Approaching Care Plans

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This page will guide you through a stepwise, thoughtful process for identifying and articulating what you would like to accomplish with a Care Plan before building one. Ideally, Care Plans should follow evidence-based guidelines which should be used as a reference when building the plan.

Step 1: Identify the Patients

Determine which patients you are trying to identify with the Care Plan you are creating. This needs to be very exact and should address the following questions:

- All patients or Active only? What about In Collections or other statuses that you may use? How well do you maintain your Active patient list? Do you periodically look for patients who haven't been seen in the last two or three years and find out if they are still your patients?
- Age of patients. Some HEDIS or other quality metrics define an age (for example, of patients with asthma, or diabetes).
- Is this an insurance-driven Care Plan (for example, lead testing in patients with Medicaid or CHIP)?
- Is this a diagnosis-driven Care Plan (for example, asthma, diabetes, or premature infants)? If so, is the diagnosis driven by an ICD codeset, SNOMED codeset, or both?
- Do you want to create a group Care Plan (which may include multiple diagnoses or a different indicator) for Special Needs patients? How will you identify who they are?
- Is this a medication-driven Care Plan (for example, Nexplanon or Depo-Provera)?

Example: Issues to Address for a Diagnosis-related Care Plan - how will OP identify the correct patients with the diagnosis?

- Should it be patients with a certain code or codes on the Problem List?
- Should it include active problems only, tracking, or both?
- How is the Practice capturing the problems, by SNOMED or ICD-10? Additionally, if there are patients that may still have old ICD-9 codes, consider agreeing on a method for converting these codes to SNOMED or ICD-10.
- After completing Steps 2 and 3, make a list of all diagnosis codes that you want to include.
- If your Practice is not good about maintaining Problem Lists, how else will you identify these patients? From Visit Notes (both Encounters and Well?), referrals, or something else?
- Will you set this Care Plan to auto-enroll these patients? If not, who will be responsible for working through the list and deciding which patients the Care Plan should be applied to?
- If you are a multiple-location Practice, is this Care Plan location-specific (as in Medical Home)?

Step 2: Determine What to Do with the Patients You've Identified for the Care Plan

- It is important to get a full agreement (from all Providers and staff in your Practice that will be using the Care Plan) regarding how these patients should be managed. Care Plans cannot work across a Practice if every Provider has their own way of handling various issues (such as chronic conditions). If Providers and staff have their own way of approaching patient care, you need to go back to Step 1 to customize a Care Plan for each Provider, which illustrates why it is simpler and more efficient to obtain agreement regarding how patients should be managed and to create care plans that everyone can use.

  Remember: The best care plans are based on evidence-based guidelines and have total practice buy-in.

- You must determine the actions you want to include as part of the Care Plan, how the information should be captured in OP, and at what periodicity so that it will meet the timeframe you have set for Recall. For example, for patients we identified in Step 1 with asthma, we may want to chart:
  - Spirometry once per 365 days and record that in the Diagnostic Tests section of OP using CPT x and LOINC code y

    - Pulse oximetry every 6 months using the vital sign for pulse ox
    - An asthma severity survey every 3 months using the ACT in the Survey tool in OP
    - An Office Visit, using a template similar to Asthma Follow-up Symptom Template, every 3 months
    - An Asthma Action Plan every 6 months using the embedded Asthma Action Plan in OP

- You must also ask yourself the following:
    - Is what I just outlined above realistic, and do I have enough room in my schedule to make all of this happen?
    - Do I have orders for the appropriate workflow to the right people in my Practice to get pulse ox, spirometry, an ACT survey, and an Asthma Action Plan? Are these built into the template we'll be using? Or, should these actions be built specifically into a Care Plan template to be used at the point of care? Are they the appropriate standing vs. routine status?
    - If your workflow includes patient-oriented surveys (such as the ACT), what is your workflow for making sure appropriate patients know how to complete them before the Office Visit?

Step 3: Build the Care Plan Using SQL

After you have thoroughly designed your Care Plan (Steps 1 and 2), only then are you ready to begin writing your Care Plan in OP. Writing Care Plans in OP involves the use of predefined SQL queries. SQL is a programming language designed to query databases, and writing additional SQL queries requires SQL expertise.

Most Practices do not have in-house SQL expertise that is required to write the queries (without some degree of difficulty) that are the basis of the Care Plan. It is important that you follow the best guidance by allowing those who are experts in SQL to perform this task for you.

If you are going to use the Care Plan repeatedly to provide good care and create Recalls, it is a worthwhile investment to have an expert build the Care Plan. This usually costs about the same as seeing two patients.

Step 4: Put Your Care Plan to Work

- Share knowledge. There should be knowledge sharing with all appropriate members of your Practice team. Knowledge sharing should include:
    - Discussing the reason for the Care Plan. For example, "Our patients with asthma have higher ER utilization and hospitalization rates than our peers and we are not meeting their needs and delivering consistent, high-quality care."
    - Explaining what the Care Plan is trying to accomplish. For example, "Reduce ER use and hospitalization and improve our HEDIS asthma scores which allow us to get additional revenue through Pay for Performance Incentives from our biggest payer."
    - Demonstrating what Care Plan items that are Due look like in OP. If people ignore red items on the Care Plan, never visit that tab, or look only at the Overview section of the chart, the Care Plan will not be successful.
    - Determining which team members will own which parts of the Care Plan.
- Establish good work habits.
    - If any of your Care Plan items are dependent on templates, then the scheduler needs to be using the appropriate templates or the end-user needs to be applying the correct templates at the point of care.
    - To make sure there were no missed opportunities to deliver great care, you need to create a culture of end-of-day task clean-up. If there are a lot of tasks never completed on patient charts, the team will not see the important information through the background noise of too much to see and do. Finding out next week that no one performed spirometry on a patient will create gaps in care delivery unless you make the patient come back for those missed services.
- Use the Demographic Analysis and Recall Report effectively.This is where you can identify patients who did not come in for follow-up care appropriately or missed certain services.
    - You need someone to own this process, become educated and comfortable with how to run the Recall based on specific Care Plans.
    - You need to have a defined operating procedure that establishes:
        - Who will run recalls?

- How often they will run them?
- How they will have protected time to run them?
- How you will then contact those patients who need care (electronic messaging reminders, portal messages, phone calls)?

Step 5: Continuously Improve Your Care Plan

- From the outset, you should determine how you will measure success with your Care Plan. You need to establish some baseline measurements and then be realistic about how you are going to implement the Care Plan and continuously work to improve it. For example, if none of your patients with asthma currently have Asthma Action Plans, is 90% a realistic initial goal for the first year, or should it be 25%?

- You should refine your Care Plan along the way. If it's too difficult, simplify it and limit what you are trying to accomplish. You can:
  - Narrow the number of patients. For example, limit patients to one insurance plan that gives you P4P incentives, or one age group, or only moderate to severe persistent patients with asthma.
  - Narrow the number of items you want to accomplish. You may decide you first want to do Asthma Action Plans annually and an asthma follow-up visit every 6 months initially as your first targets in order to build in realistic success and to limit frustration.
  - Add additional items or complex items as you refine your care of patients.

- Solicit feedback from your Practice team about what's working and what's not. Maybe the workflow or periodicity needs to be adjusted. Maybe everyone wants a 4-5 PM appointment, and there is no room in your schedule. How will you problem-solve together? Maybe it's taking too long for voice confirmation and you may want to invest in some messaging automation such as electronic messaging reminders?

- Celebrate as a Practice team! This is not the work of one person or one role in your office. It takes everyone working together to do this important work. Take time to celebrate hard work and small successes along the way to build a culture of continuous improvement.