Patient-Centered Care Plan Guidelines

The Patient- Centered Care Plan should be developed with active participation from the recipient and their supports if applicable and must include the following:

- Basic recipient information (Name, DOB, etc.)
- Medical conditions
- Medications or document that the medications listed in the EHR were reviewed and/or updated.
- A summary of the recipient's health-related social needs (housing, employment, transportation etc.)
- A summary of durable medical equipment needs if applicable.
- Goals to improve health and overcome barriers.
- Progress notes documenting progress made towards achieving goals.
- Family members/friends involved in care.
- Behavioral health needs if applicable including documenting:
    - Last depression screening (date and/or results)
    - Last substance use screening (date and/or results)
    - Whether they are engaged in active treatment and when their most recent appointment occurred
- Community resources the recipient was referred to.
- Indicate if the recipient can self-manage their conditions including if they are using self-management tools to record the results.
- Specialist the recipient was referred to including documentation that an electronic summary of care was provided to the specialist.
- Documentation of future appointments including
    - Next primary care provider appointment, if known.
    - Other healthcare appointments
- The dates when care plan was originally created.
- The date the care plan was last updated/reviewed.

Health Homes are not required to use a specific form for the Patient-Centered Care Plans.