ☐Build an understanding of CM/CC code requirements

Sim PCMH Initiative page

SIM PCMH Web Page Link

Let’s pause a moment to address any questions or comments

Shared Care Plan

Definition

A shared care plan is a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and social health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care.

Agency for Healthcare Research and Quality. Integration Academy. https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan

Shared Care Plan

Definition

A shared care plan gives patients a tool to learn about and practice principles of self-management, producing activated and engaged patients. In addition, it gives health care professionals a communication tool to provide timely information that supports planned care and patient self-management.

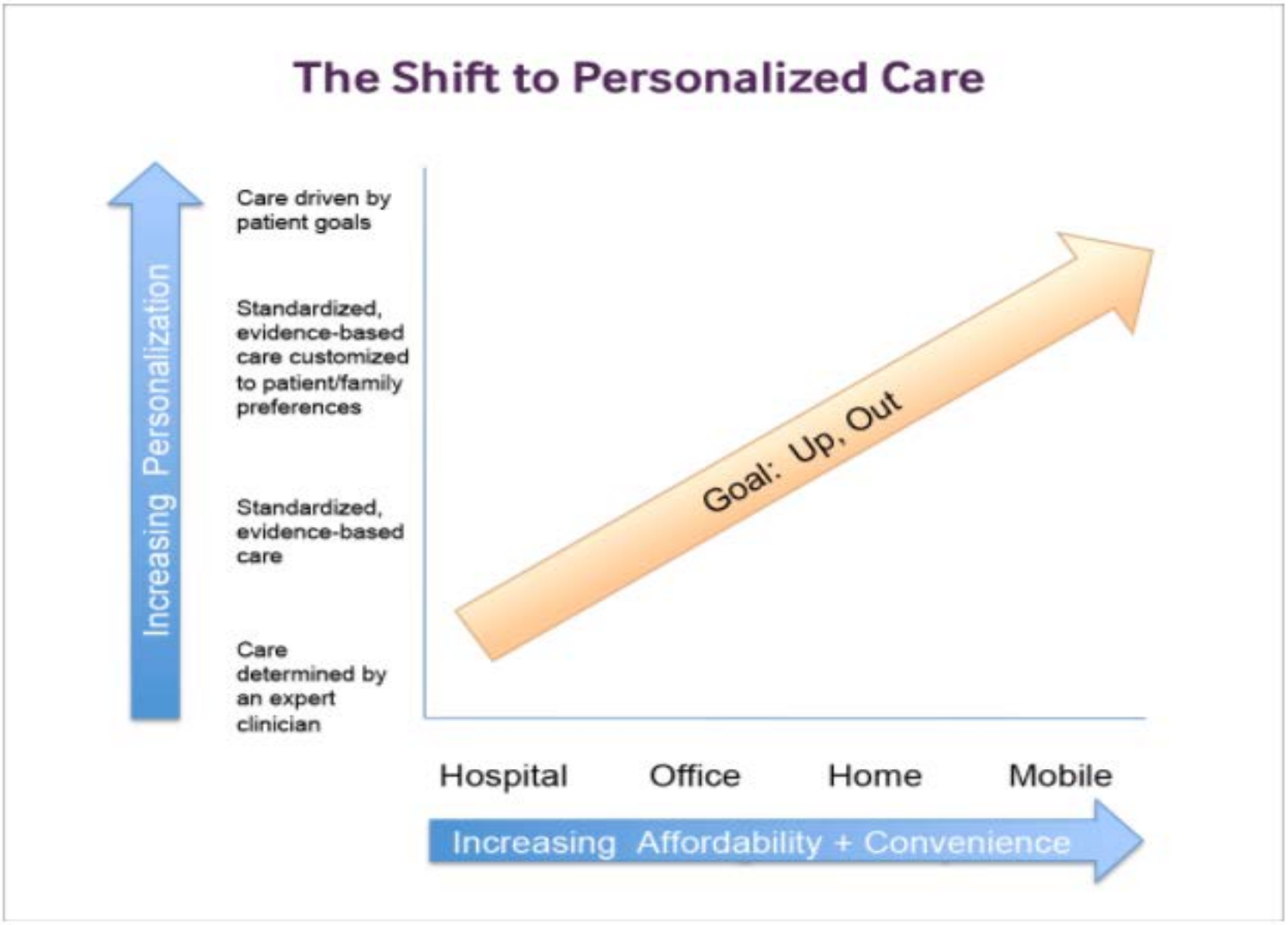
http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx

Shared Care Plan

Purpose

Giving patients the opportunity to help develop and negotiate their care plans transforms the relationship between patients and providers. By emphasizing transparency and cooperation in developing shared care plans, your practice can reshape and improve its relationship with patients

Agency for Healthcare Research and Quality. Integration Academy. https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan



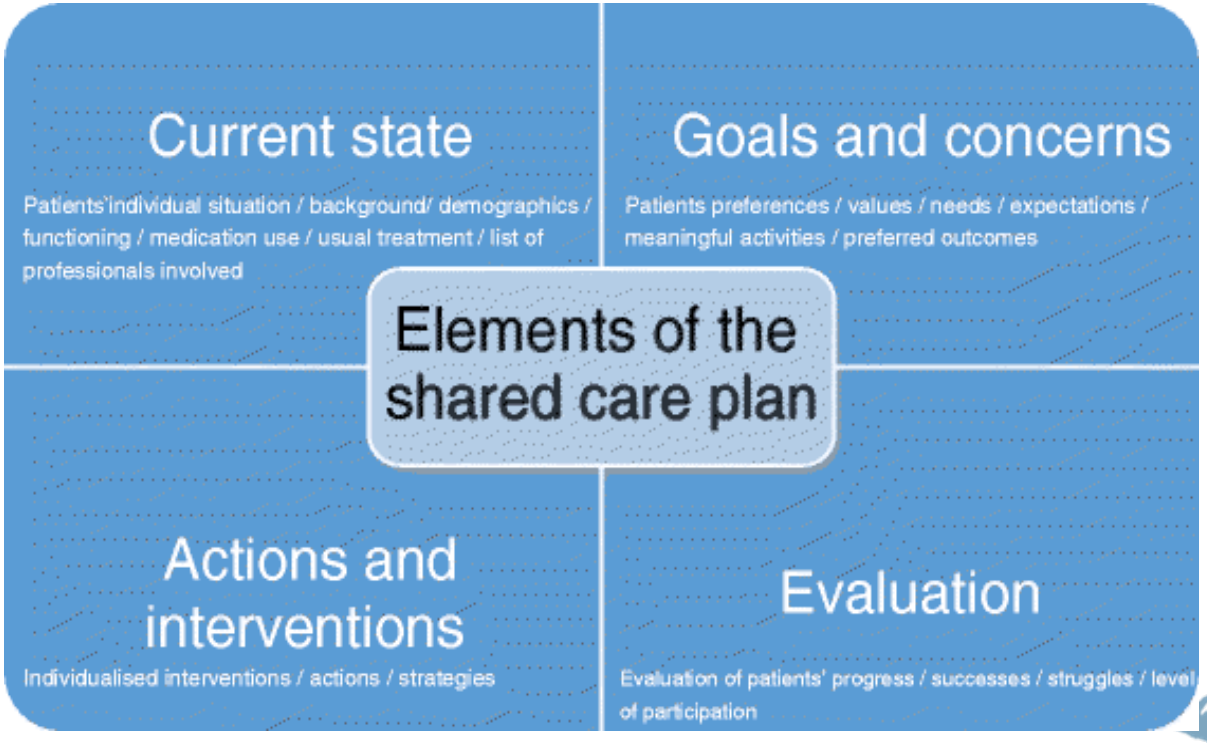
http://catalyst.nejm.org/care-redesigned-for-a-new-age/

- Is your practice utilizing shared care plans?

- Who in your practice is able to view the shared care plan? – please type into the question box.

Shared Care Plan

Elements



Shared Care Plan

Elements

Collaborative Definition of Problems

- Collaborative management begins when patients and care providers define problems clearly
  - Providers usually define problems in terms of diagnosis, poor compliance with treatment, or continuation of unhealthy behaviors (such as smoking or a sedentary lifestyle)
  - Patients are more likely to define problems in terms of pain, symptoms, interference with functioning, emotional distress, difficulty carrying out treatments or lifestyle changes, or fears about unpredictable health consequences of illness
  - Even small steps, such as asking a patient to identify the biggest problems faced in managing illness, may provide a basis for improved collaboration

Patients are more likely to benefit when these two perspectives are harmonized!

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http://annals.org/aim/article/711027/collaborative-management-chronic-illness

Shared Care Plan

Elements

Targeting, Goal Setting, and Planning

- Focusing on a specific problem, establishing realistic objectives, and developing an action plan for attaining those objectives are beneficial steps in managing chronic illness
  - Targeting is critical because patients and providers often initiate many changes at once, which can lead to poor adherence and discouragement
- Once patients and physicians define a problem and agree that it is important, they can establish a behavioral goal and an action plan for achieving it that allows patients and providers to monitor progress
  - Action planning consists of identifying a menu of options for achieving a goal, choosing one option, developing specific implementation plans, foreseeing obstacles, and making a commitment to put the plan into effect

http://annals.org/aim/article/711027/collaborative-management-chronic-illness

Shared Care Plan

Elements

Creating a Continuum of Self-Management Training and Support Services

- Patients' abilities to care for themselves are enhanced by services that teach skills needed to carry out medical regimens, guide health behavior change, and provide emotional support. Because needs differ, a variety of services should be available, ranging from minimal, self-help approaches to more intensive case management
  - Many effective ways of teaching skills and providing support exist, including individual and group instruction, high-quality educational materials with personalized feedback, and interactive instruction given by computer
- It is important that these kinds of services be individualized, tailored to each patient's motivation and readiness, and aligned with priorities agreed upon by patient and provider

http://annals.org/aim/article/711027/collaborative-management-chronic-illness

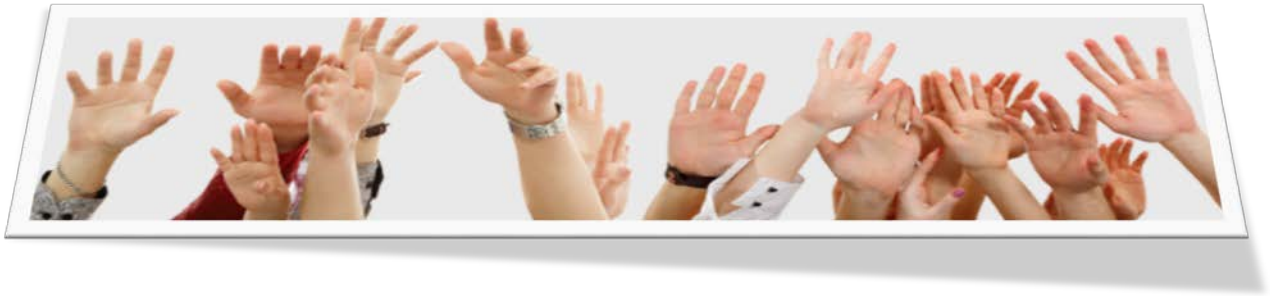
Shared Care Plan

Elements

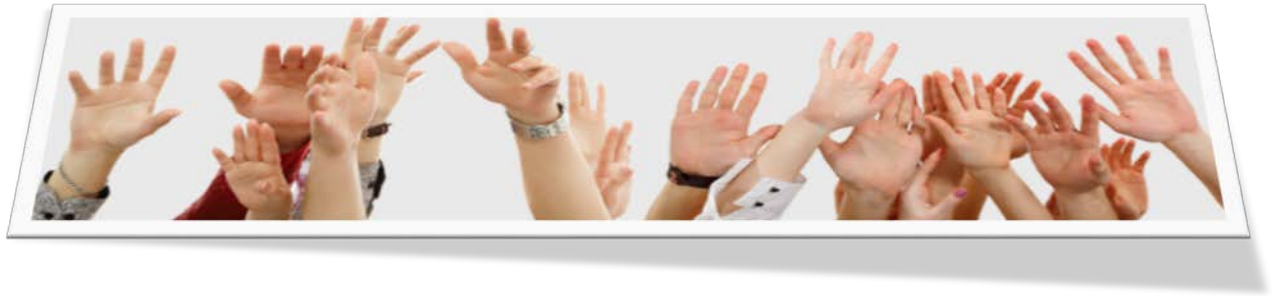
Active, Sustained Follow-up

- Contact with health care providers that is planned and sustained over time improves patient outcomes
- By contacting patients at specified intervals, *care providers can obtain information on medical and functional status, identify potential complications early, check progress in implementing the care plan, make necessary modifications, and reinforce patient efforts*
  - Patient follow-up can be accomplished by scheduled *return visits, telephone calls, electronic mail, or mailed forms*

http://annals.org/aim/article/711027/collaborative-management-chronic-illness



- Raise your hand if you would like to share the elements of your shared care plan



- Raise your hand if the patient receives a copy of the shared care plan?
- Raise your hand if you would like to share how the patients' shared care plan differs from what's in the EMR.

- Does your EMR or other electronic software assessment data auto populate the shared care plan

Let’s pause a moment to address any questions or comments

Shared Care Plan Example

- Let's now take a look at an example of a shared care plan submitted by Deana Koscielny, RN from Lakewood Clinic

Date: 06/20/17 : 12:31pm

Title: Patient-Centered Care Plan

Patient Name:

Provider:

Date:

Top Concerns and Barriers

The main things she would like to fix or improve about her health care are:

-

-

-

The main things preventing her from improving her health are:

-

-

-

Symptom Management

The main symptoms she wishes to reduce or eliminate are:

-

-

-

Health Care Providers

List any other providers she sees regularly for health care (for example, ophthalmologist, cardiologist, therapist):

-

-

Resources and Supports

Besides her health care team, who could she turn to for health-related problems (for example, family members, friends, a spiritual leader)?

-

-

Current Medications:

Patient has reviewed the current medication list (see above) and confirms that it is accurate:

Allergies:

Patient agrees to do the following:

- Discuss concerns they have about taking any of their medications with their primary care provider (PCP) and/or pharmacist.
- Advise their PCP if they choose to stop taking their medication(s), including their reasons for stopping, and discuss potential alternatives.
- Advise their PCP of bothersome side effects from their medication(s).
- Inform their PCP if new medications are added by other providers.

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Major Problem List:
VIRGINIA has reviewed the list of conditions:

Treatment Goals/Targets
These are mutually agreed upon, measurable goals to help her improve or control their medica conditions or manage their symptoms (for example, LDL cholesterol <100; BP <150/90; weight of 150 pounds; 7 hours of uninterrupted sleep; average pain level of 5; ability to walk to my mailbox daily):
-
-
-

Summary of things Patient needs to do
List action needed and time frame for each item. If not applicable, indicate N/A or none:
Tests to complete:
Other health professionals to see:
Community resources to use:
Medication changes to make:
Other treatments to get:
Health-related education to pursue:
Short-term activities to do:
Lifestyle changes to make (for example, quit smoking, lose 10 pounds, buy a pedometer and walk 5,000 steps per day; SMART goals - specific measurable, achievable, realistic, time-bound are recommended):
Diet:
Exercise:
Stress Management:
Safety:
Smoking:
Other habits:
Frequency of planned future appointments here:

Care Manager
If patient needs help arranging care outside this office or has questions or concerns about any of the things they need to do (above), they can contact:
Name:
Phone:
Patient will ask other providers to send a summary of their care to this office:
Expected Outcome/Prognosis
If patient follows the treatment/action plan above, they can expect the following to happen:

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Affinity Group Case Study Adult

Dr. James asks you to meet with Mr. Bowers during his office appointment to work with his chronic condition control.

Medical Record information: Mr. Bowers a 75 y/o male has diagnosis of heart failure, type II diabetes, COPD, depression, rheumatoid arthritis and HTN. In last 6 months he was hospitalized twice for HF. He is widowed, lives alone and has a daughter.

You meet with Mr. Bowers to explain CM services, gain his consent and start initial assessment.

Assessment information: Bowers states since losing his wife it is difficult to care for himself. He relied on his wife for managing of his chronic conditions. His arthritis makes it difficult at times to shower, prepare meals, drive and open medication bottles causing him to miss medications and appointments. He has lost 7-pound in 3 months and has little desire to eat, no cooking skills and does not socialize outside the home. Daughter's time is limited. A neighbor helps occasionally with transportations and meals.

Mr. Bowers is afraid he may be placed in a nursing home but wants to stay in his home.

For more information on shared care planning and its elements visit:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

For a copy of "My Shared Care Plan" and information regarding shared care planning visit:
https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan

My name: Mr. Bowers	Birthdate: 1/1/1941	Updated date: 8/3/2017
Phone: (days) 555-555-5555 (eves/wknds)	Email address:	
Insurance Company:		
Emergency contact and phone: Laura (Daughter) 555-555-5555		

I want the person working with me to know…

I have challenges with: ☑ Transportation ☐ Vision ☐ Hearing ☑ Mobility ☐ English as a second language (ESL) ☐ Other

Comments: Difficulty with ADL's, opening medication bottles and driving

I have issues with Diet:	☑ YES	☐ NO	Comments:
My Religion/Spirituality impacts my health care:	☐ YES	☑ NO	Comments:
Advanced Directives			
Healthcare Advance Directives	☐ YES	☑ NO	Comments: Interested in discussing Advance Directives
Physician Orders for Life Sustaining Treatment (POLST)	☐ YES	☑ NO	Comments:
Power of Attorney (Financial / Healthcare)	☐ YES	☑ NO	Comments:

I live: ☑ alone ☐ partner/spouse ☐ Extended family ☐ Other:

I learn best by: ☐ Reading ☐ Being talked to ☑ Being shown how ☐ Listening to tapes ☐ Seeing pictures or video

I have access to the Internet: ☐ YES ☑ NO

Next appointment	Name	Office Phone	On-Call Number	Role
Tuesday Aug 10th	Dr. James	555-555-5555		Primary Care Doctor
Tuesday Aug 10th	Nancy (Care Manager)	555-555-5555		

I authorize that my personal health record to be shared with my care team listed above: ☑ YES ☐ NO

Others with whom I agree to view my plan include: Daughter Laura

I am concerned about:

- [x] My ability to manage my chronic condition
- [x] My decreased energy level / Fatigue
- [ ] Financial issues
- [x] Having access to healthcare
- [ ] Emotional issues
- [x] Family issues
- [ ] Spiritual support
- [ ] Thinking or memory problems
- [x] End of life issues
- [x] Other: Transportation and Medications

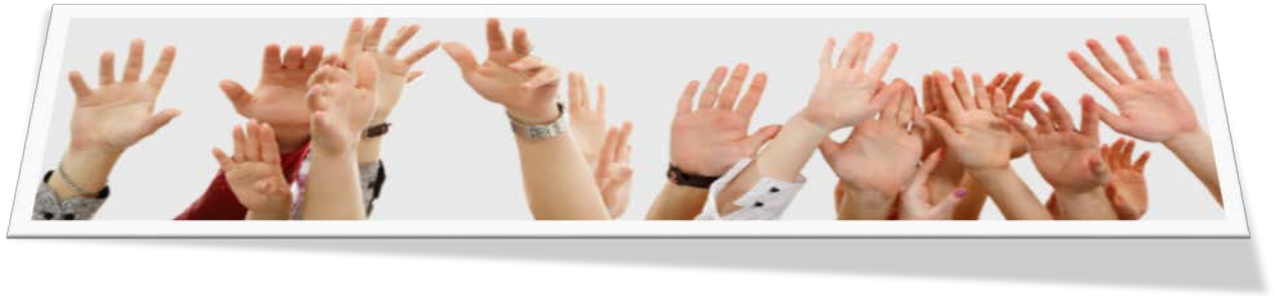
My Next Steps:

This section to be completed by you in partnership with your care team. Steps may include concerns about medical condition, problems, barriers or goals and are followed by action, solutions, observations, the current status of the step, etc.

Date	Concerns / Problems / Actions / Comments / Status	By Whom
8/3/17	Concern expressed over inability to complete activities of daily living including managing medications,	
	completing activities of daily living, preparing meals and driving.	
	- Mr. Bowers short term goals:	
	1. Adhere to medication regimen	
	3. Reliable transportation to and from doctors appointments	
	4. Discuss Advance Directives	
	-Mr. Bowers long term goals:	
	1.2. Maintain independence in his home	
	Care Management Interventions:	
	1. Consult with Pharmacist to discuss Mr. Bower's medication regimen and the possibility	
	of home delivery and blister packs.	
	2. Contact insurance company for transportation benefits to and from appointments	
	3. Set up follow up appointment to discuss Advance Directives.	
	Follow up: 1 week with PCP and Care Manager	

How do you document Shared Care Plan progress, changes and any revisions to the Care Plan Goals, Interventions, and Target Dates-type into question box

Let’s pause a moment to address any questions or comments



- Raise your hand if you have an example of a shared care plan you would like to share with the group

Questions or comments

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