Getting on the Same Page

Patient Centered Care Plans as a Collaborative Tool

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Patient-Centered

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

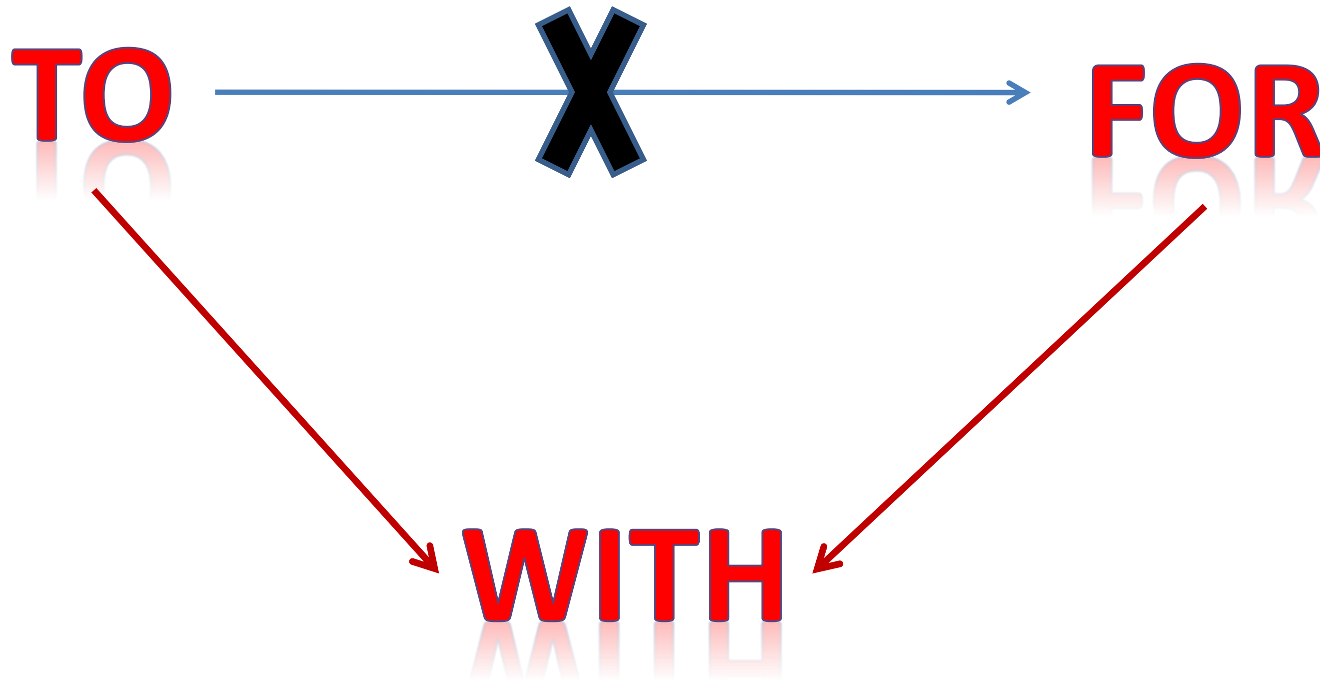
– Dr. Don Berwick

What 'Patient-Centered' Should Mean: Confessions Of An Extremist Donald M. Berwick
Health Aff July/August 2009 28:4w555-w565; published ahead of print May 19, 2009, doi:10.1377/hlthaff.28.4.w555

Or

"Nothing about me, without me."

PATIENT & FAMILY CENTERED CARE



Patient-centered care is not moving from doing things “to” the patient to doing things “for” the patient but rather changing the relationship to partner “with” the patient and family.

Experience

Engagement

TO FOR WITH

Care

Patient care means doing two jobs:

1. CARE FOR:
Provide the right interventions for the right person at the right time.

2. CARE ABOUT:
Provide a system of care where patients feel known, heard, and valued.

PLAN

Address Goals & Problems

Assign Roles & Responsibilities

Accountability for Action & Timeline

Objective

Use a tool to bring the patient's voice into the medical record in order to improve collaboration both with the patient and between medical and behavioral health providers.

History of the Patient-Centered Care Plan (PCCP)

- Not your Momma’s care plan
- Disease-based vs. patient-centered
- Created by a multi-disciplinary team

What is the purpose of a PCCP?

- Addresses and embraces complexity
- Aligned with Patient-Centered Medical Home (PCMH) concepts
- Creates a space for the patient’s voice in the EMR
- Tool for communication and consistency
- Prompts motivational interviewing

What is in a Care Plan?

Medical Summary

- A medical synopsis/ ‘sign-out’
- Problem list with suggested actions
- Continuum of care information
- Emergency Plan of Action

Patient Snapshot

- What the patient wants you to know
- What the team wants to communicate about the patient
- Patient’s assets, supports and strengths

Goal Directed Action Plan

- Patient goals
- Negotiated action plan &person responsible

PCCP vs CP:

Patient Centered Care Plans are different from traditional care plans because:

- They have a Medical Summary, Patient Snapshot and Goal-Directed Action Plan.
- Input from all disciplines is combined.
- Negotiated goals govern the plan.

Joan’s Story

PERSONAL

COORDINATED

TEAM

PART 1: MEDICAL SUMMARY

Name:____________________ Nickname_______________ DOB________

Address: ____

Phone # (preferred)_________ (Blocked? ❒Y ❒ N) Best time to reach______

How do you prefer to be contacted: __________________________________

E-mail______________________________ Alternate Phone___________

Emergency Contact_______________ Phone ______ Relationship________

Health Insurance/Plan_________________________ Identification #_______

Emergency Plan? ❒ Yes ❒ No **Advance Directives?** ❒ Yes ❒No

Allergies/reaction:

Medications/dose/purpose:

PCP______________ **Phone**______ **Fax**__________ **E-Mail**____________

Care Manager_______ **Phone**______ **Fax**__________ **E-Mail**____________

Team RN __________ **Phone**______ **Fax**__________ **E-Mail**____________

Medical Synopsis/Sign-out:

Who else is involved in your care? (specialists, nurses, outside agencies)

#1 Name Clinic/Hospital Phone	Other (fax, e-mail, etc.):
	Release? ❒ Y ❒ N
#2 Name Clinic/Hospital Phone	Other (fax, e-mail, etc.):
	Release? ❒Y ❒ N
Who are the most important people in your life? *(family members, a partner, friends, coworkers, people you live with)*	

Who can we talk to about your care?

#1 Name Relation Phone	Other (fax, e-mail, etc.):
	Release? ❒ Y ❒ N
#2 Name Relation Phone	Other (fax, e-mail, etc.):
	Release? ❒ Y ❒ N

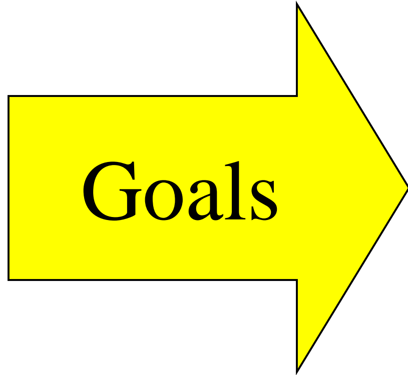
WHOLE PERSON APPROACH

PLANNED CARE

PART 2: SNAPSHOT

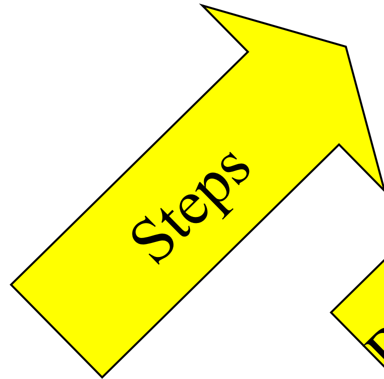
Snapshot: What do you want your healthcare team to know about you? *(This can include your most important medical and/or emotional concerns. You can also include information about what you like to do in your free time, what you do for work, what your spiritual or religious affiliations are, what your financial situation is, what your unique talents or hobbies are, and what makes you happy.)*	
My provider wants my care team to know:	
Urgent Plan of Care: *Do you have any recommendations for how your healthcare team should respond if you are in a crisis?*	

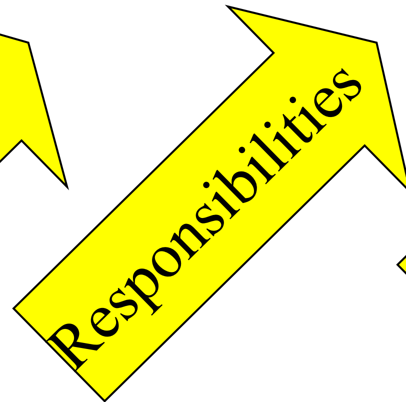
PART 3: ACTION PLAN

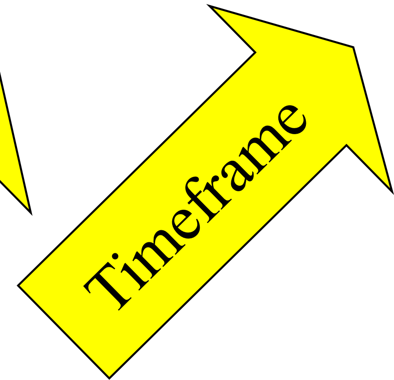


Patient goals	Provider goals
Short-term	
Long-term	

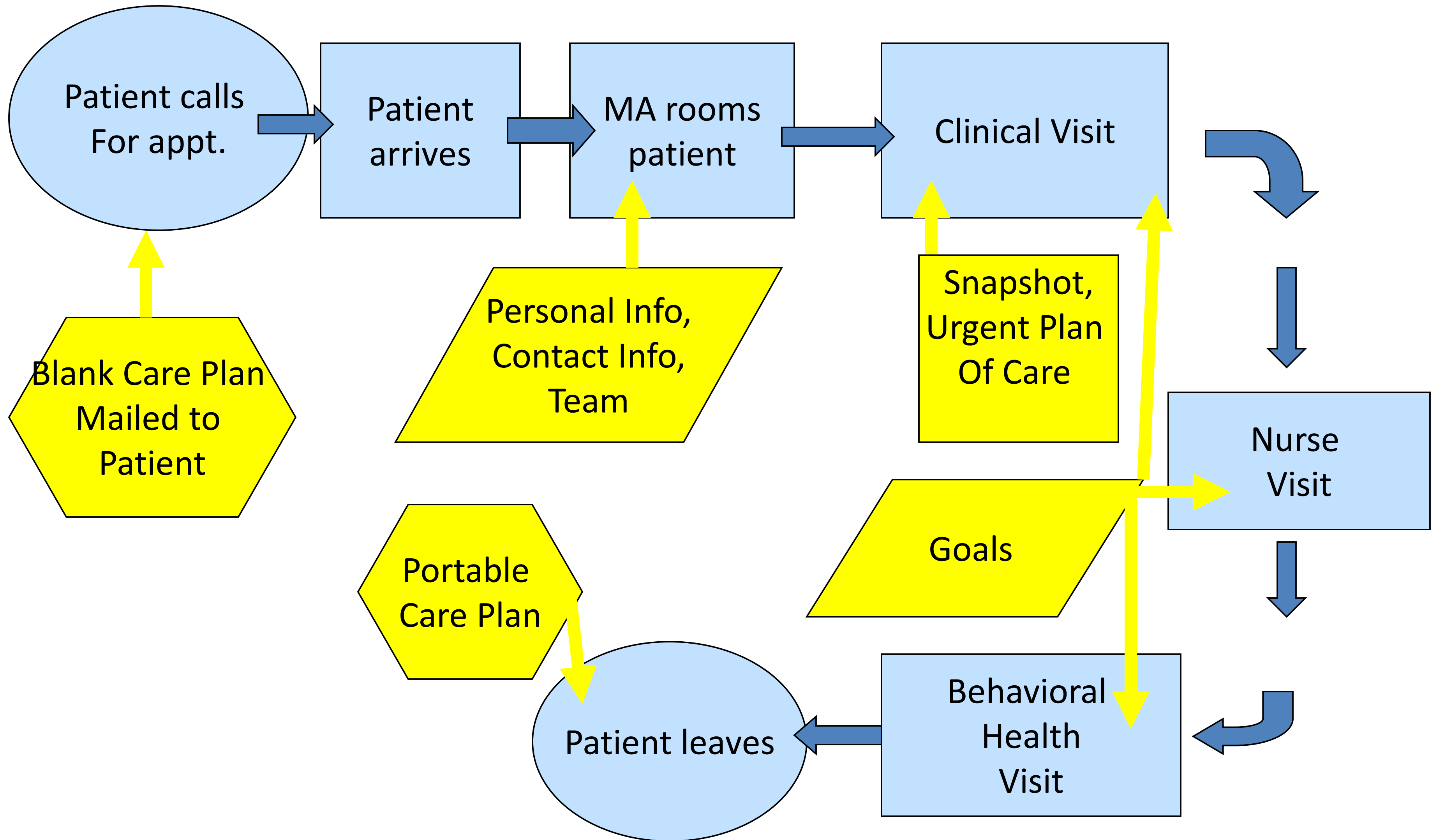
Negotiated Goal	Action Plan	Person Responsible	Time Frame
1.			
2.			







Sample PROCESS MAP



Asynchronous ways of completing PCCP

- Mail
- Phone contact
- Medical Assistants
- Nurses
- Behavioral Health
- Providers
- Future: Patient Portals

A PCCP Culture

- Involving all discipline stakeholders
- Clear but flexible leadership
- Positively reinforcing early adopters
- Building skills in:
  - Self-reflection
  - Patient-centered conversations
  - Motivational interviewing
  - Collaborating in a multidisciplinary team
- Persistence

Impact

- Aids in preventive care:

"When there are a lot of issues, like social, medical, or if they are coming in or calling all the time, (to identify) ways that can help them manage before becoming a crisis… Some people with PCCPs would be described as ones whose behaviors are difficult to work with. These patients evoke negative feelings like frustration, dread, or anger in the team."

– BH Clinician

Impact

- Aids preventive care
- Increases continuity:

"I've been coming for 10 years. They graduate and leave. With a new doctor, I asked if he'd read my PCCP."

– Patient

Impact

- Aids preventive care
- Increases continuity
- Enhances communication:

"With information all over the chart, I find PCCPs help me synthesize the essentials for the patient. I also get the patient's input, which is very valuable."

– Physician

Impact

- Aids preventive care
- Increases continuity
- Enhances communication
- Feeling ‘known’:

> *“I know if they read my PCCP by how the respond. Because I get really nasty when my sugar is off. They know when I call and say I’m ready to rip somebody’s head off. They know it’s a blood sugar problem. They tell me, ‘It’s okay, don’t worry, you’re all right.’”*
>
> *– Patient*

Impact

- Aids preventive care
- Increases continuity
- Enhances communication:
- Feeling ‘known’
- Enhanced patient-centeredness:

“With the PCCP, we picked up that someone’s illiterate. Before, we kept sending letters to that patient.”

- Nurse

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A Medical Home: Changing the Way Patients and Teams Relate Through Patient-Centered Care Plans

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The patient-centered medical home model incorporates patient-centered care as a central tenet and espouses the health care team partnering with an engaged patient. The tools to accomplish this type of care have not evolved along with these values. This report describes how the adoption and use of a patient-centered care plan (PCCP) document enhanced care for complex patients and changed the relationships with health team members. The PCCP was used in a residency-affiliated community hospital, group family medicine site and provided patient-centered, goal-directed care for complex patients. Use of the PCCP changed the patient–team relationship, showing that this care plan document can support the practice of the patient-centered medical home model by enhancing patient-centered, coordinated, comprehensive care.

Keywords: patient-centered care, care plan, medical home, goal directed care, patient engagement

Questions? Comments?

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