

CHELAN-DOUGLAS RSN/PHP POLICY AND PROCEDURE MANUAL		Chapter:	2.5
Title:	MANAGED CARE SERVICES	Page:	1 of 2
		Date Effective:	July 1, 2002
Subject:	PLAN OF CARE	Date Revised:	May 23, 2002
		Authorizing Signature:	

AUTHORITY: Guiding Principle(s): Consumer Focused, Holistic/Humanitarian, Accessible, Normalizing/Non-Stigmatizing, Responsive
RCW 71.24, Community Mental Health Services Act
DSHS Title XIX Contract and Federal Waiver

SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Health Plan (CDRSN/PHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: This policy directs CDRSN/PHP contractors to develop a Plan of Care (treatment plan) in collaboration with the consumer based on the individual's identified needs and preferences.

DEFINITIONS: Plan of Care (treatment plan). A plan developed by the provider in collaboration with the consumer and others providing supports to the consumer. The individualized plan is developed with the consumer and people who know the consumer best; focuses on and enhances consumer strengths as defined by the consumer; is flexible and responsive to the consumer's changing needs; and focuses on meeting those basic needs for persons of similar age, gender, and culture.

POLICY:

- A. A Plan of Care shall be developed for every individual receiving services.
 1. The Plan of Care shall address each of the consumer's identified needs as indicated in the assessment.
 2. Consumer's shall have access to meetings where plans for their care are made, voice in the development of those plans, and ownership in the final product.
 3. The Plan of Care shall reflect focused, short-term, and goal directed treatment.
 4. The Plan of Care shall reflect less restrictive commitment orders when present.
 5. Intervention and support strategies are normalized (e.g., developmentally appropriate; built on strengths; utilize natural

- supports and other key persons, and responsive to the consumer's culture, community, and age).
6. Consultation is sought and utilized as indicated (e.g., ethnic minority, disability, medical/psychiatric, sexual minority, age, deaf, drug/alcohol, sexual offender, etc.).
 7. Services and supports to persons other than the primary identified client shall be incorporated into the plan.
 8. Development of strategies to address needs of children should consider the balance between an individual and family approach.
 9. There is clear identification of other persons and/or systems involved in supporting the consumer, including their roles and responsibilities; any needs primary addressed by other systems are included with the strategy section articulating the role of the case manager in monitoring, coordinating, etc.
 10. A Risk Management Plan is formulated, communicated to others, and updated as necessary (see Chapter 3.11).

B. Case Management Services. The Contractor is responsible for ensuring individuals who receive case management services have a plan of action to achieve mutually agreed upon outcomes.

C. Community Support Services

1. The case manager is responsible for facilitating the development and implementation of a comprehensive Plan of Care in collaboration with the consumer and/or family to be completed within thirty (30) days of initiating community support services.
2. The Plan of Care shall be mutually reviewed at the request of the consumer, as frequently as indicated, or at a minimum of every **180 days**, for appropriateness of goals, progress towards goals, and changes needed in strategies to further goal attainment. Input shall also be solicited from significant others, and systems involved in meeting the consumer's needs (always abiding by relevant laws of confidentiality).

SEE ALSO: Chapter 2.2, Mental Health Assessment and Intake Evaluation
Chapter 2.4, Brief Intervention Services
Chapter 2.5, Community Support Services
Chapter 3.11, Individual Crisis Plan, Case Consultation and Coordination
Glossary of Terms and Acronyms