Section 4.10 Implement

CCC Patient Plan

This tool provides an overview of the community-based care coordination (CCC) Patient Plan for use by a care coordinator (CC) in planning for and tracking program services for a patient. Ideally, it should be used in a database/repository or electronic health record (EHR) format.

Time required: 1 hour

Suggested other tools: CCC Patient Plan Template; Patient Action Plan (and template)

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How to Use

1. **Review** the overview of the Community-Based Care Coordination plan (CCC) Patient Plan and its relationship to the Patient Action Plan.
2. **Understand** the components of the CCC Patient Plan and how to develop a CCC Patient Plan.
3. **Review** the resources available for additional understanding of community-based care coordination and chronic care management.

Overview of the CCC Patient Plan

A Community-Based Care Coordination (CCC) Patient Plan is intended for use by the care coordinator (CC) and covers the full range of services that may be needed by a patient. The CCC Patient Plan provides detailed information about a specific patient and is prepared from all currently-known information prior to meeting with the patient for the first time. It is then updated as more information about the patient is obtained – either from the patient during a CC visit, or from other sources.

Note: It is not the role of the CC to provide treatment, but to coordinate treatment and other resources that would aid the patient in improving his/her health status. If the CC is also the patient's provider, treatment should be conducted in the clinic setting as a separate visit.

Relationship of CCC Patient Plan to Patient Action Plan

Although it is feasible to use a copy of the Patient Action Plan (see *Patient Action Plan*) as the care coordinator's guide for supporting a patient's care coordination needs, the more comprehensive CCC Patient Plan helps the CC better understand the patient's condition(s), environment, health care challenges and potential needs *prior* to working with the patient to develop the Patient Action Plan. The CCC Patient Plan is then used on an ongoing basis throughout the provision of CCC services, and includes notes on barriers and progress, as well as tracking mechanisms for the various care coordination activities needed for that patient**.**

Developing a CCC Patient Plan

Prior to meeting with a patient, it is essential to set up a CCC Patient Plan, populating it with what is known about the patient and what best practices and resources would likely be appropriate and needed for coordinating that patient's care. (See *CCC Patient Plan Template* for a fillable form.)

Components of the CCC Plan include:

- ***General information about the patient:***
  - Patient contact information
  - Emergency contact information
  - Primary care provider
  - Specialty providers
  - Advance directives
  - Other information, as applicable
- ***Patient's current problem list***, including identification of needed education (see educational resources below) and the patient's response to the education and care coordination activities.

CCC Patient Plan

General Information				
Patient Name:			Phone:	
Emergency Name:			Phone:	
Alternate Emergency:			Phone:	
Primary Care Provider:			Phone:	
Specialist (Type:):			Phone:	
Specialist (Type:):			Phone:	
Care Coordinator:			Date CCC Started:	
Advance Directives:			Date:	
Current Problem List				
Problem	**Onset Date**	**Provider**	**Education or Supplied**	**Pt Response to CCC**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
Current Medication List Allergies: ❑ PCN ❑ Sulfa ❑ Other:			❑ Food:	
Medication Name	**Dose**	**Route**	**Sig**	**Prescriber**	**Compliance/ Needs**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

- ❑ ***Patient's current medication list***, including patient adherence to medications, any additional medications being taken (such as over-the-counter medications), and educational or other unresolved needs.

- ❑ ***Current Health Risk Assessment*** results, if available/applicable in order to anticipate and identify management strategies to overcome barriers. (See *Health Risk Assessments.*)

Health risk assessments that may be appropriate for a particular patient in a CCC program include an assessment of:

- o Depression risk
- o Digital literacy
- o Environmental risk
- o Fall risk
- o Functional status
- o Health literacy
- o Medication reconciliation
- o Social and financial risk
- o Substance use

- ❑ ***Patient's current treatment plan***, including appointments with primary care provider, specialists, therapists, pharmacists, diagnostic studies to be performed/results tracked, etc.

- ❑ ***Lifestyle changes*** applicable to patient's condition(s), including noting which have been identified by the patient as a goal (from the *Patient Action Plan* process), how confident the patient is in being able to achieve the goal, what barriers exist, what assistance the CC is providing (e.g., arranging for nutritionist support, meals–on-wheels, diet instruction, ADL assistance, support group, referrals, other instructions or educational materials), and results the CC observes over time, which may result from motivational interviewing techniques:
  - o Diet
  - o Exercise
  - o Tobacco cessation
  - o Alcohol and substance treatment
  - o Sleep
  - o Mood
  - o Others

  (See *Supportive Communications* and *Coaching Patients in Self-Managemen*t.)

- ❑ ***Home monitoring needs*** applicable to the patient's condition(s), including determining instructional needs, set up assistance, assistance in acquiring the home monitoring tools (if patient needs monitoring but does not have those tools, including financial), and agreement on how monitoring results will be reported (e.g., to home health nurse daily, to CC daily/weekly), and clinical results over time:
  - o Blood pressure
  - o Blood sugar

- Pulse oximeter
- Scale
- Medication reminder system
- Health diary (see Health Diary/Personal Health Record)
- Other

❑ ***Schedule of dates/times for future contacts*** and notes upon completion of each contact, including patient's preferred form of communication (recognizing the need for telephone calls and face-to-face time during visits with primary care provider, if needed and feasible).

Resources for Community-Based Care Coordination

The following are useful references to learn more about evidence supporting community-based care coordination, including examples of Patient Action Plans:

- Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse: Transitional Care. Evidence-based geriatric nursing protocols for best practice. Available at: http://www.guideline.gov/content.aspx?id=43940
- Coleman, EA and C Boult. (2007). Improving the Quality of Transitional Care for Persons with Complex Care Needs. American Geriatrics Society (AGS) Position Statement. Assisted Living Consult, March/April, 30-32. Available at: http://www.caretransitions.org/documents/Improving%20the%20quality%20-%20JAGS.pdf
- Coleman, MT and KS Newton. (2005). Supporting self-management in patients with chronic illness. American Family Physicians; 72(8):1503-1510. Available at: http://www.aafp.org/afp/2005/1015/p1503.html
- Greene, J and JH Hibbard. (2012). Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes. Journal of General Internal Medicine 27(5):520-6. Available at: http://link.springer.com/article/10.1007/s11606-011-1931-2#page-1
- Handley, M, et al. (2006). Using Action Plans to Help Primary Care Patients Adopt Health Behaviors: A Descriptive Study. Journal of the American Board of Family Medicine;19:224-31). Available at: http://www.jabfm.org/content/19/3/215.full.pdf+html
- MacGregor, K. et al. (2005). Behavior-Change Action Plans in Primary Care: A Feasibility Study of Clinicians. Journal of the American Board of Family Medicine.;19:215-23. Available at: http://www.jabfm.org/content/19/3/224.full.pdf

Chronic Care Resources for CC

The following additional resources may be helpful to have on hand. Some are geared more toward professionals, others to patients, and some to both:

- **Choosing Wisely** – evidence-based recommendations from leading specialty societies of things that should be discussed to help make wise decisions about the most appropriate

care based on a patients' individual situation. Available at: http://www.choosingwisely.org/

- **Diabetes in the elderly** – strategies for controlling diabetes suitable for providers and patients. Available at: http://diabetes.niddk.nih.gov/dm/pubs/type1and2/daily.aspx
- **Congestive heart failure** – strategies for managing congestive heart failure suitable for providers and patients. Available at: http://cccma.org/conditions-heart-failure.html
- **Chronic obstructive lung disease** – educational materials for patients on COPD (requires free registration). Available at: http://www.copdfoundation.org/Learn-More/Educational-Materials/Downloads.aspx#SSRG
- **Hypertension** – guidelines for patients on managing hypertension and conversations to have with providers. Available at: http://www.ahrq.gov/patients-consumers/prevention/disease/hbppatient.html
- **Coronary artery disease** – (fairly high-level) information on coronary artery disease for patients. Available at: http://www.cvapc.com/handler.cfm?event=practice,template&cpid=26595
- **Ischemic vascular disease** – information for patients about ischemic vascular disease. Available at: http://vasculardisease.org/flyers/focus-on-ischemia-flyer.pdf

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For support using the toolkit

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