INSTRUCTIONS FOR MY CARE PLAN AND COMMUNITY SUPPORT PLAN

INFORMATION ABOUT ME

1.	**Member Name.**
2.	**Health Plan ID Number.**
3.	**Health Plan Name.**
4.	**Care Plan Completion Date.** Date the care plan is completed.
5.	**Member Phone Number.**
6.	**DOB** (Date of Birth). Enter member's date of birth.
7.	**Member Product (MSHO, MSC+) Enrollment Date.** Enter member's date of enrollment and the current product. For example, if a member continues with the same health plan but switches from MSHO to MSC+ on 1/1/2016, the Care Coordinator/Case Manager would enter 1/1/2016 as the product enrollment date on the care plan.
8.	**Member Address.**
9.	**Rate Cell.** Enter the member's Rate Cell (A, B, D, E). A= Community non-EW; B=Community EW; D=Nursing Home; E=Hospice.
10.	**Diagnosis.** Enter the member's diagnosis. This box allows for multiple diagnoses.
11.	**Assessment Date.** Enter the date the assessment was completed.
12.	**Assessment Type.** Choose the type of assessment done.
13.	**Is there an Advanced Directive or Health Care Directive in place?** Check yes or no. Document that a discussion occurred by checking yes or no. If no discussion occurred, document reason.
14.	**Primary Language.** If the member's language is not on the list, check "Other" and document their language in this section. Is an interpreter needed? Check yes or no. Enter the name and number of the interpreter, if applicable.
Interdisciplinary Care Team (ICT). The composition of this team will vary based on an individual member's assessment. The care coordinator uses professional judgment and experience when establishing an interdisciplinary team's membership. The role of the ICT is to provide assistance in maintaining and maximizing the member's functional abilities and quality of life. Interdisciplinary teams consist at a minimum of the member and/or his/her representative; the Care Coordinator, and the primary care practitioner (PCP).	
15.	**Name of Care Coordinator (CC)/Case Manager (CM) and Phone Number.**
16.	**Primary Physician.** Enter the name, phone number, and fax number of member's primary care provider.
17.	**Clinic.** Enter the name of the member's primary care clinic.
18.	**Emergency Contact.** Enter name and phone number of the person who should be contacted in case of an emergency.
19.	**Member's Representative** (if applicable). Representative is anyone the member delegates, either formally (e.g., Authorized Representative for county paperwork, power of attorney; legal guardian; conservator) or informally (e.g., family member) to act on member's behalf. Please indicate what the representative can be contacted for. Not all representatives would need to have access to all information. Best Practice Recommendation: Obtain a copy of the legal documents if the representative is formal.
20.	**Mental Health Targeted Case Manager.** Check yes or no. If, yes, enter name and phone number.
21.	**Other Interdisciplinary Care Team Members.** Enter names of additional ICT members and their relationship to the member. Examples of other team members may include but is not

	limited to other physicians, specialists, psychiatrist, psychologist, etc. Document yes or no if the member would like the care plan shared with these ICT members. If, yes, enter the date the care plan is sent.

WHAT'S IMPORTANT TO ME?

22.	Enter information and preferences the member identifies as important to them. (i.e., their culture, beliefs, dignity, living close to family, visiting friends, attending church). Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include six-month check-ins or any other updates throughout the year.

MY STRENGTHS

23.	**Member's Strengths.** Include a list of the member's skills, talents, interests and general information about themselves. (i.e. is a strong advocate, enjoys being social) Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include six-month check-ins or any other updates throughout the year.

MY SUPPORTS AND SERVICES

24.	Enter member's preferences for services and supports. Includes person-centered choices for support and services that the member finds important to achieve or maintain independence. Also discuss if the support requested is formal or informal. These supports and services could be a part of the members Self-management plans which are activities undertaken by members to help them manage their condition. Examples of these would be member asking for help maintaining a prescribed diet, taking medications as directed, charting daily readings, changing a wound dressing as directed, management of equipment. Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include six month check-ins or any other updates throughout the year.

CAREGIVER

25.	**Caregiver Listed on HRA/LTCC. A caregiver is someone who provides unpaid support or is paid but goes above what they may be paid to provide.** (Example, though daughter is paid for 3 hours of PCA but is providing 24-hour support. Check yes or no. If yes, check appropriate box indicating how the caregiver assessment form was completed or if it was declined. Enter the date it was completed or mailed.

MANAGING AND IMPROVING MY HEALTH CC/CM should have an educational conversation with the member or member's authorized representative about applicable health prevention/chronic conditions listed—***Target levels were verified by Geriatric Physician. If applicable member should be referred to physician to discuss further action***

26.	**Check the box if an educational conversation took place.** If the educational conversation did **not** take place, see #28 and/or add any applicable documentation in the Notes column
27.	**Check the box if goal is needed.** If the member needs assistance with a risk or identified need, create a goal in Section VII.
28.	**Check applicable box if the Condition/Screening or goal is not applicable, contraindicated, or declined.**
29.	**Notes.** Free form area for any additional applicable information such as date of the screening or scores or reason for declining a goal.
	Annual Preventive Health Exam
	Mammogram (Within past 2 years ages 65-75)
	Continence needs (Evaluated by a physician)
	Colorectal Screening (Up to age 75)
	At Risk for Falls (Afraid of falling, has fallen in the past)
	Pneumovax (Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago &before age 65)
	Flu shot (Annually ages 50+ and persons at high risk)
	Tetanus Booster (Once every 10 years)
	Hearing Exam
	Vision Exam
	Dental Exam
	RX for Calcium Vitamin D. CC/CM should advise member to check with their doctor before taking medication and take as directed.
	RX for Aspirin. CC/CM should advise member to check with their doctor before taking medication and take as directed.
	Blood Pressure. (Goal is <140/80 to age 75. After 75 based on individual
	Cholesterol Check.
	Diabetic routine checks as recommended by physician. CC/CM should inquire whether a member with diabetes has routine diabetic checks with their doctor. If not, CC/CM should encourage the member to schedule a visit and attempt to create a goal to address this in Section VII. CC/CM should review and discuss with member patient education topics such as the importance of an additional diagnosis of Hypertension; neuropathy; eye exam; cholesterol (i.e. diet); and knowing their A1C.
	Other. Enter any other test or condition not addressed in this section.
	Mental Health Diagnosis (if applicable) Check N/A if no mental health diagnosis. If there are mental health diagnosis, CC/CM should review whether their diagnosis is being managed by other health professionals (Psychiatrist, Psychologist, Primary Care Physician). Check either "yes" or "no". The CC/CM should also explore if a goal is needed. Check either "yes" "no" or "Declined".
	My Medications. CC/CM should discuss whether member needs help with their medications? ? Check yes or no or not applicable. If, yes, attempt to create a goal with the member to address this.
	List of Medications. If not on HRA/LTCC or other form.

	Health Improvement Referral. Check yes, declined, or N/A. If yes, include the diagnosis. *All health plans have different diseases and processes for their Disease Management Programs; please check with the member's health plan for direction.*
	Hospitalizations. Document the number of hospitalizations in the past year, dates (if available) and the reason for each one. Reminder: The CC/CM must complete the required transitions of care (TOC) activities and "Transition of Care Log" if not previously done. See TOC Log and Instructions for further information.
	ER visits. Document the number of ER visits, dates (if available) in the past year and the reason for each one.

MY GOALS Goals for: everyday life (taking care of myself or my home); my relationships and community connections; my safety; my heath; and my future plans.

30.	**Rank by Priority.** Care Plan goals should be prioritized. When ranking the goals, the CC/CM should consider the member's specific situation or condition as well as their and their caregivers, needs and preferences. Member's preferences may include, for example, care or services that are in accordance with the member's desire to remain in their own home and to maintain their independence and current daily activities. Member's social needs and personal preferences can drive activities, supports and care coordination service. An understanding of these areas is useful for creating an individualized and person-centered care management plan. Goals can be documented in any order, as long as the order of priority is clear. Care plan must contain at least one high priority goal. Prioritizing goals is a member centered activity. **There is no right or wrong way as long as the member/responsible party is involved.**
31.	**My Goals.** List appropriate member centered goals to meet the risks identified by the member or found during the HRA/LTCC, or other related member documentation. Goals should be SMART (Specific, Measurable, Attainable, Relevant, and Time-bound. (The first known usage of the term was by George T. Doran in 1981.)
32.	**Support Needed.** Document any intervention(s) related to achieving this goal: What will the member need to accomplish the goal and how will the CC/CM help the member achieve the goal?
33.	**Target Date.** List the target date (month/year) for completion of the goal. "On-going" "yes" or "no" are not acceptable target dates. Members should have at least one "active" or "open" goal on their care plan and the target date should extend to the next annual assessment.
34.	**Monitoring Progress/Goal Revision Date.** This column should be used to document progress during the 6-month contact and/or as needed throughout the year. The CC/CM should have a discussion with the member about each goal and the member's progress toward meeting a goal. This discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward. The CC/CM should document the date (month/year) of the review and a brief progress note. Reminder: The plan of care is a "living document" that should be updated at minimum twice a year. Best Practice Recommendation: The CC/CM should document their monitoring of the care plan and/or updates directly on the care plan. If CC/CM uses case notes to document progress on goals, the progress regarding **each** goal should be clearly addressed in the case notes.
35.	**Date Goal Achieved/Not Achieved.** This column is used to document the goal outcome. Document the date (month/year) the goal was achieved or if not achieved, the date (month/year) it was reviewed. This column may also be used to document progress notes. And must, at minimum, include the final outcome of each goal at annual reassessment (e.g., goal discontinued, modified, or carried forward to next year's care plan).

BARRIERS TO MEETING MY GOALS

36.	Care Coordinators/Case Managers Document member identified barriers that may prevent them from meeting their goals. If the member does not identify any barriers the CC/CM should document that a discussion took place. This is also an area where the CC/CM can document if the member is unable to participate in the care plan due to cognitive/mental health reasons. Barriers could include: language or literacy, lack of or limited access to reliable transportation, a member's understanding of their condition, financial or insurance issues, cultural or spiritual beliefs, visual or hearing impairments. If there are no barriers mark the box to indicate NO barriers identified. Complete the first row at the initial/annual assessment. Updates should be entered in the second row. Updates include six-month check-ins or any other updates throughout the year.

MY FOLLOW UP PLAN

37	**CC/CM Follow-Up Plan.** Check box that describes frequency of follow-up contacts or visits; e.g., once a month, every three months, every six months, or "other". If "other" is selected, describe frequency. **Enter the purpose of CC/CM contact** (i.e., six month face-to-face to check on member's goals, follow-up on services that are currently in place, assess if new services are needed). The CC/CM reviews with the member the list of reasons that they can or should contact their CC/CM.

MY SAFETY PLAN

38.	**Safety Plan** CC should review members identified safety concerns and the services/supports documented in the members care plan and enter "Yes". Though additional notes are not required, there is additional room in this section for any notes the CC wants to add. If there are identified health and safety risks document how these will be addressed with services or the members plan for managing risk. If the member doesn't have a plan because member doesn't have risks identified or doesn't believe they have any risks, then CC should note that on this section of the care plan. If the CC offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted in this section.
39.	**Emergency Plan.** Discuss and document with the member/ representative what the member would do in case of an emergency.
40.	**Self-Preservation/Evacuation.** Describe evacuation plan for a member who cannot evacuate independently; e.g., customized living evacuation procedure would be followed. Describe other self-preservation concerns or plans; e.g., member at risk for financial or physical abuse: what is the plan to address risk?
41.	**Essential Services Backup Plan.** Essential services are services that if the member did not receive them, the member's health or ability to maintain safety in their home would be compromised. If the member has essential services document what the providers back up plan is as agreed to by the member. Example, the member's only source of nutrition is Meals-on-Wheels, then it is an essential service.

42.	**Community-Wide Disaster Plan.** Enter the member's/ representatives plan in the event a community wide disaster occurs such as a flood, tornado, blizzard, etc.
43.	**Additional Case Notes.** Free form text field for CC/CM to document anything not covered in another area.

CHOOSING COMMUNITY LONG TERM CARE— *Member/ Representative checks the boxes*

44.	**I have been offered a choice of home and community based services or nursing home services if needed:** The member/representative checks yes or no.
45.	**I have been offered a choice of different types of services that can meet my needs:** The member/authorized representative checks yes or no.
46.	**I have been offered a choice of providers:** The member/authorized representative checks yes or no.
47.	**I have annually received my appeal rights**: Inform member/authorized representative that their annual appeal rights are sent with any DTR and with their annual Evidence of Coverage (EOC). The member/authorized representative should check yes or no. CC/CM can direct member/authorized representative to customer service if they need a copy of the appeal rights documents.
48.	**I am aware that healthcare information about me will be kept private (Data Privacy rights):** Inform member/authorized representative that their privacy rights are sent annually. The member/authorized representative should check yes or no. CC/CM can direct members/authorized representative to customer service if they need a copy of their EOC, which contains data privacy information.
49.	**I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want:** The member/authorized representative checks yes or no.
50.	**I agree with the plan of care as discussed with my care coordinator/case manager:** Check yes or no.
51.	**Sharing Care Plan Information with EW Providers and PCA Providers (if applicable) /Provider Signatures:** Discuss with member or representative the CMS requirement of sharing their pertinent care plan information and support instructions with EW and PCA (if applicable) providers to help them deliver their services in a person-centered manner. And that EW and PCA (if applicable) providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined. **Notes:** Residential Services Tools or Individual Community Living Supports Planning Forms may be sent to providers for signature in lieu of this requirement if the member has made an informed choice to do so. This requirement does not apply to the following: • Community Well persons who have PCA but is not on Elderly Waiver;

	• Durable Medical Equipment, • Approval-option: purchased-item services (formerly Tier 3), • Consumer Directed Community Supports (CDCS). • Personal Emergency Response Systems (PERS) **Choice #1**: Inform the member that their care plan information may be shared in either format: • Complete Care Plan, or • Care Plan Summary Letter **Choice #2**: Inform the member they may decide to share care plan information only with selected EW and PCA (if applicable) providers. **Choice #3**: Inform the member they may also decide to share no care plan information with EW and PCA (if applicable) providers. The member/representative checks the box corresponding with their choice.
	Provider 1 – 5: Enter the name of each provider and check the box corresponding with the member's choice of sharing: Complete Care Plan or Care Plan Summary Letter or none. If member chooses <u>not</u> to share any care plan information with <u>any</u> EW and PCA (if applicable) provider, the member checks the corresponding box and the CC does not need to complete this section.
	Complete Care Plan: If member chooses to share the entire care plan, the Care Coordinator must do the following: 1. Send a copy of the entire care plan along with a; 2. Completed Provider Care Plan Cover Letter to each of the selected EW providers for signature within **30 days** of the date the care plan was completed. Included in the cover letter is an area the care coordinator should enter timeline for monitoring the services; instructions for the provider to sign and a timeframe for return when reviewed and, if applicable, support instructions. 3. Keep a copy of this letter in the case file. Best practice is to document the date it was sent in your case notes. 4. Follow-up attempt for EW provider signature must be done within **60 days** of the date the plan was completed. a. Document this follow-up attempt in your case notes. **Care Plan Summary Letter:** If the member chooses to share a care plan summary, the CC must do the following: 1. Complete the Provider Care Plan Summary Letter for each of the selected EW providers. The care coordinator must enter support instructions, implications and member goals related to the service provided along with a timeline for monitoring. In addition, there are instructions for the provider to sign and a timeframe for return when reviewed. 2. Send to the selected providers for signature within **30 days** of the date the care plan was completed.

	3. Keep a copy of this letter in the case file. 4. If the provider does not return the signature sheet the Care Coordinator must make an additional attempt to obtain the signature within **60 days** of the date the plan was completed. 5. Document this follow up attempt in your case notes. Changes to service plan see #60 below.
52.	**Member/ My Representative Signature and Date.** CC/CM must obtain signature.
53.	**Care Coordinator/Case Manager Signature and Date.**
54.	**Enter the Date Care Plan was Mailed/Given to the Member.**
55.	**Enter the Date Care Plan or Summary was Mailed/Given to PCP** (Verbal, Phone, Fax, Electronic Medical Record).

HOME AND COMMUNITY BASED SERVICE PLAN/BUDGET WORKSHEET: DHS's audit protocol requires documentation of type of service; amount, frequency, duration and cost of each service; and type of service provider, including non-paid caregivers and other informal community supports or resources. Services/Supports should be based on a determination of available benefits and resources. In addition, documentation of all services offered to the member must be present on the care plan. Fully completing this (or a similar) budget worksheet provides the required documentation for these audit elements as long as it incorporates all services offered.

56.	**Services Offered, if appropriate.** Mark "X" if service was offered. If member accepts, fill in applicable sections below. If the CC offers a service that is critical to the member's health and safety that is not accepted by the member, this should be noted in the safety plan section.
57.	**Formal/paid services authorized:** For each formal paid service that the member accepts, the CC should type in the name of the provider; from the drop down select the service provided; enter the schedule/frequency, start/end dates, and total cost per month.
58.	**Informal, Non-Paid Community Supports or Resources**. The CC should complete this section for each informal, non-paid supports and resources for which the member is receiving assistance. CC should complete the columns with the informal providers name, service provided and schedule/frequency. For example: (volunteers doing yardwork; or daughter assisting with a meal, bill paying, etc.)
59.	**Additional comments:** Optional free form text area for CC notes.

UPDATES TO THE SUPPORT PLAN The following must be done when there are changes to the plan that affect how the Elderly Waiver and PCA (if applicable) service is provided (i.e., changes in hours/units, change in provider, or addition of a new provider). Note: These requirements do not change the DTR process

60.	**Updates to the Support Plan—Discussion with the Member:** The Care Coordinator should discuss, with the member or representative, the change in service (frequency, new provider, etc.) and what changes, if any, are made to the member's care plan information, support instructions, implications and member goals related to the service change. Review with member or representative the CMS requirement of sharing their pertinent care plan information and support instructions with EW and PCA (if applicable) providers to help them deliver their services in a person-centered manner. And, that EW and PCA (if applicable) providers must sign to indicate their acknowledgement of the services and supports in the plan and their agreement to deliver them as outlined. As in #51 above the member should decide how they want their updated care plan information shared with the EW and PCA (if applicable) provider (either a copy of their updated care plan, care plan summary letter, or share no information). Come to an agreement with the member on these decisions and inform the member that you will be sending them a letter that they need to sign and return acknowledging their agreement to the change. The member should also decide if they want to receive a copy of the updated care plan or the budget worksheet. Complete the following steps. 1. Update the budget worksheet as applicable 2. Update any other applicable sections of the care plan 3. Complete a Member Service Change Letter 4. Enclose a copy of the updated budget worksheet **or** the full care plan per their choice above 5. Send it to them for their signature 6. Document this discussion in a case note (see page # for a sample case note). 7. **Share Care Plan Information with EW and PCA (if applicable) Providers/ Provider Signatures.** If the member agreed to share this updated care plan information with the EW and PCA (if applicable) provider, follow the steps for sending the information and obtaining provider signature as outlined in #51 above.

ADDENDUMS

GOAL EXAMPLES Goals should be SMART (Specific, Measurable, Attainable, Relevant, and Time-bound. (The first known usage of the term was by George T. Doran in 1981.)

My Goals	Rank by Priority	Support Needed	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
I want to be smoke free	☐**Low** ☐**Medium** ☒**High**	-I will schedule appointment with PCP to discuss smoking cessation aides -CC will provide information regarding Health Plan's quit line -I will take OTC products or medication as prescribed by PCP	3/2016	9/20/2015 – Has talked with PCP about smoking cessation. No OTC products or prescriptions used at this point. Member developed plan with quit plan representative. Has cut down to 5 cigarettes/day. Priority changed to Medium	3/15/2016- Goal Met. Member has been smoke free since 1/1/2016. Goal modified on next care plan to "member will remain smoke free".
My PTSD signs/symptoms will be under control as evidenced by my sleeping at least 4-6 hours per night	☐**Low** ☒**Medium** ☐**High**	-I will take sleep aide medication as prescribed -CC will provide information on MH supports and refer as needed -I will contact MD if signs/symptoms worsen for possible medication adjustment	3/2016	9/20/2015-Reviewed with member at 6 month check-in. Member reports she has been sleeping at least 4 hours most nights.	Reviewed 3/15/16- Member stated she has been sleeping well at night (at least 4 hours each night). Goal met, member would like to continue. See goal on new Care Plan.
I want my Congestive Heart Failure to remain stable	☐**Low** ☐**Medium** ☒**High**	-I will follow cardiac diet -I will do regular w-Weight checks -I will take cardiac meds daily -I will utilize health coach referrals	9/2016	3/2015 Member states she follows cardiac diet, no calls needed to MD for weight gain	

CASE NOTE EXAMPLE FOR CHANGE IN EW SERVICE TYPE

Case Note Title:	**<u>Change in (type) Service</u>** (be clear about what the service is)
Discussion with member	Include detail about what the change in service is (i.e., changes in hours/units, change in provider or addition of a new provider, etc.) and what changes are made to the member's Care Plan. • Document members choice of sending a copy of the updated budget worksheet **or** the full care plan to them for their signature and returned to CC. and • Document members decision to share care plan information with this EW provider and which format (copy of care plan or care plan summary). or • If member does not want care plan information sent to this EW provider, document that.
Document date sent to member	Include what was sent and how it was sent. I.e.: CC mailed cover letter and updated budget worksheet to member for their signature and instructions for returning signature page to CC for member file.
Document date sent to provider	Include what was sent and how it was sent (I.e., CC faxed Care Plan Summary letter or copy of updated care plan with service change details to provider for signature and instructions for returning signature page to CC for member file.)

<u>Example Case Notes:</u>

7/10/17 Change in XYZ Homemaking Service *- CC talked with member on the phone about her approved request for an increase in homemaking hours from 2 hours/week to 3 hours/week due to her decreased mobility after breaking her foot. Member is in agreement with the plan and wants a copy of the updated budget worksheet sent to her for signature. Informed member that CC will send her a summary letter along with updated budget worksheet instructing her to sign and return. Discussed sharing her pertinent care plan information and support instructions with XYZ provider. Member decided to share a care plan summary with XYZ provider.*

7/11/17 CC mailed cover letter and updated budget worksheet to member for signature with instructions for returning signature page to CC for member file.

7/12/17 CC faxed Care Plan Summary Letter with service change to Homemaking provider for signature with instructions for returning signature page to CC for member file.

8/1/17 CC received signed member signature page for change in Homemaking Service hours. CC attached document to member's Care Plan.

8/1/17 CC received signed provider signature page from Homemaking provider for change in homemaking service hours. CC attached document to member's Care Plan.

8/15/17 ***Change in Homemaking Service – 2nd attempt*** *CC made follow-up phone call to homemaking provider; and left a detailed message reminding provider to sign and return the signature page that was faxed to them by CC on 7/12/17. Advised provider to contact CC if they have any questions about this.*