1. **What is a care coordination plan?** A care coordination plan provides a roadmap for the care coordinator and member to achieve the member’s desired health and psychosocial outcomes in a systematic and structured way. It outlines the problem or need; the desired outcome; and the methods and resources that are needed to achieve the goal. It also includes an expected timeframe to complete the goal.

2. **How are problems identified?** Problems are identified through the Needs Assessment process. Any gap between the member’s present state and their desired state might be identified as a problem, and problems are prioritized through discussion with the member. Ideally, the problems that are causing the most interference with the member’s health should be assigned the highest priority. Problem statements should emphasize the impact the problem has on the member and should reflect the member’s perspective. For example, “My drinking is a problem because it interferes with my job and my family relationships. I currently drink 7 out of 7 days per week, often to the point of intoxication.”

3. **How are goals established?** In most cases, a goal states what it would look like when the problem is resolved. Goals need to be concrete and measurable. For example, “I would like to control my drinking in order to improve my relationships and my performance at work. I would like to drink only on weekends and would like to drink only 2 beers on any occasion that I drink.”

4. **What are objectives?** Objectives are perhaps the most important part of the care coordination plan. Objectives are the steps that take the member from the current (problem) state to the future (desired) state. They are clear, measurable, sequential, and time-limited. The objectives will help the member and care coordinator evaluate whether progress is being made. For example, “I will make and keep an appointment with a substance abuse counselor by the end of this month.” It may be helpful to have some very simple short-term objectives to help build a sense of momentum that will motivate the patient. The objectives should list who is responsible for the task and what resources might be needed. For example, “The Care Coordinator will transport the client to the Department of Human Services office to apply for Food Stamps.” Objectives need to be SMART (small, measurable, attainable, realistic, and time-limited).

5. **How many goals should be included in a Care Coordination Plan?** Although there is no absolute rule about how many goals should be in a care coordination plan, it can feel overwhelming to some patients to have a long list of goals to complete. Additionally, if there are too many goals, each problem can lose focus and progress can stall. As a general rule of thumb, it is better to have between one and three goals on a plan. Once those goals have been addressed, the plan can be updated with new problems and goals.

6. **How often should a plan be reviewed?** Again, there is no absolute rule or requirement about how often a Care Coordination Plan should be reviewed. However, it is important to review often enough to keep both the patient and the Care Coordinator on track to achieve the patient’s goals. Minimally, it should be reviewed each time the patient visits with the Care Coordinator.
7. **What else should a plan include?** A plan should always include the signatures of the member and the Care Coordinator and the date of the plan.