

## Appendix 11f ▪ Deinstitutional Care Plan Form Instructions

### Instructions for Deinstitutional Care Plan

The care plan document will be completed fully and accurately for each individual. The sites may modify the care plan form; however, the basic integrity and all components of the form must be maintained and ample space given to each section to facilitate recording the required information. A sample care plan form follows these instructions. Whatever the format, the care plan document **will** include the following components:

**A. Date**

Enter the date the problem was originally identified. Dating the problems will ensure that care plans are updated/revised when warranted by changes in the individual's condition and goals.

**B. Problem #**

List problem statements in a sequential manner. Care Plan problem numbers remain the same as long as the problem is active. Numbers will be added sequentially as additional problems are identified.

**C. Problem Statement**

1. This section of the care plan must contain descriptive problem statements. Problem statements are derived from areas of concern identified in the assessments for which specific services and/or care management activities are provided.

**Note:** The medical diagnosis and the description of an individual's function can be linked to describe a problem. The client's medical diagnoses may not define the problem or substantiate the need for services. Problem statements are written in complete sentences and **must** address specific needs/functional deficits

2. If there are problem areas identified that will not be addressed in the care plan, an explanation **must** be documented in the progress notes.
3. The problems identified on the care plan **must**:
  - a. Justify the need for care management,
  - b. Substantiate the need for service delivery, including informal, referred, and purchased services,
  - c. Clearly describe the circumstances within the client's informal and referred service resources that necessitate purchases with waiver service dollars; and

- d. Reflect the interdisciplinary team collaboration on assessment findings. During the care planning conference, problems not identified prior to the conference should be added.

**D. Goal/Outcome**

This section will address client goals for identified needs or problems; it **must** be measurable, reflect the client's input and consider the client's preferences.

Measurable goals **must** describe desired improvements and/or achievements. The goals specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met, etc.

For example:

- a. Client will report zero missed medical appointments over the next 12 months as confirmed during monthly contacts.
- b. Client will report skin remains intact during each monthly contact
- c. Client will maintain current weight of 150 lbs for the next six months.

**E. Service Provider Name and Type**

The Service Provider and Type will list the service provider for all services (purchased and referred). The type of provider(s) for each service will also be entered (Section 3.930, Authorization and Utilization of Services):

- I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers.
- R = Referred: a service provided without cost through referral to a formal organized program or agency (e.g., Meals on Wheels, transportation funded by Title IIIB, etc.).
- P = Purchased: a service or item purchased with waiver service funds.
- C = Care Management: is the coordination of care and services provided to facilitate appropriate delivery of care and services.

More than one provider type may be entered for an individual service.

**F. Plan/Intervention**

The Plan/Intervention section lists information pertinent to the problem and outlines possible actions, plans or solutions to solve the problem.

Interventions that have the greatest probability of success are those that consider the client's preferences, perception of the problem or situation, and are compatible with the client's beliefs, values, and attitudes.

**G. Date Resolved/Comments**

This section documents the result to be obtained from interventions provided.

Comments include information regarding the results of care management intervention; whether the problem was improved, resolved or in need for further monitoring, as well as client input regarding choices and concerns.

**G. Bill to Waiver**

Enter the amount of Waiver Services dollars actually spent on each purchased Service/item. The total of this column will provide the amount to bill at the conclusion of DCM services (see section 9.110 Billing Process).