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.

---

[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