POLICY: 1.008 CARE PLAN

Care Plans must be developed and completed with each patient enrolled in the HH program using information obtained from the assessments/reassessments. Care plans must be created face-to-face, and developed in conjunction with the patient and the patient's family/other supports (as appropriate). Initial Care Plans must be developed during the Assessment phase. Care Plans must be updated every 6 months (180 days) and with every reassessment while the patient remains actively enrolled in the HH program.

What is a Care Plan?

A Care Plan details goals, action steps and appropriate timelines to address patient's medical, behavioral health, and social service needs identified by the assessment and reassessments.

Why is it Important?

The Care Plan is a fundamental component of care management for Health Home patients. It outlines all of the activities that will need to be implemented to provide coordinated, efficient, quality care to improve patients' overall health and ensure that they stay healthy.

PROCEDURE:

Initial Care Plan

1. ACD pre-populates components of the Care Plan using information collected in the patient's assessment.
2. Initial Care Plan (pre-assessment) is developed directly in the care plan section in ACD
3. Assigned qualified and experienced Care Managers (CMs) must review the pre-populated Care Plans and make modifications as needed throughout the care plan process
    2.1 Consider the patient's characteristics, such as their acuity, health status, and acute service use patterns when assigning a CM.
4. Care Plans must be reviewed/updated face-to-face with the patient and the patient's family/other supports, as appropriate.
5. It is strongly recommended that care plans utilize the SMART Goal framework for generating patient-centered goals, objectives, and activities/tasks (see *Appendix E* for an overview of SMART).
6. Each initial care plan must include the following components:
    a. Patients' goals to improve their health and overall wellbeing during the first six months of enrollment in the HH program;
    b. Specific action steps patients are willing to take to meet their goals;

c. Time frames for carrying out specified action steps; time frames cannot exceed a 6-month period;
d. Any outreach and engagement activities that are needed to meet patient's needs;
e. Patients' functional needs as they relate to their goals;
f. Patients' preferences and strengths for achieving goals;
g. A clear indication of the person responsible for each step to achieve goals. This can include the patient's medical and behavioral health and social service providers, as well as social supports, such as community networks, friend, family, or other caregiver; and
h. Any community-based referrals that need to be made for patient to achieve goals.

7. Clinical Care Plan goals are to incorporate feedback from the patient's care team (e.g., medical providers).
8. The Care Plans are to be shared with the patient, the patient's medical and behavioral health and social service providers, the patient's family and other supports, as necessary.
9. Care Plans must be printed and patients must sign the plans to confirm that they have reviewed and are in agreement with the goals, action steps, and time frames detailed in the Care Plan.
10. Signed Care Plans must be scanned and uploaded into ACD.
11. If patients cannot sign the Care Plan, the CM is responsible for identifying barriers to signing and documenting them in ACD.
12. A system must be in place for reviewing and approving Care Plans *within 30 days* of enrollment into HH services.
13. For HARP / HCBS patients, the care plan created meets the Federal Plan of Care requirements and must be submitted to the MCO for approval. For HARP/HCBS workflows and requirements, please see policy 1.012.

Crisis Plan Development and Management

1. If NYPHH or the CMA identify patients who are in crisis, or the patient has a prior history or recent crisis, the CMA will develop a Crisis Management Plan and identify the level of support needed to stabilize the patient.
2. The Crisis Management Plan must include:
    a. Potential stressors and risk factors for crises and hospitalization
    b. Strategies to manage identified risk factors and stressors
    c. Key person(s) and resources used to stabilize the patient
3. As stated in the "Initial Care Plan" procedure, the Crisis Management Plan must be developed with the patient and care team members as needed.
4. The CMA must document the Crisis Plan as a part of the patient's care plan in ACD and follow the guidelines set forth in the "Initial Care Plan" portion of this policy. A separate care plan is not required.

Care Plan Updates

1. Review care plans *must be reviewed during the following situations:*
    - **a.** *Every six months*
    - **b.** *Annually with the Comprehensive Reassessment*
    - **c.** *During Crisis Management*
    - **d.** *Within 30 days of a patient transitioning from the settings identified in the Transitional Care policy*
2. Care Plans must be updated to assess and / or whether patients are meeting their goals.
3. Upon reviewing Care Plans, update them to specify new goals and/or action steps, and time frames; time-frames cannot exceed a 6-month period.
4. If upon review it is determined the patient has met their goals, needs another level of care coordination (including Health Home Plus), and / or transitioning to a long term care program (MLTC, Nursing Home, etc.), the CM must discuss disenrollment / graduation with the patient.
5. The patient and CM must be in agreement with all Care Plan updates, including potential disenrollment/graduation from the NYP Health Home Program.
6. Updated Care Plans must also be printed, signed by the patient and uploaded into ACD.

Documentation

1. Confirm that Assessments/Reassessments on ACD have been completely filled out.
2. Review pre-populated Care plans and/or create new Care plans on ACD as needed.
3. Print and have patients sign initial and updated Care Plans, and upload them onto ACD.

APPENDIX E: S.M.A.R.T. Framework

- **Specific**
  - What do we want to achieve?
  - Six "W's"
    - Who is involved
    - What do we want to achieve?
    - Where do I need to go?
    - Which are my requirements and restraints?
    - Why am I /Why do I need to do this? What are the benefits / rewards to accomplishing this goal?

  Goal: I will manage my diabetes

  Specific Goal: I will manage my diabetes by meeting with the dietician and following the nutrition plan

- **Measurable**
  - How will I know that the goal has been reached?
  - How do we measure progress?
  - Having goals with a means to measure progress will help clients to evaluate their own successes and barriers

  Goal: I want to lose weight.

  Measurable Goal: I want to lose 10 pounds in 3 months.

  Task: Go walk.

  Measurable Task: Go on a 15-minute walk 3 times a week

- **Attainable**
  - Also known as Action Plan
  - Set goals that you are able to achieve
  - Is this too challenging? Too easy?

- What resources do I need to accomplish this goal?
- What tasks/activities must I do to count myself as being successful?
  - Use the questions at the end of the Comprehensive Assessment as a guide to you and the client

- **Realistic**
  - Also known as Relevant
  - Are the expected outcomes something the client or Case Manager can control?
  - Given barriers, constraints and other things going on, can this goal be achieved?

- **Time Oriented**
  - When should have I completed all of the tasks and activities?
  - How will I review my progress throughout the time period?
  - Should be a mixture of short – term and long-term goals and tasks.

  Goal: I will take my medications on time.

  Time-Oriented Goal: I will take my medication at 9 am and 9 pm, per the doctor's orders.

  Task: Fill pill box.

  Time-Oriented Task: Fill my pill box on Sunday evenings with medications for the entire week.