Care Management Care Plan Requirements

Each recipient receiving care management services with the Alabama Coordinated Health Network (ACHN) shall have a care plan documented in an Agency approved Health Information Management System (HIMS). The PCCM-e shall apply evidence-based guidelines and best practices when developing and implementing the care plan. The process shall involve the recipient, their caregiver/family member (when appropriate and/or requested by the recipient), applicable healthcare providers, and community-based providers as appropriate.

- The care plan shall be current, person-centered, individualized and identify and address each of the recipient's diagnoses and needs. Staff shall specify those services necessary to meet the client's needs (The needs may include functional, social, spiritual, cognitive, educational, barriers to care such as cultural and language, community resources or lack thereof, transition of care, access to care, and self-care. Include referrals as appropriate for needed services and identify the expected outcomes for each specific issue.

- The care plan shall include, at a minimum, five components: an assessment of identified needs, goals, intervention, rationale, and evaluation.

- The care plan shall be evaluated for the recipient's progress to the goals and the effectiveness of the established interventions with each encounter. The care plan will be updated with new goals and/or interventions as needed with documentation in the Agency approved HIMS to support the completion of an update and evaluation process.

Components of the Care Plan
At a minimum, the care plan shall include the following components:

1. Assessment of Identified Needs
    a. The PCCM-e shall identify and assess and identify the clinical and psychosocial issue that will be the focus of care management. The recipient's individualize needs based on the recipient's initial assessment and through the collection of objective and subjective data during recipient encounters. The identified needs shall also include documenting of the recipient's risk stratification. The assessment of identified needs process shall include, but not be limited to:

    b. Engaging the recipient, recipient's family and /or caregiver in the care plan process. Identified persons shall have the opportunity to participate in the care plan process during the development, implementation, and ongoing assessment of the recipient's care

plan.

c. Meeting and addressing communication barriers.

d. Engaging the Primary Care Provider (PCP), Maternity Care Provider (MCP), other Providers, and/or a legal representative, as applicable and appropriate. Identified persons shall have the opportunity to participate in the care plan process during the development, implementation, and ongoing assessment of the recipient's care plan.

e. Identify and form support systems as needed.

f. Identifying and addressing the recipient's personal or cultural preferences related to the types or amounts of services.

g. Identifying and addressing the recipient's preference of providers and any preferred characteristics, such as gender or language.

h. Identifying and addressing barriers and obstacles that may impede the recipient achieving optimal physical, mental, or social health outcomes.

i. Identifying and arranging a back-up plan for receiving critical services (i.e., emergency health issues, behavioral health issues, substance abuse relapse).

j. Identifying and establishing crisis plans for a recipient with behavioral health conditions, as applicable.

k. Identifying and addressing other needs through ongoing care management

2. Goals
   a. Recipient centered actions specifically chosen to resolve an identified need or achieve a want or desire.
   b. The recipient's goals should be SMART Goals: Specific, Measurable, Achievable, Relevant, and Time based.

3. Interventions
   a. Actions taken by the care management staff to assist the recipient in achieving the goal. The intervention process shall include, but not be limited to:

   b. Referrals to community or social service agencies, as needed (calling or submitting a written request on behalf of the recipient,

provider, caregiver/family) and validate the recipient received the service.

c. Linking recipient to needed resources or healthcare providers (Perform activities to assist the recipient connect to the resource or provider, and validate the recipient received the service).

d. Conducting timely follow-up with the recipient, referral resources, and his/ her providers as appropriate.

e. Performing medication reconciliation, as applicable.

f. Establishing support systems.

g. Providing relevant education

h. Conducting transitions of care between care settings which may include obtaining the discharge / transition plan/summary.

4. Rationale
    a. The rationale is the "why" of the care plan.
    b. It is the explanation a Care Manager provides for choosing a particular intervention.

5. Evaluation
    a. The evaluation process includes documenting follow-up and monitoring of the recipient's progress toward the goals and determining if the interventions were appropriate. This process includes determining if the goal and or intervention will improve the recipient's quality of health (mental physical, social, etc.) and meet their needs. Care management staff shall:
    b. Document the recipient's progress toward accomplishing each goal. Documentation shall include the status of each goal i.e., met, unmet, or in progress along with a summary what was (un)accomplished and why.
    c. Document the effectiveness of the intervention; determine if new or revised interventions are needed along with the need for continued management.
    d. The care plan shall be evaluated with each recipient encounter with documentation to support the completion of an evaluation process.

6. Revisions
    a. Care plan revisions include modifying the goals and interventions based on the evaluation of the recipient's progress and needs to ensure the appropriateness of the services to suit the recipient's needs. Revisions are required when:
    b. There is a change in the recipient's health status or needs.

c. There is a change in recipient's diagnosis.

d. There is a change in recipient's caregiver status.

e. The recipient experiences a significant health care event (e.g., hospital admission or transition between care settings).

f. There is a request or need identified by the recipient or the recipient's caregiver.

g. There is a request of need identified and by the recipient's healthcare providers.

h. There is a change to the recipient's goals.
i. The intervention chosen is not suitable to aid in achieving the goal.

j. There is a lack of progress with achieving a goal after 90 days (modify/change the goal and or intervention).

k. During reassessments.
l. After a change stratification level

The care plan is valid when the recipient/legally responsible person and the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the care plan to document the recipient's participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the care plan.