



COMMUNITY LIVING PROGRAM

Policy/Protocol: Action/Care Plan

Purpose: The Action/Care Plan is the result of the process of developing an agreement between the consumer and Care Coordinator regarding identified problems, outcomes to be achieved, and services to be pursued in support of goal achievement. It provides a focus for the needs identified in the assessment; it organizes the delivery system to the consumer; and it helps to assure that the services being delivered are appropriate to the problem. It is a collaborative document that is developed between the consumer, their family (when appropriate) and the CLP Care Coordinator.

Without a specific document delineating the plan, important issues are likely to be neglected. An action/care plan provides a "road map" of sorts. It serves as a tool that guides, strengthens, and provides accountability for the intervention and all who are involved.

Policy: Action/Care Plans will be utilized for all CLP Consumers. Although the Action Plan is developed and refined throughout the process, the initial action plan should be started at the first home visit or within two weeks after the date of enrollment and a copy of the initial action plan will be made available to the consumer.

While the CLP case is "open", the Care Coordinator, consumer and family are continually assessing and evaluating the necessity and appropriateness of the services and potentially identifying new resources and problems. Consequently, the action/care plan can and likely will be updated and revised.

Procedure:

1. During the initial enrollment visit, the Care Coordinator will support the consumer to clarify their goals and develop actions steps that will meet those goals. If appropriate for the consumer's readiness, the Care Coordinator will document these goals and action steps using the Action/Care Plan document (G:\Community Living Program (CLP)\Policies\2011 Action Plan.doc).
2. Elements of the Action/Care Plan include:
 - a. Outcome oriented goal statements and conditions for case closure;
 - b. Both formal and informal services to be provided;
 - c. Agencies responsible for service provision;

- d. Frequency of service provision;
 - e. Duration of service provision;
 - f. Specific steps required to implement the plan
3. The plan is developed collaboratively between the Care Coordinator and the consumer and their family. Only those goals and action steps that the consumer agrees to are included on the plan.
Note: Care Coordinators are obligated to address issues of safety and risk whether or not the consumer agrees to suggested interventions.
 4. Plans will be reviewed by supervisor following initial development and as needed throughout the case.
 5. Plans (G:\Community Living Program (CLP)\Policies\2011 Action Plan.doc) may be handwritten or typed (preferable). If typed, save a copy of the plan in G:\Community Living Program (CLP)\CARE PLANS.
 6. Consumers will receive a copy of the plan as soon as possible in the process and if the plan is revised while the case is open, it is recommended that a copy of the revised plan be sent to the consumer with the closing letter and survey.
 7. Following case closure, Care Coordinators will indicated status of outcome for each action step (see below) and provide a copy of the Action Plan to the Grant Coordinator within one week of closure.

Outcome Status:

- **A** = Achieved (the step was completed and the intended outcome at least partially achieved)
- **0** = Not Achieved (the steps was not completed or completed and the intended outcome was not achieved)
- **?** = Outcome Unknown
- **D** = Consumer Declined to pursue