

Behavioral Health Home Care Plan Components Example

While MDHHS provides latitude to the Lead Entities (LEs) and Health Home Partners (HHPs) to develop, implement, and monitor care plans for beneficiaries enrolled in the Behavioral Health Home (BHH), the Behavioral Health Home Care Plan must align with the statutorily required Health Home core services, including: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Social Support Services. Considering this, the following table is an *example* of standards that should be considered when developing the BHH care plan for an enrolled health home beneficiary. The BHH care plan should be developed with the care team, beneficiary, and the beneficiary’s support system (e.g., family, caregiver, etc.) when able. All parties should agree to and sign off on the care plan before the plan is implemented.

Focus Area	Goal(s)	Outcome(s)
<p>Diagnosis</p> <p><i>The care plan should address and monitor the following focus areas of a beneficiary’s health. Specific goals should be developed to improve health conditions as agreed upon by the care team and beneficiary.</i></p> <ul style="list-style-type: none"> • Physical health • Behavioral health • Risk Factors/co-morbidities 	<p>Goal 1:</p> <p>Level of confidence to complete goal:</p> <p>Not Sure 0 1 2 3 4 5 6 7 8 9 10 Very Sure</p>	<p>Description:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Goal completed <input type="checkbox"/> Goal in progress <input type="checkbox"/> Goal revised <input type="checkbox"/> Goal discontinued, explanation <hr/>
<p>Patient Engagement</p> <p><i>The care plan should focus on engaging the beneficiary to achieve better health outcomes and to promote positive beneficiary behavior. The beneficiary should feel empowered to participate in their care.</i></p> <ul style="list-style-type: none"> • Readiness to change (document on a standard scale) • Patient activation • Health literacy • Goal setting and self-care plans • Coaching and support 	<p>Goal 1:</p> <p>Level of confidence to complete goal:</p> <p>Not Sure 0 1 2 3 4 5 6 7 8 9 10 Very Sure</p>	<p>Description:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Goal completed <input type="checkbox"/> Goal in progress <input type="checkbox"/> Goal revised <input type="checkbox"/> Goal discontinued, explanation <hr/>

<p>Barriers to Success/Areas of Concern</p> <p><i>The care plan should identify areas which might inhibit the beneficiary of obtaining the identified goals outlined in the care plan. Barriers or areas of concerns can include items outside of healthcare such as transportation, housing, food, medication access, social support, etc.</i></p> <ul style="list-style-type: none"> • Social Determinants of Health 	<p>Goal 1:</p> <p>Level of confidence to complete goal:</p> <p>Not Sure 0 1 2 3 4 5 6 7 8 9 10 Very Sure</p>	<p>Description:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Goal completed <input type="checkbox"/> Goal in progress <input type="checkbox"/> Goal revised <input type="checkbox"/> Goal discontinued, explanation <hr/>
<p>Plan Activation</p> <p><i>The care plan should include steps on how the beneficiary and care team will work together to achieve the goals set forth in the care plan. The beneficiary's support system should be included whenever possible.</i></p> <ul style="list-style-type: none"> • Steps to implement the plan • Agreement by patient, care team, and family/caregiver support 	<p>Goal 1:</p> <p>Level of confidence to complete goal:</p> <p>Not Sure 0 1 2 3 4 5 6 7 8 9 10 Very Sure</p>	<p>Description:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Goal completed <input type="checkbox"/> Goal in progress <input type="checkbox"/> Goal revised <input type="checkbox"/> Goal discontinued, explanation <hr/>