LITERATURE RESEARCH

http://www.nhs.uk/Planners/Yourhealth/Pages/Careplan.aspx

"A care plan is an agreement between you and your health professional (and/or social services) to help you manage your health day-to-day. It can be a written document or something recorded in your patient notes."

Care Plans should include the following things:

- the goals you want to work towards, such as getting out of the house more, returning to work, or starting a hobby
- the support services you want, who is in charge of providing these services, what the support services have agreed to do and when they will do it
- emergency numbers, such as who you should contact if you become very unwell and your doctor's surgery is closed
- medicines
- an eating plan
- an exercise plan

Also suggests having regular care plan reviews, about once a year, to adjust it as necessary

http://cirrie.buffalo.edu/encyclopedia/en/article/18/

An excerpt from the article:

> Following are several of the factors that precipitated the development of life care planning methodology:
>
> 1. The need for a summative statement. Individuals and their families, particularly in pediatric cases, needed to have a **concise summary of a long-term plan** that could be reviewed following a comprehensive evaluation, then referred to as a guideline in future.
> 2. A tool of communication. In most catastrophic or complex care cases, many professionals are involved in the care and rehabilitation effort. The effectiveness of these efforts depends upon the **coordination, cooperation, and communication between all parties involved** in the rehabilitation process. The life care plan provides a format for a clear, concise, and sensible presentation of the complex needs of the patient.
> 3. Forethought of planning. One of the foundations of catastrophic case management asserts that **proactive, preventative measures must guide the planning process**. Otherwise, crisis situations, which are neither healthy for the patient nor optimal decision-making circumstances, will dictate the resultant care plan.
> 4. Analysis of complex concerns into basic components. Life care planning methodology establishes that the **most basic components of each recommendation be identified and accounted for** within the plan. Once outlined, the prevention of complications becomes a more manageable goal.

5. Plans are **individualized** to meet the unique needs of each patient. Life care plans are not generic formulas applied to a patient according to their diagnosed disability or injury. Integral to the process of life care planning is a review of patient-specific records; a clinical interview; and extensive evaluation of the injury/disability, the individual's goals and preferences, the needs of the family, and an analysis of the geographical area of residence.
6. Needs, rather than funding sources, drive the planning process. **At no time during the plan development process should budgetary concerns influence care and rehabilitation recommendations.** The life care plan was designed with the intention of citing all of the items and services made necessary by the onset of a disability/injury. Once the implementation phase of the process begins, planners may collaborate with the patient, family, and other professionals to identify collateral sources of funding.

Careplans NEED consistent methodology

Points out the need to achieve foundation in four critical areas: Medical, rehabilitation, case management, psychological

http://www.nia.nih.gov/health/publication/advance-care-planning

"Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know about your preferences, often by putting them into an advance directive."

http://www.paulmdeutsch.com/FAQs-life-care-planning.htm#1

Life Care Plans should include the following things:

- Projected evaluations
- Projected therapeutic modalities
- Medication
- Diagnostic testing and educational assessments
- Supply needs
- Wheelchair needs
- Wheelchair accessories and maintenance
- Home care or facility-based care needs
- Projected routine future medical care
- Orthopedic equipment needs
- Projected surgical treatment or other aggressive medical care
- Orthotic or prosthetic requirements
- Transportation needs
- Home furnishings and accessories
- Architectural renovations

- Aids for independent function
- Leisure or recreational equipment

The most respected life care planners follow a consistent approach to plan development with each and every case. These steps involve:

- Comprehensive review of records and supportive documentation.
- Clinical interview and history with the patient and whenever possible a family member or significant contact who knew the patient pre-morbidly as well as post-morbidly.
- Interaction with the medical and health related treatment team to obtain answers to questions not established in the medical records review.
- Research to develop relevant clinical practice guidelines to further establish needs and recommendations as well as support medical and case management foundation.
- Research on relevant research literature to further establish needs and recommendations as well as support medical and case management foundation.
- Where necessary establish further data through staffing with consulting specialists.

http://onlinelibrary.wiley.com/doi/10.1111/j.1471-6712.2007.00493.x/abstract

[Need Access]

COMPETITOR RESEARCH

www.Careplans.com

"Careplans.com is the #1 online resource for nursing assessment, planning, implementation and evaluation. This site includes tools, web applications, articles, links, and libraries to assist both caregivers and students in the careplanning process. Our extensive library of care plans have been developed by nurses, for nurses to assist in all areas of the care planning process."

Fee includes access to a careplan builder that aids nurses in developing individualized plans for their patients, with parameters like: problem statement, goal, approach, rationale, diagnoses, risk factors, etc. It also includes libraries of canned choices for each of these parameters.

http://www.kryptiq.com/

Kryptiq is a service that offers patient relationship management empowered by clinical and financial data. It is broken down into three main services:

- Population Health Management: activates healthcare data

for physicians to use at the point of care

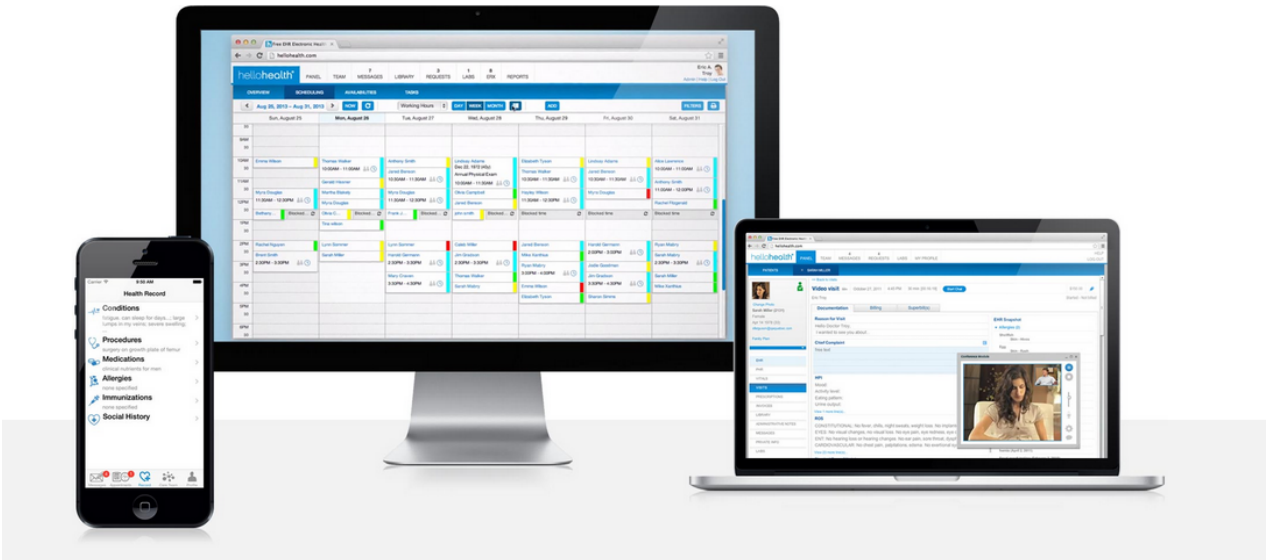
- Patient Relationship Management: a platform for patient outreach and coordinated care, incorporating EHRs.
- Advisory Services: assess organizations' existing structures and provide instruction for organizational/cultural transformation

It is compatible with desktop, tablet, and mobile.

[ADS Data Systems Care Plan]

- ADS Care Plans Module comes with a Care Plan Library based on the NANDA (North American Nursing Diagnosis Association) List.
- Create new or edit existing care plans within the care plan library. The system has automatic spell check for your documents.
- Standardized Care Plans import to the participant's care plan form from the Care Plan Library. They may be edited for the participant's individual needs.
- The participant's 'Long Term Goals', 'Diagnosis' and 'Medical History' will import to the Care Plan form. This information will help you decide what to put in the participant's Plan of Care from the Care Plan Library.
- The CP document keeps a history of active or discontinued needs & problems within the Care Plan Problem List.
- Automatic Due Dates are based on the frequency your facility is required to update its Care Plans. As the end user you determine the due date frequency for your facility.

[Hello Health]



A practice management system, patient portal with telemedicine, Electronic Health Record, billing software

"At the heart of Hello Health is our proprietary technology. The Hello Health New Revenue Practice Platform significantly improves the experience for both providers and patients by reducing paperwork, integrating billing and revenue cycle management, streamlining processes and leveraging the latest online and mobile communication applications to allow providers and patients to engage efficiently and conveniently."

EHR, patient portal, and support is free, but in-office training, revenue generation potential, and credit card on file program costs extra

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CARE PLAN RECOMMENDATIONS

- should seamlessly interact with or be a part of EHR (meaning all information and interactions currently present in EHR should be easily accessible through care plan)
- should accommodate patients in lifestyle transitions (moving, going to school, etc.)
- features should at a minimum include patient goals (and rationale for those goals), support services the patient wants, emergency numbers and health ID information, as well as a plan for medicines, nutrition, and exercise
- should be required to have annual reviews to keep information updated and evaluate any new components that should be added to the plan
- should aid in coordination, cooperation, and communication of all parties involved (doctor, patient, specialist, counselors, trainers, etc.)
- should address medical issues, rehabilitation, case management, and psychological issues
- should be as basic as possible
- should be individualized to each patient
- an informative summary of the status of patient health should always be available
- should address all aspects of patient life planning, from birth planning to advance care planning for end of life (this might include necessary financial planning)
- should show projections based on current and past patient health and effectively communicate that information to the patient so they can make necessary changes; include population health metrics and potential risk factors