

Health and Wellness Care Plan

The Health and Wellness Care Plan is an individualized, structured, goal-oriented schedule of services developed jointly by the patient and the treatment team. The plan must contain written medical-related goals and measurable objectives. After the Basic Needs Assessment is conducted, the Care Plan should be created based on an identified set of a patient's needs, whether they are medical, behavioral, or social needs. The Care Plan serves as a roadmap to keep track of the work the patient and CHW are doing towards the patient's long-term health goals. Establishing a Care Plan will define a set of specific tasks that all parties involved (i.e. patient, CHW, caregiver, case manager, family members) will do in order to accomplish a goal. The Care Plan serves as a form of communication with the PCMH team and CCP team about what needs to be done to address your patient's current priorities.

Key Objectives

1. Prioritize most important health concerns and work with patient to establish a long-term (one year) goal to address their key concerns.
2. Establish a quarterly goal every 3 months that works towards the patient's long-term goal. Break down the goal into tangible action steps with specific timeframes to be taken by the patient, CHW, and others (family, social worker, provider, etc.).
3. Use the quarterly goals and specific action steps as guidance for meetings with your patient. Regularly check-in on progress and adapt action steps and goals accordingly. Use "Encounter Notes" in ORCHID to document progress that the patient is making regarding their Care Plan.

Protocol Steps

Step 1: Assess patient's concerns and needs

After completing the Basic Needs Assessment, the CHW will have learned more about the patient's medical and social needs. CCP patients often have many significant health concerns and social needs, but it is not possible to address all of them at the same time. When starting a **Care Plan**, the CHW will work with the patient to identify the top priorities that the patient is willing to work on with the CHW. The Problem List in ORCHID, which summarizes the patient's medical and behavioral health diagnoses, can help guide the CHW to identify top clinical concerns. It is important to directly ask the patient which concerns are their greatest and/or what they need the most help with. The PCP and other members of the PCMH team may have specific input about what they want the CHW to focus on based on the acuity of the patient's medical conditions. It is important to ensure that the patient understands the care management team's concerns and these concerns may guide the prioritization process. There are four general areas that the CHW may focus their tasks with the patients on:

1. Medical
2. Behavioral Health (i.e. substance abuse, depression, etc.)
3. Patient Activation (i.e. medication adherence, keeping appointments, etc.)
4. Social (i.e. housing, food, transportation, etc.)

Step 2: Identify Care Coordination Participants, Long Term Goals, and Patient's Strengths

Care Plan participants are anyone who is involved in the care of the patient, which can include family members, friends, other agencies (i.e. DMH) and/or community-based organizations. It is important to identify key players within the patient's existing social support network. Record Care Plan participants, their relationship to the patient, and their telephone number on the **Care Plan** form. If records from other agencies are needed for the coordination of care, have the patient sign a consent form. See the **Consent Form Protocol** for more detailed information.

Ask the patient to describe their long-term goals for their health. Nonjudgmental active listening is essential when having this conversation with the patient. Asking, "Where do you see yourself in 6 months, 1 year, 3 years, etc.?" may help frame long-term goal setting for the patient. It is important to have a big picture of long-term health goals before breaking it down into more tangible, short-term goals and specific actions towards these goals. Record the long-term goal on the **Care Plan** form, using the patient's own words as best as possible.

Using motivational interviewing techniques, it is important to help the patient identify the strengths they possess that will help them work towards their Care Plan goals. Using the perspective of the patient, caregiver, PCMH team, and/or your own knowledge about the patient, record the patient's strengths on the **Care Plan** form.

Step 3: Create a Quarterly Goal

Once top health concerns and long term goals have been established, work with the patient to establish a goal (or a few) that works towards their Care Plan and can be reasonably achieved over the course of the next three months. If it is too overwhelming for the patient to set a 3-month goal, the goal can be broken down into a shorter time frame (1 month, 2 weeks, etc.). The Care Plan is a guide for goal setting and can be adjusted based on each patient. Record the Quarterly Goal(s) on the **Care Plan** form. The goal(s) should be **SMART** goals: Specific, Measurable, Attainable, Realistic, and Time-Based. (See Box below.)

Step 4: Break Down Quarterly Goal(s) into Concrete Actions

The quarterly goal(s) should then be broken down into specific, tangible actions that the patient, CHW, and if necessary, others, will take to work towards the goal. These smaller actions/goals should also follow the SMART goal format. CHW actions will include proposed interventions related to patient's goal and health, i.e. delivering a diabetes WRAP if the patient is working on lowering their HbA1c level. During this part of the conversation, it is important to ask the patient what barriers there are to achieving their goal and how they might be able to address identified barriers.

Step 5: Record Progress through Encounter Notes and Quarterly Care Plan Reviews

During each patient encounter, the CHW should ask the patient about the progress of action steps related to their quarterly goal. When making an "Encounter Note" in ORCHID, the note should give a current update of the patient's goal progress and any new barriers that have arisen.

SMART GOALS

Specific: What do you want to achieve and how you will do it?

Ask: What does the patient want to accomplish? How will he/she do it?

Examples:

Not specific: To exercise

Specific: To get in shape by walking

Measurable: How you will know when your patient reached his/her goal. Ask: How much? How often?

Examples:

Not measurable: To walk often

Measurable: To walk for 30 minutes, 5 times a week

Attainable: That your goal is possible. Ask patient: Do you feel like you can do this?

Examples:

Not attainable: To walk 5 miles in 30 minutes

Attainable: To walk 1 ½ miles in 30 minutes

Realistic: That your goal is appropriate for you. Ask patient: Are you willing to work towards this goal? Do you have the skills and resources you need to achieve your goal?

Use confidence scale to determine if the goal is realistic. How confident are you, on a scale of 1-10, that you can complete your goal?

You should identify goals that a patient has a 7 or greater confident that they can achieve it.

Time-Based: When you plan to reach a goal. Ask patient: When will you achieve this?

Examples:

Not time-based: To walk 5 times a week until I feel fit

Time-based: To walk for 30 minutes, 5 times a week for a month.

Every 3 months, the CHW should meet with the patient to evaluate the outcome of their quarterly goal. If the goal was achieved, the CHW and patient can discuss another goal that can be set to work towards their long term goal and primary health concerns. If the goal was not achieved, the CHW and patient should discuss what their primary barriers were and then create an adjusted goal for the next quarter.

Summary Steps

- 1) Assess and prioritize patient's needs and concerns.
- 2) Introduce the purpose of the Care Plan and identify key care coordination participants, long term goals, and patient's strengths.
- 3) Create a quarterly goal.
- 4) Break down the quarterly goal into action steps.
- 5) Record progress of Care Plan goal(s) through encounter notes and quarterly care plan review sessions.

Health and Wellness Care Plan

PATIENT NAME	MRN	CCP ID
PROVIDER	CARE MANAGER	
CHW	DHS SITE	

CARE COORDINATION INFORMATION

CARE PLAN START DATE	END DATE (1 year from start date)	PREPARED BY
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COMPREHENSIVE SURVEY/WRAP PLAN DATES

INITIAL COMPREHENSIVE SURVEY DATE: _____ SUPERVISOR INITIAL _____

INITIAL WRAP PLAN COMPLETION DATE: _____ SUPERVISOR INITIAL _____

CARE PLAN QUARTERLY REVIEW

1ST QUARTER

CARE PLAN REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

WRAP PLAN(S) REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

2ND QUARTER

CARE PLAN REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

WRAP PLAN(S) REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

3RD QUARTER

CARE PLAN REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

WRAP PLAN(S) REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

4TH QUARTER

CARE PLAN REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

WRAP PLAN(S) REVIEW DATE _____ PATIENT INITIAL _____ CHW INITIAL _____ SUP INITIAL _____

NOTE: Care plan is a confidential document. Duplication of this document for further disclosure is prohibited, without prior written authorization of the patient/authorized representative to whom it pertains unless otherwise permitted by law.

All care plans must have a medical goal completed with PCP.

All behavioral health goals are to be done in consultation with one of the following individuals: Social Worker/Provider/CM. If patient is already receiving services from DMH clinic or other outpatient mental health provider, please get patient's signed consent for release of information and to coordinate services.

CARE COORDINATION PARTICIPANTS

CARE PLAN PARTICIPANTS: Anyone who is involved in the care of the patient, and is not a part of the patient's primary care medical health team should be listed below. Please have patient sign a consent form for anyone involved in patient's care.

NAME	RELATIONSHIP	TELEPHONE NUMBER

OTHER AGENCIES INVOLVED: Please list all agencies that will be involved in or will impact patient's care. Please include their contact information including contact person. Please have patient sign a consent form for anyone involved in patient's care.

Agency	Contact Person	Address	Telephone	Relationship to Patient

Long Term Goal: (In patient's own words)

Patient's Strengths: (From the perspective of the patient, caregiver, pcmh team, and/or CHW completing the care plan)

PATIENT:	CCP ID:
CHW:	SITE:
<i>Los Angeles County-Department of Health Services/Care Connections</i>	

Medical Conditions

COPD Diabetes CHF Hypertension Coronary Artery Disease Other:

My Quarterly Goal (Specific, Measurable, Attainable, Realistic, Timeframe)

This is meant to represent one of the patient's most important medical goals over the next 3 months. After reviewing medical conditions and current health status the patient and physician will determine a goal with high priority.

eg: I will lower my hemoglobin A1C from 8.9% to less than 7.0% by April 30, 2016

How We Will Achieve the Goal

Patient Actions:	CHW Actions:	Others (Family, SW, PCP, etc.):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____

Did I Achieve My Goal

Yes No (if yes indicate what was helpful in goal achievement; if no indicate what prevented goal achievement)

Signature

Patient Signature: _____ Date: _____

PCP Signature: _____ Date: _____

PATIENT:	CCP ID:
CHW:	SITE:
<i>Los Angeles County-Department of Health Services/Care Connections</i>	

Date Started: _____

GOAL NUMBER _____	<input type="checkbox"/> Patient Activation <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Social	PROVIDER APPROVAL Provider Initial _____ Date _____
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SHORT-TERM GOAL (Specific, Measurable, Attainable, Realistic, Time)

ACTIONS TAKEN BY PATIENT TO ACHIEVE GOAL

- 1.
- 2.
- 3.

ACTIONS TAKEN BY CHW (Describe proposed interventions related to patient's goal and health, i.e.; diabetes conversation)

- 1.
- 2.
- 3.

ACTIONS TAKEN BY OTHERS (Indicate who, their role, and how they will participate; should have consent)

- 1.
- 2.

BARRIERS TO ACHIEVING GOAL	PLAN TO ADDRESS BARRIERS
1.	1.
2.	2.
3.	3.

SIGNATURE: Patient _____ CHW _____

OUTCOME

Achieved goal: YES NO Please describe how patient achieved or not achieved goal, barriers to achieving goal, and plan.

Date Goal Completed: _____

PATIENT:	CCP ID:
CHW:	SITE:
<i>Los Angeles County-Department of Health Services/Care Connections</i>	