**For use if POC embedded in EMR**

**Care Plan Template:**

*Include date POC developed & CM name/credentials (if EMR auto dates entry, that is fine)*

Member’s Goal Priority (High, Medium, Low):

Member SMART goal:

Target date to reach goal:

Goal achieved date:

Barriers to meet goal:

CM Interventions to help member reach goal:

Member actions or self-management plan to reach goal:

Member acknowledges / agrees with interventions and goal? *(Yes/No)*

Does member have an Advance Directive (or POLST/5 Wishes, etc.)?

**(\*SMART = Specific, Measurable, Attainable, Realistic, Timebound)**

**Care Plan Follow Up Notes:**

*Include date of follow up and CM name/credentials (if EMR auto dates entry, that is fine). Doesn’t necessarily need a separate note for Follow Up – just need to be able to document CM interventions provided and Member progress.*

CM Intervention Provided:

Member Progress towards Goal: