

Section 4.11 Implement

Patient Action Plan

This tool provides an overview of the Patient Action Plan, a self-management tool for the care coordinator (CC) to use in developing specific plans for patients based on their health conditions, during the provision of community-based care coordination (CCC) services.

Time required: 2 hours

Suggested other tools: Patient Action Plan Template; CCC Patient Plan (and template); Health Risk Assessments; Promoting Patient Self-Management; Patient Care Coordination Variance Reporting

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How to Use

1. **Review** and understand the importance of the Patient Action Plan in promoting patient engagement and self-management.
2. **Review** steps in developing a Patient Action Plan with the patient.
3. **Consider** how to use or modify the Patient Action Plan template for patient-specific or cohort-specific needs.

Importance and Use of a Patient Action Plan

Unlike the CCC Patient Plan that is intended for use by the care coordinator (CC) and that covers the full range of services that may be needed by a patient, the Patient Action Plan is a patient-friendly, self-management tool to be negotiated between the patient and CC. It is one of the first steps a CC does with a patient once the patient begins using community-based care coordination (CCC) services.

Increasing evidence shows that patient self-management reduces hospitalizations, emergency department (ED) use, and overall cost of care.¹ Self-management has been defined as the “ability of the patient to deal with all that a chronic illness entails, including symptoms, treatment, physical and social consequences, and lifestyle changes.”² Self-management support provided by a CC leads to self-efficacy and the patient’s belief in his/her own ability to accomplish a specific goal or behavior or to achieve a reduction in symptoms, which leads to improved clinical outcomes.³

CCs can support self-management in patients by building their confidence and helping them make choices that lead to better outcomes. Tactics to promote self-management include motivational interviewing (see *Supportive Communications*), developing a *Patient Action Plan* (this tool), and following up with patients on achievement of their health goals.

Developing a Patient Action Plan with a Patient

Listed below are eight steps to help develop a Patient Action Plan with a patient. However, if the CC’s first encounter with the patient is in the hospital or emergency department and discharge planning is being undertaken, the CC should determine the most appropriate time to develop the Patient Action Plan with the patient. It may be during the discharge planning, during a discharge follow-up call within 24 to 48 hours of discharge, or it may be during a separate communication activity (e.g., call, clinic visit, home visit) with the patient.

Care coordination should ideally start during a hospital admission when a patient is identified as high-risk and needing CCC services, or at the latest during discharge planning (from the hospital or emergency department) for such a patient. The CC should make sure all applicable steps are being taken to transition the patient to his/her home.

Steps in Developing the Patient Action Plan

1. Review patient’s health record and treatment plan.

Before development of the Patient Action Plan is initiated, first review the patient’s health record and current treatment plan. Determine if the Patient Action Plan template contains the right choices for the patient’s specific set of conditions. The *Patient Action Plan Template* tool is a good starting point for patients with chronic obstructive pulmonary disease (COPD), diabetes, heart disease, and other common chronic diseases and co-morbidities. Modify the template as needed, especially if there are multiple conditions present.

2. Introduce the concept of patient self-management to the patient

- a. *Discuss the number of things that the patient can do to help him/herself feel better and reduce the need for hospitalization and emergency department visits. Suggest that doing all of the things all of the time is difficult for anyone to do, but identifying one or two things to do at a time can help set the course for getting and*

staying healthier. Indicate to the patient that no one is forcing him/her to do more than is possible and that the CC will be available to help guide and answer questions. (Note: While ideally every provider would like patients to follow all of the recommendations for improving the state of their patients' health, it is generally found that this is unrealistic for high-risk patients to make such a sudden, and often overwhelming, change in their lifestyle. Taking a slow, but steady, approach toward improvement generally yields far better results.)

- b. *Explain that a Patient Action Plan helps the patient understand* the types of things that can help them feel better and stay out of “trouble.” It helps the patient set goals for carrying out specific steps that the patient thinks are feasible to change in the short term. The Patient Action Plan also identifies and offers suggestions and help for overcoming barriers, and helps the patient become more confident in his/her ability to achieve personal health goals.
- c. *Ask the patient to identify the condition(s) that need managing.* This step assures that the patient acknowledges the state of his/her health. If the patient is not clear about the state of their health, consider using a Health Literacy Assessment to gauge the extent of education needed. Once any additional education is provided, point out the potential things the patient can do to manage his/her condition. Determine what the patient is most sure can be done and then ask the patient to select one or two additional steps of interest from the list.

3. Discuss options for next steps with the patient

Ask the patient what he/she would like to know about the steps chosen. Doing so provides insights about what the patient already knows and helps “put the ball in his/her court” toward self-management. Provide specific information requested. It can be helpful to have educational resources for each condition handy to leave with the patient – but do not use these as a substitute for the discussion.

4. Ask patient about concerns and barriers

Ask the patient what concerns he/she may have about his/her condition and about the steps that can help the patient. Seek information about how realistic the patient is about his/her health. Encourage the patient to see that there is “a road ahead” with steps that can be taken to improve upon how the patient feels today. Using the Patient Action Plan, have the patient write down the specific barriers foreseen.

Barriers might include:

- a. Symptoms from co-morbidities that he/she views as precluding doing certain things – For example, a patient with COPD and diabetes may not be able to do the exercise needed for diabetes control. However, if the initial focus is on breathing exercises, other exercises may be able to be introduced later that would help the diabetes. There may be signs of depression. If depression screening has not been done previously, an RN CC may refer the patient to his/her primary care provider or a clinical social worker, or an NP CC may do a depression screening and refer the patient to his/her primary care provider for appropriate treatment. (Remember, whatever the credentials of the CC, it is not the CC's role to provide treatment. If the CC is also the patient's provider, conduct any treatment within the context of a clinical visit, not during the care coordination process. If for no

other reason, the care coordination encounter may not be reimbursed in the same manner as an office visit.) Refer to the *Health Risk Assessment* tool to determine if there are other functional areas that need attention.

- b. Financial issues, such as not having enough money to pay for proper food – CCs generally do not have the means to conduct a financial risk assessment or address financial issues with the patient. In this case, it may be necessary to make a referral to a social worker, local public health department, or other community service that can provide financial assistance counseling (see *Community Resource Directory*). The CC can take certain steps to introduce the patient to food supplements (such as protein bars or nutrition shakes), help the patient create a food budget and grocery list, and be alert to the potential that money is being spent on alcohol or other things that raise additional issues to be addressed. The CC may need to refer the patient to a nutritionist.
- c. Transportation, which can preclude the patient from doctor visits or grocery shopping – The CC can aid the patient in finding reliable transportation services and discuss the need to potentially adjust his/her life schedule.
- d. Health literacy in general – This may not be a stated barrier and may not always be immediately apparent, but throughout the interview with the patient this will likely manifest itself. Consider performing a Health Literacy Assessment if appropriate. Refer to the *Approaches to Patient Communications* tool for tips such as “teach-back” and other techniques to help ensure patient understanding. Clear instructions on self-monitoring, taking medications and keeping appointments help immensely, all of which may be a part of the Patient Action Plan or a separate document.
- e. Family/caregiver support, if the patient lives alone or if the support person is also aging and/or infirm – An Environmental Risk Assessment may uncover unexpected issues, such as the fact that the spouse is deaf, has less health literacy than the patient, or has other issues that preclude optimal support for the patient. Discuss this with the patient, and determine if there are any other support mechanisms that can be relied on (e.g., daily call from a child that lives a distance away, parish nurse check-in, or remote patient monitoring).
Determine if there are community resources that may be used to provide necessary support. If a patient needs regular home health services, make a referral as applicable. If the patient uses a computer, encourage using any number of the apps available for home monitoring, reminders, and education. Encourage the patient to engage in online support groups. (See *Technology Tools and Optimization for CCC*.)
- f. Home monitoring use – This may be a barrier if the patient or family/caregiver is not technologically savvy, there are financial issues, the home is very remote, or if the patient has uncertainties or resistance to using a computer for even documenting information such as weight, blood pressure, etc. Determine if assistance with set-up is needed for any equipment involved and if the durable medical equipment (DME) provider can help. If not applicable, consider other resources available in the community such as a social worker, local public health

department, pharmacist, or even a neighbor. If documentation is an issue, determine if it is feasible for the patient to use a “smart” device. Determine if results will be communicated to the patient’s computer or smart phone only, or will be transmitted to a home health nurse or the CC for closer monitoring.

- g. Have the patient note any additional barriers on the Patient Action Plan – Make note of these barriers and any others observed on the CCC Patient Plan to be held for future discussions

5. Work with patient to develop goals

Ask the patient to state specific goals relative to each of the actions selected that will move the patient toward a healthier lifestyle. Clarify any goal statements to be sure they include specific, measurable actions. A goal as simple as “I will take all of my medications on time” is an extremely important goal for a patient who has a history of not always remembering to take medications. If the patient identifies a goal of making healthier meal choices, work with the patient to define specifically what that means: “low sodium soup,” “fruit instead of candy” or “lemon juice instead of salt.” Have the patient write these down on the Patient Action Plan.

6. Discuss patient’s level of confidence to take next steps

Ask the patient how confident he/she is that he/she has the ability to carry out the action steps. Most of the literature suggests using a 10-point scale. If the confidence level is below 7, ask the patient what would help make him or her be more confident. Have the patient add that to his/her goal statements and/or list of barriers to be overcome. Do not push the patient to adjust the confidence rating, but encourage him or her to make that change for him/herself.

7. Develop action plan with the patient

Based on the discussion, have the patient record specific actions he/she plans on taking, as well as the goals. Review the Patient Action Plan and make sure all elements are complete:

- a. Have the patient record the specific medications to be taken.
- b. Have the patient record what, when, and how goals for vital signs monitoring (e.g., weight, blood pressure, blood sugar) and other actions (e.g., exercise, diet, tobacco cessation, alcohol restrictions, sleep, inhaler use) selected by the patient will be undertaken.
- c. Review any follow-up appointments for doctor visits with the primary care provider, specialists, therapists, or other (e.g., need for flu shots, pneumovax, shingles vaccine, tetanus/whooping cough, etc.) and have the patient document these.
- d. If the patient needs to keep a health diary, ask the patient to provide an example of documentation on a health diary supplied by the CC, using what he/she has already done that day (e.g., medications taken, home monitoring performed, diet, exercise, and appointment kept). (See *Patient Health Diary* and *Personal Health Record*.)

- e. Reach agreement with the patient on how and when the patient and CC will communicate with each other. Some patients may be willing and actually prefer to use email or texting with the CC. Use these as applicable, but be sure there are also telephone calls and potentially face-to-face meetings, especially if the CC is co-located in the office of the patient's primary care provider. Do not force the patient to use a computer, but if there appears to be interest or means to use a computer, conduct a Digital Literacy Assessment and make recommendations as applicable.

8. Create an agreement

State that the Patient Action Plan is an agreement or contract between the patient and the CC. When complete, either make a photocopy or generate two printouts. Sign the form(s) and ask the patient to sign the form(s). Give the original to the patient.

If this is performed at the patient's home, sign the original form and leave it with the patient, transferring pertinent information to the CCC Patient Plan before leaving. Better yet, take a photo of the signed form using a smart phone camera and include the image in the patient's file for documentation.

Ongoing Use of the Patient Action Plan

To stress the importance of patient self-management, use the Patient Action Plan as the starting point for each follow-up communication process with the patient.

- Have an agenda for each communication. Ask the patient to describe his/her progress toward goals. Obtain specific information on any health diary being maintained.
- Use the CCC Patient Plan to check on any other actions that needed to be taken.
For example, if the patient was scheduled to visit a specialist, check that the patient had appropriate transportation. Document on the Variance Report any issues with the transportation service. Inquire about the visit and what medications may have been prescribed or renewed, and any additional or different treatment regimens that need to be followed. Add these to the list of medications the patient is taking, monitoring what needs to be performed or other steps to be taken. Ask the patient (and/or family/caregiver) if there are any questions about these medications and if the prescription has been filled. Follow up to ensure the specialist has communicated with the primary care provider about findings and any specific treatment plans and medication changes, and obtain a copy or review via the electronic health record (EHR).
- When the patient has reached the stage that the initial goals are being met regularly, commend the patient and work with the patient to set the next specific goal or goals, using the same tactics as for the initial development of the Patient Action Plan.

Patient Action Plan Templates

A variety of Patient Action Plan templates are available – commercially and from various associations, foundations, and specialty societies. There are a number of excellent tools available for download and direct use, or purchase. However, be careful while browsing the web for alternative templates. Because the U.K., Australia, and New Zealand are very active in promoting self-management, be sure to review any tools from those countries to make sure they are consistent with the standards of practice adopted in the U.S. and with evidence-based

guidelines used by the community. In addition, some simple things may need to be changed, such as “Get a flu shot in March” which applies only to countries south of the equator.

Keep in mind that most Patient Action Plans available on the web are specific to a single condition. However, because most high-risk patients have multiple conditions, it may be more useful to use a generic template to which the CC can add specifics for each condition relevant to a given patient.

In general, Patient Action Plans should be very easy for patients to understand, displayed with large font and color, and limited to one page (front and back). The key components should include:

My Management Plan side

- Patient name, contact information, and emergency contact information
- Primary care provider name and contact information
- Care coordinator name and contact information
- List of conditions the patient must manage
- Current medications list
- Goals (with space for patients to write specifics)
- Patient’s confidence level for achieving goals (1–10 scale)
- Next appointments
- Signature signifying agreement to follow plan

My Action Plan side

- Management plan (disease-specific symptoms and actions to be taken)

See *Patient Action Plan Template* for a fillable form and examples.

References

¹ Lorig, KR, Et al. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Medical Care* 2001;39:1217-23

² Barlow, J, et al. Self-management approaches for people with chronic conditions: a review. *Patient Education and Counseling* 2002;48:177-87.

³ Coleman, MT and KS Newton. Supporting Self-management in Patients with Chronic Illness. *American Family Physician* 2005;72/8:1503-1510. Available at:

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Updated 01/06/2015

Produced under contract with The Office of the National Coordinator for Health Information Technology (ONC)

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