# New CBAS Individual Plan of Care (IPC) Training

## October 3, 2018

## Housekeeping Items:

- Webinar is being recorded and will be posted on the CDA website
  https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/CBAS_Training/Default.aspx
- The IPC Form and Instructions and FAQ document will be available on the CDA website
  https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Eligibility_and_Service_Authorization/
- Q & A at the end of webinar (submit questions via the webinar "Questions" box)

# Presenters

- **Jill Sparrow**, MSW, Chief, California Department of Aging (CDA) CBAS Branch
- **Leigh Witzke**, RN, Nurse Evaluator, CDA CBAS Branch
- **Lin Benjamin**, MSW, MHA, Health Program Specialist, CDA CBAS Branch

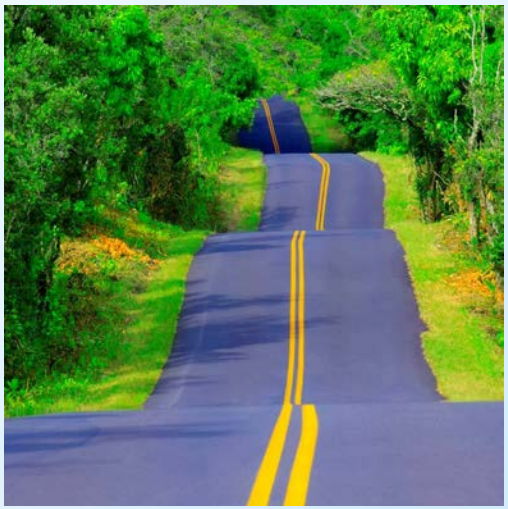
# Agenda

- Status Report on IPC & Implementation
- Why the new IPC and How We Developed It
- Federal Person-Centered Planning Requirements
- Walkthrough of the IPC
- Operationalizing the New IPC
- Q and A

# Implementation Status

- **Medi-Cal Provider Manual (CBAS Sections) including IPC, IPC instructions (with definitions), and program description/requirements**
  - ✓ Moving through the publication process
  - ✓ Publication and implementation dates uncertain
  - ✓ Required IPC implementation no earlier than March 1, 2019
  - ✓ Implementation will be on a rolling basis as each participant's IPC comes up for review and renewal, and new Treatment Authorization Requests (TARS) are submitted

# How did we get here?



# The "Why" and "How" of the New IPC

In a nutshell:

Why? ⇨ Federal regulations

State commitment to person-centered planning principles and revising the IPC

How? ⇨ 1.5 year stakeholder process

# Person-Centered Planning Regulations

**Federal Regulations for Person-Centered Planning, U.S. Code of Federal Regulations, 42 CFR 441.301(c)(1)(2)(3)**

- Define person-centered planning requirements for persons in Home and Community-Based (HCB) Settings—emphasizing the goals, wants, needs, and strengths of the individual
- Establish strong consumer protections in the person-centered planning process
- CBAS centers to implement person-centered planning NOW

***Federal Guidance for Implementing Standards for Person-Centered Planning***

# Person-Centered Planning Regulations

## Federal Person-Centered Planning regulations address:

- Person-Centered Planning **Process**
  - ✓ Led/directed by participant to extent possible
  - ✓ Includes individuals chosen by participant
  - ✓ Offers informed choices regarding services and supports
- Person-Centered **Plan**
  - ✓ Reflects individual's strengths, preferences, goals, desired outcomes, choices
  - ✓ Reflects risk factors/measures in place to minimize them
  - ✓ Finalized and agreed to with informed consent of participant
- **Review** of the Plan
  - ✓ Reviewed and revised upon reassessment (at least every 12 months), when participant's circumstances/needs change significantly, or at participant's request

# Person-Centered Planning Regulations

**CBAS Special Terms and Conditions/STC 49(c) requires the IPC to:**

- Identify each enrollee's preferences, choices and abilities and strategies to address those preferences, choices and abilities,
- Allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollees choosing,
- Ensure that the enrollee has informed choices about treatment and service decisions,
- Is collaborative, recurring and involves an ongoing commitment to enrollee

# New CBAS IPC

Centers may need to adjust, plan, train, develop programs, establish Multidisciplinary Team (MDT) processes to develop the IPC to meet person-centered planning requirements.

# CBAS IPC - Walkthrough

# New CBAS IPC

Designed to:

- Support person-centered planning
- Bring the IPC up- to-date with current program requirements
- Facilitate information exchange between CBAS providers and managed care plans for treatment authorization and service coordination
- Increase capacity for documenting, tracking and measuring beneficiary clinical data, quality indicators, and outcomes
- Improve the form's design, functionality, and ease of use

# New CBAS IPC

## The IPC has two-parts:

- ✓ Part I - Participant profile (Boxes 1-11)
- ✓ Part II - Care plan (Boxes 12-17)

# New CBAS IPC

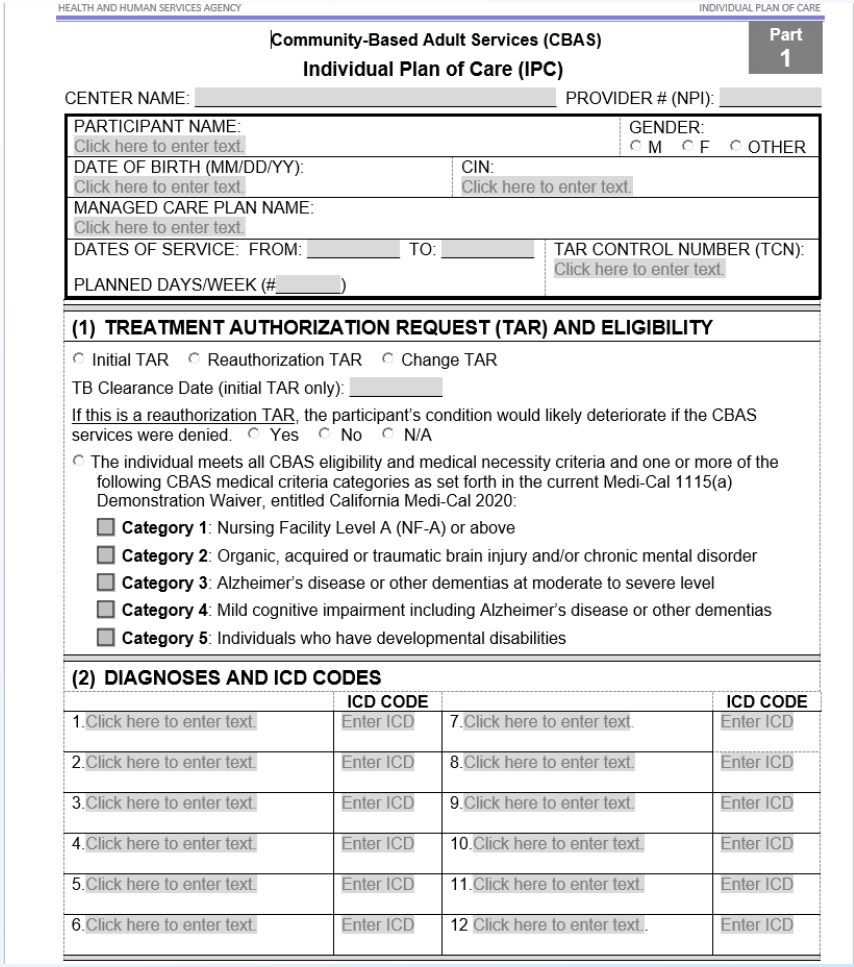
- The following slides will review each box of Parts I and II, and address:

  ✓ How to gather information needed to complete Box 12 – i.e., to get participants and/or representatives to express what they want from the center, their needs, goals, and desired outcomes.

  ✓ How does the information in Box 12 inform the completion of Boxes 13 & 14.

# Walk-through of IPC Part 1 (Boxes 1-11)

- Center & Participant Information
- Box 1: Treatment Authorization Request (TAR) & Eligibility
- Box 2: Diagnoses and ICD Codes



HEALTH AND HUMAN SERVICES AGENCY — INDIVIDUAL PLAN OF CARE

**Community-Based Adult Services (CBAS)**
**Individual Plan of Care (IPC)**

Part 1

CENTER NAME: _____ PROVIDER # (NPI): _____

| PARTICIPANT NAME: Click here to enter text. | GENDER: ○ M ○ F ○ OTHER |
|---|---|
| DATE OF BIRTH (MM/DD/YY): Click here to enter text. | CIN: Click here to enter text. |
| MANAGED CARE PLAN NAME: Click here to enter text. | |
| DATES OF SERVICE: FROM: _____ TO: _____ PLANNED DAYS/WEEK (#_____) | TAR CONTROL NUMBER (TCN): Click here to enter text. |

**(1) TREATMENT AUTHORIZATION REQUEST (TAR) AND ELIGIBILITY**

○ Initial TAR ○ Reauthorization TAR ○ Change TAR

TB Clearance Date (initial TAR only): _____

If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were denied. ○ Yes ○ No ○ N/A

○ The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories as set forth in the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020:

- ☐ **Category 1**: Nursing Facility Level A (NF-A) or above
- ☐ **Category 2**: Organic, acquired or traumatic brain injury and/or chronic mental disorder
- ☐ **Category 3**: Alzheimer's disease or other dementias at moderate to severe level
- ☐ **Category 4**: Mild cognitive impairment including Alzheimer's disease or other dementias
- ☐ **Category 5**: Individuals who have developmental disabilities

**(2) DIAGNOSES AND ICD CODES**

| | ICD CODE | | ICD CODE |
|---|---|---|---|
| 1. Click here to enter text. | Enter ICD | 7. Click here to enter text. | Enter ICD |
| 2. Click here to enter text. | Enter ICD | 8. Click here to enter text. | Enter ICD |
| 3. Click here to enter text. | Enter ICD | 9. Click here to enter text. | Enter ICD |
| 4. Click here to enter text. | Enter ICD | 10. Click here to enter text. | Enter ICD |
| 5. Click here to enter text. | Enter ICD | 11. Click here to enter text. | Enter ICD |
| 6. Click here to enter text. | Enter ICD | 12 Click here to enter text. | Enter ICD |

# Walk-through of IPC Part 1 (Boxes 1-11)

- Box 3: Medications*

| (3) MEDICATIONS | | | |
|---|---|---|---|
| ☐ No medications or supplements | | | |
| **ACTIVE PRESCRIPTIONS** | 5.Click here to enter text. | 10.Click here to enter text. | **OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS** |
| 1.Click here to enter text. | 6.Click here to enter text. | 11.Click here to enter text. | 1.Click here to enter text. |
| 2.Click here to enter text. | 7.Click here to enter text. | 12.Click here to enter text. | 2.Click here to enter text. |
| 3.Click here to enter text. | 8 Click here to enter text.. | 13.Click here to enter text. | 3.Click here to enter text. |
| 4.Click here to enter text. | 9.Click here to enter text. | 14.Click here to enter text. | 4.Click here to enter text. |
| Center administers participant's prescribed medication(s) ○ Yes ○ No | | | |
| Participant self-administers prescribed medication(s) at center ○ Yes ○ No | | | |

*Separate Slide

# Instructions: Box 3

**Box 3: MEDICATIONS**

- "No medications or supplements" check box
- Active prescriptions *(current/non-expired prescriptions from licensed practitioner; includes prescribed OTC/supplements)*
- Over-the-Counter (OTC) Medication and/or Supplements *(not prescribed)*
- Medication administration at center (PCR definitions)
  - ✓ Center administers prescribed medications
  - ✓ Participant self-administers prescribed medications

# Walk-through of IPC Part 1 (Boxes 1-11)

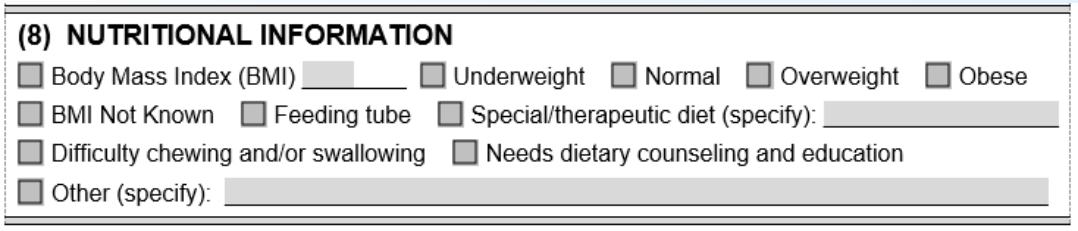
- Box 4: Active Personal Medical/Mental Health Care Providers
- Box 5: ADL/IADL Status
- Box 6: Current Assistive/Adaptive Devices
- Box 7: Continence Information
- Box 8: Nutritional Information*

**Separate Slides*

# Instructions: Box 8

## Box 8: NUTRITIONAL INFORMATION

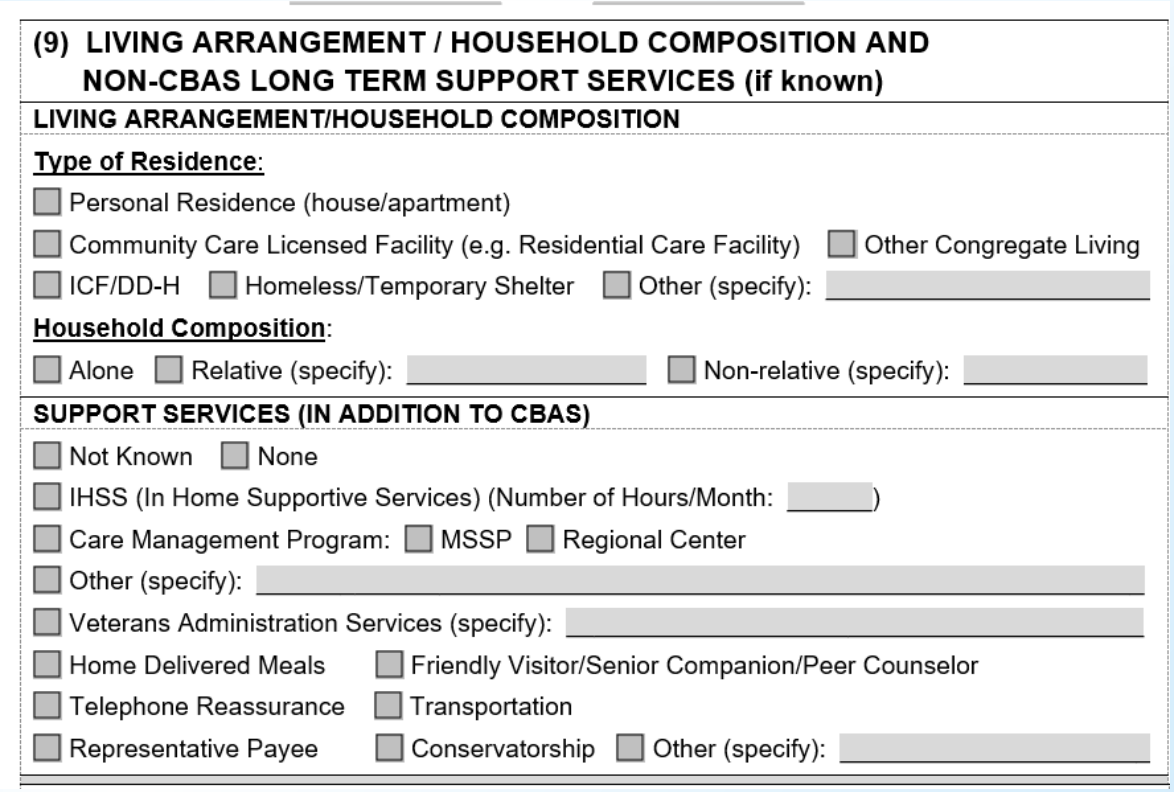
- Body Mass Index (BMI) –must be calculated if know participant's weight and height
  - ✓ Calculation instructions provided
- BMI identifies if
  - ✓ Underweight
  - ✓ Normal
  - ✓ Overweight
  - ✓ Obese




- Therapeutic Diet (PCR definition)
- Dietary counseling and education

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 9: Living Arrangement/Household Composition and Non-CBAS Long Term Support Services (if known)



**(9) LIVING ARRANGEMENT / HOUSEHOLD COMPOSITION AND NON-CBAS LONG TERM SUPPORT SERVICES (if known)**

**LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION**

**Type of Residence:**

☐ Personal Residence (house/apartment)

☐ Community Care Licensed Facility (e.g. Residential Care Facility) ☐ Other Congregate Living

☐ ICF/DD-H ☐ Homeless/Temporary Shelter ☐ Other (specify): _____

**Household Composition:**

☐ Alone ☐ Relative (specify): _____ ☐ Non-relative (specify): _____

**SUPPORT SERVICES (IN ADDITION TO CBAS)**

☐ Not Known ☐ None

☐ IHSS (In Home Supportive Services) (Number of Hours/Month: _____)

☐ Care Management Program: ☐ MSSP ☐ Regional Center

☐ Other (specify): _____

☐ Veterans Administration Services (specify): _____

☐ Home Delivered Meals ☐ Friendly Visitor/Senior Companion/Peer Counselor

☐ Telephone Reassurance ☐ Transportation

☐ Representative Payee ☐ Conservatorship ☐ Other (specify): _____

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 10: Other Health Services (if known)-within past 6 months

- Box 11: Risk Factors*

**Separate Slides*

# Instructions: Box 11

**Box 11: RISK FACTORS**

*(conditions/circumstances that increase risk for adverse events/outcomes such as hospitalization)*

- INTERNAL/CLINICAL RISK FACTORS
  - ✓ *Ex: Medical/mental health conditions, cognitive, medication, functional status*
- EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH
  - ✓ *Ex: Limited social supports, unstable housing, food insecurity, caregiver stress*

# Instructions: Box 11 (cont'd)

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME: _____ CIN: _____

DATES OF SERVICE: _____ TO _____

**(11) RISK FACTORS** (check all that apply at time of IPC completion)

**INTERNAL/CLINICAL RISK FACTORS**

- ☐ None

| | |
|---|---|
| ☐ Mental Illness | ☐ High Fall Risk |
| ☐ Substance Use/Abuse | ☐ Chronic Pain |
| ☐ Cognitive Impairment | ☐ Frailty |
| ☐ Polypharmacy (6+) | ☐ Wandering/Exit-Seeking Behavior |
| ☐ Medication Mismanagement | ☐ Significant Sensory Impairment |
| ☐ ADL Functional Limitations (3+) | ☐ Other (specify): _____ |

**EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH**

- ☐ None

| | |
|---|---|
| ☐ At Risk When Home Alone | ☐ Homeless/history of homelessness |
| ☐ Limited or No Social Supports/Family | ☐ Financial Insecurity/Poverty/Lack of Resources |
| ☐ Caregiver Stress/Inconsistency | ☐ Food Insecurity |
| ☐ IHSS Inconsistency | ☐ Lack of Transportation to Medical Visits |
| ☐ Social Isolation/Loneliness | ☐ Limited Health Literacy |
| ☐ Emergency Department (ED) visit within 30 days | ☐ Language/Communication Barriers |
| ☐ Hospitalization (unplanned) within 60 days | ☐ Other (specify): _____ |
| ☐ Unstable or Unsafe Housing | |

# Instructions: Box 11 (cont'd)

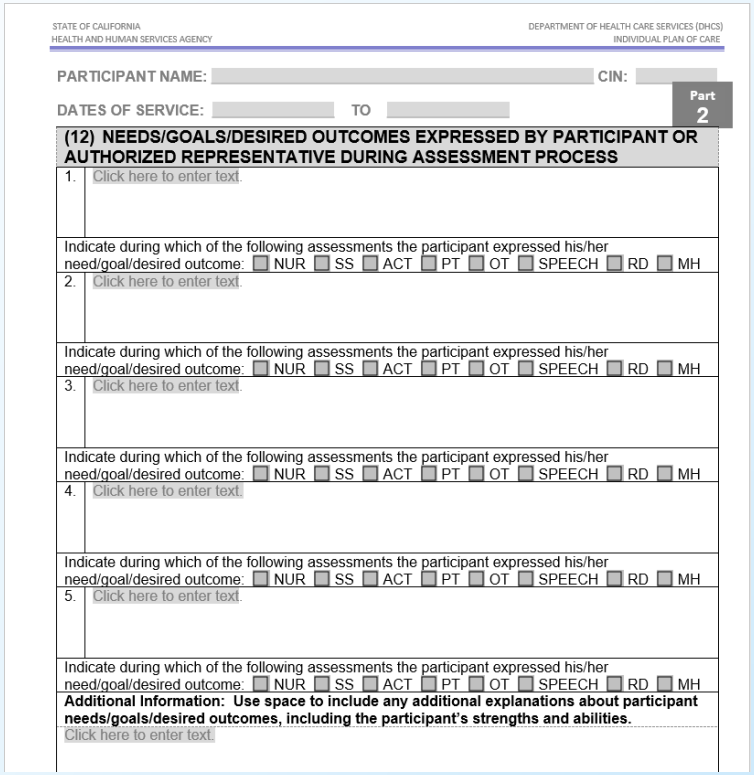
- Addressing risk factors may enable participant to continue living safely/independently in the community
- All risk factor terms are defined in instructions
- Check all risk factors that apply based on MDT assessment and info provided by participant, family/caregiver, authorized representative *(use Box 16 to explain if necessary)*
- If no risk factors apply, check "None"

# Instructions: Box 11 (cont'd)

- Checked risk factors support participant's need for CBAS
- Risk factors may need to be addressed in the care plan in Boxes 13 & 14
- If use screening and/or assessment tools (such as for fall risk, depression, cognitive impairment, etc), document name of tool and results in health record

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 12: Needs/Goals/Desired Outcomes Expressed by Participant or Authorized Representative During Assessment Process*



STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME: CIN:

DATES OF SERVICE: TO

Part 2

**(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS**

1. Click here to enter text.

Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH

2. Click here to enter text.

Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH

3. Click here to enter text.

Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH

4. Click here to enter text.

Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH

5. Click here to enter text.

Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH

**Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.**

Click here to enter text.

**Separate Slides*

# Instructions: Box 12

**Box 12: NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS**

- Each discipline engages participant in person-centered manner to express needs/goals/desired outcomes (seek input from participant's authorized representative/family/caregiver)

  ✓ What do you need/want that the center staff can help you with?
  ✓ What concerns you most about your health?

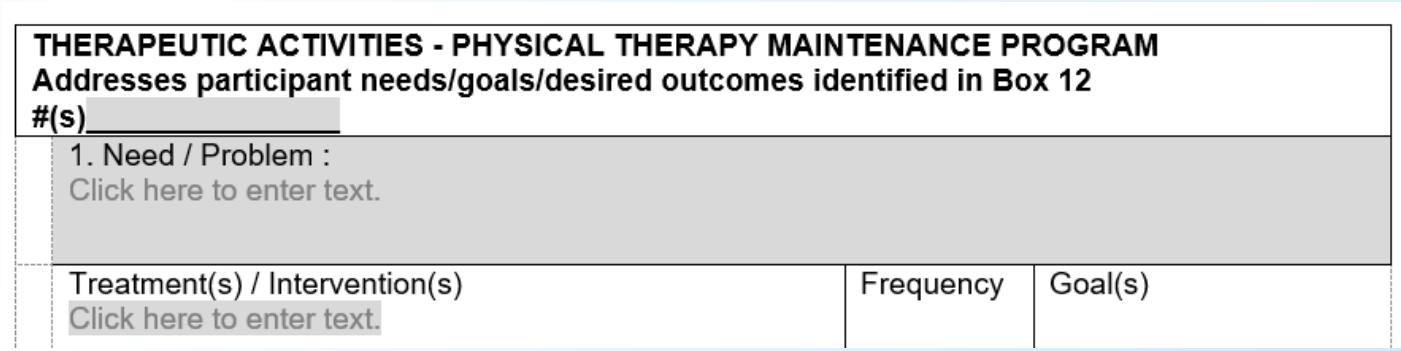
# Instructions: Box 12 (cont'd)

- Center must document at least one participant-expressed need/goal/desired outcome
- Indicate during which discipline assessment the participant expressed each of his/her needs/goals/desired outcomes
- Provide additional information about participant needs/goals/desired outcomes including <u>strengths and abilities</u> such as:
  - ✓ Participant's motivation to remain in home
  - ✓ Caregiver's willingness to assist

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 13: Core Services*
  - ✓ Professional Nursing, Personal Care Services, Social Services, Therapeutic Activities - including Physical Therapy Maintenance Program and Occupational Therapy Maintenance Program

Example of PT Maintenance Program box:



| THERAPEUTIC ACTIVITIES - PHYSICAL THERAPY MAINTENANCE PROGRAM<br>Addresses participant needs/goals/desired outcomes identified in Box 12<br>#(s)_____ | | |
|---|---|---|
| 1. Need / Problem :<br>Click here to enter text. | | |
| Treatment(s) / Intervention(s)<br>Click here to enter text. | Frequency | Goal(s) |

*Separate Slides

# Instructions: Box 13

**Box 13: CORE SERVICES**

For each of the core services, indicate:

- ✓ Which of the participant-expressed needs/goals/desired outcomes from Box 12 are being addressed
- ✓ ***Need / Problem*** – identified by MDT in collaboration with participant; one need/problem per box
- ✓ ***Treatment(s) / Intervention(s)*** – related to need/problem; individual/group
- ✓ ***Frequency*** – time/duration
- ✓ ***Goals*** – related to intervention, attainable, measurable

* *Same process applies to Box 14: ADDITIONAL SERVICES*

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 14: Additional Services*

  ✓ Physical Therapy, Occupational Therapy, Speech Therapy Services, Registered Dietician Services, Behavioral Health Services, Transportation Services

Example of Transportation Services box:

| **TRANSPORTATION SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s)_____** | | |
|---|---|---|
| 1. Need / Problem :<br>Click here to enter text. | | |
| Treatment(s) / Intervention(s)<br>Click here to enter text. | Frequency<br>Click here to enter text. | Goal(s)<br>Click here to enter text. |

**Separate Slides*

# Instructions: Box 14

## Box 14: ADDITIONAL SERVICES

For the relevant additional services, indicate:

- ✓ Which of the participant-expressed needs/goals/desired outcomes from Box 12 are being addressed
- ✓ ***Need / Problem*** – identified by MDT in collaboration with participant; one need/problem per box
- ✓ ***Treatment(s) / Intervention(s)*** – related to need/problem; individual/group
- ✓ ***Frequency*** – time/duration
- ✓ ***Goals*** – related to intervention, attainable, measurable

# Walk-through of IPC Part 2 (Boxes 12-17)

- Box 15: Significant Changes Since Previous IPC (For reauthorization TARS only)
- Box 16: Additional Information (Include critical history/information not included elsewhere in this IPC and relevant to the authorization of this TAR)
- Box 17: Signatures of Multidisciplinary Team and Program Director

# A Sample IPC

**The following slides contain:**

- An abbreviated case study
- Examples of completed Boxes 12-14

# Participant Example for Care Planning

**A Participant, diagnosed with hypertension, status post cerebral vascular accident with right hemiparesis, and depression was asked,**

- ***"What concerns you most about your health?"***

**She replied,**

- ***"I am not able to get to the bathroom in time or get my pants back up since my stroke, my husband has to help me."***
- ***"I am supposed to be practicing with my walker, but I just don't feel up to it. I usually just sit in my recliner and watch T.V."***
- ***"I used to enjoy cooking and working on projects around the house. Now, it's just easier for us to have carry out meals."***

# Participant Example for Care Planning

Through reflecting and summarizing conversations, the MDT was able to confirm that the participant would like to work on gaining independence with ambulating, toileting, and adapting to new ways to prepare meals for her family.

- ✓ *Nursing services* added that monitoring and controlling her blood pressure would lessen her risk of another stroke and keeping track of her moods would help the nurses know if her antidepressant was working for her. They let her know that they would provide communication with her PHCP in the case any of her medications were not doing what they were supposed to do. She agreed that monitoring the effectiveness of her medications would help her reach her goals and avoid a setback.

# Participant Example for Care Planning

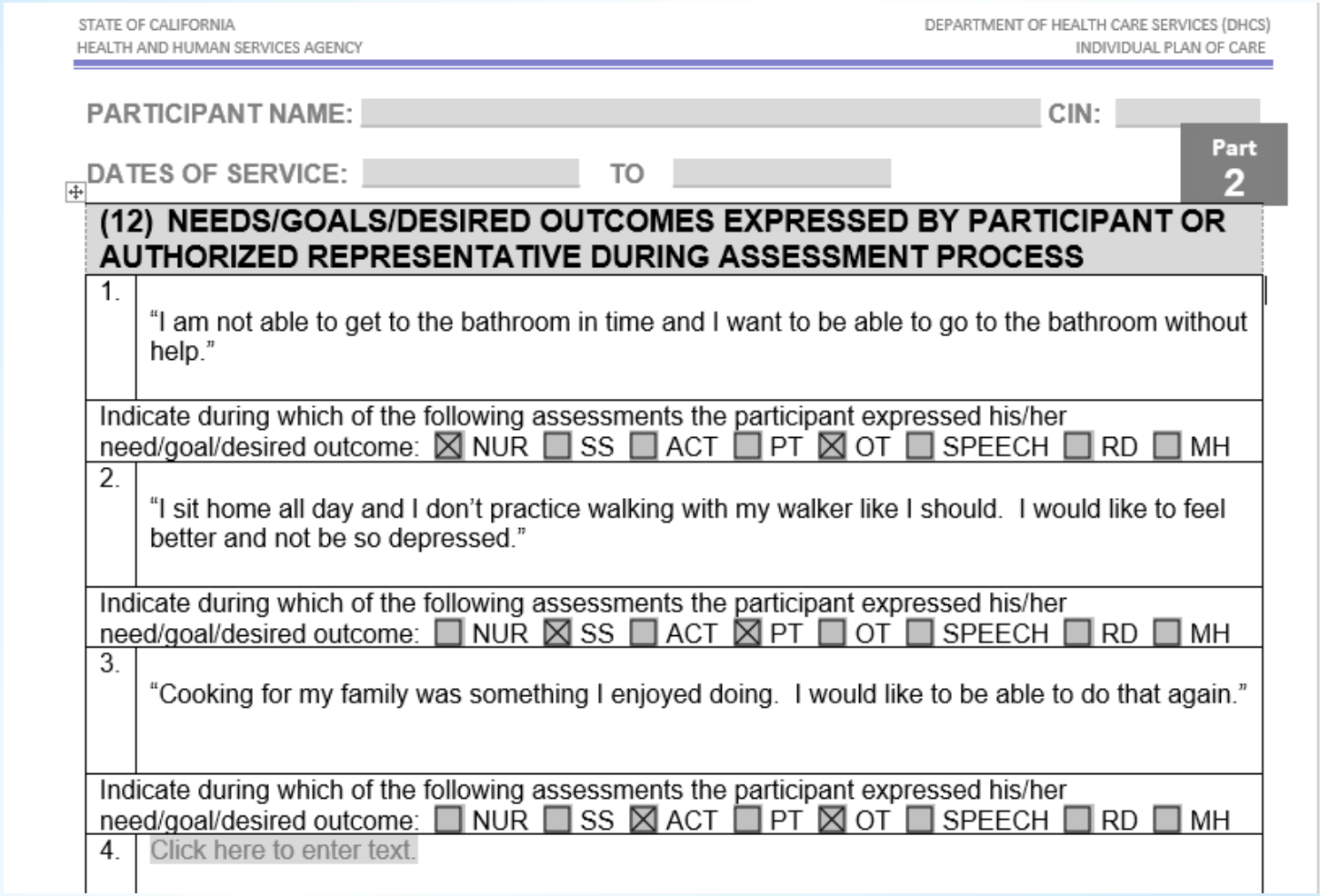
- ✓ *Social Services,* through open ended questioning, recognized that the participant was feeling a sense of loss from her lack of independence and not being able to do the things that gave her a sense of purpose.

  The social worker informed her that center participants are actively involved in choosing a monthly theme each month and they have a women's group that does the planning for the themed celebration that occurs one time a month. This group is facilitated by a social worker and promotes regaining a sense of community through active discussions and working toward group goals. She agreed that being actively involved in a project would help her feel as if she was doing something positive and help give her a sense of purpose.

# Participant Example for Care Planning

- ✓ *Therapeutic Activities* affirmed with the participant that she would be a valuable addition to the cooking group that was in charge of picking out an appropriate menu item, consistent with the centers chosen theme, to make for the celebration that they have one time a month. The participant expressed that she would bring in some of her favorite cookbooks to share.

# Sample of Completed Box 12



STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME: CIN:

DATES OF SERVICE: TO

Part 2

**(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS**

| | |
|---|---|
| 1. | "I am not able to get to the bathroom in time and I want to be able to go to the bathroom without help." |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☒ NUR ☐ SS ☐ ACT ☐ PT ☒ OT ☐ SPEECH ☐ RD ☐ MH | |
| 2. | "I sit home all day and I don't practice walking with my walker like I should. I would like to feel better and not be so depressed." |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☒ SS ☐ ACT ☒ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH | |
| 3. | "Cooking for my family was something I enjoyed doing. I would like to be able to do that again." |
| Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☒ ACT ☐ PT ☒ OT ☐ SPEECH ☐ RD ☐ MH | |
| 4. | Click here to enter text. |

# Sample of Completed Box 13

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME: CIN:

DATES OF SERVICE: TO

**(13) CORE SERVICES**

**PROFESSIONAL NURSING SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12**
**#(s)_1, 2_____**

1. Need / Problem
Ptp would be unsafe if not cued for safe transfer techniques. Ptp forgets to use walker 100% of the time and exhibits unsafe transfers on/off toilet and chair. Unsafe to walk independently due to lack of mobility.

| Treatment(s) / Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| Stand by assist with cue for safe techniques for transfers and ambulation. Cue for walker use at all times and provide daily 1:1 ambulation inside/outside as tolerated | 1x/day 1:1 ambulation and as needed per incidence as ptp moves about center | Ppt will be consistent for use of walker and safe transfer techniques without cue 100% of time. Ptp will maintain ability to ambulate safely and avoid falls 100% of time |

# Sample of Completed Box 13

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME: _____ CIN: _____

DATES OF SERVICE: _____ TO _____

**PERSONAL CARE SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12**
**#(s)_1_____**

1. Need / Problem :
Ptp would be incontinent 100% of time if not cued and assisted to toilet. Ptp has difficulty with clothing management and requires assistance.

| Treatment(s) / Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| Implement toileting schedule. Provide stand by assist to BR. Provide assist with clothing management using cue's per OT | Q2-3 h QD | Ptp will be independent with clothing management and avoid incontinent episodes 100% of time |

# Sample of Completed Box 13

**SOCIAL SERVICES**
**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) 2,3_____**

1. Need / Problem :
Ptp requires social outlet and opportunity to develop sense of purpose following loss of functional ability due to stroke. Would be isolated at home if not attending.

| Treatment(s) / Intervention(s) | Frequency | Goal(s) |
|---|---|---|
| 1) 1:1 with ppt to explore positive ways to manage loss of mobility.<br><br>2) Women's monthly party planning committee group specifically to nurture friendships and develop sense of purpose.<br><br>3) Admin GDS | 1) 1xweek<br><br>2) 1x month and prn<br>3) Q 6 months and prn | Ptp will report less sadness and attend center 100% of time scheduled.<br><br>Will attend Women's group and plan one party meal in six months.<br><br>Ppt's GDS score will decrease |

# Sample of Completed Box 13

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
INDIVIDUAL PLAN OF CARE

**PARTICIPANT NAME:** _____ **CIN:** _____

**DATES OF SERVICE:** _____ **TO** _____

| **THERAPEUTIC ACTIVITIES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12**<br>**#(s) 3** | | |
|---|---|---|
| 1. Need / Problem :<br>**Ptp lacks the opportunity to prepare food and cook meals related to changes with her functional abilities. Limited dexterity requires increased time to complete meal prep activities.** | | |
| Treatment(s) / Intervention(s)<br>**Cooking group: group to choose one dish each month to prepare and cook for the center or for a special luncheon. Meet one time to choose menu item approved by RD and develop shopping list. Meet one time to prepare food items for serving** | Frequency<br>**2x/mo** | Goal(s)<br>**Ptp will have an opportunity to complete a meal prep and cooking activity in a safe environment** |

# Sample of Completed Box 14 - Transportation

PARTICIPANT NAME: _____ CIN: _____

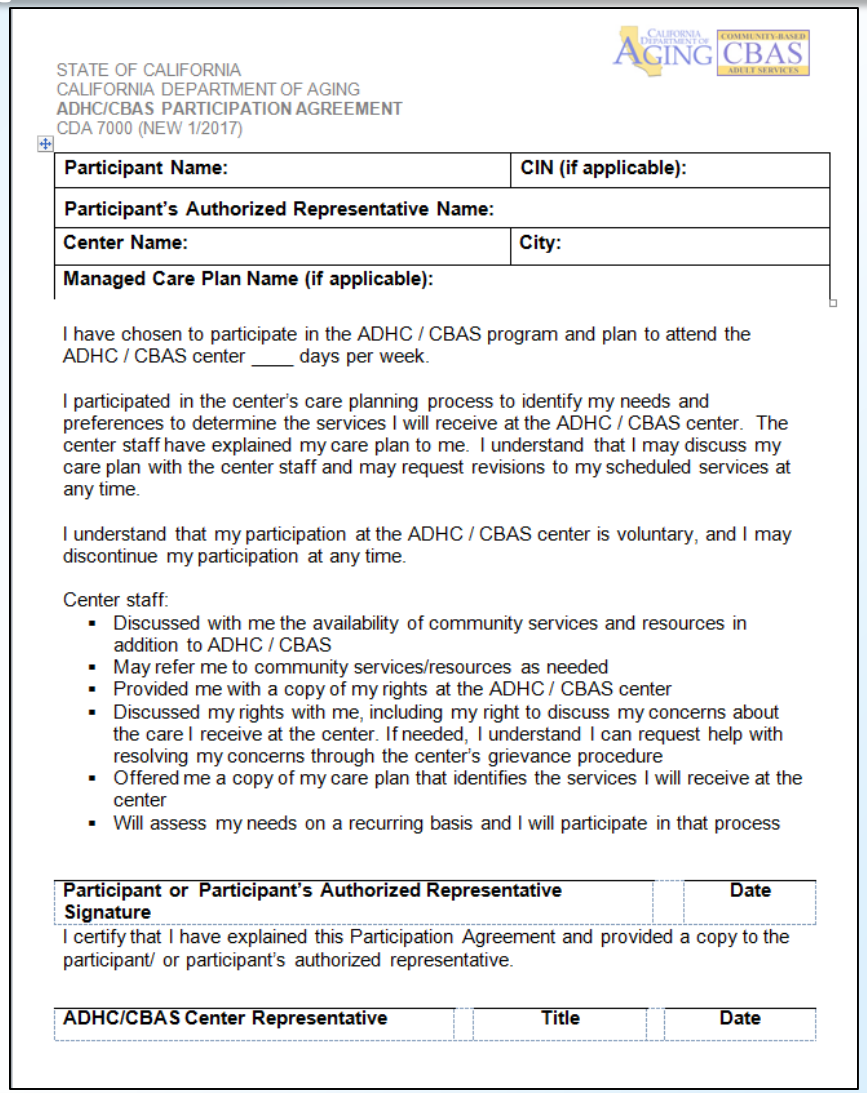
DATES OF SERVICE: _____ TO _____

| **TRANSPORTATION SERVICES**<br>**Addresses participant needs/goals/desired outcomes identified in Box 12 #(s)_____**<br><br>*(The participant may or may not express a need for transportation to be provided to/from the ppt's residence and the CBAS center. However, if the ppt needs transportation, then the center is to provide or arrange for it.)* | | |
|---|---|---|
| 1. Need / Problem :<br>The ppt requires transportation to and from her home and the CBAS center. | | |
| Treatment(s) / Intervention(s)<br>The center will transport the participant in the center van to/from the ppt's home and the CBAS center | Frequency<br>Each day of ppt's attendance at the center (3x/week) | Goal(s)<br>Ppt's transportation needs will be met. |

# ADHC/CBAS Participation Agreement (CDA 7000)

- Companion document to the IPC
- Standardized to meet federal person-centered planning requirements for participant's informed consent to attend the CBAS center
- Required for use by all CBAS centers for new and continuing participants effective March 1, 2017

# ADHC/CBAS Participation Agreement (CDA 7000)



STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
**ADHC/CBAS PARTICIPATION AGREEMENT**
CDA 7000 (NEW 1/2017)

| | |
|---|---|
| **Participant Name:** | **CIN (if applicable):** |
| **Participant's Authorized Representative Name:** | |
| **Center Name:** | **City:** |
| **Managed Care Plan Name (if applicable):** | |

I have chosen to participate in the ADHC / CBAS program and plan to attend the ADHC / CBAS center ____ days per week.

I participated in the center's care planning process to identify my needs and preferences to determine the services I will receive at the ADHC / CBAS center. The center staff have explained my care plan to me. I understand that I may discuss my care plan with the center staff and may request revisions to my scheduled services at any time.

I understand that my participation at the ADHC / CBAS center is voluntary, and I may discontinue my participation at any time.

Center staff:

- Discussed with me the availability of community services and resources in addition to ADHC / CBAS
- May refer me to community services/resources as needed
- Provided me with a copy of my rights at the ADHC / CBAS center
- Discussed my rights with me, including my right to discuss my concerns about the care I receive at the center. If needed, I understand I can request help with resolving my concerns through the center's grievance procedure
- Offered me a copy of my care plan that identifies the services I will receive at the center
- Will assess my needs on a recurring basis and I will participate in that process

| **Participant or Participant's Authorized Representative Signature** | | **Date** |
|---|---|---|

I certify that I have explained this Participation Agreement and provided a copy to the participant/ or participant's authorized representative.

| **ADHC/CBAS Center Representative** | **Title** | **Date** |
|---|---|---|

# Resources

- CDA has posted information on the CDA website relevant to completing the IPC and Participation Agreement and person-centered planning:
  - ✓ *IPC Form/Instructions and Participation Agreement*
  - ✓ *Participant Rights* – *in user-friendly format*
  - ✓ *CBAS Updates* Newsletter
  - ✓ *Federal Standards for Person-Centered Planning*
  - ✓ *"A Right to Person-Centered Care Planning" – Justice in Aging*
  - ✓ *Person Centered Care Articles (The SCAN Foundation Website)*

# CDA Contact Information

| CDA on the Web | www.aging.ca.gov |
|---|---|
| Addresses | California Department of Aging<br>CBAS Branch<br>1300 National Drive, Suite 200<br>Sacramento, CA 95834<br><br>cbascda@aging.ca.gov |
| Phone | (916) 419-7545 |

# Q & A