UPDATED INSTRUCTIONS FOR COLLABORATIVE CARE PLAN – January 2011

I. MEMBER INFORMATION
1. Member Name:
2. Health Plan ID Number:
3. Health Plan Name:
4. Today's Date: (date the care plan is completed)
5. Member Phone Number:
6. DOB: Enter member's date of birth
7. Member Product (MSHO, MSC+) Enrollment Date: Enter member's date of enrollment in the current product. For example, if a member continues with the same health plan but switches from MSHO to MSC+ on 12/1/2011, the care coordinator would enter 12/1/2011 as the product enrollment date on the care plan.
8. Member Address:
9. Emergency Contact: Enter name and phone number of the person who should be contacted in case of an emergency.
10. Member's Power of Attorney or Guardian: (if applicable)
11. Care Coordinator/Case Manager: (include phone number)
12. Primary Physician: Enter the name, phone number, and fax number of member's primary care provider.
13. Clinic: Enter the name of the member's primary care clinic.
14. Assessment Date: Enter the date the assessment was completed.
15. Assessment Type: Choose the type of assessment done.
16. Assessment Tool: List the tool used for the assessment, i.e., Health Risk Assessment tool, LTCC, or other.
17. Case Mix: Enter the member's Case Mix. (A-L)
18. Rate Cell: Enter the member's Rate Cell. (A, B, D)
19. Diagnosis: Enter the member's diagnosis: (this box will allow you to enter as many as you want to enter)

20. Does Member Have A Mental Health Diagnosis? Yes or no. If yes, list diagnosis and proceed to 21.
21. Is Mental Health Managed by Health Professional: Including Psychiatrist, Psychologist, and/or Primary Care Physician, if yes, stop here. If no, see 22.
22. Mental Health Goal: Do you, as the Care Coordinator, believe a goal should be created around mental health?
23. If yes, create a goal in the care plan. If member declines a goal and intervention, document as declined.
23. Mental Health Targeted Case Manager: If yes, enter name, and phone number.
24. Does the Member Have an Advance Directive: Answer yes or no? If no, document that a discussion occurred and explain why there is no Advanced Directive.
25. Language: Check the primary language of the member. If the member's language is not on the list, document their language in the "other" section.
26. Is An Interpreter Needed? Answer yes or no. Include the name and number of interpreter.
II. MEMBER'S STRENGTHS
27. Member's strengths: Enter member's supports, and describe what works best for the member. Include a list of the member's skills, talents, and/or interests. Complete the initial assessment in the first row. Updates should be entered on the second row.
III. MEMBER'S CHOICE OF PERSONAL GOALS
28. Does member want help? If so, document the supports the member requesting (these are member's choice). Complete the first row
IV. HRA/LTCC-CC/CM RECOMMENDATIONS
29. List the services and supports recommended by the care coordinator: Enter CC recommendations based on identified needs and note if the member declines interventions. Complete the first row at the initial assessment. Updates should be entered on the second row.
30. Caregiver listed on HRA/LTCC: Check yes or no. If yes, how was the caregiver assessment form completed? Include date completed.

V. HEALTH PREVENTION/CHRONIC CONDITION – *Target levels were verified by Geriatric Physician.*
31. Care Coordinator should have an educational discussion with the member or member's representative about applicable conditions and/or regularly scheduled screenings. Indicate that you have had an educational discussion with the member when appropriate. You may collect additional information such as the date of the screening or scores in the "notes" section.
32. If contraindicated or not applicable, check the appropriate box.
33. If a member needs assistance with a risk or identified need, create a goal in Section VI. If member declines services, please note that the member declined.
34. RX for Calcium Vitamin D: Take as directed by your physician. Do not start taking medication without checking with your doctor.
35. RX Aspirin: Take as directed by your physician. Do not start taking medication without checking with your doctor.
36. Do you have a routine diabetic check with your doctor, if not you may want to schedule a visit.
34. Other: Enter any other test or condition not addressed in the above section.
35. Does the member take their medication as prescribed: Check yes or no. If no, create a goal to address this in Section VI.
36. Disease Management Referral: Check yes, no, or N/A. If yes, include the diagnosis. *All health plans have different diseases and processes in their disease management programs; please check with the member's health plan.*
37. List of Medications: (if not on HRA/LTCC or other form).
38. Hospitalizations: Document the number of hospitalizations in the past year and the reason for each one.
39. ER Visits: Document the number of ER visits in the past year and the reason for each one.
40. Use information from 38 and 39 to identify members at risk of transition.
VI. ISSUES, NEEDS, AND ALL AREAS OF CONCERN IDENTIFIED ON THE HRA/LTCC MUST BE ADDRESSED IN THE CARE PLAN.
41. Member Goals: List appropriate goals to meet the risks identified on the HRA/LTCC, or other related member documentation.
42. Intervention: Document any intervention(s) related to achieving this goal; how will you help the member achieve the goal or what will the member need to do to accomplish the goal.

43. Target Date: List the target date for completion of the goal. For example - "Member wants to remain living in their home." If the care plan is created on 12/18/2010, the target date may extend for one year to 12/18/2011. Another example-"Member will be safe when bathing." The intervention might be to get a bath bench for the member. The bath bench will be delivered in 2 weeks so the target date could be 1/3/2011. "Ongoing," "yes or no," is not acceptable.
44. Monitoring Progress/Goal Revision Date: Record the member's progress toward meeting a goal. Be sure to document the date you make the note. A goal may be revised when the original goal is not working. The care coordinator should document the change and the reason for the change. Include the date of the change or revision.
45. Date Goal Achieved: The care coordinator must enter a month and a year. For a goal that extends beyond one year, such as "member will remain safe in their home," the CC may continue the goal from year to year. In that situation, the care coordinator should document that the goal is being continued on next care plan.
46. Goal Not Achieved: if the member does not achieve the goal, identify a new target date, discontinue the goal, or carry the goal forward to next care plan.
VII. MEMBER PLAN
47. Personal Risk Management Plan: a PRM plan must be completed if the member refuses any EW service the care coordinator recommends. CC should document whether the member or authorized representative declined the service. The CC should also document that the risk plan was discussed with the member.
48. Follow-up plan: Describe plan for follow-up visits i.e., once a month, every 3 months, or every 6 months?
49. Emergency plan: Discuss with family and/or member and document member's plan in case of an emergency.
50. Self Preservation/Evacuation: Evacuation plan for members who cannot evacuate independently.
51. Essential Services Backup plan: Is member receiving essential services (such as meals on wheels if that is their only source of nutrition)? What is the member's back-up plan if essential service providers do not show up?
52. Additional case notes: Space for CC to document anything not covered in another area.

VIII. CHOOSING COMMUNITY LONG TERM CARE
53. I have been offered a choice of home and community based services or nursing home services if needed: Member or guardian would check yes or no.
54. I have been offered a choice of providers: Member/guardian would check yes or no.
55. I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want: Member/guardian would check yes or no.
56. I agree with the plan of care as written by my care coordinator/case manager: Member/guardian would check yes or no.
57. I received the Bill of Rights.
Signatures:
58. Member (or Guardian) Signature:
59. Date:
60. Signature of person completing this plan: Care Coordinator/Case Manager would sign here:
61. Date:
62. Care plan mailed or given to member: Enter date.
63. Care plan or summary mailed/Given to PCP (verbal, phone, fax):
64. Date:
65. Home and Community Based Service Plan:

*** Examples on following page**

Examples

Goal	Intervention	Target Date	Monitoring Progress/Goal Revision/Date	Date Goal Achieved.
Preventive care visit with PCP	Will help member set up a doctor visit	7/1/11	4/10/11 Progress note written	5/21/11 member has had a preventive care visit
Provide daily supervision of ADLs including hygiene	Will get member into an Adult Daycare	2/1/11	7/1/11 Adult day care did not work out. Will schedule try another day care by 8/31/11	7/20/11 document the goal has been achieved
Member will remain living in own home	Services and supplies will be provided to keep member in their home	12/31/10	7/1/11 added homemaking services to help member stay in their home	12/28/11 member able to continue living in own home. Will continue goal on next care plan
Safety with bathing	Will order bath bench.	01/01/11	2/31/11 first vendor refused EW payment, selected another vendor.	3/25/11 Bath bench delivered