Change Idea: Shared Care Plans
My Total Health Plan

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Change Idea: Shared Care Plan

CCC Change Package, Theme III, J, Page 9:

i. Develop and use processes for the collecting and updating shared goals among client/patient and providers

ii. Develop and use processes for communicating and supporting client's shared goals among providers

Objectives

At the conclusion, you will be able to:

1. Describe how a Shared Care Plan supports better coordination of care and discuss how a shared care plan can be designed to reflect both client/patient health goals as well as shared provider goals.
2. Identify how a Shared Care Plan promotes client engagement in their own care and self management of health/behavioral health conditions.
3. Develop a CCC Team Shared Care Plan (modifying/adapting a template) and determine how plan will be shared with client, across providers and entered into CC tracker/registry
4. Begin to decide how the Shared Care Plan will be shared and updated

Shared Care Plan - Supporting Client Health Priorities And Shared Provider Goals

Purpose-Why use a Shared Care Plan?

- Shared accountability to address key health/treatment goals with client and across all providers.
  - Example: Increase physical activity to improve mood and stabilize blood sugar levels)

What is a Shared Care Plan?

- Shared care plan identifies goals for patient/consumer with complex conditions and multiple providers. It generally includes who is involved in care, the main issues, agreements re: goals and planned actions among patient and providers. Often web based.

What a Shared Care Plan is NOT?

  - Not a compilation of (detailed) treatment plans from each provider

Shared Care Plan - Supporting Client Health Priorities And Shared Provider Goals (cont.)

- Shared Care Plans are emerging best practice and are being adopted in health settings/primary care in US and internationally

  Examples:
  - Australia: Primary Care Partnerships
  - TEAMcare: Katon,MD,et.al., UW - My Better Health Plan
  - AHRQ-Shared Care Plan Personal Health Record is a tool for patient self-management and communication among care team members. It is a personal health record that lets patients organize and store vital health information and then share it with their family, physicians, and others they feel should have access to this information.
    https://www.sharedcareplan.org/OtherPages/Phms.aspx

- For CCC, Shared Care Plan supplements the registry and is a tool that client/patient can use to focus on his/her self-management and providers use to address overall goals.

Consumer Perspective: Why Change Current Practice? How Does A Shared Care Plan Support Better Health?

Whole Health Self-Management of Diabetes

Physical Health Issues Assessed After Labs

- High LDL Cholesterol and A1c (7.8%)
  - ✓ Question related to mental health and substance use
    - o Am I abusing food as a substance and not using food as medicine?

Prevention

- Lower risk of having a stroke and heart attack

Shard Care Plan

- *Goal – Lower LDL Cholesterol and A1c*
  - ✓ Exercise 30 min. over 5 days (addressing mental health as well)
  - ✓ Increase intake of fish and Omega-3's as I cannot tolerate Statins
  - ✓ PCP has assigned a cardiac nurse

Failed Piece of Shared Care Plan

- Pharmacist, Ophthalmologist and Diabetes Nurse failed to check on how Statins affect my eyesight; they now know I cannot take these medications to lower my LDL cholesterol as I cannot tolerate them in my system

CCC Change Package-Shared Care Plan

II. **Engage Clients in their whole health**

e) Actively engage each client/patient in his/her Care Planning:

h) Collaborate with the client/patient/family to develop a whole health service plan including services from agencies outside the partnership

III. **Deliver Coordinated Services**

j. Develop Shared Care Plans across primary care, mental health and substance use :

i. Develop and use processes for the collecting and updating shared goals among client/patient and providers

ii. Develop and use processes for communicating and supporting client's shared goals among providers

My Total Health Plan

INSTRUCTIONS
Use this form for the information that you would like to share with all of your care team -- including your doctor(s), nurses, counselors, or others. Show your providers this information at your visits so that everyone on your team knows about your personal health goals.

THIS PLAN BELONGS TO:
Your Name

.MY HEALTH GOALS	
GOAL DESCRIPTION	STEPS I NEED TO TAKE TO MEET THIS GOAL
Goal #1	1.
	2
	3.
Goal #2	1.
	2
	3.
Goal #3	1.
	2
	3.

MY CARE TEAM			
NAME	ROLE / RELATIONSHIP	CLINIC / LOCATION	TELEPHONE

PHARMACY		
PHARMACY NAME	ADDRESS / LOCATION	TELEPHONE

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My Total Health Plan

- Template that Teams can modify
  - May/may not decide to include Meds (pg. 2)
- Reflects client/patient's goals as well as goals that require all providers attention during visits
  - Patient should have copy to take to appointments.
- Generally the Care Manager develops and monitors with client and across providers
- Care Goals should be entered into registry

Shared Care Plan Exercise/Activity

STEP 1 (30 min): Review and modify Shared Care Plan Using Template provided

1. What changes/additions would you make to Plan?
2. How will it be made available to client and shared with providers?
3. Who is responsible for developing/updating Shared Care Plan? Changes routinely entered into registry—routine workflow? Care Coordinator role?
4. Expectations of providers to check in re: Shared Care Plan goals?

STEP 2 (15 min): Full Group Discussion: Change strategies