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# A new life for the care plan?

By Laura K. Heermann Langford, PhD, RN; Ann Tinker, MS, RN;  
and Marc-Aurel Martial, MPH, RN

**T**he current hot topic within clinical informatics is meaningful use and incentive payments defined under the Health Information Technology for Economic and Clinical Health (HITECH) Act's electronic health record (EHR) incentive program.<sup>1</sup> This recent legislation calls for healthcare providers to meet a set of minimum requirements using a certified EHR. The point of this government program is to support the widespread adoption of the EHR. The program lays out an overall plan that incentivizes hospitals and providers to implement, adopt, and "meaningfully" use an EHR. The incentive program starts with basic data entry and exchange in a standardized manner, with an eye

the care plan to contain the identified care needs and treatment goals, the strategy to meet those needs and goals, and any progress toward meeting the goals.<sup>2</sup> The Joint Commission also requires the care plan to be regularly evaluated and revised as needed. However, bedside nurses often view care plans as holding little or no value to direct patient care.<sup>3</sup> The Kardex is frequently more valued as a source of information and communication for nurses because it supplies specific data about the individual patient, whereas the care plan outlines the nursing interventions and expectations but is incomplete in regard to the interventions and expectations of the entire care team. Care plans in use today are typically created and maintained within each clinical discipline's silo and have minimal crossover to other disciplines. In addition, care plans are usually initiated and resolved from care setting to care setting, offering no assistance in the continuity of care between caregivers and venues. (See *Figure 1*.)

Although each care plan has similarities in content, the specifics of each can be very different and domain-specific. The lack of crossover or visibility from one domain to another contributes to inefficiencies in care and perhaps even decreased patient safety. Another challenge today is that care plans aren't part of care delivery workflows. Therefore, they necessitate extra work for clinicians to create, modify, and maintain to meet regulatory and accreditation agencies requirements.

## Care coordination

The terms interdisciplinary care and multidisciplinary care are often used interchangeably. Dobay defines the interdisciplinary care plan as being "written by representatives of every area who join together with the patient and/or

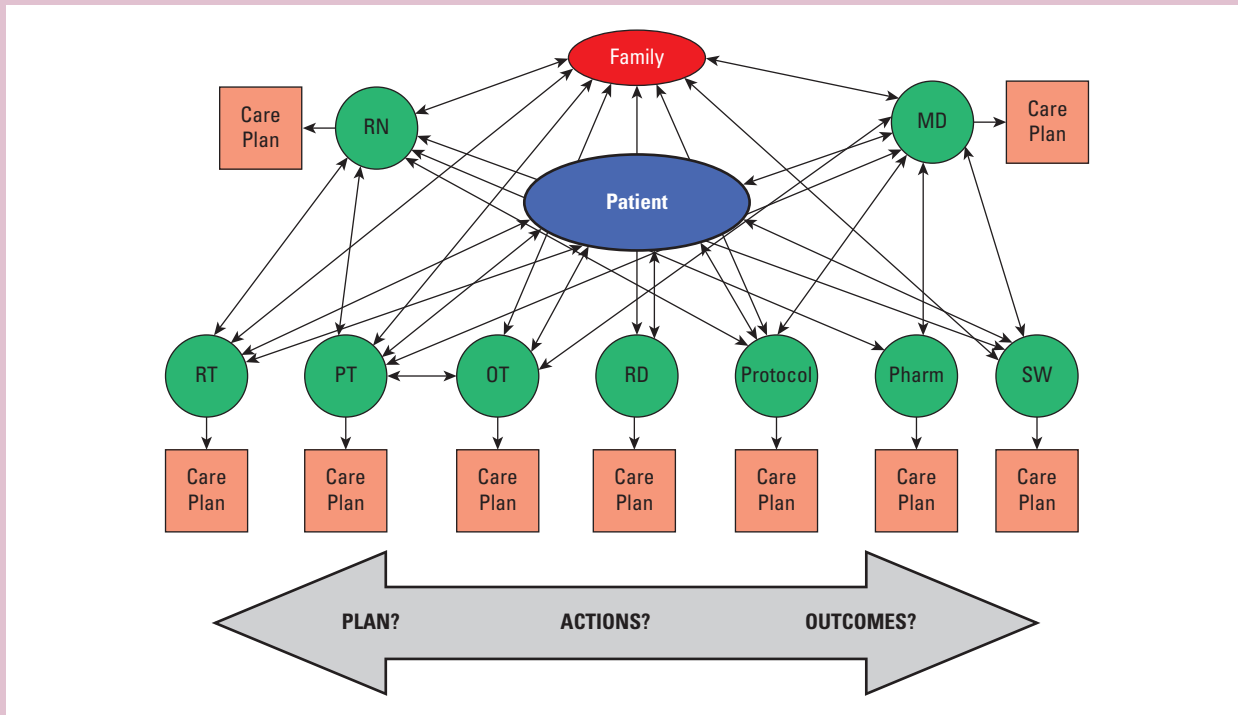
## *Is the interdisciplinary plan of care a key piece to meeting the requirements of meaningful use?*

on long-term exchange and sharing of complete patient records to enhance patient safety.

The core set of requirements for data entry to meet meaningful use standards includes many data elements common to the plan of care, such as patient demographics; base vital signs; lists of comorbidities, medications, and allergies; and smoking status, as well as a summary of care provided. Is the interdisciplinary plan of care a key piece to meeting the requirements of this new legislation?

## The problematic care plan

Nurses have long been "keepers" of the inpatient care plan. The Joint Commission requires

**Figure 1: Silo approach to care planning**

patient representative or advocate to discuss the problems, goals, and objectives for that patient and to determine a plan of care that is most conducive to bringing about agreed upon goals.”<sup>4</sup> Dobay goes on to define a multidisciplinary care plan as “written by each discipline independent of the rest of the care team. Problems, goals, and objectives for a patient are relevant only to that disciplines area of expertise.” Von Gunten et al. describe multidisciplinary teams as working sequentially with the medical record (being the chief means of communication) and interdisciplinary teams as working collaboratively with regular meetings to discuss patient status and the evolving plan of care.<sup>5</sup> The interdisciplinary team is characterized by shared decision making and flexible leadership.

The integrated care encompassed by the interdisciplinary approach promotes seamless continuity that results in high-quality patient care.<sup>6</sup> Working and sharing knowledge across functional domains, however, can be extremely difficult and is recognized as a major challenge in the safe delivery of care. Domain-specific knowledge is localized and embedded into practice.<sup>6</sup> For the integration of care to be effective, care providers must share information about and with patients continually through the care process.

The real-time sharing of information is critical to allow all caregivers the benefit of acting on the most current and pertinent findings and issues for each patient. The rise of chronic illness means that a patient’s care, treatment, and services likely include an array of providers in a variety of healthcare settings, including the pa-

tient’s home.<sup>2</sup> The process of coordinating care provided by a healthcare organization, including referral to the appropriate community resources and liaison with other care providers, to meet the ongoing identified needs of individuals to provide quality care without unnecessary duplication of services can be very complex.

The EHR and interdisciplinary care plan allow for real-time collection and better communication between team members and with their patients.<sup>7</sup> However, what’s in an electronic care plan, the expectations of its use, and its fit into each discipline’s unique workflow must be carefully considered.

#### **The electronic, integrated, interdisciplinary care plan**

Standardized content of an interdisciplinary care plan hasn’t been defined. Common elements across

multidisciplinary care plans include problem lists, targeted outcomes, actions and interventions essential to achieving the targeted outcomes and goals, and the evaluation of progress toward meeting the targeted outcomes and goals.<sup>8</sup> One benefit of the EHR is the ability to collect and store data once but use them many times. Applying this concept to interdisciplinary care plans allows caregivers to view and collaborate on these common care plan content areas. Maintaining one problem list and managing one medication list and one allergy list between caregivers is the ultimate goal of patient-centered care. Collecting and sharing information related to patients' personal health goals and their progress toward

but have discipline-specific views to streamline its specific workflow. The content of the care plan may be entered and stored so that business rules can be applied determining what may be hidden for a discipline-specific view and what should always be visible.

Another benefit of the EHR is the accessibility of information either through shared systems or the exchange of information between systems. This sharing and exchange of information opens up new possibilities in the coordination of care and care planning. Imagine an individualized care plan that contains demographic information (such as phone numbers and family and support structures), advance directives, healthcare summary information

interacts with ordering, documentation, and results review components. It can also promote collaboration between all relevant caregivers to enhance the patient's overall care and well-being.

This is possible, and the HITECH Act's activities are one step along the way to making it happen. When it does, the care plan will have a new life assisting in the provision of cost-effective, efficient, safe, and holistic care giving. **NM**

#### REFERENCES

- Centers for Medicare & Medicaid Services. EHR incentive programs overview. [http://www.cms.gov/EHRIncentivePrograms/01\\_Overview.asp#TopOfPage](http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage).
- The Joint Commission. 2010 E-dition Compliance Monitor. <http://ecm.jcrinc.com/Frame.aspx>.
- Crabtree C, Howard PB, El-Mallakh P. The care and outcomes management plan and Kardex. A design for improving documentation of nursing plan of care and patient outcomes. *J Healthc Inf Manag*. 2009;23(1):50-55.
- Dobay NJ. Curbing the cost of interdisciplinary care plans. *Contemp Longterm Care*. 1988;11(11):84-85.
- Von Gunten CF, Ferris FD, Portenoy RK, Glajchen M. *CAPC Manual: How to Establish a Palliative Care Program*. New York, NY: Center to Advance Palliative Care; 2001.
- Protti D. Integrated care needs integrated information management and technology. *Healthc Qual*. 2009;13 Spec No:24-29.
- Clarke A. Implementing electronic integrated care pathways: learning from experience. *Nurs Manag (Harrow)*. 2005;12(2):28-31.
- Ambrose MS, Quinless WF. Fundamental procedures. In: Mills EJ, Bartelmo MJ, Devlin MM, Perrong M, eds. *Nursing Procedures*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2004:26.

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### ***The electronic interdisciplinary care plan can be an integral piece of the clinical information system that interacts with ordering, documentation, and results review components.***

meeting those goals brings the care team into a common focus. Each discipline applies its unique skills and knowledge toward assisting the patient to meet those goals and is aware of efforts being made by the other disciplines. This can lead to more synergistic and complementary care and decrease duplication or missed opportunities to enhance progress initiated by a fellow caregiver.

There may be concern of one discipline "cluttering" another discipline's work or making a problem or medication list so long that it impedes workflow. But this is where the value of using electronic tools to manage the care plan can also be realized. Each discipline may have access to the full care plan for review

(such as blood type), the problem list, allergies and intolerances, active medications, recent procedures, and interventions and results, in addition to the patient's current health goals and progress made toward those goals, that's accessible in any care setting by any of the patient's care providers. Imagine this information, common between caregivers and care settings, doesn't have to be collected and recorded at each visit or admission but is simply reviewed and reconciled with any updates or changes. Imagine the care plan is included in the care delivery workflow and not perceived as additional work by the clinicians. The electronic interdisciplinary care plan can be an integral piece of the clinical information system that