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06.10 INTRODUCTION

Service planning encompasses a comprehensive review of the participant's problems and strengths. Goals are set based on the participant's identified needs. This service planning process allows for participation of the participant and/or primary contact, physician, service providers, and CLTC case management team. Service planning provides the involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

Service planning includes service coordination with other involved agencies, i.e., home health, case management hierarchy agencies, etc., to ensure all services are considered in the development of the service plan. (Refer to Section 05.34)

Completion and implementation of the service plan is a function of the **Case Manager**.

06.20 SERVICE PLAN POLICIES AND PROCEDURES

06.21 Development of the Service Plan

The **Case Manager** and **Nurse Consultant** must discuss the assessment information for service plan development and to enroll the participant in the waiver. The **Case Manager** is responsible for documenting the team conference in the narrative and completing and implementing the initial Service Plan upon entering the participant into the waiver.

The Service Plan is developed by the **Case Manager** from the assessment information, information obtained from the team conference with the **Nurse Consultant**, input from the participant, primary contact, and/or other permitted caregiver support, and agencies providing services to the participant.

Several factors influence the service planning process and the determination of the services to be authorized. These factors include:

1. The amount and type of assistance in place.
2. The degree of assistance required and the time required to complete the needed care.
3. The participant’s cognitive ability.
4. The participant’s expressed need for assistance and the value he/she assigns to that need.
5. The availability of other resources to meet these needs.
6. The most cost-effective way to meet these needs.

Active participation and planning with the participant and/or the primary contact regarding the participant's long term care is an integral part of the CLTC Program. Development of a realistic and thorough Service Plan and its implementation in the community involves numerous contacts and extensive planning and coordination.

Service planning must address problems identified through the assessment process as well as viable solutions. It must include resources currently utilized by the participant, both waiver and other, as well as additional services which may be available to meet the participant's needs.

All payment sources, where appropriate, should be considered prior to using Medicaid services (including waiver services) in the Service Plan.

06.22 Purpose of the Service Plan

The results of the service planning process are documented on the Service Plan. It is the intent of the Service Plan to be a multidisciplinary plan rather than a nursing care plan. A completed Service Plan is required on all waiver participants.

Each Service Plan should be individualized for a particular participant and completed so that a service professional unfamiliar with the participant can have, by reading the plan, a clear picture of the participant's problems, planned interventions, and person(s) performing the interventions.

06.23 Elements of the Service Plan

The Service Plan includes five (5) elements:

- Waiver/ Non-waiver/Caregiver supports
- Problems
- Goals
- Planned Interventions
- Service Plan Participant Agreement

The date the participant enters the waiver and the initial Service Plan date must be within 7 days.

06.23.10 Caregiver Supports and Non-waiver Supports

The Caregiver Supports and Other Supports sections of Phoenix contain information on the family and other non-waiver caregivers assisting the participant in the community. All the corresponding fields in Phoenix should be completed.

The caregiver release must be signed. The participant should sign if capable. If not capable, the Primary Contact should sign. If neither the Primary Contact nor participant is capable, the **Case Manager** or **Nurse Consultant** may sign. If the **Case Manager** or **Nurse Consultant** signs, an explanation must be written in the comment section of Caregiver Supports section. At the next visit, the caregiver permission should be signed by an appropriate person, if possible. In the event there are no caregiver supports to list in this section, the blank Caregiver Release form should be signed.

The following should be completed in the Caregiver Support Section of Phoenix:

1. Name of the caregiver;

2. Relationship to the participant;

3. Tasks completed by the caregiver and an indication of whether or not the caregiver is the primary caregiver for the task;

4. Frequency - how much of the care the support person is able to complete for the participant;

5. Address and Phone number(s) of the caregiver;

6. Dates of task coverage;

7. Interview of caregiver support indicated as primary for the task.

Diagnosis: Diagnoses are generated on the Service Plan from the information entered into Phoenix. This medical information can be obtained from the participant's medical records as stated by the participant's physician and/or as stated by the participant and/or primary contact, home health services, etc.

While it is expected that most service plans should cover all assessment components, there will be some cases in which a particular component will not be addressed. In such cases, it should be determined by the **Case Manager** that no active problems exist in that area.

The service plan Comments Sections should be used only for insertion of clarifiers and should not be used as a Narrative.

06.23.11 Waiver Supports

The Waiver Support Section in Phoenix is used to enter information on waivered services in place for the participant. It is also used to generate service authorizations for waivered services.

06.23.12 Personal Goals

Personal goals are determined by a discussion with the participant or primary contact (if participant is unable.) The goal should be realistic and the steps to achievement may involve waiver supports or other means.

The **Case Manager** will list the steps identified by the participant/primary care giver to achieve this goal. The **Case Manager** must indicate when the steps are achieved or terminated.

The Personal Goals must be addressed at the initial visit, quarterly visit and re-evaluation visit.

06.24 Service Plan Components

There are seven (7) components identified on the Service Plan. These components have applicable information which can be identified through the assessment instrument as follows:

- Medical
- Skin/Nutrition
- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Psychosocial
- Caregivers
- Home Assessment

Problems

In order to develop a plan for intervention, a problem must be defined clearly. The problems listed on the Service Plan should be those problems with which the CLTC staff, participant, and primary contact will be actively working. Each listed problem should have corresponding goals and interventions.

When the **Case Manager** identifies services that are needed but unavailable, they should be noted in the body of the Service Plan as a problem and identified as an unmet need under the intervention. The Service Plan must address all areas in which the participant requires at least limited/moderate assistance.

Goals

To evaluate the effectiveness of a Service Plan, the expected outcome or goal for an intervention must be identified. A goal may be rehabilitative, maintenance, participant, or caregiver oriented. A goal is developed as a joint effort between the participant, primary contact, physician, therapist, and CLTC **Service Planning team**. Each problem must have a related goal.

A goal must be:

1. Stated in positive terms, not in terms of what should be avoided;

2. Defined in terms of the expected outcome (a result or condition to be achieved rather than an activity to be performed);

3. Written in quantifiable (measurable) terms, so that all involved persons may know when the goal is reached;

4. Achievable, taking into consideration known resources;

5. Designed as a joint commitment between the participant and the **Case Manager**, taking into account the participant's wishes and priorities; and,

6. Written to achieve a single end, not a conglomerate of expected outcomes.

Planned Interventions

Once a goal has been established, interventions should be selected to reach the goal.

06.25 Service Plan Completion and Implementation

The Service Plan must be completed within seven (7) business days of waiver enrollment. The Service Plan is complete upon team staffing and signing.

A copy of the Service Plan must be routed to all appropriate waiver service providers **within seven (7) business days** of completion. In most situations, Phoenix will submit the initial plan and annual re-evaluation service plan to the provider. The CLTC representative/worker should insure the service plan is sent and will need to initiate copy routing if the service plan is updated during the 365-Day cycle. The Caregiver Supports, Non-waiver Supports, and Waiver Supports sections are a part of the Service Plan and must be included in the routing to all appropriate waiver service providers.

06.26 Service Plan Revision Within 365-Day Cycle

The Service Plan may require revisions when changes in the participant's condition and/or service needs occur which do not affect the re-evaluation cycle itself. Any additions or revisions in the Service Plan, including waiver, caregiver supports, and other supports, within the re-evaluation cycle must be entered into the Service Plan. A copy of the revised Service Plan is sent to the providers as appropriate.

Goals, interventions, or actors that are longer appropriate should NOT be deleted, but should be addressed in the comments. The comments must include the subject changed and the date of the change.

06.27 Team Involvement

Service planning is always a team effort. Staffing for levels of care and service plan reviews at enrollment and reevaluation must be done with DHHS staff in a manner where both parties can see the most current information in Phoenix. (This may be the **Case Manager II, State Case Manager, Lead Team Case Manager, Area Administrator, Lead Team Nurse Consultant, or Nurse Consultant.**) Team signatures are completed in Phoenix.

06.28 Service Plan Agreement

The Service Plan Agreement Section is part of the current Service Plan and is presented to the participant, primary contact, and/or permitted other caregiver support as the last page of the service plan. The Service Plan Agreement Section serves as a record that the Service Plan has been developed, reviewed, and

evaluated with the participant, primary contact, and/or permitted other caregiver support. The Service Plan Agreement Section is signed and dated at **the Initial Visit** AND during the participant's **first quarterly visit following a re-evaluation** visit. The dated Service Plan Agreement Section is signed by both the **Case Manager** and the participant, primary contact, and/or permitted other caregiver support. It is used on an on-going basis and is maintained in Phoenix.

A copy of the Service Plan should be offered to the Participant/Primary Contact.

06.29 Service Plan at Re-evaluation

Ensuring the service plan's effectiveness and accuracy is an on-going process.

At re-evaluation, the new Service Plan Interventions should reflect only the current services received or planned. The participant and/or primary contact, physician, and providers, must be contacted, as appropriate, for their input in evaluating the effectiveness of the Service Plan, and any changes that have occurred in the participant's condition or support system. **The creation, completion, staffing, and signing in Phoenix of the Service Plan must be within seven (7) business days of the re-evaluation assessment completion.**

The time frame for the formal evaluation depends on many factors and may vary, but it must be completed **by the 365-day** re-evaluation. However, should significant changes occur in a participant's condition or location or in the status of the primary contact, an immediate review of the Service Plan's appropriateness must be completed. The participant who is unstable and who has a limited support system may need evaluating more frequently than every 365 days. Should the participant have significant changes resulting in the need for a new assessment, a new service plan will need to be completed.

A new Service Plan is completed and routed to all appropriate waiver service providers **within seven (7) business days** of completion and/or revision.

A copy of the Service Plan should be offered to Participant/Primary Contact.