Appendix 37A ▪ Care Plan Instructions

The care plan document must be completed fully and accurately for each MSSP participant. The sites may modify the care plan form; however, the basic integrity and all components of the form must be maintained with space allotted to record the required information. The care plan document must include the following components:

A. Participant Name

Enter the participant's first and last name.

B. MSSP ID

Enter the participant's assigned MSSP number.

C. Dates

1. Care Plan Conference Date

   Enter the date of the care plan conference. Care plan conference date must be documented on the care plan form. May also be documented in the monthly progress notes.

2. Duration of Care Plan

   The duration of the care plan is twelve months beginning with the month of enrollment. (The duration date for an April 2026 enrollment would be April 2026 – April 2027. Month and year are required components; day is optional. A participant enrolled April 5, 2026, has a care plan duration date of April 5, 2026 – April 30, 2027).

3. Date (1st column)

   Enter the date the participant need was originally identified or reconfirmed.

D. Participant Need #

The "Participant need #" section will list participant need statements numerically in a sequential manner. The participant need statement numbers remain the same as long as the participant need statement is active. Retired participant need statement numbers can be reactivated due to recurrence.

Participant need statements may be renumbered starting with "1" if the care plan is completely rewritten during the month of reassessment. Care managers must document in the progress notes what has happened to previous participant need statements, e.g., whether the participant need statements have been combined into a new participant need statement or resolved. This information can also be documented on the care plan form under the "date resolved/comments" column.

Many participant need statements remain active as long as the participant is enrolled in MSSP. Providing and/or discontinuing interventions will not always result in the need for/or resolution of participant need statements.

E. Participant Need Statements

1. Participant need statements are derived from areas of concern identified in the re/assessments for which specific services and/or care management activities are provided.

2. Participant need statements must address specific needs and include the participant's functional status.

3. Description of a participant's functional status can include the medical diagnoses in participant need statements. The participant's medical diagnoses alone may not define the participant need statement or substantiate the need for services.

4. In addition to the functional status the participant need statement should include reference to the impact on the participant (i.e., what is the risk to the participant or how is this a problem for the participant).

5. Whenever new needs are identified, they must be added to the care plan. They may be handwritten or electronically entered on the existing care plan and do not require a new participant signature. Participant need statements can be added during the year as issues arise.

6. The participant need statements 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. Reflect the multi-disciplinary team collaboration on assessment findings. Problems not identified prior to the conference should be added at the care planning conference.

7. If needs have been identified that will not be addressed in the care plan, an explanation must be documented in the re/assessment, or in the progress notes. These include areas that are sensitive in nature or need the participant chooses not to address through the care management process.

F. Participant Goal/Outcome

- Goals must be measurable, reflect the participant's input and consider the participant's preferences.
- Measurable goals must describe outcomes and/or achievements that pertain to participant need statements.
- Goals specify the skills to be acquired, behaviors to be changed, information to be provided, health or psychosocial conditions to be met.

G. Service Provider Name and Type

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

Type	=	Definition
I	=	Informal: a service provided without cost through the participant'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 vendor/provider and/or provider type may be entered for an individual service.

For purchased services/items using Waiver Service funds, the site should enter the name of the provider if known. A generic entry for a vendor (Building Supply Store) or specific name (Home Depot) can be made on the care plan. Once a purchase is made, the item(s)/service(s) must be documented on the care plan (handwritten or electronically). The provider information may also be added to the care plan.

All purchased interventions listed on the SPUS must be on the care plan.

H. Plan/Intervention

The Plan/Intervention section lists information pertinent to participant need statements and outlines possible actions, items to be provided, plans, or solutions to address the participant need statements. Interventions that have the greatest probability of success are those that consider the participant's preferences, perception of the problem or situation, and are compatible with the participant's beliefs, values, and attitudes. The services and/or items may be in a format specified by the site (i.e., list; narrative).

It is acceptable to enter a generic category of services/items as an intervention (e.g., safety equipment) at the onset. Once specific services/items are purchased (e.g., transfer pole, smoke alarms, etc.) a notation must be entered on the care plan (handwritten or electronically) defining all services and items purchased using Waiver Service funds. When a new issue arises, the existing participant need statements should be evaluated to determine whether the new intervention(s) can be added. The addition of an intervention may be handwritten or entered electronically on the care plan. This does not require the participant's signature. It is recommended that maximum quantities (monthly) of items/services to be purchased be added to the care plan.

All interventions must be listed on the care plan. Failure to record an intervention on the care plan could result in recovery of funds.

I. Date Resolved/Comments

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

Comments include:

- Information regarding the results of care management interventions; (e.g., when an item was delivered/provided, service provider names)
- Whether the problem has improved, resolved or is in need of further monitoring
- Participant input regarding choices and concerns
- Handwritten entries or addendums are acceptable and should include staff initials and date

J. Signatures

1. The Primary Care Manager (PCM) and SCM must both sign and date the care plan within two weeks of the last re/assessment. These signatures are required to activate the plan and to initiate purchases with Waiver funds.

2. The participant's signature* must be obtained at or before the first quarterly home/telehealth visit following care plan activation. The participant's signature indicates their acceptance of the plan but is <u>not</u> required prior to the commencement of any services.

   Pending receipt of the participant's signature on the care plan the progress notes must reflect discussion of the care plan. This discussion and the participant's verbal acceptance must be documented in the progress notes for the first monthly contact unless the participant has signed the care plan <u>prior</u> to the first monthly contact (Chapter 3, Section 3.640.4, Care Plan Activation: Signatures and Review Process).

   If sites are unable to obtain the participant's signature, documentation should be included in the progress notes explaining that all documents were reviewed with the participant, the participant confirmed they understand them, as well as confirmation that the participant understands their rights to freedom of choice of services/providers and appeal rights. The required document (care plan, AUDPHI, etc.) should indicate the participant's verbal agreement on the form and the date of the agreement until the signature can be obtained (Chapter 3, Section 3.1530, Telehealth as a Service Delivery Method).

3. The care plan must be rewritten annually. Timeframes for signatures (PCM, SCM, and participant) follow the parameters described above. The revised care plan must have the PCM and SCM signatures prior to the commencement of any new services.

*Participant's signature: for a participant who is unable to sign, the signature may be provided by their conservator, agent, or personal representative (Chapter 3, Section 3.640.4 Care Plan Activation: Signatures and Review Process; Chapter 5, Section 5.810 Staff Signatures and Signature Requirements).