Care Planning Toolkit

For Patient-Centered Primary Care Homes

August 2022

PATIENT CENTERED
PRIMARY CARE HOME PROGRAM

Editable versions of the templates included in this toolkit can be found at the PCPCH Resources and Technical Assistance webpage.

Click here to see…

PCPCH Program Care Plan Guidance & Tools:

- Extra Guidance on PCPCH Measure 5.C.3
- Care Plan Template Guide
- General Care Plan Template & Example
- SMART Care Plan Template & Example

More Care Plan Examples:

- OHSU: Shared Care Plan for Children & Youth with Special Health Needs
- St Charles Health System: EHR Care Plan Template & Example
- Salem Clinic: Adult High-risk Patient Care Plan Template

Additional Guidance on Creating SMART Goals:

- CDC: Guidance on Writing SMART Objectives
- MDH: Tips on Writing Meaningful Goals and SMART Objectives

PCPCH Measure 5.C.3 – Care Planning

This document provides extra guidance around Measure 5.C.3 under the Patient-Centered Primary Care Home Program's 2020 Recognition Criteria. The full technical specifications for this measure are available in the 2020 PCPCH TA Guide.

5.C.3	PCPCH collaborates with diverse patients, families, or caregivers to develop individualized written care plans for complex medical or social concerns.	**15 points**

Intent of Standard 5.C

Care coordination is an essential feature of a primary care home. The intent of this standard is to ensure that PCPCHs deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of diverse patients with complex care needs, and communicate clearly to patients, families, and caregivers about who they can contact at the practice to help coordinate their care. Measure 5.C.3 within standard 5.C also promotes the development of individualized care plans for diverse patients with complex medical and social needs to help coordinate and integrate their care. Identifying patients with higher health risks, implementing a strategy to help those most in need, and effectively coordinating and managing care for higher risk sub-populations can help prevent exacerbations of illness and other health complications.

Building a Care Plan

Care planning is a detailed approach to customizing care to an individual patient's needs. Care plans are most impactful when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions.

Generally, care plans include, but are not limited to: [1]

- Patient-identified goals for a patient's health status
- Established timeframes for re-evaluation
- Resources that might benefit the patient, including a recommendation or referral to the appropriate level of care or community resources
- Planning for continuity of care, including assistance making the transition from one care setting to another
- Collaborative approaches to health, including family participation and other healthcare providers when necessary

The care plans must include, at a minimum:

- Patient-specific short-term and long-term health goals
- The action plan for achieving these goals or managing the patient's condition
- Three elements from across the two lists on pages 112-113 (primary and supportive services) that the practice has determined to be most impactful to individual patients and their overall treatment/ management plan. These can be from either the primary or supportive elements list, depending on what is most important to the individual patient's care.

Guiding Principles

- Care plans should be developed collaboratively with each patient or patient's family and/or caregivers.
- Care plans should be written in the patients' preferred language, at an appropriate health literacy level, accessible by individuals with disabilities, documented in the medical record, and updated regularly.
- Care plans are not for every patient, but rather those with the most complex needs and medical and/or social concerns as identified by the practice.
- The is no single "right" template for care plans that a practice should follow. However, the care plan format should fit into the care team's workflow and should be delivered to the patient in their preferred format.
- When appropriate, care plans should be shared with specialists and community partners that the patient is working with for optimal health.

Step-by-Step Approach to Building a Care Plan: Example

Below is an example of building a care plan for an adult patient seen in a primary care practice[2]

- Problem statement with an action plan that is measurable, obtainable, and important to this unique patient.
- What is the highest priority for the patient?
- What the patient wants to happen/do when they've met their goals
- Barrier(s): Any factor that can limit the patient from achieving the goals set forth in the care plan (i.e. lack of transportation, financial issues, social issues, lack of knowledge).
- Intervention(s): The steps that need to be taken to assist the patient in reaching the goal(s):
    - Intervention must be customized for each patient and designed to resolve the issue/problem that will have the highest impact on patient's health status. These can be identified from the primary and supportive elements listed on pages 112-113 in the TA guide.
    - Continuous reprioritization of the care/interventions for the patient must occur based on the most recent interactions and new information
- Evaluation: Ongoing review and revision of the care plan until goals are met. This may include development of new goals.

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[1] Partnering in Self-management Support: A Toolkit For Clinicians: Ihi
http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx

[2] (2021). Retrieved 18 January 2021, from
https://www22.anthem.com/providertoolkit/SS3_UpdatedCarePlanPlaybook_EMPIR.pdf

Care Plans

Introduction

This template guide is intended to help practices evaluate or develop a care plan template that meets the specifications for PCPCH Measure 5.C.3 under the 2020 PCPCH Recognition Criteria. The full specifications for the care planning process are described on pages 111-113 of the 2020 PCPCH Technical Assistance Guide. Additional guidance, templates, and examples of care plans can be found on the PCPCH Resources and Technical Assistance webpage, which also contains resources on how to improve the health literacy and cultural competency of your care plans.

Care Plan Template Requirements

To meet PCPCH Measure 5.C.3, a typical patient care plan at your practice must include, at a minimum:

1. The patient's **short-term and long-term health goals.**
2. The **action plan** for achieving these goals or managing their condition.
3. **Three additional elements** from the lists below that the practice has determined to be the most impactful to the individual patient and their overall treatment/management plan.

Primary Elements

(Most commonly found in care plans)

- Patient-specific education regarding conditions and treatment(s)
- Self-management of chronic conditions (a contingency plan for exacerbations, such as
- asthma care plan, diabetes, CHF)
- Names and roles of community-based support or services outside the practice
- Behavioral health or substance use disorder treatment(s)
- Barriers to care and potential solutions
- Psychosocial concerns and coordination of health-related social needs (HRSN) resources
- Coordination with sub-specialists

Supportive Services Elements

(Often applied in pediatric practices and used to support patient self-identified goals and/or Interventions)

- Equipment (e.g., tracheostomies, gastronomy tubes, wheelchair, orthotics)
- Appliance/Assistive technology (e.g., nebulizers, wheelchairs, orthotics, walkers)
- Therapies (e.g., speech, physical therapy, occupational therapy)
- Individualized Education Program (IEP)
- Individual Family Service Plan, 50448
- Home care/nursing services
- Developmentally Disabled (DD) Waiver

The following pages will clarify and provide examples for each of these categories.

1) Patient's Health Goals

The care plan must include both the short-term and long-term health-related goals that the practice has worked with the patient or caregiver/family to develop.

Short-Term Goals: Immediate or priority goals, such as learning how to monitor their condition or ensuring transportation to the clinic for regular checkups.

Long-Term Goals: More long-term health goals or lifestyle changes, such as increasing exercise, improving nutrition, or improving housing conditions. Ideally, these goals will be personalized, minimize medical jargon, and take into account the patient's unique conditions, lifestyle and values. What motivates this particular patient to be healthy? For example, rather than "keep a systolic blood pressure of less than 120" a more personalized long-term health goal would be "learn how to cook healthy and delicious meals", "take a yoga class" or "take grandchildren on hikes."

2) Action Plan

The care plan must also include the steps that the patient can take to meet these goals or manage their condition. It might include steps such as reading or discussing patient-specific education on their condition with their care team, keeping self-management tools in a visible area and using them regularly, attending a workshop, or any other actions that would help them meet their short-term and long-term goals. This list of actions should be easily digestible to the patient, so feel free to get creative with checklists or visual cues!

3) Three Additional Components

Patient-Specific Education

Patient education materials will vary based on the patient but will typically include an overview of the patient's condition(s), causes, symptoms, progression, treatment, and other relevant information. Below is and example of what patient-specific education might look like:

- Spina Bifida Association – Type 2 Diabetes

Self-Management Materials & Support

Self-management materials or support will vary based on the patient but typically include tools or resources that help patients monitor their condition/symptoms, a contingency plan for exacerbations, and/or tools for improving their health. Below is some additional guidance on delivering successful self-management support, as well as some examples of what a self-management tool might look like:

- AHRQ: Self- Management Support and Health Literacy Action Plans
- AllCare Health Plan – Exacerbation Action Plan & Protocol
- American Lung Association – Asthma Action Plan
- The Physician Alliance - Diabetes Action Plan

Community-Based Support & Services

The care plan may include the names, roles, contact information, and other relevant information for external entities that can assist the patient in managing their condition or achieving their health goals. Below are some examples:

- Living Well with Chronic Disease Self-Management Programs (CDSMPs)
- Yoga Classes or nutritional cooking class

Behavioral Health or Substance Use Treatment(s)

The care plan may include referrals, medication and treatment regimen(s), roles, contact information, or other relevant information regarding the management of the patient's behavioral health condition or achievement of their health goals. Below are some examples:

- Referral to behavioral health provider (i.e. details that are relevant/useful to the patient)
- Medication Assisted Treatment (MAT) plan
- Identified roles of those involved in patient's behavioral health care
- Contact information for a substance use sponsor
- Goal for attending substance use treatment meetings such as AA

Barriers and Solutions

The care plan may include a list of barriers to health that the patient and practice have identified and the plan or steps towards addressing these barriers.

Psychosocial concerns and coordination of Health-related Social Needs (HRSN) resources

The care plan may include referrals, roles, contact information, or other relevant information regarding the management of the patient's psychosocial concerns or coordination of their health-related social needs. Below are some examples:

- Identified psychosocial needs and/or health related social needs (i.e. a completed HRSN screening tool that specifies HRSN needs)
- Referral to community-based organization or service provider (i.e. details that are useful to patient)
- Identified roles and contact information
- Goal for following up with specific services or organizations

Coordination with Subspecialists

The care plan may include a list of specialists within or outside the practice that the patient has been referred to or is already seeing, along with their contact information.

Medical Equipment or Supplies

The care plan may include the equipment or supplies that the patient can or should use to manage their condition, as well as the contact information of the entities that can supply or maintain them. Examples include tracheostomies, gastronomy tubes, orthotics, etc.

Appliance/Assistive Technology

The care plan may include the appliances or assistive technologies that the patient can or should use to manage their condition, as well as the contact information of the entities that they can reach out to for assistance with these appliances/technologies. Examples include nebulizers, wheelchairs, walkers, etc.

Therapies

The care plan may include the therapies that the patient has been prescribed and/or referred to and any relevant providers, roles, and contact information. Examples include speech therapy, physical therapy, occupational therapy, etc.

Individualized Education Program (IEP)

The care plan may include a patient's IEP plan, which lays out the special education instruction, supports and services the patient needs to thrive in school.

Individual Family Service Plan (IFSP)

The care plan may include a patient's IFSP or the components that relate to the patient's care, such as information on the child's functional ability across five developmental areas: Physical (including vision and hearing), Cognitive, Communication, Social/Emotional, and Adaptive.

Home care/Nursing Services

The care plan may include information on the services provided to a patient for them to live and age safely in their home. This could include (but is not limited to):

- Assistance with adhering to medication regimen
- Companionship/emotional support
- Self-hygiene assistance
- General provision of patient's condition

Developmentally Disabled Waiver (DDW)

The care plan may include the details of a patient's DDW that relate to services that enhance or support their overall care. This could include (but is not limited to):

- Household assistance
- Social activities support and supervision
- Community inclusion
- Meals delivered
- Work force habituation

My Care Plan

Insert Practice Logo Here

[Patient Name]

Care Plan Updated & Approved: [Date]

My Health Goals

Immediate Health Goals

- [Short-term Goal]
- [Short-term Goal]
- [Short-term Goal]

Goals for a healthy future

- [Long-term Goal]
- [Long-term Goal]
- [Long-term Goal]

Action Plan

My care team's plan:

- ☐ [Action that will help patient meet health goals above]
- ☐ [Action that will help patient meet health goals above]
- ☐ [Action that will help patient meet health goals above]

My plan:

- ☐ [Action that will help patient meet health goals above]
- ☐ [Action that will help patient meet health goals above]
- ☐ [Action that will help patient meet health goals above]

My Care Team

[Provider type]	[Name of provider]	[Contact Information]
[Provider type]	[Name of provider]	[Contact Information]
[Provider type]	[Name of provider]	[Contact Information]
[Provider type]	[Name of provider]	[Contact Information]

[Practice website or patient portal]
[Practice phone number]

My Care Plan

Insert Practice Logo Here

[Relevant Care Plan Element]

[Include a care plan element that is relevant to this patient. A list of care plan elements can be found on pages 112-113 of the PCPCH Technical Assistance Guide and a description of each element can be found in the PCPCH Care Plan Template Guide.]

[Relevant Care Plan Element]

[Include a care plan element that is relevant to this patient. A list of care plan elements can be found on pages 112-113 of the PCPCH Technical Assistance Guide and a description of each element can be found in the PCPCH Care Plan Template Guide.]

[Relevant Care Plan Element]

[Include a care plan element that is relevant to this patient. A list of care plan elements can be found on pages 112-113 of the PCPCH Technical Assistance Guide and a description of each element can be found in the PCPCH Care Plan Template Guide.]

[Practice website or patient portal]
[Practice phone number]

My Care Plan

Lady Bug Clinic

James Doe
Care Plan Updated & Approved: 3/1/2022

The patient's care plan can be updated at regular intervals as determined by the care team.

My Health Goals

Patient's short-term and long-term health goals (required in a care plan to meet PCPCH Measure 5.C.3)

Immediate Health Goals

- Go on walks three days per week
- Drink less soda
- Get Photo ID to qualify for housing

Goals for a healthy future

- Move into own home
- Lower A1C
- Lower blood pressure

Action Plan

Action plan (required in a care plan to meet PCPCH Measure 5.C.3)

My care team's plan:

- ☐ Contact housing agencies to get Jim on list for housing
- ☐ Enroll Jim in diabetes education class

My plan:

- ☐ Read this packet and put the "Diabetes Zones" chart on fridge for daily reminder
- ☐ Start only buying one liter of soda per week
- ☐ Get new walking shoes
- ☐ Join Marsha (daughter) when she takes the dog for a walk
- ☐ Work with Marsha to make sure DMV paperwork is completed
- ☐ Do YouTube yoga with Marsha once per week to reduce stress
- ☐ Attend bi-monthly diabetes education class

Ideally, the care plan avoids medical jargon and uses plain language that is familiar to the patient

My Care Plan

Lady Bug Clinic

My Care Team: *Blue Team*

Primary Care Provider	Dr. Johnson	503-222-2222
Care Coordinator	Nurse Maria	503-222-2222
Community Health Worker	Mark	503-222-2222

My Specialists

This particular care plan includes "coordination with subspecialists" as one of its additional care plan elements (care plans must include at least three additional care plan elements to meet PCPCH Measure 5.C.3)

Cardiologist	Dr. Smith	503-999-8542
Dermatologist	Dr. Paulson	503-744-2202
Endocrinologist	Dr. Mounds	503-324-6547

About Type 2 Diabetes

This care plan includes "patient-specific education" as one of its additional care plan elements. This sample of patient education was drawn from the CDC website but practices may choose to include their own version of patient education on various conditions. It's always best to use plain language and to include visuals such as diagrams and charts. Practices may include patient-specific education in the care plan itself as shown, or provide it as a separate document or packet.

What is Type 2 Diabetes?

With type 2 diabetes, your body doesn't use insulin well and can't keep blood sugar at normal levels. About 90-95% of people with diabetes have type 2. It develops over many years and is usually diagnosed in adults (but more and more in children, teens, and young adults). You may not notice any symptoms, so it's important to get your blood sugar tested if you're at risk. Type 2 diabetes can be prevented or delayed with healthy lifestyle changes, such as losing weight, eating healthy food, and being active.

What Causes Type 2 Diabetes?

Insulin is a hormone made by your pancreas that acts like a key to let blood sugar into the cells in your body for use as energy. If you have type 2 diabetes, cells don't respond normally to insulin; this is called insulin resistance. Your pancreas makes more insulin to try to get cells to respond. Eventually your pancreas can't keep up, and your blood sugar rises, setting the stage for prediabetes and type 2 diabetes. High blood sugar is damaging to the body and can cause other serious health problems, such as heart disease, vision loss, and kidney disease.

My Care Plan

Lady Bug Clinic

Symptoms and Risk Factors

Type 2 diabetes symptoms often develop over several years and can go on for a long time without being noticed (sometimes there aren't any noticeable symptoms at all). Because symptoms can be hard to spot, it's important to know the risk factors and to see your doctor to get your blood sugar tested if you have any of them.

Testing for Type 2 Diabetes

A simple blood test will let you know if you h
tested at a health fair or pharmacy, follow up
results are accurate.

This care plan includes "self-management materials and support" as one of its additional care plan elements. This summary and the chart on the next page were drawn from the CDC website and AllCare Health Plan but practices may choose to include their own self-management information and materials. It's always best to use plain language and tools that make it easy for patients to monitor and improve their condition. Practices may include information on self-management in the care plan itself as shown, or provide self-management tools/support as a separate document or packet.

Managing Type 2 Diabetes

Unlike many health conditions, diabetes is managed mostly by you, with support from your health care team (including your primary care doctor, foot doctor, dentist, eye doctor, registered dietitian nutritionist, diabetes educator, and pharmacist), family, and other important people in your life. Managing diabetes can be challenging, but everything you do to improve your health is worth it!

You may be able to manage your diabetes with healthy eating and being active, or your doctor may prescribe insulin, other injectable medications, or oral diabetes medicines to help manage your blood sugar and avoid complications. You'll still need to eat healthy and be active if you take insulin or other medicines. It's also important to keep your blood pressure and cholesterol close to the targets your doctor sets for you and get necessary screening tests.

You'll need to check your blood sugar regularly. Ask your doctor how often you should check it and what your target blood sugar levels should be. Keeping your blood sugar levels as close to target as possible will help you prevent or delay diabetes-related complications.

Stress is a part of life, but it can make managing diabetes harder, including managing your blood sugar levels and dealing with daily diabetes care. Regular physical activity, getting enough sleep, and relaxation exercises can help. Talk to your doctor and diabetes educator about these and other ways you can manage stress.

Make regular appointments with your health care team to be sure you're on track with your treatment plan and to get help with new ideas and strategies if needed.

My Care Plan

Lady Bug Clinic

Whether you were just diagnosed with diabetes or have had it for some time, meeting with a diabetes educator is a great way to get support and guidance, including how to:

- Develop a healthy eating and activity plan
- Test your blood sugar and keep a record of the results
- Recognize the signs of high or low blood sugar and what to do about it
- If needed, give yourself insulin by syringe, pen, or pump
- Monitor your feet, skin, and eyes to catch problems early
- Buy diabetes supplies and store them properly
- Manage stress and deal with daily diabetes care

Ask your doctor about diabetes self-management education and support services and to recommend a diabetes educator, or search the Association of Diabetes Care & Education Specialists' (ADCES) nationwide directory for a list of programs in your community.

Please visit the PCPCH "Resources & Technical Assistance" webpage for additional guidance, templates, and examples of care plans under Measure 5.C.3, as well as additional examples of patient-specific education and self-management tools.

https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Resources-Technical-Assistance.aspx

Diabetes Zones

Green Zone

ALL CLEAR – This zone is your goal.

You have **no** symptoms of high or low blood sugar and you have:

- ❖ A **fasting** blood sugar of 90-130 (before food or drink in the morning).
- ❖ A blood sugar 1 to 2 hours **after** meals that is less than 180.
- ❖ A1c (your average blood sugar over several months) under 7%.

Yellow Zone

CAUTION – These are warnings of LOW blood sugar

- Shakiness, dizziness, extreme hunger, headache, pale skin, sweating
- Sudden mood or behavior changes (crying without reason)

What to Do:

1. Check your blood sugar (if possible) and write it down.
2. Eat 15-20 grams of sugar or starches. (Such as 1/2 cup of fruit juice, or regular soda; or 4 or 5 saltine crackers; or 4 teaspoons of sugar; or 1 tablespoon of honey or corn syrup.)
3. Wait 15-20 minutes and check your blood sugar again. If it is still below 60, eat 15-20 grams of sugar/starch again.

If your symptoms do not go away, call your Primary Care Provider NOW, and tell them: "I have diabetes and my blood sugar is too low. I need to talk to my Provider or the Medical Assistant."

CAUTION – These are warnings of HIGH blood sugar

- Extreme thirst, or
- Increase in urinating/passing water, or
- Nausea and vomiting, or
- Fruity smelling breath, or
- Belly (stomach) pain, or
- Deep/rapid breathing, or
- Blood sugar of 240 (or higher if you are used to higher levels).

What to Do:

Call your Primary Care Provider NOW and tell them: "I have diabetes and my blood sugar is too high. I need to talk to my Doctor or the Medical Assistant."

Red Zone

EMERGENCY – Call 911 or go to the Emergency Room if you have ANY of these symptoms:

- Lack of coordination and confusion, or
- Double vision, or
- Fainting or passing out, or
- Convulsions or a seizure.

Shared Care Plan

Updated & Approved: [Date]

Put practice logo here

About the Patient	
Name:	Preferred Name:
Gender identity:	Pronouns:
Preferred Language:	Date of Birth:
Name of relevant family or caregiver(s):	Phone Number:
Other notes (conditions, allergies, special considerations, etc.):	

Care Team

Role	Name	Phone
Other notes (care team name, etc):		

Health Goals & Action Plan

Immediate Health Goals

Short-Term Goal	Person	Action	By When	Done
		☐		
		☐		
		☐		

For a Healthy Future

Long-Term Goal	Person	Action	By When	Done
		☐		
		☐		
		☐		

[Relevant Care Plan Element]

[Include a care plan element that is relevant to this patient. A list of care plan elements can be found on pages 112-113 of the PCPCH Technical Assistance Guide and a description of each element can be found in the PCPCH Care Plan Template Guide.]

[Relevant Care Plan Element]

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[Relevant Care Plan Element]

[Include a care plan element that is relevant to this patient. A list of care plan elements can be found on pages 112-113 of the PCPCH Technical Assistance Guide and a description of each element can be found in the PCPCH Care Plan Template Guide.]

Shared Care Plan

Updated & Approved: 3/1/2022

The patient's care plan can be updated at regular intervals as determined by the care team.

Lady Bug Clinic

About the Patient

Name: James Doe	Preferred Name: Jim Doe
Gender identity: Male	Pronouns: He/Him
Preferred Language: English	Date of Birth: 1/25/1965
Name of relevant family or caregiver: Marsha (daughter)	Phone Number: 503-555-5555

Other notes (conditions, allergies, special considerations, etc.):

- Type 2 Diabetes
- Allergic to Apidra
- Temporarily living with Marsha

In addition to the patient's short-term and long-term health goals and action plan seen on the next page, to meet PCPCH Measure 5.C.3 care plans must also include at least 3 additional care plan elements listed in the PCPCH Technical Assistance Guide. This particular care plan example includes 4 such elements. Here you can see one of them: "coordination with subspecialists."

Care Team & Specialists

Role	Name	Phone
Primary Care Provider	Dr. Johnson	503-222-2222
Care Coordinator	Nurse Maria	503-222-2222
Community Health Worker	Mark	503-222-2222
Cardiologist	Dr. Smith	503-999-8542
Dermatologist	Dr. Paulson	503-744-2202
Endocrinologist	Dr. Mounds	503-324-6547

Other notes (care team name, etc): **Your care team is the BLUE TEAM**

Health Goals & Action Plan

Patient's short-term and long-term health goals and action plan (required in a care plan to meet PCPCH Measure 5.C.3)

Immediate Health Goals

Short-Term Goal	Person	Action	By When	Done
Drink less soda	Jim	☐ Read Type 2 Diabetes packet and put Diabetes Zone Tool on fridge for daily reminder ☐ Only buy one liter of soda per week	4/1/22	
Go on walks three days per week	Jim	☐ Get new walking shoes ☐ Join Marsha when she takes the dog for a walk	4/1/22	
Get Photo ID to qualify for housing	Jim	☐ Work with Marsha to make sure DMV paperwork is completed	5/15/22	

Ideally, the care plan avoids medical jargon and uses plain language that is familiar to the patient

For a Healthy Future

Long-Term Goal	Person	Action	By When	Done
Move into own home	Mark	☐ Contact housing agencies to get Jim on list for housing	6/1/22	
Lower A1C	Mark & Jim	☐ Mark: enroll Jim in diabetes education class ☐ Jim: attend bi-monthly class	9/1/22	
Lower blood pressure	Jim	☐ Do YouTube yoga with Marsha once per week to reduce stress	9/1/22	

This care plan includes "medical equipment or supplies" as one of its additional care plan elements.

Medical Supplies

Nebulizer Parts:
Providence Home Health
503-541-9855

CPAP Parts:
Norco Medical
503-874-5874

This care plan includes "patient-specific education" as one of its additional care plan elements. Practices may include patient-specific education in the care plan itself or provide it as a separate document or packet. The following pages include an example of a patient education packet.

Patient Education

Your ***Type 2 Diabetes*** packet will tell you what you need to know about diabetes and what you can do to stay healthy (such as lowering your "A1C"). Feel free to call your care team with any questions!

This care plan includes "self-management materials and support" as one of its additional care plan elements. Practices may include information on self-management in the care plan itself or provide self-management tools/support as a separate document or packet. The last page of this care plan sample includes an example of such a tool.

Self-Management

Your ***Diabetes Zone Tool*** and ***Diabetes Education Class*** will tell you what you need to know about managing diabetes and what to do if symptoms are getting worse.

SBA National Resource Center:
800-621-3141

SPINA BIFIDA ASSOCIATION

Type 2 Diabetes

Adequate treatment of pre-diabetes and diabetes can add years to the lives of people with Spina Bifida and is worth the effort.

This example of patient-specific education was drawn from the Spina Bifida Association but practices may choose to include their own version of patient-specific education on various conditions. It's always best to use plain language and to include visuals such as diagrams and charts.

What is Type 2 Diabetes?

Also called adult onsetor non-insulin dependent diabetes type 2 diabetes is a chronic condition that affects how the body uses insulin to metabolize glucose (sugar), which is the body's main source of fuel. It is the most common type of diabetes, but is also the most preventable.

People who have type 2 diabetes either do not produce enough insulin, or the body resists the effects of the insulin, as a consequence of the metabolic changes that result from being overweight and obese. This problem often comes on slowly, and may initially appear as "pre-diabetes," also called metabolic syndrome.

What is Pre-diabetes?

Pre-diabetes, a state of "higher than normal blood sugars, but not high enough to be diagnosed as diabetes", causes acanthosis nigricans — a darkening of the skin, beginning at the back of the neck and spreading around the neck, to later involve the axilla (arm pits), and other skin folds. The skin can have a velvety appearance. It is caused by the body making too much insulin and is a definite warning sign that a person is at risk for type 2 diabetes. All people with acanthosis should be evaluated by a physician for type 2 diabetes.

When Does Pre-Diabetes Become Type 2 Diabetes?

As insulin resistance increases, and the insulin does not work as well, diabetes can result, with elevated blood sugars and spilling of glucose in urine. It must

ood sugars can damage the kidneys, heart, and eyes; and predispose diabetics to other serious medical problems. A family medical history of type 2 diabetes puts someone at greater risk.

Other risk factors include a person's ethnic group, with Hispanics, African Americans, and American Indians being at particularly high risk. type 2 diabetes is usually a problem of people older than 45 years old, but is now appearing in children as young as 8 years old.

What Causes Type 2 Diabetes?

Obesity is the main cause of type 2 diabetes. When BMI is within the 85th to 95th percentile, a person is considered overweight; and obesity occurs when BMI is greater than the 95th percentile. Obesity is a national problem. About 50% of children and adults with Spina Bifida are obese. Although obesity may not be their fault, it is their problem.

People with Spina Bifida are prone to obesity for the following reasons:

- It is harder to "burn fat by exercise" when you use a wheelchair
- Some people with Spina Bifida have a lower metabolic rate, so what they eat, "sticks to them" more easily

- A sedentary lifestyle
- Eating food that tastes good rather than food that is good for you
- Family history of diabetes

How does a physician evaluate for Diabetes and Pre-Diabetes?

- A history should be taken for symptoms of diabetes:
  - "Polydipsia, polyphagia, and polyuria" – drinking too much, eating too much, and urinating too much
  - Sleep disordered breathing -snoring and pauses in breathing
  - Exercise intolerance.
- An examination might include measurement of weight, arm span, waist; and an assessment for acanthosis
- Blood work might include:
  - Complete blood count
  - Vitamin D levels
  - Comprehensive metabolic panel (which includes liver enzymes and electrolytes)
  - Fasting insulin level; fasting insulin c-peptide; and fasting lipid panel.
  - Hemoglobin A1C test which indicates the body's long term control of blood sugar

Hemoglobin Levels
Normal = less than 5.7%
Pre-Diabetes = 5.7% – 6.4%
Diabetes = 6.5% or higher

What lifestyle changes are needed for prevention and Treatment?

- Weight loss and exercise are paramount to delaying, preventing and improving type 2 diabetes.
- Eat less and move more. Of the two, eating less is the most important action.
- No person at risk for obesity, including all people with Spina Bifida, should drink sugar drinks. This includes sweetened fruit juices, sweetened iced tea, or soft drinks. Beginning early in life instilling this habit can result in long-term health benefits
- Eat three meals a day of moderate proportion
- Do not snack between meals
- Avoid junk food (foods that make you fat and provide no nutritional value)
- Consult with a dietician for more formal guidance on healthy eating if needed
- Have regular blood sugar checks at home or your physician's office. Blood sugar checks may indicate that a change in diet or exercise is needed

How is Type 2 Diabetes treated?

- When diet and exercise are not sufficient, medication may be required. Metformin, an oral medication is commonly used to control blood sugar, treat the liver abnormalities that accompany type 2 diabetes; and may help with weight loss
- The combination of Topiramate and Phentermine shows some promise as a weight reduction agent, but hasn't been studied in Spina Bifida patients or in children yet
- Weight loss surgery ("bariatric surgery") works for some; but can result in diarrhea, which may cause fecal incontinence in people with Spina Bifida who do not have adequate anal sphincter control
- When pills and weight loss measures are not effective, some people require injections
- Supportive programs that emphasize exercise and diet are always helpful
- Routine visits to the doctor are an important part of the treatment process-about every 3 months when sugar is not well controlled, and every 6 months when it is under control

Contributing Editor
Gordon Worley, MD.

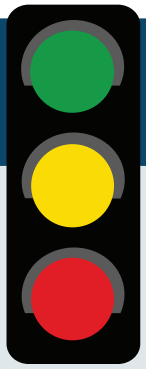
Additional resources

http://www.diabetes.org/living-with-diabetes/?loc=GlobalNavLWD

http://www.diabetes.org/

ZONE TOOL | Diabetes

This self-managment tool was drawn from Alliant Heath Solutions but practices may choose to include their own self-management information and materials. It's always best to use plain language and tools that make it easy for patients to monitor and improve their condition. Tools such as this can be modified or tailored to specific thresholds or patient needs (see blanks below).



Diabetes means that you have too much sugar (glucose) in your blood. High blood sugar levels can lead to serious health problems. Keeping your blood sugar under control is very important. Use this document to help understand what to do when your levels rise too high or low, as directed by your doctor.

GREEN Zone: All Clear!

- A1c under 7%
- Fasting blood sugar 90–130
- Blood sugar less than 180 (1-2 hours after eating)
- Blood pressure less than 130/80
- LDL cholesterol target less than 100mg/dL if no cardiovascular disease
- LDL less than 70mg/dL for those with a history of cardiovascular disease (e.g., ischemia, angina, stroke, heart attack)

GREEN Zone Means:

- Your blood sugars are under control
- Continue taking your medications as ordered
- Continue routine blood glucose monitoring
- Follow healthy eating habits
- Keep all physician appointments

YELLOW Zone: Caution. Call Your Physician!

- A1c between 7% and 8%
- Average blood sugar 150–210
- Most fasting blood sugars under 200
- Blood pressure greater than 140/90

Work closely wi cator if you are going in abits levels.

Please visit the PCPCH "Resources & Technical Assistance" webpage for additional guidance, templates, and examples of care plans under Measure 5.C.3, as well as additional examples of patient-specific education and self-management tools.

https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Resources-Technical-Assistance.aspx

YELLOW Zone Means:

- Your blood sugar may indicate that you need an adjustment of your medications
- Improve your eating habits
- Increase your activity level

RED Zone: Medical Alert!

- A1c greater than 9%
- Average blood sugars are over 210
- Most fasting blood sugars are well over 200

RED Zone Means:

- You need to be evaluated by a doctor
- If you have a blood glucose over:

_____ , _____

Call your doctor and call 9-1-1

Physician Contact

Doctor: _____

Phone: _____

www.alliantquality.org

This material was prepared by Alliant Health Solutions, a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. AHSHQIC-TO3H-21-659

ALLIANT QUALITY
The Quality Improvement Services Group of ALLIANT HEALTH SOLUTIONS

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Shared Care Plan

for Children and Youth with Special Health Needs

Child/youth name:	**Necessary releases obtained:** ☐ Yes ☐ No
Child/youth likes to be called:	**Team meeting date:**
Date of birth:	**Meeting location:**
Parent(s):	**Referred by:**
Parent phone #:	**Other:**
Primary care provider: / **Interpreter (if applicable):**	
Gender identity: ☐ M ☐ F ☐ Other, please specify:	
Pronouns: ☐ She/Her ☐ He/Him ☐ Other, please specify:	

Child/Family Strengths and Assets

Child/Family Language and Culture

Child/Family Concerns and Goals

For today:

For the longer term:

Brief Medical Summary	
Diagnosis:	
Medications:	
Current Interventions:	**Tried Interventions:**
Health Care Providers:	
Other Important Medical Information (Allergies/Alerts):	
Preferred Hospital:	**Preferred Pharmacy:**

Brief Summary of Involvement with Education/Community-Based Services

Team Members Contact List *Note: Initial next to name to note attendance at meeting. Add rows as needed.*

Name	Role/Responsibility	Best way to contact
	Family member	
	Primary care provider	
	Education	
	Mental/behavioral health	
	Public health	
	Health plan/insurance	
	Interpreter	

Action Plan

Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
Date identified:	**Notes:**		
Date resolved:			

Action Plan

Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	**Who?**	**Is doing what?**	**By when?**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
Date identified:	**Notes:**		
Date resolved:			

Action Plan

Note: Add rows as needed.

- The first goal of the team should be one that is identified by the family as a priority.
- If the child/youth is aged 12 or older, include a minimum of one goal focused on the transition to adult healthcare.

Shared goal:	Who?	Is doing what?	By when?
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
	This person	Will take this action	By this date **Date completed:**
Date identified:	**Notes:**		
Date resolved:			

This project is funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Oregon's Title V Maternal and Child Health Block Grant (#B04MC28122, in the amount of $1,859,482) and the "Enhancing the System of Services for Oregon's CYSHCN" grant (#D70MC27548, in the amount of $300,000). The project receives no nongovernmental funding. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government. To request permission to use this template please contact occyshn@ohsu.edu

St. Charles Health System: EHR Care Plan Template

Patient-Centered Primary Care Home Program Key:

Text in black font = Examples of care plan elements that are required or can be used to meet PCPCH Measure 5.C.3 under the 2020 PCPCH Recognition Criteria

Text in blue font = Additional care plan elements that St. Charles Health System has decided to include but are not required or relevant to PCPCH Measure 5.C.3

Smartphrase Template

Care plans look slightly different based off of disease process, which is driven by the OP Care Plan tasks and education provided in the AVS Discharge summary. Each section below has separate drop-down boxes pertaining to the disease process.

Patient name:

Patient address:

[Name] provided verbal consent to care planning on [date]

Care Plan Status:

[Name]'s Priorities (short-term and long-term goals):
You said that what is important to you is:
You said that what worries you about your health is:
You said something that you think would help improve your health/well-being is:

Primary Care Provider's Stated Health Goal:

[Patient Name]'s Clinical Goals:

The following symptom management action plans reviewed with and provided for [Name]:

Education Provided to: [Name]

PLEASE REFER TO PATIENT EDUCATION FOR DETAILS

Referral Made to:

Plan For Followup:

Patient Care Team:

Barriers to Health & Resources:

This is an active and comprehensive care plan for [Name], developed as part of the RN Care Management Program at St Charles Family Care. A copy of this care plan was given to [Name]. The care team can be reached by calling your primary care clinic or through MyChart.

Patient Care Plan Example

This is the format if a letter is mailed to the patient or sent via MyChart. If the patient is in clinic or has a telehealth visit with the RNCC, the patient's information is copied into the AVS discharge summary which can be viewed in EPIC. The AVS discharge summary for outpatient looks exactly like the inpatient AVS discharge summary.

ST CHARLES FAMILY CARE MADRAS

480 NE A ST
MADRAS OR 97741-1844
541-475-4800

John Doe
123 Example Lane
Madras, OR 97741

Please review the attached care plan.

John provided verbal consent to care planning on January 1st, 2022.

John's Priorities:
You said that what is important to you is: *Being healthy enough to take grandkids on day trips*
You said that what worries you about your health is: *Medications*
You said something that you think would help improve your health/well-being is: *Work on getting in with the nutritionist for further diabetic diet management*

Primary Care Provider's Stated Health Goal
Improve A1C goal to normal range A1C <9%

John's Clinical Goals
implement dietary/lifestyle changes to improve your health, reduce or prevent unnecessary emergency department utilization, reduce or prevent unnecessary hospital admissions, reduce barriers to getting your basic needs met, improve or maintain regular engagement with your Primary Care team, improve or maintain regular engagement with your Behavioral Health team/counseling and improve your health numbers (e.g. your vital signs, results of lab studies, etc.)

The following symptom management action plans reviewed with and provided for John
DIABETES ACTION PLAN: recognition of signs and symptoms of high or low blood sugar, and of a diabetic emergency (ketoacidosis or a very low blood sugar). Reviewed what actions to take (e.g. when to call clinic versus go to the emergency department). *PLEASE REFER TO DIABETES ACTION PLAN FOR DETAILS.*

Education Provided to John
DIABETES EDUCATION: Carb counting/meal planning, blood sugar emergencies, hypoglycemia, medications, foot care, and exercise. *PLEASE REFER TO PATIENT EDUCATION FOR DETAILS.*

Referral Made to: CHE, Nutrition, Behavioral Health and Clinic RN

Plan For Followup: every two weeks

Patient Care Team: Blue Team

This is an active and comprehensive care plan for John Doe, developed as part of the RN Care Management Program at St Charles Family Care. A copy of this care plan was given to John. The care team can be reached by calling your primary care clinic or through MyChart.

FOLLOW UP INSTRUCTIONS

Return in about 1 week (around 11/4/2021) for care coordination.

Patients are given the RNCC's direct line to contact in the event care coordination is needed prior to agreed upon date of next call along with clinic information for contact.

BARRIERS TO HEALTH & RESOURCES

LACK OF TRANSPORTATION

Currently receiving rides through CET ride transportation. Also has a scooter.

UNABLE TO PREPARE MEALS

- John referred to social work and meal assistance programs
- Jane Doe, RN discussed meal prep with patient
- Note: Continued plan to work on this: John will see DM educator and nutritionist

---

RELIABLE FOOD SOURCE

- John referred to food insecurity resources
- Jane Doe, RN will reach out with support programs for affordable food

---

FINANCIAL HARDSHIP

- Joseph Miller, RN working with CHE to establish OHP and free phone through OHP services.
- Contacted insurance company to determine options
- Mellissa Doe, RM will continue follow up with Best Care Peer Support
- Jane Doe to refer John to community resources for help with financial hardship with meds

---

MED ADHERENCE

Goal: Record your blood sugar as directed

Long-Range Goal: Consistently take medications as prescribed

- Jane Doe, RN discussed barriers to medication adherence with John
- John educated on frequency and refill details of meds
- John assisted on frequency and refill details of meds

ACTION PLAN FOR DIABETES BLOOD SUGAR EMERGENCIES

How can you prevent a blood sugar emergency?
An important part of living with diabetes is keeping your blood sugar in your target range. You'll need to know what to do if it's too high or too low. Managing your blood sugar levels helps you avoid emergencies. This care sheet will teach you about the signs of high and low blood sugar. It will help you make an action plan with your doctor for when these signs occur.

Low blood sugar is more likely to happen if you take certain medicines for diabetes. It can also happen if you skip a meal, drink alcohol, or exercise more than usual.

- You may get **high blood sugar** if you eat differently than you normally do. One example is eating more carbohydrate than usual. Having a cold, the flu, or other sudden illness can also cause high blood sugar levels. Levels can also rise if you miss a dose of medicine.
- Any change in how you take your medicine may affect your blood sugar level. So it's important to work with your doctor before you make any changes.

CHECK YOUR BLOOD SUGAR:

Work with your doctor to fill in the blank spaces below that apply to you.
Track your levels, know your target range, and write down ways you can get your blood sugar back in your target range. A log book can help you track your levels. Take the book to all of your medical appointments.

- Check your blood sugar ___4_ times a day, at these times:Before meals and at bedtime. *(For example: Before meals, at bedtime, before exercise, during exercise, other.)*
- Your blood sugar target range **before** a meal is per nutrition/diabetic educator. Your blood sugar target range **after** a meal is per diabetic educator/nutrition.
- Do this—take your insulin as instructed by MD_—to get your blood sugar back within your safe range if your blood sugar results are elevated. *(For example: Less than 70 or above 250 mg/dL.)*

Call your doctor when your blood sugar results are less than 70 or greater than 250. *(For example: Less than 70 or above 250 mg/dL.)*

What are the symptoms of low and high blood sugar?

- Common symptoms of **low blood sugar** are sweating and feeling shaky, weak, hungry, or confused. Symptoms can start quickly.
- Common symptoms of **high blood sugar** are feeling very thirsty or very hungry. You may also pass urine more often than usual. You may have blurry vision and may lose weight without trying.
- But some people may have high or low blood sugar without having any symptoms. That's a good reason to check your blood sugar on a regular schedule.

WHAT SHOULD YOU DO IF YOU HAVE SYMPTOMS?

Work with your doctor to fill in the blank spaces below that apply to you.

Low blood sugar

- If you have symptoms of low blood sugar, check your blood sugar. If it's below __70_ (*for example, below 70*), eat or drink a quick-sugar food that has about 15 grams of carbohydrate. Your goal is to get your level back to your safe range. Check your blood sugar again 15 minutes later. If it's still not in your target range, take another 15 grams of carbohydrate and check your blood sugar again in 15 minutes. Repeat this until you reach your target. Then go back to your regular testing schedule.
- Children usually need less than 15 grams of carbohydrate. Check with your doctor or diabetes educator for the amount that is right for your child.

- When you have low blood sugar, it's best to stop or reduce any physical activity until your blood sugar is back in your target range and is stable. If you must stay active, eat or drink 30 grams of carbohydrate. Then check your blood sugar again in 15 minutes. If it's not in your target range, take another 30 grams of carbohydrates. Check your blood sugar again in 15 minutes. Keep doing this until you reach your target. You can then go back to your regular testing schedule.

If your symptoms or blood sugar levels are getting worse or have not improved after 15 minutes, seek medical care right away.

Here are some examples of quick-sugar foods with 15 grams of carbohydrate:

- 3 or 4 glucose tablets
- 1 tablespoon (3 teaspoons) table sugar
- ½ cup to ¾ cup (4 to 6 ounces) of fruit juice or regular (not diet) soda
- Hard candy (such as 6 Life Savers)

High blood sugar

If you have symptoms of high blood sugar, check your blood sugar. Your goal is to get your level back to your target range. If it's above 250 (*for example, above 250*), follow these steps:

- If you missed a dose of your diabetes medicine, take it now. Take only the amount of medicine that you have been prescribed. Do not take more or less medicine.
- Give yourself insulin if your doctor has prescribed it for high blood sugar.
- Test for ketones, if the doctor told you to do so. If the results of the ketone test show a moderate-to-large amount of ketones, call the doctor for advice.
- Wait 30 minutes after you take the extra insulin or the missed medicine. Check your blood sugar again.

If your symptoms or blood sugar levels are getting worse or have not improved after taking these steps, seek medical care right away.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

Where can you learn more?

Go to https://www.healthwise.net/patientEd

Enter **G983** in the search box to learn more about "Diabetes Blood Sugar Emergencies"

Your Action Plan.

Current as of: December 20, 2019 (Content Version: 12.6)

PATIENT EDUCATION

PCPCH Note: *Some practices may choose to include this in a separate packet or document from the care plan.*

LEARNING ABOUT MEAL PLANNING FOR DIABETES

Why plan your meals?
Meal planning can be a key part of managing diabetes. Planning meals and snacks with the right balance of carbohydrate, protein, and fat can help you keep your blood sugar at the target level you set with your doctor.

You don't have to eat special foods. You can eat what your family eats, including sweets once in a while. But you do have to pay attention to how often you eat and how much you eat of certain foods.

You may want to work with a dietitian or a certified diabetes educator. He or she can give you tips and meal ideas and can answer your questions about meal planning. This health professional can also help you reach a healthy weight if that is one of your goals.

What plan is right for you?
Your dietitian or diabetes educator may suggest that you start with the plate format or carbohydrate counting.

The plate format
The plate format is a simple way to help you manage how you eat. You plan meals by learning how much space each food should take on a plate. Using the plate format helps you spread carbohydrate throughout the day. It can make it easier to keep your blood sugar level within your target range. It also helps you see if you're eating healthy portion sizes.

To use the plate format, you put non-starchy vegetables on half your plate. Add meat or meat substitutes on one-quarter of the plate. Put a grain or starchy vegetable (such as brown rice or a potato) on the final quarter of the plate. You can add a small piece of fruit and some low-fat or fat-free milk or yogurt, depending on your carbohydrate goal for each meal.

Here are some tips for using the plate format:

- Make sure that you are not using an oversized plate. A 9-inch plate is best. Many restaurants use larger plates.
- Get used to using the plate format at home. Then you can use it when you eat out.
- Write down your questions about using the plate format. Talk to your doctor, a dietitian, or a diabetes educator about your concerns.

Carbohydrate counting
With carbohydrate counting, you plan meals based on the amount of carbohydrate in each food. Carbohydrate raises blood sugar higher and more quickly than any other nutrient. It is found in desserts, breads and cereals, and fruit. It's also found in starchy vegetables such as potatoes and corn, grains such as rice and pasta, and milk and yogurt. Spreading carbohydrate throughout the day helps keep your blood sugar levels within your target range.

Your daily amount depends on several things, including your weight, how active you are, which diabetes medicines you take, and what your goals are for your blood sugar levels. A registered dietitian or diabetes educator can help you plan how much carbohydrate to include in each meal and snack.

A guideline for your daily amount of carbohydrate is:

- 45 to 60 grams at each meal. That's about the same as 3 to 4 carbohydrate servings.
- 15 to 20 grams at each snack. That's about the same as 1 carbohydrate serving.

The Nutrition Facts label on packaged foods tells you how much carbohydrate is in a serving of the food. First, look at the serving size on the food label. Is that the amount you eat in a serving? All of the nutrition information on a food label is

based on that serving size. So if you eat more or less than that, you'll need to adjust the other numbers. Total carbohydrate is the next thing you need to look for on the label. If you count carbohydrate servings, one serving of carbohydrate is 15 grams.

For foods that don't come with labels, such as fresh fruits and vegetables, you'll need a guide that lists carbohydrate in these foods. Ask your doctor, dietitian, or diabetes educator about books or other nutrition guides you can use.

If you take insulin, you need to know how many grams of carbohydrate are in a meal. This lets you know how much rapid-acting insulin to take before you eat. If you use an insulin pump, you get a constant rate of insulin during the day. So the pump must be programmed at meals to give you extra insulin to cover the rise in blood sugar after meals.

When you know how much carbohydrate you will eat, you can take the right amount of insulin. Or, if you always use the same amount of insulin, you need to make sure that you eat the same amount of carbohydrate at meals. If you need more help to understand carbohydrate counting and food labels, ask your doctor, dietitian, or diabetes educator.

How can you plan healthy meals?
Here are some tips to get started:

- Plan your meals a week at a time. Don't forget to include snacks too.
- Use cookbooks or online recipes to plan several main meals. Plan some quick meals for busy nights. You also can double some recipes that freeze well. Then you can save half for other busy nights when you don't have time to cook.
- Make sure you have the ingredients you need for your recipes. If you're running low on basic items, put these items on your shopping list too.
- List foods that you use to make breakfasts, lunches, and snacks. List plenty of fruits and vegetables.
- Post this list on the refrigerator. Add to it as you think of more things you need.
- Take the list to the store to do your weekly shopping.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

Where can you learn more?
Go to https://www.healthwise.net/patientEd
Enter X936 in the search box to learn more about "Learning About Meal Planning for Diabetes."

Current as of: December 17, 2020 (Content Version: 13.0)

Salem Clinic: Adult High-Risk Patient Care Plan Template

Patient-Centered Primary Care Home Program Key:

Text in black font = Examples of care plan elements that are required or can be used to meet PCPCH Measure 5.C.3 under the 2020 PCPCH Recognition Criteria

Text in blue font = Additional care plan elements that Salem Clinic has decided to include but are not required or relevant to PCPCH Measure 5.C.3

Risk Score:

Primary Insurance:

Secondary Insurance:

Relationship:

Pain Contract:
- Reason:
- Medication(s):
- Prescriber:
- Problem list reflects pain contract management agreement.

Last Office Visit:

Last Hospitalization/ED Visit:

Number of Hospital Visits in the past 12 months:

Significant Past Medical and/or Mental Health History:

Labs:
- Pertinent Lab Results & Date:
- Follow-up labs needed:

Imaging:
- Pertinent Imaging Results:
- Follow-up Imaging needed:

Anticoagulation Care:
- Anticoagulation followed by:
- Next Appointment:

Hemodialysis:

Yes/No
Hemodialysis followed by:
Days patient receives hemodialysis:

Preventive Health Needs:

Barriers to Care & Possible Solutions:

Specialty Follow-up Appointment:

Medications Review:

Is patient able to afford medication co-pays?

Contact Documentation:

COVID-19 Screening:

Has the patient been tested for COVID-19?
If yes, assess for the following: Date of testing, result of test, was the patient's PCP notified?
If yes, did they follow proper quarantine protocol?

Chronic Illness Plan of Care and Action Plan for Exacerbation:

Action Plan Reviewed:
Action Plan:

- ☐ Reviewed with ***, will mail *** a copy with a letter explaining the purpose of the Action plan.
- ☐ Reviewed with ***, *** already has a copy at home. *** was encouraged to place the Action Plan in a location that is easily visible.
- ☐ *** declined to review at this time, will mail *** a copy with a letter explaining the purpose of the Action plan.

What zone is the patient currently in? (ZONE COLOR)
Nursing Education Appointment:

- ☐ Offered a nursing education appointment, *** accepted, messaged routed for scheduling.
- ☐ Offered a nursing education appointment, *** declined at this time.
- ☐ Nursing education appointment not needed, *** is literate on their chronic disease and has not had any recent complications.

Activities of Daily Living:

Patient Short-Term and Long-Term Self-Management Goal(s):

Patient Care Team:

Resource Needs/Educational Materials:

Writing SMART Objectives

No. 3b | updated August 2018

This brief is about writing SMART objectives. This brief includes an overview of objectives, how to write SMART objectives, a SMART objectives checklist, and examples of SMART objectives.

Overview of Objectives

For DASH funded programs, program planning includes developing five-year program goals (a broad statement of program purpose that describes the expected long-term effects of a program), strategies (the means or broad approach by which a program will achieve its goals), and annual workplan objectives (statements that describe program results to be achieved and how they will be achieved).

Objectives are more immediate than goals; objectives represent annual mileposts that your program needs to achieve in order to accomplish its goals by the end of the five-year funding period.

Each year, your workplan objectives should be based on the strategies you have selected to reach your program goals. Because strategies are implemented through objectives and program activities, multiple objectives are generally needed to address a single strategy. Objectives are the basis for monitoring implementation of your strategies and progress toward achieving your program goals. Objectives also help set targets for accountability and are a source for program evaluation questions.

Writing SMART Objectives

To use an objective to monitor your progress, you need to write it as a SMART objective. A SMART objective is:

1. **Specific:**
   - Objectives should provide the “who” and “what” of program activities.
   - Use only one action verb since objectives with more than one verb imply that more than one activity or behavior is being measured.
   - Avoid verbs that may have vague meanings to describe intended outcomes (e.g., “understand” or “know”) since it may prove difficult to measure them. Instead, use verbs that document action (e.g., “At the end of the session, the students will list three concerns...”)
   - Remember, the greater the specificity, the greater the measurability.
2. **Measurable:**
   - The focus is on “how much” change is expected. Objectives should quantify the amount of change expected. It is impossible to determine whether objectives have been met unless they can be measured.
   - The objective provides a reference point from which a change in the target population can clearly be measured.
3. **Achievable:**
   - Objectives should be attainable within a given time frame and with available program resources.
4. **Realistic:**
   - Objectives are most useful when they accurately address the scope of the problem and programmatic steps that can be implemented within a specific time frame.
   - Objectives that do not directly relate to the program goal will not help toward achieving the goal.
5. **Time-phased:**
   - Objectives should provide a time frame indicating when the objective will be measured or a time by which the objective will be met.
   - Including a time frame in the objectives helps in planning and evaluating the program.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

C296013-C November21,2018

Objectives Checklist

Criteria to assess objectives	YES	NO
1. Is the objective **SMART**? • **Specific:** Who? (target population and persons doing the activity) and What? (action/activity) • **Measurable:** How much change is expected • **Achievable:** Can be realistically accomplished given current resources and constraints • **Realistic:** Addresses the scope of the health program and proposes reasonable programmatic steps • **Time-phased:** Provides a timeline indicating when the objective will be met		
2. Does it relate to a single result?		
3. Is it clearly written?		

SMART Objectives Examples

Non-SMART objective 1: Teachers will be trained on the selected scientifically based health education curriculum.

This objective is not SMART because it is not specific, measurable, or time-phased. It can be made SMART by specifically indicating who is responsible for training the teachers, how many will be trained, who they are, and by when the trainings will be conducted.

SMART objective 1: By year two of the project, LEA staff will have trained 75% of health education teachers in the school district on the selected scientifically based health education curriculum.

Non-SMART objective 2: 90% of youth participants will participate in lessons on assertive communication skills.

This objective is not SMART because it is not specific or time-phased. It can be made SMART by specifically indicating who will do the activity, by when, and who will participate in lessons on assertive communication skills.

SMART objective 2: By the end of the school year, district health educators will have delivered lessons on assertive communication skills to 90% of youth participants in the middle school HIV- prevention curriculum.

For further information or assistance, contact the Evaluation Research Team at ert@cdc.gov. You can also contact us via our website: http://www.cdc.gov/healthyyouth/evaluation/index.htm