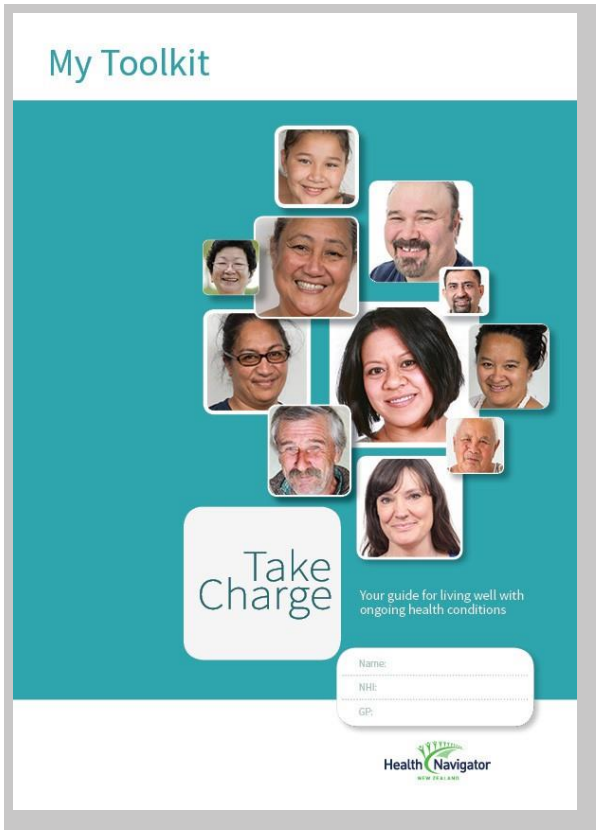
Health Navigator
NEW ZEALAND

A guide to Care Planning using Take Charge resources



What is *Take Charge – My Toolkit*

Take Charge – My Toolkit has been designed to help people with a long-term condition or complex health issues to build their own care plan and keep all of their health information in one place. Some people will feel confident enough to work through the toolkit on their own, however most people will need some additional guidance and support from a nurse, doctor, or health coach.

Take Charge follows a step by step process from identifying what is important through to making and reviewing a plan.

1. What's important to you?
2. What's stopping you doing this?
3. Set a goal
4. Make a plan to achieve your goal
5. Put plan into action
6. Review and refine

Take Charge – My Toolkit sections

Section 1
My Plan

Guidelines and goal setting techniques.

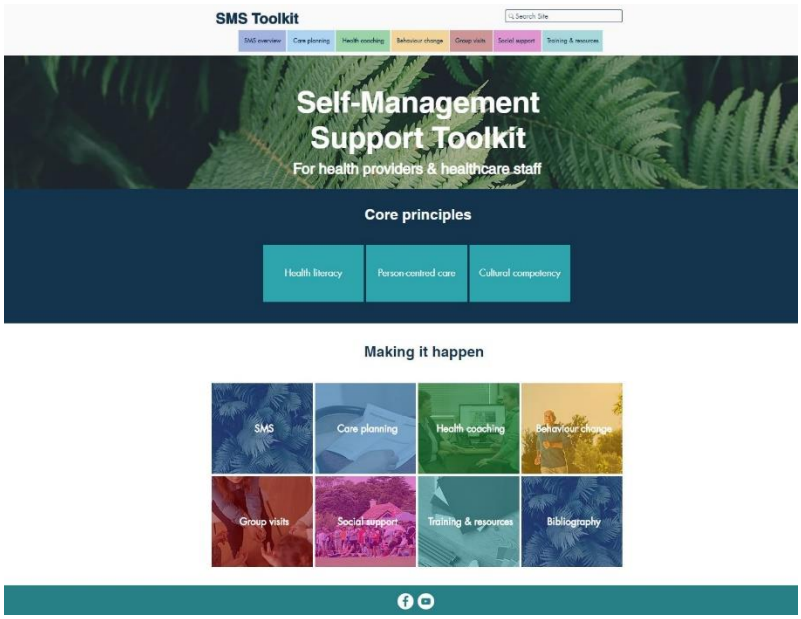
Section 2
Learn More

Information, tools, and links to more resources.

Section 3
Keeping Track

Useful forms that you can use to track your progress.

There are many links to further information and resources throughout the document. In most instances, you will be directed to the Self management support website.



What do we mean by the term "CarePlanning"

Care planning is a means of helping people to understand and confidently manage their own condition, deal with its consequences and know when to ask for help.

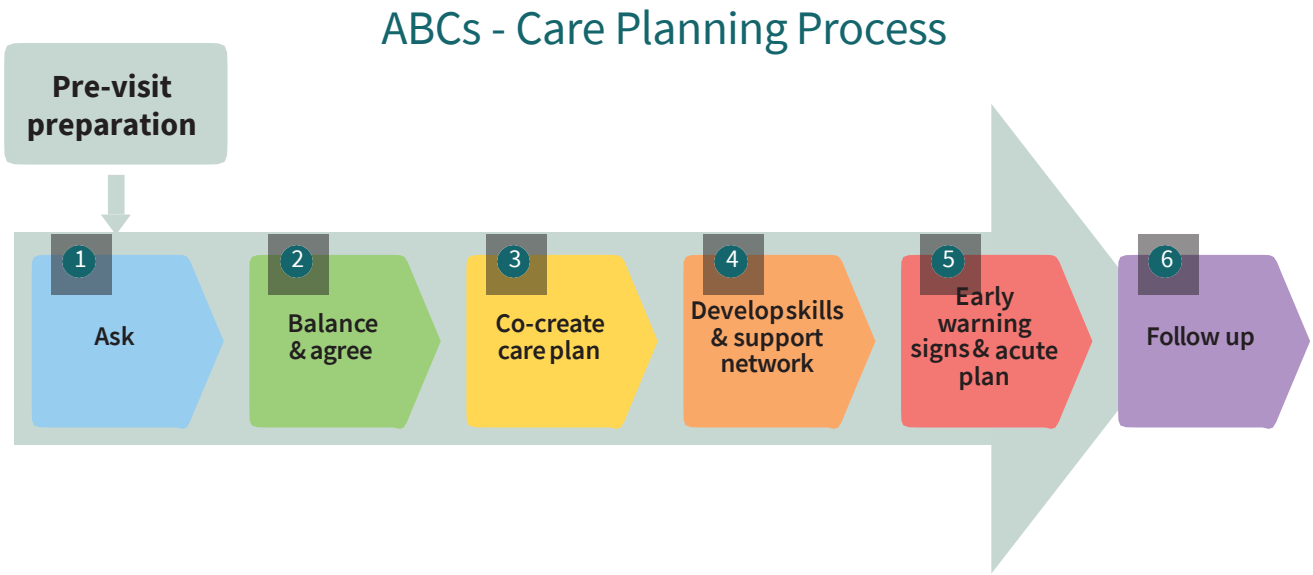
It is a systematic method of providing self management support using a health coaching approach. Care planning is most effective when delivered within a structure, agreed and understood by all those involved. The plan should be regularly reviewed to ensure that it remains relevant and supports improved outcomes and quality of life.

Care planning improves the care experience and helps everyone involved to be on 'the same page'.

How can the Toolkit help with care planning?

The 'Take Charge toolkit' was designed to help people with mild to moderate Long Term Conditions develop their own self-management plan and to share it with their healthcare team.

People with more complex needs will require help from their healthcare team, therefore 'Take Charge' follows the ABC care planning process and provides a structured approach to health coaching conversations that many teams are telling us is so useful. There are a number of tools included throughout, that are designed to support a behavioural/coaching approach to conversations, encourage reflection, and stimulate people to ask questions.



Pre-visit Preparation

As a nurse, health coach or GP your role in care planning will vary widely depending on the context of the care environment and people you are working with.

For all care planning appointments – whether you are using Take Charge or not, it is important, and makes such a difference, if you support the person to come prepared for this appointment by:

- Checking that the person understands the reason for appointment
- Ensuring blood tests or other measures are done and results documented
- Supporting person to prepare questions and share concerns about health condition(s)
- Facilitating transport to appointment – where needed
- Enabling a support person to attend – where needed
- Advocate on behalf of the person as appropriate

Using 'Take Charge' and having care planning conversations

Introducing Take Charge

- Introduce the idea of developing a plan using the Take Charge booklet.
- Ask permission to proceed.
- Explain how it will work, where a summary of the information will be held – other than in the booklet (PMS, shared care patient portal etc.)
- Clarify expectations - time taken for appointment and likely follow up (visit, phone call, text, portal etc.) a written agreement between you may be useful.
- Document the contact details of key members of the healthcare team on page 2 (inside front cover)

Use care planning conversations to support behaviour change

Working with someone to develop a care plan can be complex. Everyone is different, and every care planning conversation needs to be tailored according to individual needs.

As a health provider, you will be used to talking to people about their health problems and providing information to them about their conditions. This is the cornerstone of what you do, but there are ways you can use information giving to promote behaviour change?

Include behaviour change prompts and strategies

Whilst general information can be useful it is important to tailor or personalise the information to the person you are working with. For example: Instead of 'regular exercise helps lower blood pressure' try 'What ideas do you have for how you could introduce more activity into your day to help with lowering your blood pressure?'

Providing information about what others do can help offer choice to the person rather than telling them what to do. For example: Instead of 'you need to eat less sugary and fatty foods' try 'other people have found that making changes to what they eat, such as eating smaller portions or less sugary and fatty foods helps.

Sometimes reframing the information that suggests that others will approve of the change is also useful. For example, 'you will notice that friends and family will be very supportive when they see you making changes for your health.'

How others have introduced this toolkit

One idea that is working well is to introduce the idea of a creating a care plan at a consultation for something else. This way teams can give someone the toolkit and suggest they read through the first few pages and have time to think about what is most important to them and prepare for a subsequent care planning visit in 1 to 2 weeks. The team can then also make sure all the necessary information is available such as up to date blood test results.

Toolkit Page Highlights

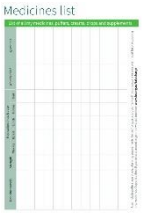
In this section, you'll find pages from the toolkit and suggestions on how to use it.

About me (page 5)

This page is a place to keep all of the important information about the person, including people, conditions, interests etc. There is also an opportunity to ask questions about interest in patient portal access and advance care plans.

Medicines (page 6 & 7)

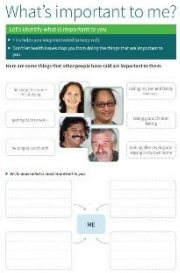
Page 6 is a medicines list (equivalent to a yellow card). Page 7 includes some useful questions designed to help explore possible concerns about their medication.



Behaviour change opportunity

Studies show only about 50% of patients are taking any long-term medication at 12 months. One of the useful aspects of care planning with a toolkit such as Take Charge is finding out what patients are really doing or understand about their medicines. When appropriate, one can then explore ways of addressing adherence issues. More information about medicines can be found on pages 25-27.

Assessing and exploring importance and priorities (page 8-10)



These pages provide an opportunity to explore 'what's important' and what's 'stopping' a person doing what matters to them. There may be other assessment tools being used such as the Flinders Partners in Health tool©, so important to acknowledge these and include findings in the Conversation.

Key messages

What's important to me (page 8) assumes that a person's condition/s does not define them.

Captures what is important to them and what their personal aspirations are as a person in their daily life.

What's stopping me (page 9) covers a broad range of health and social issues that people living with a long-term condition commonly experience. Some of these things may not have been identified in other assessments.

The 'what could I do' work sheet (page 10) facilitates discussion about prioritising the things that are getting in the way of doing 'what's important'. It provides an opportunity to brainstorm ideas and introduces the concept of structured problem solving (page 20, 21) .

Behavioural change opportunity

Plans for change work best when a goal captures both the 'heart and 'mind'. Then the motivation for change is included in the goal/action statement.

People are more likely to make changes if they have come up with the idea themselves OR have a sense of choice.

Structured problem solving (page 20, 21) is a simple, quick, and easy tool to use to generate and analyse ideas about how to solve a particular problem. Can be used at any time during a Conversation. Again, another tool to help someone to generate their own ideas.

Making changes (page 11)

Behavioural change opportunity

Making changes to our habits and lifestyle are difficult! The Making changes page provides opportunity to encourage people to talk about why change may be important. As one of the fundamental steps of motivational interviewing, when done well, patients can noticeably move from ambivalent to being motivated to make the effort required and literally talk themselves into doing it. It has been described as 'like flicking a switch".

Key message

These tools are useful to help someone think through the reasons why they want to make changes by coming up with their own reasons or motivation for change.

Setting a goal and making a plan

Some people might not be ready to set a goal and develop a plan. They may prefer time to think about what you have discussed and talk things over with whanau and friends. If this is the case then be sure to arrange a further appointment, suggest that they look through 'Take Charge' and bring it back with them next time.

Two types of goals

- **Behavioural goals** – these are developed to encourage a change in behaviour. The behavioural goal must be something that the person wants to do and must take account of what is important to the person. Ideally the behavioural goal statement should contain the motivation for change. A person should only be working towards one behavioural goal at a time at that goal should be simple and easily achievable in the first instance.
- **Outcome goals** – in the context of care planning these are usually clinical in nature such as reduction in blood pressure, weight, HbA1c etc. They are generally achieved as a result of a change in behaviour. For example, a reduction in blood pressure (outcome) as a result of regular exercise (behavioural). Pages 12 and 13 includes other people's stories and a worked example.

My plan – My goal (page 14)

Key messages

For the majority of long-term conditions, outcome goals or clinical goals are largely achieved through a change in the person's lifestyle behaviour.

Therefore, 'My Goal' should be a behavioural goal and the goal statement should refer to 'what's important to me' and/or the motivation for change. It can also make reference to an outcome goal. See Annie's example on page 13.

'How will this help' and 'what could I do to achieve this' will all be drawn from the information gathered earlier. 'Why do I want to do this' is a place to clearly state the persons motivation for change.

Behavioural change opportunity

This provides an opportunity to reflect on the earlier conversations and reinforce what was said. For example: 'Earlier I heard you say that you wanted to…..' This gives the person that you are working with confidence that you are listening to them and hearing what they are saying.

It may be helpful to summarise what has been discussed earlier before discussing the goal and action plan. Always restate the 'why' or the 'motivation' for change.

Setting a goal and making a plan

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My plan – My action plan (page14)

Key messages

Action plans are detailed descriptions of actions that support a behaviour change.

Action plans are about changing behaviour. When helping someone develop an action plan it is important to target the behaviour rather than the outcome. For example, walking or not eating between meals (behaviours) rather than weight loss (outcome).

An action plan should have a goal and a brief description why they want to do it and how it will help achieve the overall care plan goal. (see action plan template)

A person should select one behaviour to work on at a time and it should be something that they want to do.

When working with someone to develop an action plan it is important to assess how how confident they are in achieving the action plan.

Action plans should facilitate progress by starting small/easy to achieve and building up and getting harder as the person progresses/improves. See Annie's example on page 13.

Always try to build on success.

Action plans are regularly reviewed, updated and changed.

Behavioural change opportunity

People who develop goals and action plans, write them down and share them with others are 70% more likely to achieve them than those who just think about it.

Important to avoid setback early on. Have a plan/idea for 'what if' or 'rain days'. See Pace Yourself page 24

People are more likely to do something if they have others in their everyday life who are supporting and encouraging them. Identify support person/people. (use page 16 'Who can help me')

Start small and keep it simple. Avoid the 'overactivity rest trap' (page 24) where a person gets enthusiastic and does too much on one day and feels exhausted the next and struggles to feel strong enough to try again.

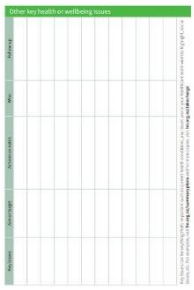
Check that the person is confident that they will be able to carry out the action plan.

To assess person's confidence in achieving their action plan. Confidence level needs to be at a 7 or more as an indication of confidence level (self-efficacy). If they are under 7 ask a 'forward' question "What would it take for you to be a 7?" Don't force the person to increase their confidence to a 7.
Instead, make the action plan/goal smaller or break it down more.

Sometimes it's helpful to make a plan that describes progression over a 3-4-week period. See Annie's example on page 13.

The activity, sleep and food diary pages 41-44 may help people to develop and monitor their action plans

My plan – Other key health or wellbeing issues (page15)



This is a place to include a summary of other key health issues and/or people. Examples may include, specialist referral and treatments, district nurse or allied health treatments/actions, personal and social care services etc. The My Check-ups page 45 may help to keep track of multiple appointments. Doing this might help rationalise appointments and reduce the number of visits to outpatients or rearrange a visit to a service closer to home.

My plan – Who can help me (page16)

Encourage the person to write down the names and contact details in 'Who can help me' (page 16) Provide information about local support groups, SME groups, other community resources.

Key messages

People who achieve their goals will often credit those around them who have given them support and encouragement.

Behavioural change opportunity

Changing behaviour is hard, so it important to help build a support team or network with the person who is trying to make changes.

Ask if they know of someone who has successfully made changes, could this person/people be a role model…

Am I on track? (page17)

Key messages

Keeping a record of progress towards goals and learning how to self-monitor are important self- management skills.

Information about health targets/outcome goals and tracking health behaviour are both important.

Being able to problem solve when something goes wrong and being able to clearly identify bad consequences of actions/behaviours are important for avoiding health crises or problems getting worse.

There are many tools available to assist with self-monitoring such as online tools and phone apps.

Behavioural change opportunity

Self-monitoring using the forms at the end of 'Take Charge' or other log/diary helps track progress important for keeping up momentum and motivation.

The self-monitoring forms are also useful for helping to solve problems when things go wrong. 'Staying on track' (page 39 & 40) will also help to explore some of these issues.

Keeping a record helps reflect on past success and can provide incentive to try again.

What to do when unwell (page 18)

Key messages

Emergency or acute plans provide clear step by step information about what to do when feeling unwell and how to stop getting worse.

The template on page 18 can be used to develop an emergency plan for a person. However, there are many good evidence-based plans available and an appropriate one should be selected. This can either be stapled to page 18 or left loose for the person to keep in a prominent place at home.

Behavioural change opportunity

People who have an emergency or acute plan and know how to act on it are less likely to have unplanned emergency and hospital admissions.

Provide instructions/demonstrate how to do a task/use equipment where it is an important aspect of the emergency plan.

Follow up – Keeping on track (Section 3, page 38)

Key messages

Follow up of goals and action plans should be frequent, particularly in the beginning.

Follow up can happen in different ways to suit the preferences of the people involved. Phone calls, texting and messaging via the patient portal have all been found to be useful ways of following up on progress. Face to face visits are better done at monthly or three-monthly intervals.

The main purpose of a follow up conversation is to discuss progress towards goal and to update/ modify the action plan. Acknowledging what they have done since last conversation

Behavioural change opportunity

Follow up conversations are useful for checking on progress and helping people get back on track.

Use open questions to find out what the person has been doing towards their goal or how they are getting on with their action plan. For example:

'What have you been doing since we last spoke .... (action plan or goal)

If things are going well suggest increasing/doing more or adding a new activity or

action. Try asking:

'What would you like to work on now'

create a new action plan and remember to ask 'how confident are you…. And 'what might get in the way of you doing….'

Make a what if or rain day plan

If things are not going so well try problem solving (page 20 & 21 Take Charge)

Remember you have lots of other tools at your disposal - use them. If you are giving the person more information remember.

Documenting the care plan

A summary of the main points should be included in the shared care plan if available. This can be printed out and a copy given to the person and/or they should be encouraged to view it via the patient portal. If the person does not have a shared care plan then document the summary in the PMS, in line with practice policy.

Direct the person to the forms at the back of Take Charge. Fill in relevant 'numbers' on 'My Progress' form (page 46) and discuss and agree on 'targets'.

Clarify link between goals action plan and targets.


My Progress

To keep track of my health

Care plan review

The care plan should be reviewed regularly, the frequency will depend on the time agreed with the person and within the context of the organisations' care planning review policy e.g. quarterly, annually etc.

Circumstances may arise which mean that an earlier care plan review is required such as:

- Have the person's circumstances and / or care or support needs changed, including any changes in their informal support networks?
- Has the person had a change in health status
- A care plan review whether planned or urgent must explore:
- Is the person, carer or their advocate satisfied with the plan?
- What is working in the plan; what is not working and what might need to change?

The purpose of the review is to refresh the plan and make sure it is accurate, up to date and supporting the person's health and wellbeing.

Care planning is a continuous process. The planned review closes the loop back to Ask.

At all stages, the person whose plan it is, must be involved, consulted with and in control.

More tools and information in TakeCharge

There are some common issues that people living with long term conditions experience. Take Charge includes summary information and navigation to further resources on:

- Pain (pages 22 & 23)

- Emotional wellbeing (pages 28 – 30)

- Sleep (page 31)

- Relaxation and breathing (pages 32 & 33)

- Healthy eating (page 34)

- Being active (page 35)

- Patient portals (page 36)

- Advance care planning (page 37)

For more information about Take Charge, care planning and self management support go to