Instructions for Special Needs BasicCare (SNBC) – Medica AccessAbility Solution® and Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced® Care Plan

INFORMATION ABOUT ME

1.	**Member Name.**
2.	**Health Plan ID Number.**
3.	**Care Plan Completion Date.** Date the care plan is completed.
4.	**Member Phone Number.**
5.	**Product**
6.	**Product (SNBC, ISNBC) 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 SNBC to ISNBC on 1/1/2020, the Care Coordinator/Case Manager would enter 1/1/2020 as the product enrollment date on the care plan.
7.	**My Address.**
8.	**Date of Birth**
9.	**Diagnosis.** Enter the member's diagnosis. This box allows for multiple diagnoses.
10.	**Date of My Assessment Visit.** Enter the date the assessment was completed.
11.	**Assessment Type.** Choose the type of assessment completed.
12.	**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.
13.	**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).	
14.	**Name of Care Coordinator (CC)/Case Manager (CM) and Phone Number.**
15.	**Primary Physician.** Enter the name, phone number, and fax number of member's primary care provider.
16.	**Clinic.** Enter the name of the member's primary care clinic.
17.	**County Waiver Worker.** Enter the name of the County Waiver Worker, if applicable
18.	**County Waiver Program.** Check the County Waiver Program member participates in, if applicable
19.	**Emergency Contact.** Enter name and phone number of the person who should be contacted in case of an emergency.
20.	**Power of Attorney/Guardian** (if applicable). Enter the name and phone number of POA/guardian. 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.
21.	**Mental Health Targeted Case Manager.** Check yes or no. If, yes, enter name and phone number.
22.	**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.

WHAT'S IMPORTANT TO ME?

23.	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

24.	**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

25.	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

26.	**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**.**

27.	**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
28.	**Check the box if goal is needed.** If the member needs assistance with a risk or identified need, create a goal in Section VII.
29.	**Check applicable box if the Condition/Screening or goal is not applicable, contraindicated, or declined.**
30.	**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
	Breast Cancer Screening (Women 40+ at PCP recommendation depending on risk factors)
	Child & Teen Checkup (Up to age 21)
	Colorectal Screening (Men and Women 50+ or earlier depending on risk factors)
	Dental Exam
	Flu shot (Annually)
	Hearing Exam
	Pneumovax (Immunize those at high risk. Re-immunize once if 1st pneumovax was received more than 5 years)
	Tetanus Booster (As needed and once every 10 years)
	Vision Exam
	Blood Pressure. (Goal is <140/80 to age 75. After 75)
	Cholesterol Check. (All ages as directed by PCP)
	Continence Needs (Evaluated by PCP)
	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.
	Medication Compliant CC/CM should discuss medication management with member, this should assist in determining whether member is compliant with medications. Check yes or no. If no, attempt to create a goal with the member to address this
	Safe Disposal of Medications. Check "yes" documenting the required conversation took place and supporting documents were provided. Check N/A if not applicable. Optional Comments can be used to document what information was provided or reason for N/A. *Confirm with member's health plan for direction about which members the CC is required or not required to have this conversation.*
	Risk for Falls (Afraid of falling, has fallen in the past)
	Education/Employment. CC/CM should inquire if member is currently participating in education/employment and has concerns of if this is something new they would like to consider. CC should create goal if this is an identified need.
	Family Planning. CC/CM should inquire if member currently has family planning needs. CC should create goal if this is an identified need.
	Housing. CC/CM should inquire if member currently has housing needs. CC should create goal if this is an identified need.

	Rehabilitative Services. CC/CM should inquire if member is currently participating in rehabilitative services and has concerns of if this is something new they would like to consider. CC should create goal if this is an identified need.
	Transportation. CC/CM should inquire if member currently has housing needs. CC should create goal if this is an identified need.
	Behavioral Health/Substance Use (if applicable) Check N/A if not applicable. If there are behavioral health or substance use 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".
	Disease Management/Complex Case Management Referral. Check yes or no. If yes, include the diagnosis.

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. All areas of concern identified on the HRA must be addressed on the Care Plan

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 person centered & SMART (Specific, Measurable, Attainable, Relevant, and Time-bound. (The first known usage of the term was by George T. Doran in 1981.)
32.	**Intervention/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 identified follow-up 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.	**Emergency Plan.** Discuss and document with the member/ representative what the member would do in case of an emergency.
39.	**Self-Preservation/Evacuation Plan.** 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.

ACCESSABILITY SOULUTION/ACCESSABILITY SOLUTION ENHANCED SNBC SERVICE PLAN: DHS's 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.

44.	**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.
45.	**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.)
46.	**Additional comments:** Optional free form text area for CC notes.

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	Intervention/ Support Needed	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved/Not Achieved (Month/Year)
I want to be smoke free by next review.	-I will schedule appointment with my doctor to discuss smoking cessation aides -My Care Coordinator will provide information regarding Medica's quit plan -I will take medication as prescribed my doctor	3/2021	9/20/2020 – Has talked with doctor about smoking cessation. No prescriptions used at this point. Member developed plan. Has cut down to 5 cigarettes/day.	3/15/2021-Goal Met. Member has been smoke free since 1/1/2021. Goal modified on next care plan to "I will remain smoke free through next review".
My PTSD signs/symptoms will be under control as evidenced by my sleeping at least 4-6 hours per night	-I will take sleep aide medication as prescribed -My Care Coordinator will provide information on Mental Health supports and refer as needed -I will contact my doctor if signs/symptoms	3/2021	9/20/2020-Reviewed with member at 6 month check-in. Member reports she has been sleeping at least 4 hours most nights.	Reviewed 3/15/21-Member stated she has been sleeping well at night (at least 4 hours each night). Goal met, member would like to continue. See

	worsen for possible medication adjustment			goal on new Care Plan.
I want my Congestive Heart Failure to remain stable through my next review this includes: weight gain, shortness of breath and swelling.	-I will follow my cardiac diet -I will complete weight checks daily -I will notify my doctor if I my shortness of breath increases -I will notify my doctor if I am having swelling -I will take my cardiac meds daily	9/2020	6/2020 Reviewed with member at 3 month check-in. Member states she follows cardiac diet, no calls needed to MD for weight gain, shortness of breath, or swelling. 9/2020 Reviewed with member at 3 month check-in. Member states she continues to follow cardiac diet, no calls needed to MD for weight gain, shortness of breath or swelling.	9/2020. Goal met. Member would like to continue. See goal on new Care Plan.