

Care Plans 2.0

Consumer Principles for Health and Care Planning in an Electronic Environment

The lack of coordination and communication is one of the most ubiquitous consumer complaints about the US health care system¹, and is a key driver of poor quality and unaffordable care. A major contributor to this problem has been the inability to plan and communicate effectively across settings and clinicians, with active engagement by all members of the care team – including individuals and their family and other designated caregivers.

Care plans are gaining increasing attention among federal health policy makers² as a tool to enhance care coordination and optimize health outcomes. While the concept of a care plan is not new, there is little uniformity in what these plans look like or how they are used. To achieve robust and effective planning and communication, we must move beyond our mental construct of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning *process* built on a dynamic, electronic platform.³ This next generation of care plans – Care Plans 2.0 – should function as a roadmap for patients, families, and health care providers to follow toward the best possible health or functioning.

As the health care system moves toward a focus on wellness, these next-generation care plans offer the promise of a much-needed collaborative platform where patients and their loved ones can play leading roles with their care team in identifying and pursuing the health and wellness goals most meaningful to them. Of course, early efforts to develop care plans will, and should, focus first on those with the greatest need – individuals needing more complex care, such as those with chronic conditions. However, our approach to care planning should evolve from episode- or illness-based care planning to proactive, all-encompassing wellness planning, from which *all* individuals stand to benefit.

While the process of care planning is driven by human interaction, technology can help make necessary information available and actionable, connect all people who have a role in an individual's care plan, and provide a shared platform for the ongoing maintenance and management of an individual's care and wellbeing. Electronic platforms also make it possible to scale plans according to individual needs and various stages of life – supporting, for example, a woman during her childbearing years, through menopause, and ultimately guiding her advance directives toward the end of life.

The “meaningful use” Electronic Health Record incentive program offers an immediate opportunity to advance the technological foundation for care plans, and the process of care (and ultimately wellness) planning. The HIT Policy Committee is currently considering objectives for Stage 3 of meaningful use. The following set of overarching principles is a consumer-directed starting place for building the concept of a “care plan” into health IT (with detail listed below).

¹ Campaign for Better Care Focus Group Report, Lake Research Partners, 2009

² National Quality Forum, ONC HIT Policy & Standards committees, Standards & Interoperability Framework

³ For purposes of brevity, we refer in places to “patient” and “care plan,” though these terms to some could imply a medical model with a focus on episodes of illness. The independent living movement uses the terminology “integrated person-centered planning” in lieu of “care planning,” which we support. Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

- 1) Care plans should be goal-oriented, dynamic tools (not static documents).**
- 2) Care planning and tools should facilitate decision-making and specify accountability.**
- 3) Care plans should identify the ability and readiness of an individual for successfully meeting their goals, as well as potential barriers.**
- 4) Tools that facilitate care planning should enable all members of the care team to access and contribute information, according to their roles.**
- 5) Every individual would benefit from care planning and tools.**

1. Care plans should be goal-oriented, dynamic tools (not static documents).

- Care plans should be centered on the achievement of individual goals, supported by appropriate clinical goals.
 - Information about an individual's needs, preferences, and values should be captured as part of the care plan and updated as needed.
 - Care plans should address the unique needs of individuals and diverse populations.
- Care plans should contain specific and measurable action steps necessary for meeting agreed-upon goals.
 - Longer-term goals should be broken down into short-term, incremental steps.
- Care plans should be flexible and accommodate real-time updates based on changing circumstances and previous experience. This may include revision of the goals themselves, as well as the individual steps in the plan.
- Care plans should reflect actions for healthy living, and therefore should not be developed exclusively from a medical perspective.

2. Care planning and tools should facilitate decision-making and specify accountability.

- Care plans should include a method of monitoring both patient and care team member progress in completing action steps, as well as meeting agreed-upon goals and improving health outcomes.
- Care plans should clearly reflect what action is to be taken, by whom, and when, in order to ensure clarity of responsibility and support coordination of care.
 - An initiation or revision of a care plan should always be followed by mutual confirmation of each relevant actor's understanding of the plan and his or her role in the plan.
- Care plans should connect to clinical decision-support (CDS) tools so that clinicians are able to receive automated prompts based on patient-specific goals, preferences, and clinical information.
 - Identification of high-risk behaviors or adverse health events should trigger the modification or addition of action steps in the care plan.

3. Care plans should identify and reflect the ability and readiness of an individual for successfully meeting their goals, as well as potential barriers.

- Care plans should take into account differences in culture, language, and faith, which inform an individual's perspective on health and health goals.
 - Information about an individual's knowledge, skills and confidence related to managing one's own health and care, as well as health literacy needs, should be captured as part of the care plan and updated regularly.
- Care plans should take into consideration both barriers and facilitators to achieving stated goals.
 - Social assessment information and environmental barriers relevant to an individual's ability to achieve the agreed-upon goals should be integrated into the care plan.
 - Arrangements for additional information and supports necessary for addressing barriers should be included in the care plan. This may require coordination with and management of non-medical community resources and supports in concert with medical interventions.

4. Tools that facilitate care planning should enable all members of the care team to access and contribute information, according to their roles.

- Relevant information from care plans should be accessible across health care settings and to non-health care supports in the community to enable refinement and updating at the point of care.
 - A list of care team members and contact information and should be included.
- Individuals, family and other designated caregivers, and care team members granted access by the patient should be able to initiate modifications and record progress related to care plans, including new barriers to achieving goals and changes in circumstances or lifestyle.
 - A record of when the care plan was last updated and who made modifications should be kept.
- Care plans should be organized or customizable into different views in order to enable each care team member to see clearly what his or her assigned actions are, relative to the comprehensive plan.
 - Care plans should be displayed to patients and families in non-medical language and leverage consumer-friendly interfaces.

5. Every individual would benefit from care planning and tools.

- Care plans and the ability to initiate the care planning process should be available to every individual, and should be advanced as a routine activity.
 - Development of care plans should initially be prioritized for individuals with needs that would most greatly benefit from better care coordination and planning, such as individuals with disabilities or multiple chronic conditions.
 - Care plans should be established prior to a crisis situation, when possible.
 - Proactive development of a care plan for all individuals who want one will require a shift in cultural norms and expectations. To ease the transition, the process

could coincide with pre-established interactions with the health care system, such as childhood immunizations, annual wellness visits, or pneumonia vaccinations for seniors.

- Care plans should be scalable to support individual needs and stages of life.
 - Care planning may not be a priority for every individual at any given time. Individuals should be able to initiate (and suspend) the care planning process consistent with their needs and priorities.

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