Integrated Care Plan Example For NC Tailored Plans

In North Carolina's Medicaid Tailored Plans, care coordination requires a person-centered, interdisciplinary approach. This example care plan template aligns with NC DHHS guidance and ISP requirements by integrating physical, behavioral, and social needs into one shared document. It lists member demographics, strengths, goals and interventions with assigned team members and timelines, meeting NC Targeted Case Management documentation standards for roles, outcomes, and progress tracking.

Member Demographics & Diagnosis Summary

- **Name:** [Member Name]
- **DOB:** [MM/DD/YYYY]
- **Gender/Pronouns:** [e.g., Female/She-Her]
- **Medicaid ID:** [Number]
- **Address/Contact:** [City, County, Phone]
- **Primary Diagnosis:** [e.g., Schizophrenia, TBI, etc.]
- **Secondary Diagnoses:** [e.g., Diabetes, COPD, Depression, SUD, etc.]
- **Other Diagnoses/History:** [Brief relevant medical or psychiatric history]

This section captures the member's basic info and medical/behavioral health diagnoses. North Carolina TCM policy requires documenting all relevant diagnoses to guide integrated planning. (Additional demographic details, guardian or caregiver names, and communication preferences can be added as needed.)

Interdisciplinary Team Members

- **RN Care Manager:** [Name] – Oversees overall care plan implementation, coordinates with PCP and specialists.
- **Peer Support Specialist:** [Name] – Provides lived-experience support, linkage to community resources, and motivates member engagement.
- **Primary Care Provider (PCP):** Dr. [Name] – Manages medical conditions and prescribes medications.
- **Behavioral Health Clinician:** [Name/Title, e.g., LCSW or Psychologist] – Provides therapy/psychiatric care for SMI or SUD.
- **Community Health Worker (CHW)/Community Liaison:** [Name] – Assists with addressing social needs (housing, food, transportation) and care coordination outside the clinic.
- **Other Supports (if applicable):** [Family Member, Guardian, Case Worker, etc.]

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All relevant team members should be listed per NC Tailored Plan guidance. Clear role descriptions promote accountability. For example, NC regulations expect the RN case manager to “coordinate services across settings” and the peer specialist to engage members based on shared experience. These roles collaborate on a shared care plan, ensuring two-way communication.

Member Strengths and Preferences

- **Strengths:** [e.g., Motivated to improve health; has supportive family; good communicator; interest in cooking or gardening; no history of violence]
- **Preferences:** [e.g., Prefers phone/text reminders; enjoys group therapy; values independence; likes outdoors activities; concerned about childcare arrangements]
- **Cultural/Language:** [e.g., Speaks Spanish, Christian faith, culturally values community gatherings]

Highlighting strengths and preferences ensures a person-centered plan. NC care coordination guidance emphasizes building on individual strengths and honoring preferences (communication, cultural needs, etc.) when developing goals. For example, noting that the member prefers evening appointments or values peer-led groups can guide interventions.

Physical Health Goals

- **Goal 1:** Control diabetes – achieve **HbA1c < 7%** within 6 months through diet, exercise, and medication adherence (currently 9%).
- **Goal 2:** Manage hypertension – reduce **BP to < 130/80** by next quarter, through medication and lifestyle changes.
- **Goal 3:** Increase activity – walk 30 minutes **4 times/week** for 3 months to support weight management.
- **Goal 4:** Complete preventive care – schedule and attend annual wellness exam and necessary screenings (e.g., mammogram, colonoscopy) within 3 months.

These goals target identified medical issues. NC documentation standards encourage setting SMART goals (Specific, Measurable, Achievable) for physical health, with assigned providers (RN, PCP) to support monitoring. Each goal should have clear metrics (e.g., lab values, blood pressure targets).

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Behavioral Health Goals

- **Goal 1:** *Symptom Management:* Reduce symptoms of [Disorder, e.g., depression] – **PHQ-9 score < 5** in 3 months, through therapy and/or medication management.
- **Goal 2:** *Substance Use:* Achieve **30+ days sober** within 3 months; attend weekly support group or counseling.
- **Goal 3:** *Coping Skills:* Practice two new coping strategies (e.g., deep breathing, mindfulness) to manage anxiety by 2 months.
- **Goal 4:** *Engagement:* Attend at least **90% of scheduled therapy/psychiatry appointments** each quarter to maintain stability.

Behavioral health goals address mental illness and/or SUD. NC Tailored Plan ISPs explicitly require goals for behavioral health and co-occurring conditions. Assigning both a clinician and peer support helps reinforce goals. Outcomes should be measurable (e.g., standardized scores, attendance rates).

Social Determinants of Health Goals

- **Housing:** Secure **stable housing** within 3 months (e.g., obtain voucher or complete shelter application).
- **Food Security:** Enroll in SNAP or a food assistance program within 1 month; participate in community meals or pantry support.
- **Transportation:** Obtain consistent transportation (e.g., bus pass or ride service) in 1 month to attend all appointments.
- **DV/SA Safety:** If applicable, develop a **safety plan** for domestic violence or sexual assault within 1 month; connect with appropriate advocates.
- **Other Needs:** Address [e.g., employment, childcare, legal issues] by [target date] via referrals to job training, childcare subsidies, or legal aid.

NC policy requires that plans address SDOH factors affecting health. By setting explicit goals (like housing and food), the plan integrates social needs. Each goal ties to an intervention (e.g., CHW referral) and has a timeline for accountability.

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Interventions and Responsibilities

The table below outlines specific interventions/actions, the assigned team member(s) responsible, and timelines/outcomes. This format reflects best practices for clarity and accountability. Providers should add dates and notes under "Progress Updates" as actions occur.

Intervention/ Action	Assigned To	Timeline	Expected Outcome/Notes	Progress/Date
Diabetes management: RN to provide education and monitor blood glucose logs; coordinate PCP visits for medication adjustments.	RN Care Manager, PCP	Monthly	Member logs blood sugar daily; A1c decreases per goal.	
Medication adherence check: RN and Peer check in weekly to ensure psychiatric medications are taken as prescribed.	RN Care Manager, Peer	Weekly	Adherence documented; symptoms remain stable.	
Therapy appointments: BH Clinician schedules individual therapy; Peer Specialist invites member to weekly support group.	BH Clinician, Peer	Weekly therapy; Peer-group 2×/mo	Member attends ≥75% of sessions; reports 2 coping skills learned.	
Nutrition and exercise: CHW refers member to nutritionist; RN sets up exercise program (e.g., gym voucher or walking group).	CHW/Community Liaison, RN	Refer by 2 wks; program 3 mos	Member reports improved diet; weight or BMI goal reached.	

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Intervention/ Action	Assigned To	Timeline	Expected Outcome/Notes	Progress/Date
Housing assistance: CHW completes housing application; contacts local housing coordinator.	CHW	1–3 months	Member obtains [type of housing]; moves in by target date.	
Food assistance: CHW assists with SNAP/food pantry enrollment; Peer connects to community kitchen.	CHW, Peer	1 month	Member has food aid; reports regular meals.	
Transportation support: CHW arranges bus pass or ride-share account.	CHW	2 weeks	Member attends all scheduled appointments reliably.	
DV/SA Safety Plan: BH Clinician and Peer help develop a safety plan if DV/SA risks exist; refer to advocacy services.	BH Clinician, Peer	1 month	Member has written safety plan and contacts if needed.	

Each row above should be updated with date and notes when completed or at each review. This table should be filled out collaboratively; NC documentation rules call for assigning responsibilities and timelines in care plans. Expected outcomes provide measurable targets (e.g., “member reports X” or lab values). The Progress/Date column is for team members to sign off or note developments, ensuring ongoing communication.

Progress Updates and Documentation

- **Regular Updates:** Each team member should update the care plan when interventions occur. For example, after a nurse visit, the RN adds the date and notes on adherence or education provided. The peer specialist notes attendance at support groups, and the CHW records housing application status. This two-way communication keeps everyone informed.

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- **Status Notes:** In progress columns, use status markers like "Completed," "In Progress," or "Rescheduled," with dates. NC Tailored Plan policy mandates documenting progress or reasons for unmet goals in the plan.
- **Review Schedule:** The care plan should be reviewed at least every 3–6 months or whenever the member's needs change. NC guidelines require annual ISP updates at minimum. At each review, adjust goals and interventions as needed.
- **Signatures:** Consider a final section or cover page for team members' signatures or initials with date to confirm they've reviewed the updated plan. This ensures accountability per NC documentation standards.

Example Progress Entry: On 06/01/2024, RN notes: "Member's A1c down to 7.8%; continuing metformin. Will increase exercise plan." On 06/05/2024, CHW notes: "Submitted SNAP application; member approved starting 7/2024."

Usage Notes

- The care plan is a **living document**: update it in real time and share with all team members. According to NC Tailored Plans, plans should be shared care plans – meaning accessible to the member and the interdisciplinary team.
- Maintain confidentiality while documenting. Only include sensitive details in sections accessible to appropriate team members.
- Align this plan with any formal **Individualized Service Plan (ISP)** or medical care plan as required. NC guidance suggests integrating or linking ISPs with this care plan format for consistency.

References: This template is based on NC DHHS Tailored Plan care coordination policies and ISP guidelines, which emphasize person-centered goals, interdisciplinary roles, SDOH inclusion, and clear timelines. It reflects best practices for accountability and communication among team members. For example, NC policy states that "interventions must be assigned to specific members of the care team with timelines and measurable outcomes", as illustrated above.