# CARE PLAN

# INSTRUCTIONS

DOEA Programs and Services Handbook
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# CARE PLAN INSTRUCTIONS

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## OVERVIEW:

### Introduction:

This Attachment describes how to develop a care plan. The care plan form, DOEA Form 203A (and DOEA Form 203B for additional pages), is designed to assist the case manager in developing and documenting client care needs, community resources available to meet needs and costs associated with care.

### Guiding Principles:

Several principles guide the care plan development:

**A.** Every client should have a current care plan addressing problems identified by the assessment.

**B.** The care plan is based on an assessment as well as observations made between reassessments. It is a holistic evaluation of the client's situation, regarding transportation, finances, medication, mental health, substance abuse, etc.

**C.** The care plan provides a clear picture of the client's needs and identifies services that will be provided to meet the identified needs. It specifies service interventions, frequency and intensity offered, and the expected outcome.

**D.** The care plan will include DOEA-funded services, services provided by insurance companies, family caregivers, local United Way entities, health care taxing districts, and non-DOEA funded services and activities provided by community resources, volunteers, friends and family.

**E.** The client's coping skills and adaptability are assets and should be considered in developing the care plan.

**F.** Client choice and autonomy are important and should be considered in the care planning process.

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## CARE PLANNING CONCEPTS:

### General Concepts:

**A.** Effective care planning is:

1. Client-focused.
2. Derived by the assessment.
3. A team effort with the client/client representative, caregiver, and case manager.
4. Conscious of the cost of care and the safety of the client.

**B.** The resulting care plan will:

1. Respond to the appropriate amount of care required by the client and caregiver, allowing for choices.
2. Be proactive when possible and preventive in nature.
3. Commit a variety of providers to provide services.
4. Include DOEA and non-DOEA funded services and activities.
5. Be for a specific time period, addressing short-term as well as long-term problems.

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## The Four Steps in Developing a Care Plan:

**A.** Use the assessment information.

**B.** Actively involve the client/client representative, caregiver, and existing support systems.

**C.** Apply professional knowledge and judgment in using all community and family resources.

**D.** Apply client choices and reflect the client's preferences.

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## CARE PLANNING CONCEPTS: USE THE ASSESSMENT INFORMATION:

Develop the care plan with the client and the caregiver within 14 business days after the completed assessment. Begin the care plan by reviewing the client's assessment and identifying the appropriate services required by the client. All issues identified should be addressed by the care plan, even if services/resources are not currently available to meet all of the needs. The following information should be gleaned from the assessment summary:

**A.** Functional deficits, problems and health conditions, including aspects of medication management and nutrition.

**B.** Coping skills, adaptability and preferences.

**C.** Supports the client currently has in place, as well as current and potential service gaps.

**D.** Caregiver issues.

**E.** Environmental issues.

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## CARE PLANNING CONCEPTS: ACTIVELY INVOLVE THE CLIENT/CLIENT'S REPRESENTATIVE, CAREGIVER AND EXISTING SUPPORT SYSTEMS.

The existing persons/resources providing help to the client will be supported by planned services, not replaced. DOEA and non-DOEA services/resources will fill in gaps in the client's present support system. Throughout the planning process and as service provision continues, the client/client's representative and caregiver will help to evaluate how effective the services/resources are and plan together for needed changes.

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## CARE PLANNING CONCEPTS: APPLY PROFESSIONAL KNOWLEDGE AND JUDGMENT IN USING COMMUNITY RESOURCES:

The goal is to help elders to age in place with security, purpose, and dignity in an elder-friendly environment. Thus, it is important to know what services and activities are available in the community to support elders.

**A.** Learn as much as possible about the client's situation, including caregivers, employee assistance programs, insurance, etc. With input from the client and caregiver, the case manager can determine if the client can participate in his or her own care, including whether or not the client can pay for some of the services.

**B.** Find out what coping skills the client has and the client's adaptability. Then, decide how much care the client needs, the services the client will receive, and the client's choice in service providers.

**C.** The client should be empowered to choose the services that best meet his/her needs, from service providers of his/her choice. Services should be scheduled in a delivery method that complements the client's lifestyle.

1. However, when clients need more assistance with managing their care and handling their activities of daily living, it is important to identify help to be provided by family, volunteers, and others.

2. Consider which DOEA and non-DOEA funded services and activities are available to best meet the client's needs.

3. Consider all options, including insurance, employee assistance, and faith-based programs.

**D.** Become familiar with the services and community resources available. Following are suggested ways to learn what is available:

1. Talk with veteran case managers.

2. Use the resource directories produced by organizations and associations in the area, and the phone book.

3. Check with local employers and review insurance coverage.

4. Contact health care taxing districts, (local government entities which collect funds for a specific cause, such as health care).

5. Contact participants in the local service network, following agency protocols:

    a. Senior Centers.

    b. Area agencies on aging.

    c. Community Care for the Elderly provider agencies.

    d. Elder Helplines.

    e. Department of Children and Families.

6. Consider all sources of help:

    a. Families, friends and volunteers.

    b. Churches, temples, synagogues or other religious groups.

    c. Local service clubs and civic organizations.

    d. Local taxing districts.

E. Develop a comprehensive list of possible resources. Learn the specifics of services offered by each provider and be aware of eligibility requirements for each.

F. Identify a key person and a backup contact with each provider. Write down phone numbers and when key persons are available.

1. Use available services, including services covered by insurance companies and employee assistance programs.

2. Consider how to enhance the client's quality of life within the context of his or her life situation.

## CARE PLANNING CONCEPTS: APPLY CLIENT CHOICES AND REFLECT THE CLIENT'S PREFERENCES.

### CLIENT AND CAREGIVER DIRECTED OPTIONS:

**A.** Involving the client and caregiver allows for autonomy and choice. Autonomy is self-determination and freedom from unnecessary dependency and having choices in available services and providers. The following guidelines will help:

1. Find out from the client and caregiver what amount of help is acceptable.

2. Case management is a required service. Do not mandate other services as a condition for opening the case, if a client does not want a particular service.

3. Provide enough information about available services and provider options so that the client/client representative and caregiver can make an informed decision.

4. Do not arrange for others to perform activities that the client or caregiver is able to do.

5. Exhibit cultural and linguistic sensitivity when working with clients, caregivers, and family members.

6. Remember clients and caregivers have the right to accept or decline particular services, providers, or other care arrangements.

**B.** Discuss the following topics with the client/client representative and caregiver:

1. **Assessment results:**

   **a.** Explain the assessment results.

   **b.** The assessment results allow the case manager to assist the client to identify service needs and resources that help the client remain living safely in the least restrictive setting, appropriate to the individual's needs.

2. **Client goals:**

   Document the client's preference in services, providers, and scheduling.

   **a.** Discuss the client's coping skills and adaptability to determine how to fill in gaps.

**b.** Discuss the client's preference of care to determine desired results.

**c.** Understand what the client would like to achieve. What problems does the client currently communicate the need to overcome?

**3. Expectations about services:**

Inform the client and the caregiver of both DOEA and non-DOEA services and resources available.

**a.** Inform the client and caregiver that programs have lists of service providers from which clients may choose.

**b.** Discuss the frequency and duration of services to be arranged and the alternatives.

**c.** Encourage clients and caregivers to participate in decisions and arrange services according to those which are acceptable and appropriate.

**d.** Ask the client and caregiver to identity resources they would like to use.

**e.** Emphasize that priority is given to the most frail and that resources are limited.

**4. Cost of care:**

Discuss service costs, co-pay (CCE and ADI only) and the possibility of Medicaid eligibility.

**5. Quality assurance:**

Inform the client and caregiver that within two weeks following the start of services, a telephone call or visit will be made to determine if services are being provided as planned and if the client is satisfied with services, or if the client wishes to change providers.

**a.** Additional contacts may be made as needed, based upon the client's needs.

**b.** Explain to the client and caregiver that there may be changes, reductions, or terminations in services at the time of the review, based upon the client's needs and achievement of specific goals.

c. Talk with the client and caregiver to determine the effects of service delivery in meeting established needs.

d. Document all telephone contacts and visits in the case narrative.

6. **Client rights:**

Give the client a copy of the grievance procedures. Explain the client's right to appeal care plan decisions, changes in services, or termination of services.

C. A well-developed care plan shall:

1. Address all aspects of the client's care. It represents the client/client representative's, caregiver's, and professional worker's understanding of the situation, based upon the client's needs.

2. Represent the case manager's best professional, objective, and independent judgment, based upon the client's needs.

3. Reflect the client's health conditions, problems, challenges and barriers to problem resolution, outcomes to be attained, and DOEA and non-DOEA funded services and activities provided.

4. Reflect the client's preferences and choice of providers in a document unique to the client.

5. Serve as the information base to measure progress and revise services.

6. Exhibit the caregiver's contributions, maximize other non-DOEA funded services and be used to estimate the cost of needed services and activities.

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## COMPLETING THE CARE PLAN FORM:

Complete all sections of the care plan. The following information explains how each section is completed.

### A. General Information:

#### 1. Client Name

#### 2. Social Security Number (SSN)

**a.** The nine-digit number is a unique identifier for each client and is used for tracking and comparing information.

**b.** The client is not required to provide the SSN but is encouraged to do so in order for staff to screen for Medicaid eligibility and possible referral to the Department of Children and Families for services.

**c.** The client must be informed that disclosure of the SSN is voluntary and will be used for referral and screening for Medicaid in accordance with Title XIX of the Social Security Act.

**d.** If a pseudo identification number (ID) was used on the Assessment Form, the same number should be used on the Care Plan form. Directions for creating a pseudo ID are found in the DOEA Form 701D – Assessment Instructions.

#### 3. Case Manager Name

#### 4. Provider

The provider code is unique for each individual provider within a Planning and Service Area (PSA). The first digit of the provider code usually corresponds to the PSA code.

#### 5. Worker ID:

The worker identification code links the user's ORACLE ID with a provider name and validates the user's access to different screens in CIRTS. A Worker ID must be entered for each person who needs access to CIRTS.

**6. Care Plan Date:**

The date the care plan form is prepared is a reference point for determining semiannual review dates. Each time the assessment is reviewed, the case manager shall review the care plan form and make necessary changes or begin a new form. The care plan must be updated annually in CIRTS, at the time of reassessment.

**7. Care Plan Review Dates:**

**a.** Review the care plan every six months or more frequently, if the case manager and supervisor deem it necessary to meet the needs of the client.

**b.** Enter the date and reviewer's initials for each review.

## B. Health Conditions and Service Impact:

1. Identify the health conditions documented in the assessment and list them in this section. If more than three conditions exist, list the three, which are most problematic to the client.

2. Conditions which affect the individual's ability to perform activities of daily living determine the degree of frailty and should be included in the care plan.

3. Identify the most appropriate service impact for each health condition and write the corresponding number(s) next to each health condition. Four service impact possibilities are listed on the form.

## C. Problems and Gaps/ Adaptability and Coping Skills/ Challenges and Barriers:

1. Review information provided on the assessment summary to identify problems.

2. List all problems, including medication management and nutritional considerations on the care plan and address them in the case narrative.

3. Challenges and barriers listed in the assessment help to explain why the problem exists.

4. Activities of daily living (ADL) and instrumental activities of daily living (IADL) the client cannot perform independently may cause problems, unless the individual has developed methods of coping and adapting.

5. Adaptability and coping skills are ways to compensate for deficits and are considered to be resources and assets.

   a. Resources and assets documented on the assessment summary describe how the client overcomes deficits.

   b. The use of assistive devices is one means of adapting and employing coping skills.

   c. Doing activities of daily living in an unconventional or creative way, or allowing others to do certain chores or parts of chores are methods of coping.

   d. When the individual can use adaptability and coping skills to overcome challenges and barriers, problems may be alleviated or minimized.

6. Gaps exist when problems have been identified, and challenges and barriers cannot be overcome through adaptability or coping skills. Gaps determine service needs.

**D. Service/Activity:**

1. Identify the specific service or activity to address the gap related to each problem documented on the assessment summary.

2. List both DOEA funded and non-DOEA funded services and activities on the care plan.

3. Services arranged by the case manager or case aide and provided by non-DOEA funded sources must be listed in the care plan.

4. In addition, services which exist at the time of the assessment, not arranged by a member of the case management staff, and provided by non-DOEA funded sources, must be listed in the care plan.

5. Document on the care plan and in the case narrative when a change in the client's service needs or a change in providers occurs.

6. Indicate the date of the change and any unit rate changes on the care plan. Also, notify service providers in writing when changes in service are needed.

7. Updates are based on changes in the client's health conditions and other circumstances.

## E. Frequency and Duration:

1. Record the frequency and duration for services.

   a. Frequency is how often a service is planned. It is the number of hours, meals, or other units per week, monthly, and annually.

   b. Duration is how long a service will be provided.

      i. Services are planned for however long they are needed.

      ii. Case management can be planned for a year.

      iii. Other ongoing services can be planned for six months up to a year, since care plans are reviewed semiannually and annually.

      iv. Services required temporarily or short-term should be planned for shorter periods, such as six weeks to three months.

2. Because of budget restraints and other barriers, services documented on the care plan as needed may not be the same as the services that are planned.

   a. Needed services represent the frequency and duration of recommended services necessary to address the client's needs to obtain the desired outcomes stated in the care plan.

   b. Planned services represent the frequency and duration of services, which are actually planned to be provided.

   c. In order for the care plan to be an accurate reflection of the client's situation, it must be acknowledged that sometimes problems cannot be fully addressed.

      i. Thus, recognize unmet needs on the care plan and document them in the case narrative.

      ii. Document all efforts to secure non-DOEA funded services in the case narrative.

      iii. Enter the begin date and end date for needed and planned services.

iv. The begin date for needed services must be equal to or prior to the begin date of planned services.

3. When necessary, write "PRN" or "as needed" next to the amount of service noted on the care plan to indicate temporary changes may occur.

   a. Note temporary changes in the case narrative and indicate when these temporary services are terminated.

   b. Specify a duration of three months or less, if it appears the client's situation may be temporary.

   c. Record permanent changes to the care plan on the form and enter them in CIRTS.

4. Document on the care plan and in the case narrative the reason changes occur in the frequency or duration of planned services, indicating the date of the change. Notify the service providers in writing when changes in frequency or duration are being made.

**F. Desired Outcomes:**

1. Enter ST (short-term) or LT (long-term) in the "Desired Outcome" box of the care plan.

   a. The desired outcome is established for the client based upon the individual's overall status, not select problems.

   b. In most situations, the desired outcome is either short-term or long-term.

   c. In some instances, it is appropriate to enter both ST and LT in the Desired Outcome box because the individual's overall situation requires varying degrees of assistance.

2. **Short-term outcomes** address immediate concerns.

   a. The short-term outcome is that the individual's situation is stabilized and acute episodes or nursing home placement can be delayed or prevented.

   b. For instance, after relocation, hospitalization, or incapacitation of a caregiver, a client may require temporary assistance to obtain necessary access to community resources.

c. Assistance may be needed immediately, but not for an extended period of time.

3. **Long-term outcomes** address concerns that have long range implications and will exist into the future.

   a. The long-term outcome is that the individual's situation will be maintained or improved by providing assistance and that an acute episode or nursing home placement will be delayed or prevented.

   b. When a client's situation is stable, the goal is to help keep the individual as safe and healthy as possible. An example is an individual who has arthritis. Heavy chores may be difficult, but the person is able to manage small tasks if paced appropriately throughout the day.

   c. Assistance should be provided that will support the individual's abilities and offer relief from activities that might not be safe, such as cleaning the bath tub, but also allow the person to be as active as possible.

4. **Both short-term and long-term outcomes** address stabilization of a situation and concerns for the future.

   a. The overall outcome is that the individual's immediate concerns are addressed and plans are made to address long-range implications.

   b. An example is an individual who has a recent hospital discharge and needs assistance with personal care needs. Personal care assistance will be required temporarily. However, due to health conditions, the individual is no longer able to drive. The need will be long term for transportation.

## G. Non-DOEA Funded/ DOEA Funded and Provider:

Document the planned number of hours or other service units in the appropriate column.

1. Write "ND" for Non-DOEA funded and "D" for DOEA funded. Include the corresponding number for the source.

**a.** Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.

**b.** DOEA-funded sources include Older Americans Act (OAA), Medicaid Waiver (MW), Assisted Living Waiver (ALW), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Alzheimer's Disease Initiative (ADI), and Serving Health Insurance Needs of Elders (SHINE). "Other" in this section of the form refers to: Contracted Services (CS), Local Services Programs (LSP), Respite for Elders Living in Everyday Families (RELIEF), Sunshine for Seniors (SfS), and Long-Term Care Ombudsman Council (LTCOC). The provider refers to the source and the funding method.

**2.** The following are some examples:

| **a.** **Non-DOEA Funded:** | **Example:** |
|---|---|
| Family and friend | Granddaughter, niece, son, neighbor |
| Local government and taxing entities | Board of County Commissioners, County Human Resources. City Government, County Taxing District (Health Care Taxing District in Palm Beach), Medicare, Medicaid |
| Associations/ Religious/ Other | American Diabetes Association, Lutheran Social Services, United Health Maintenance Organization, Volunteer, IBM Corporation, Employee Assistance Program, Private Insurance |
| Other Non-Profit/ Other | United Way, Habitat for Humanity, Food Bank |
| Long-term Insurance | Benefits covered under long term care |

**b. DOEA Funded Provider:** **Funding Source:**

| | |
|---|---|
| Older Americans Act (OAA) | Federal |
| Medicaid Aged and Disabled Adult (A/DA) Waiver (MW) | Federal |
| Assisted Living for the Elderly (ALE) Waiver | Federal |
| Community Care for the Elderly (CCE) | State |
| Alzheimer's Disease Initiative (ADI) | State |
| Home Care for the Elderly (HCE) | State |
| Local Services Program (LSP), Contracted Services (CS), and Respite for Elders Living in Everyday Families (RELIEF) | State |
| Serving Health Insurance Needs of Elders (SHINE) and Sunshine for Seniors (SfS) | Federal |

c. Assistance may be needed immediately, but not for an extended period of time.

3. **Long-term outcomes** address concerns that have long range implications and will exist into the future.

   a. The long-term outcome is that the individual's situation will be maintained or improved by providing assistance and that an acute episode or nursing home placement will be delayed or prevented.

   b. When a client's situation is stable, the goal is to help keep the individual as safe and healthy as possible. An example is an individual who has arthritis. Heavy chores may be difficult, but the person is able to manage small tasks if paced appropriately throughout the day.

   c. Assistance should be provided that will support the individual's abilities and offer relief from activities that might not be safe, such as cleaning the bath tub, but also allow the person to be as active as possible.

4. **Both short-term and long-term outcomes** address stabilization of a situation and concerns for the future.

   a. The overall outcome is that the individual's immediate concerns are addressed and plans are made to address long-range implications.

   b. An example is an individual who has a recent hospital discharge and needs assistance with personal care needs. Personal care assistance will be required temporarily. However, due to health conditions, the individual is no longer able to drive. The need will be long term for transportation.

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## H. Date Services Began (B) and Ended (E):

1. Indicate the date each service began or ended in this column.

2. If a service or activity exists prior to DOEA involvement and is planned to continue, but the date the service began is not known, use the same entry as the problem date for the services begin date.

## I. Date Problem Resolved (RS) or Revised (RV):

1. Enter the date and "RS" when the problem is resolved and services are no longer needed.

**a.** For example, if the client's problem was an inability to hear because of a lost hearing aid, then replacing the hearing aid resolves the problem and no further service is required.

**b.** Once a resolved or revised date is posted, the problem need not be tracked in the case narrative unless the problem recurs.

**2.** Enter the date and "RV" when a problem, frequency or duration, service, or desired outcome is revised.

**a.** If the client began receiving two hours a week of personal care services on 8/14/07 and this service was revised to three hours a week on 12/22/07, the care plan would be updated to show the date of the revision.

**b.** Make a corresponding entry in the case narrative to describe the reason for the revision and any other details about the revision that occurred.

## J. Unit Cost/Individual Purchase:

**1.** Enter the approved unit rate for the corresponding DOEA-funded service in the unit cost column.

**a.** The approved rates are based upon those included and approved in the area plan.

**b.** For an example of a non-DOEA service: If the daughter provides personal care, use the approved DOEA-funded rate for personal care as the non-DOEA funded resource value.

**2.** If the service is not a service provided by DOEA and the unit rate is not known, a fair market value will need to be computed. There are four suggested ways to figure the needed value:

**a.** Call at least three sources of the service or activity in the area and average their cost. For example, if three sources of a service charged $5.00, $6.00, and $7.00 per unit, then the fair market value for the service would be $6.00, (5+6+7=18, divided by 3).

**b.** Use Web-DB average actual rates from comparable Planning and Service Areas.

**c.** Use rates from the Mercer study or a similar pricing rate study, or

**d.** Use market rate surveys as a basis for the determination that suggested rates are reasonable.

**3.** Enter the individual purchase cost of the item, service or activity, if unit cost does not apply.

## K. Monthly Cost/Value:

**1.** Enter the amount derived from the unit rate multiplied by the planned frequency for costs of DOEA-funded services and activities and for values of non-DOEA funded services and activities.

**2.** Record the letter, "c" (cost) or "v" (value) beside the amount entered.

**3.** Update this information as services begin, end, or their frequencies or unit costs change.

**4.** Necessary changes should be made in CIRTS at least annually.

## L. DOEA-Funded Monthly Care Plan Cost:

Enter the total amount for all DOEA-funded care plan services documented in the Monthly Cost/Value column.

## M. Annualized DOEA-Funded Care Plan Cost:

Multiply the number of units planned per week by 52 weeks per year, by the unit cost. Add the total cost of individual periodic purchasing to the annualized care plan cost.

## N. Non-Annualized DOEA-Funded Care Plan Cost:

**1.** Enter the cost of individual purchasing episodes documented in the "Unit Cost/Individual Purchase" column, then show on the plan as the non-annualized DOEA-funded care plan cost.

**2.** An example of an individual purchasing episode is the repair of a roof or the purchase of a washing machine.

**3.** Include HCE special subsidy purchases not made monthly.

## O. Co-Pay Monthly Amount:

Multiply the monthly co-pay amount by twelve, i.e., $27.00 X 12 = $324.00.

## P. Annualized Non-DOEA Funded Resource:

1. Enter the total amount for all non-DOEA funded care plan services documented in the Monthly Cost/Value column.

2. The costs of non-DOEA funded sources are not incurred by the state or federal government elderly programs. Thus, non-DOEA funded costs are shown separately.

3. Non-DOEA funded costs provide crucial information, indicating the value of the agency's use of other resources.

## Q. Non-Annualized Non-DOEA Funded Resource:

Enter the value of contributed individual periodic purchasing documented in the Unit Cost/Individual Purchase column, then add the value to the annualized non-DOEA funded resource.

## R. Care Plan Total:

Enter the total amount of the care plan, including costs, value of resources, and the co-pay amount.

## S. Signature:

1. Sign on the case manager line as the individual developing the care plan.

    a. The client is to sign the care plan when it is first done, and then once yearly, when reassessed.

        i. Clients do not have to sign the plan each time there is a revision.

        ii. Clients must be made aware of and have an opportunity to discuss all revisions.

        iii. There must be documentation that the client agrees with the revisions.

**b.** If the client is unable to sign the care plan, note that on the signature line.

2. The client's caregiver should sign the form when it is first completed and once yearly, when the client is reassessed.

   **a.** Note "HCE" next to the caregiver's signature if the individual is an HCE caregiver.

   **b.** The caregiver does not need to sign the care plan each time there is a revision; however, the caregiver must be informed of revisions.

3. By signing the care plan, the client acknowledges that he or she has participated in discussions about assessed needs, has helped to develop the care plan, has been given choices to address service needs, and agrees with the care plan provisions.

   **a.** Additionally, the client acknowledges that a grievance review can be requested if there is unacceptable change, reduction or termination of services.

   **b.** Information must be provided to the client in a language the client can understand and articulate.

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## ORGANIZING THE CARE PLAN:

**Method One:**

### A. Long-Term Problems:

Use one page for each long-term problem, (a page per problem).

1. These problems will likely not improve and may require services over a long period of time, i.e., more than 6 months, and may have to be changed or updated throughout the year.

2. Each change or update is shown on a new line of the care plan form.

### B. Short-Term Problems:

Use another page to list short-term problems, i.e., 3 to 6 months.

1. These problems will usually improve or be resolved over a short period of time and will not require as many changes or updates during the year.

2. Thus, the "Date Service Began/Ended" column is used most.

### C. Example: Long-Term Problem

**Health Condition:**

The client has emphysema and difficulty breathing when performing activities.

**Service Impact on health condition:**

Number "2" was selected as the condition may be maintained with intervention.

**Problem:**

Challenges and barriers to problem resolution are the client's lack of stamina and strength to do more than light housekeeping.

**Service:**

Homemaker services are needed.

**Method Two:**

**A.** List each problem (short or long-term) on one page in chronological order, including information from the assessment summary related to its challenges and barriers, and the client's coping skills and adaptability.

**B.** Any revisions will also be included chronologically.

**C.** When making revisions to a care plan using this method:

1. Identify every new entry with the problem number of the original problem statement.

2. Record a date for each revision followed by "RV" in the "Date Problem Resolved or Revised" column.

3. If the problem is resolved, record the date of resolution and "RS."

**D. Examples:**

**Short-Term Problem:**

**Health Condition:**

The client has severe arthritis and is limited in her ability to perform physical activity.

**Service Impact on health condition:**

Number "3" was selected as the condition may decline with intervention.

**Problem:**

Challenges and barriers to problem resolution are the client's inability to safely get in and out of the bathtub and the caregiver's frailty.

**Service:**

Home repair service is needed to make the bathtub accessible by installing grab bars.

**Long-Term Problem:**

**Health Condition:**

The client has renal cancer, kidney and bladder failure, incontinence problems and is very weak from dialysis. In addition, the client has uncontrolled diabetes.

**Service Impact on health condition:**

Number "3" was selected as the condition may decline with intervention.

**Problem:**

Challenges and barriers to problem resolution are the client's inability to drive to the doctor or get around without assistance. The client is also unable to properly manage her health care needs.

**Service:**

Transportation and home health care are needed services.

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## CARE PLAN UPDATES:

**A.** Review and update the care plan semiannually.

1. The care plan may be updated more frequently depending upon the client's need for more frequent reviews, such as following a hospitalization, loss of a spouse, or a physical move.

2. During the care plan review, discuss with the client the services provided and determine whether these services meet the client's needs or if changes are required.

3. Review the options and provide choices for the client.

   **a.** Are there new problems that need to be addressed?

   **b.** Additional problems identified should be added to the care plan.

**B.** Enter "same "or "no change" if some of the columns on the care plan are still accurate and do not need revising or updating, whichever method used. Only the initials of the case manager and review date are required.

**C.** The care plan for each active client will be updated in CIRTS at least annually.

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## CASE NARRATIVE:

**A.** Record the status of all active care plan problems in the case narrative after each contact with the client.

**1.** If no changes are identified, enter a statement covering multiple problems such as, "The client's needs remain the same and all services are continued."

**2.** Make sure the problem number on the most recent care plan corresponds with the problem number entry which updates the case narrative. There is no need to rewrite the problem statement in the narrative. See the example below:

**Problem statement entry from Care Plan:**

1. Client is unable to get in and out of the bathtub safely.

**Case Narrative Entry Indicating Status of the Problem:**

1. Through home modification services, Ms. Smith was able to retrofit her bathroom so that she can safely get in and out of the bathtub. She is able to take a bath daily and her caregiver helps her to wash her hair and back. The modifications to her bathroom and assistance from her caregiver are appropriate at this time.

**B.** The case narrative describes the client's progress and challenges or barriers that hinder the desired outcomes in the care plan.

**1.** The narrative reflects services consistent with the needs and service gaps identified in the care plan and provide reasons for variances.

**2.** The case narrative entries may reference specific care plan and assessment summary entries.

**3.** Case narrative entries should document the date of the contact, the type of contact (Office Visit - OV, Telephone Call - TC, Field Visit - FV), and the person making the contact.

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## CASE RECORD:

### A. Case Record Information:

The case record contains current client information. This information is the basis for continuing or adjusting the client's care plan and the basis for review. The case record contains the following:

1. **Prioritization Assessment (DOEA Form 701A):** A completed prioritization form if the client was screened prior to the completion of a comprehensive assessment, such as an individual who has been on an assessed priority client list prior to receiving services.

2. **Assessment Instrument (DOEA Form 701B):** A completed and updated assessment form, as well as at least one prior year assessment.

3. **Care Plan Form:** Current and accurate care plan form(s), covering at least the past two years. The form(s) should be signed and dated annually and should reflect the initials and dates of semiannual or more frequent care plan reviews.

4. **Release of Information Form:** A signed authorization for release information form. Written consent is required before any case information may be shared with provider agencies.

5. **Grievance Procedures:** A current notice of grievance procedures, signed and dated by the client, applicable to terminations, suspensions, or reductions in service.

6. **Case Narrative:** A current and accurate case narrative. A current detailed case narrative showing all contacts with the client and the caregiver, and notes regarding the client's progress toward achieving care plan outcomes.

7. **HCE Financial Worksheet:** A financial worksheet for HCE clients. A current and correct form should be included.

8. **Co-pay Assessment Form:** A co-pay assessment form for CCE and ADI clients. A current and correct form should be included.

9. **Specific Forms:** Program specific forms for CCE, ADI, HCE, or OAA. Forms for individual programs should be included.

10. **Other Information:** Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.

11. **Choice & Options:** Documentation of the choices and options given to the client.

## B. Standards for Case Records Maintenance:

1. Client records must be stored in a locked file at the agency.

2. The client must be informed that information collected about the client is required for service provision; the information will be treated in a confidential manner; and will be protected from loss, defacement, or unauthorized access.

3. The client and the caregiver should be told that case record information is available for their review and for the review of individuals they authorize.

4. After case closure, client records shall be retained for a period of six years or longer if required by federal regulations.

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## SUMMARY:

The essence of good care planning is the inclusion of the client at the center of the planning and selection process. All services and activities evolve around the client and flexibility is the key to effective care planning. The role of the caregiver is paramount to the client's care and the planning process. The caregiver must be included in the care planning process. The care planning process must be broad enough in scope to look at the abilities of the client, the support of the caregiver, and the resources of the community.

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