

Care plan best practice recommendations to DSS

- Person-centered -- driven by the individual's¹ goals
 - Goals include both clinical and life goals
 - Goals should be both long and short term
- Care plans are a tool to empower individuals in improving their own health
- Care planning requires individual's understanding of the problems and treatments, to the fullest extent possible
- Care planning should be guided by best practices, evidence based and appropriate to the individual and their current situation
- Care planning process centers on the individual and their wishes, values, strengths and needs, circumstances, culture, and resources to the fullest extent possible
 - Individuals must be actively engaged in development of care plans
 - Individuals give final approval to the care plan, and should have ample time to consider their approval, understand the entire plan, ask questions and get answers
- Care plans should include the individual's clinical condition and what changes, if any, are expected and when
 - Expectations may include improvement, cure, maintenance, educational, rehabilitative, or circumstances and timing of decline
 - Expectations may vary for different clinical/social conditions
 - All expectations must be driven by the individual's goals
- Care planning should include clear communications about each treatment, including medications
 - Communications should include resources and costs of each treatment or medication, resources to fund care and costs to individuals, the purpose of each treatment/medication and which health problem it is intended to address, side effects, and the probability that the treatment/medication will help the problem.
 - The discussion should address all alternative treatment options available
 - Care planners should ensure that all aspects of each treatment, including medications, is fully understood by the individual to the fullest extent possible
 - If necessary due to costs or other barriers, care planning should help individuals prioritize treatments and medications based on their goals
- An individual's approval of their care plan should never include coercion or concerns that care or other resources are contingent on their approval

¹ Throughout this summary, "individual" also refers to caregivers and family members as appropriate.

- Care planning discussions should be documented, but not necessarily in the care plan document
- Care plans should be developed in a thoughtful, proactive process rather than reacting to an incident or “disaster”
- Providers have a critical role in developing a realistic plan that meets expectations, ensuring that planned care relates to the individual’s goals and that timing and resources are realistic
- Care plans should go beyond clinical care to include social service and other needs to create a “total plan for health” that address social determinants of health
 - For individuals in every stage of life, including decline, it is critical that their social service needs be included in care planning
- Care plans should reflect both strengths and barriers to achieving the goals
- Care plans, developed in a collaborative, interpersonal process, can be facilitated by sharing on an electronic platform once developed, but the electronic record or any other format must never drive the care plan
- Sharing care plans electronically should be seamless, easily integrated into workflow, and facilitate collaboration, not serve as a barrier or burden to any provider
- Care plans connect stakeholders including individuals, providers, paid caregivers, family and personal caregivers (as appropriate), and social service providers across settings
 - The goal is for each individual to have one overarching care plan that informs care from multiple providers and caregivers
 - Individuals must always have access to their full care plan
 - Assuring that everyone involved in each individual’s care is on the same page, with a clear understanding of goals, plans and expected outcomes
 - Each stakeholder should understand their scope of responsibility in the care plan
 - Each stakeholder should be able to contribute information, update new developments, and provide feedback to the care plan’s implementation
- The care plan should be available to everyone who needs it and no one who doesn’t
- Care plans provide specific, actionable information that support the individual’s goals
 - Care plans should clearly outline actions to be taken, by whom and when
 - There should be no misunderstandings about what is in the care plan, or what it means
 - Effective care plans are foundational to ongoing decision making
- Well drafted care plans provide accountability – a standard against which performance, both for the individual and caregivers, can be measured
 - Care plans should include clear monitoring to ensure that the plan is being used in a dynamic process that supports individual goals
 - Advanced analytics should be utilized in care planning and evaluation, as appropriate
 - Care plans should be an important part of quality assessment for each health system or organization
- Care plans should not be permanent but change in response to individual circumstances, new resources, treatment trials, and changing expectations

- Care plans should include a date for reassessment, but if circumstances change substantially, it can be revised earlier as necessary
- Care plan revisions should begin with and be driven by an assessment of progress toward goals and if individuals received what was originally agreed upon
- Care plans should anticipate changes in health status and transitions
- Care plans are not written for insurance or payment purposes
- All licensure and payment requirements for care plans must be followed
- Care plans are not only for individuals with complex conditions, but anyone with health problems can benefit from setting health goals and developing a plan to achieve them