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15 Collaborative Care Plan Development

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Introduction & Learning Objectives

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Discussion about patient care plans always brings up a wide variety of opinions on the topic. They include questions about if a care plan is truly needed, what the best care plans contain, or if a patient will really adhere to it. In nursing school, students are taught how to develop a plan of care for various acute conditions. As Care Managers, we want to go one step further and create care plans in collaboration with the patient so that they are on the same page with their Care Manager and PCP, and are much more likely to be successful.

Learning Objectives

Following the completion of this course, the learner should be able to:

- Identify key components necessary to develop a patient-centered personalized care plan.
- Accurately distinguish the effective strategies utilized to engage partnership in developing a care plan.
- Describe 'SMART Goals' properly and how this technique can be applied to care plan development.
- Determine successful strategies to document care plans through a group discussion with fellow participants.

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What a Collaborative Care Plan Is and Isn't

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Nursing tasks are performed with the patient in the hospital are meant to track patients toward meeting the goals of the nurse developed care plan. On the ambulatory side of care, the after-visit summary is commonly given to a patient as a plan of care. Typically, this document is a conglomeration of medical diagnoses, a comprehensive list of the patient's medications and up to date immunizations, tests that are ordered, as well as upcoming appointments, and other tasks the provider has prescribed to the patient (e.g. follow a low sodium diet, regular exercise, etc.).

A truly patient-centered personalized care plan is none of these things. In fact, a personalized care plan is exactly that, a plan that is personally designed by the patient with the help of their Care Manager and focused on the goals and tasks that they feel ready to tackle right now. Tying back to the module on the stages of change, you would not help a patient set a goal in a plan of care for which they weren't ready to think about. The goals you establish in a personalized care plan are ones that, based on the stages of change, the patient is thinking about and ready to start. In other words – things that they are activated and engaged to do!

So let's take a moment to compare what a personalized care plan is – and what it isn't!

A Care Plan IS…	A Care Plan IS NOT…
Patient focused	Filled with medical jargon
Built around the patient's goals	Focused on lab results (unless this is the patient's focus)
Expressed in the patient's words	Complex
As simple as the patient needs it to be	Meant to be a medical history
Focused on the here and now, and what the patient is ready to do	The physician's documented plan of care

A physician's plan of care is extremely important. It focuses on the medications that are prescribed, what labs need to be completed, and the plan for follow up and any treatment regimens.

Think of the personalized care plan you create with the patient as being complementary and supplemental to the physician's plan – you are helping the patient to set goals that will ultimately track them toward achieving the physician's plan.

Example:

Jane Doe is newly diagnosed with diabetes. The physician documents Jane Doe's care plan is to:

1. Start taking new medication for diabetes and
2. Check blood sugar 4 times/day (upon waking, before lunch, before dinner, and at bedtime).

When you meet with the patient for LCM and personalized care planning, you discover the patient is terrified of needles. The patient tells you there is "no way" she can check her blood sugar four times/day; so you collaboratively work together to help the patient identify a goal she is able to achieve. You realize this will be a stepped process to move her toward the ultimate goal of checking blood sugar 4 times/day. By working together in this way, she will move forward toward success, rather than give up or ignore the instruction because she's afraid of needles and can't think beyond her fear.

Takeaways:

1. The patient-centered care plan (aka collaborative care plan) focuses on what the patient is ready to do to promote their health. It's about sharing options with the patient of things they can do to improve their health – and letting them take the wheel to decide what they're ready to start doing.
2. Small steps are good – small wins buy excitement and engagement! If you can help the patient see they are making steps toward success, their own intrinsic motivation builds, improving their chances of success.
3. Any care team member can do collaborative care planning with the patient – more likely than not though, it will be the CM that does this.
4. Be gentle with yourself – you won't be an expert the first time you do this. But you will get better and learn something new each time you do it.

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The Conversation of Care Planning

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An effective care plan meets the patient where they are. If you come from an environment or culture where the process was to tell the patient what to do in a prescriptive way, this will feel like a big shift in how you work with the patient.

Think back to the lessons learned in the module on activating patients and building trust. Engaging an individual in care planning is simply learning how to build on the skills of activation and trust!

These are a few ideas to get you thinking differently:

- [ ] Demonstrate respect and show interest –honor the patient's choices, beliefs, and spiritual & cultural heritage. Allow polite curiosity to guide the conversation to help you discover what matters to the patient, find their "Why", and what motivates them to take action toward improved health.

- [ ] Use active listening skills – this means truly LISTENING to what your patient says, what they don't say, and reflecting back what you hear. You can paraphrase what the patient has said, re-state a few of the words, and identifying trends in words and actions. For example, if the patient is describing their reaction to a new diagnosis and they say they're scared, you can acknowledge their fear by saying "yes, a new diagnosis can be scary". This simple reflection demonstrates two things, 1) that you're listening, and 2) that you empathize with them. They will feel comfort in being heard.

- [ ] Use open-ended questions (e.g. 'What concerns would you like to address today'; 'Tell me more about _____'). Open-ended questions allow the patient to elaborate on what they're thinking and feeling. Without this additional information, it's tempting to make assumptions about the patient – and unfortunately, assumptions like that tend to be from our own life perspective. We cannot expect anyone to share the same perspective on life as we do. So, asking those open-ended questions will allow the patient to put things in their own words.

- [ ] Find opportunities for small wins to build trust & engagement. If your patient has been slow to trust or engage in LCM, identify an opportunity where you can help in some way. If they need help with transportation or obtaining a prescription, help them address these needs. This will show the patient you are there to help them overcome barriers and meet their needs, thereby starting to build trust.

- [ ] Celebrate wins - there is nothing worse than feeling like a failure. And, when it comes to health and not feeling well – well, this can contribute to deep feelings of failure. Encourage your patients with each step they take, no matter how small. This will help them feel successful and gain confidence in their ability to take ownership of their actions.

- [ ] Adapt the plan if the patient's goals change. Life sometimes gets in the way and derails our plans. If this happens, go with the flow and adapt. Help them establish new goals that will meet their new needs.

- [ ] Use the formula of one big goal and two small goals. Set two small goals that are achievable and to help them make progress toward the big goal. When the two small goals are reached, establish two more small goals to continue their progress toward the big goal. This cycle is repeated until the patient achieves the big goal. Once achieved, establish a new big goal and two small goals if there is still work to do, or the patient may be ready to graduate from CM. The point is to help the patient learn how to break a large goal into smaller, more manageable pieces.

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Completing the Care Plan

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A copy of a care plan template is available for download on the Solutions Center. https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.

Concerns & Motivators

My health concerns are:

Getting healthy matters to me because:

My Goals:

Date Set	Patient Goal (short & long term)	Action Steps	Tools/ Resources	Confidence	Planned Follow up
Example 3/3/19	*Remember to take medications*	1. *Download Rx reminder app* 2. *Set up personal info in app* 3. *Set up daily medication reminders*	*Medication Reminder App*	*8*	*3/10/19*

Confidence Scale

Not confident — Somewhat confident — Very Confident

1 2 3 4 5 6 7 8 9 10

Once you have met with the patient and feel you are beginning to get a picture of their priorities and concerns, you can begin working on the care plan.

1. Explain the purpose and focus of the care plan before you start writing anything down.

2. Make note of what the PATIENT identifies as their health concerns. It will be tempting to put your own interpretation here but restrain yourself! The way patients think about their health and the way that we as clinicians do is different. For the care plan to be effective, it needs to make sense and be meaningful to the patient.

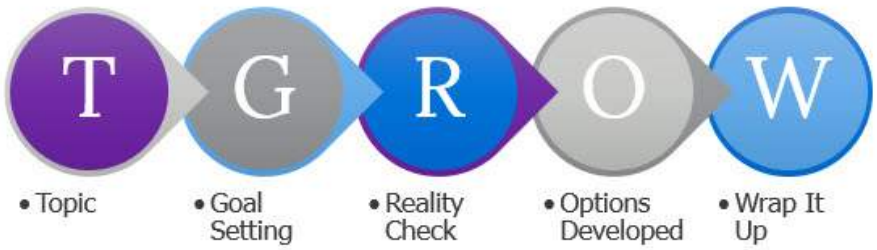
Example:

A patient with COPD wants to be able to walk his daughter down the aisle at her wedding this summer. As the care manager, you might think of the goal in terms of managing the COPD, adhering to medications, etc. But for the patient, it's as simple as being able to walk his daughter down the aisle at her wedding. So be sure to make this the big goal – and establish smaller goals around that.

1. Next, make note of why getting healthy matters to the patient. Everyone has their own unique motivation to get healthy. Find out what that is for each patient. And use this as a homing beacon of sorts, to continue to guide the patient, even when they feel discouraged.

2. Then begin working with the patient to identify their goals. The best formula for devising a care plan is to have them select two small easily achievable goals and one bigger goal that's more of a stretch

3. As you're working with the patient, use the 'TGROW' model to help guide the conversation:



- [ ] **T is the topic** – the focus of their care plan. On your care plan template, it relates to the top section "health concerns" and "Getting healthy matters to me because.

- [ ] **G is goal setting**, and this will be seamlessly used with 'R', which is the reality check.

- [ ] **R is for realistic**, as in the SMART goal format. Many patients will think they need to set a really big goal and go for something that's unrealistic like exercising for 60 minutes five days a week. When this happens, do a reality check by using the confidence scale – ask them how confident they are that they can achieve that goal.

Follow this cycle, working through developing a goal and doing a confidence check until you land on 2 small goals and 1 large goal.

- [ ] **O is for options** - once the goal is established, define action steps. After action steps are completed for all goals, make note of the red flags and warning signs patients need to watch - once the goal is established, define action steps. After action steps are completed for all goals, make note of the red flags and warning signs patients need to watch.

- [ ] **Wrap up** the session by establishing a check-in date and having the patient sign the care plan.

Helpful Tips

- Keep it focused on the information that is meaningful to the patient.
- Don't complicate the care plan with a lot of information that isn't really necessary for the patient, e.g. every diagnosis from their medical history, lab results, the goal for lab results, etc.
- If the patient IS focused on labs and lab results because they understand that sort of information & it's important to them, then find a way to include it. If it's NOT important to the patient, then you can save it for your own documentation/notes in the EHR.
- Regarding medication lists on the care plan – for many complex patients that are in LCM, their medication list is continually evolving until they're stabilized. In order to save time and ensure accuracy, simply print a (patient-friendly) copy of the current medications from the EHR each time the care plan is updated.

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SMART Goals

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Longitudinal Care of a Patient

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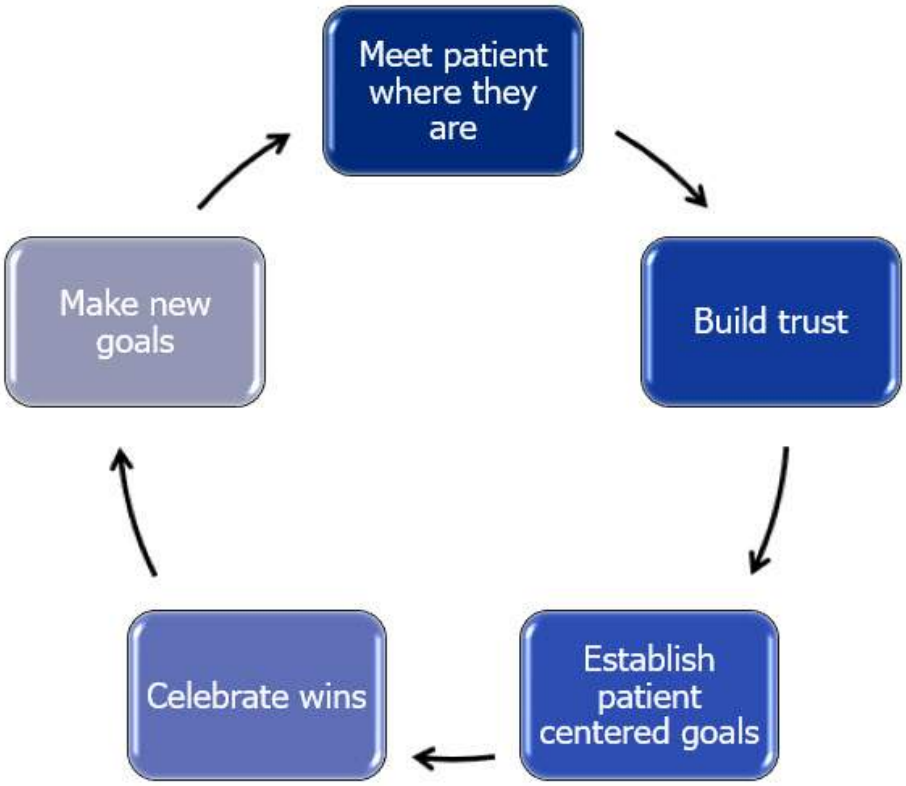
Before we close this course, we'd like to talk a little bit about managing patients over time.

Many nurses are not experienced in working closely with patients and their families/caregivers over a number of months. Our schooling trains us on the pathophysiology of chronic conditions, medications, and management of acute events. The missing piece of that education is the ongoing longitudinal care of patients, building a long-term trusting relationship, and how to help patients establish goals and effectively track toward success over a number of months

Longitudinal care of a patient requires skills like building a relationship and trust with the patient, coaching them toward their goals rather than telling them what to do to accomplish them, helping them celebrate wins, and helping them maintain momentum for the next goal.



This shift in how you work with patients does not happen overnight – or even in a few weeks. This work takes time, effort, care, and a lot of empathy for the patients.

It also takes time to build these skills. We encourage you to extend the same empathy you give to your patients to yourself. Celebrate when you feel like you've made an impact or made a difference with a patient. Celebrate when you feel you've finally used a specific motivational interviewing or teach back skill effectively. And celebrate the fact that you are making a huge difference in people's lives.

Knowledge Check

Question

01/05

Key components of a collaborative care plan include...

- [ ] They are built around the goals of the PCP
- [ ] It is focused on the present
- [ ] It is as simple as the patient needs it to be
- [ ] It is in clinical language

Question

02/05

When documenting care plans, write them in clinical language so the patient knows how important it is.

- ○ True
- ○ False

Question

03/05

What does the acronym in SMART goals stand for?

- Specific
  Measurable
  Awesome
  Realistic
  Talkative

- Specific
  Measurable
  Attainable
  Realistic
  Time Limited

- Super
  Measurable
  Achievable
  Relatable
  Timely

- Specific
  Measurable
  Awkward
  Realistic
  Timely

Question

04/05

When working to engage patients, one helpful method to achieve success is to set one big goal and two smaller goals that support the big goal.

- ○ True
- ○ False

Question

05/05

Skills that are needed for a Care Manager to be successful in Longitudinal Care Management include...

- [ ] Building relationships and trust
- [ ] Coaching the patient toward their goals
- [ ] Celebrating Wins
- [ ] When goals are achieved, make new ones

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Activity Instructions

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Practical application of what you are learning helps with skill development and retention. We have created an activity that will guide you in that type of application.

- [ ] Visit https://www.healthteamworks.org/resource/essentials-care-management-activities-and-resources.
- [ ] Find and download the activity assigned for this course.
- [ ] Complete the activity. You are encouraged to work with your team to complete the activity.

- [ ] Email the completed activity to caremanagement_nachc@healthteamworks.org.
- [ ] Make sure to add the Course Activity Title you are submitting and your full name to the Subject Line of your email.
- [ ] You will receive feedback on your completed assignments.