Care Plan/Support Plan Goals

Care Coordination Training Module #4

Support Planning

Care Planning/Support Planning is an essential and required task completed by the Care Coordinator (CC) with the member and/or authorized family members or legal guardian. Information obtained during the assessment is incorporated into a Care Plan/Support Plan that is individualized to the member and reflective of their health care needs, goals, wishes and values. The plan centers on the member goals and priorities as well as input received from the member's interdisciplinary care team (ICT) with the goal to improve or maintain their health and functioning.

Required Documents

Member Type	Legacy Tools	MnCHOICES
MSHO/MSC+ (non-Institutional)	Collaborative Care Plan (CCP)	Support Plan - HRA: Members not receiving EW or PCA/CFSS Support Plan - MCO MnCHOICES Assessment: Members receiving EW, PCA/CFSS or Essential Community Supports
MSHO/MSC+ Institutional	Facility Care Plan Review Institutional Care Plan (Effective 1/1/2024)	Facility Care Plan Review Institutional Care Plan (Effective 1/1/2024)
ISNBC/SNBC (All)	Care Plan (CP)	Support Plan - HRA
MSHO/ISNBC UTR/Ref	UTR/Ref Care Plan	UTR/Ref Care Plan
Transfer/Transitional Member	Transfer Member Health Risk Assessment if Care Plan, CSP/CSSP, or Support Plan are available. If not available, must create CCP or CP.	CCs will enter the date and type of assessment (transitional) in MnCHOICES and upload the Medica Transfer Member Health Risk Assessment if Care Plan, CSP/CSSP, or Support Plan are available. This process will likely be updated as DHS finalizes a Transitional HRA within MnCHOICES.

Support Plan as a Living Document

Medica considers the care plan/support plan to be a “living document”. It should be reviewed according to the follow-up plan and updated as changes occur in the members health care needs or following any transition.

SMART Goals

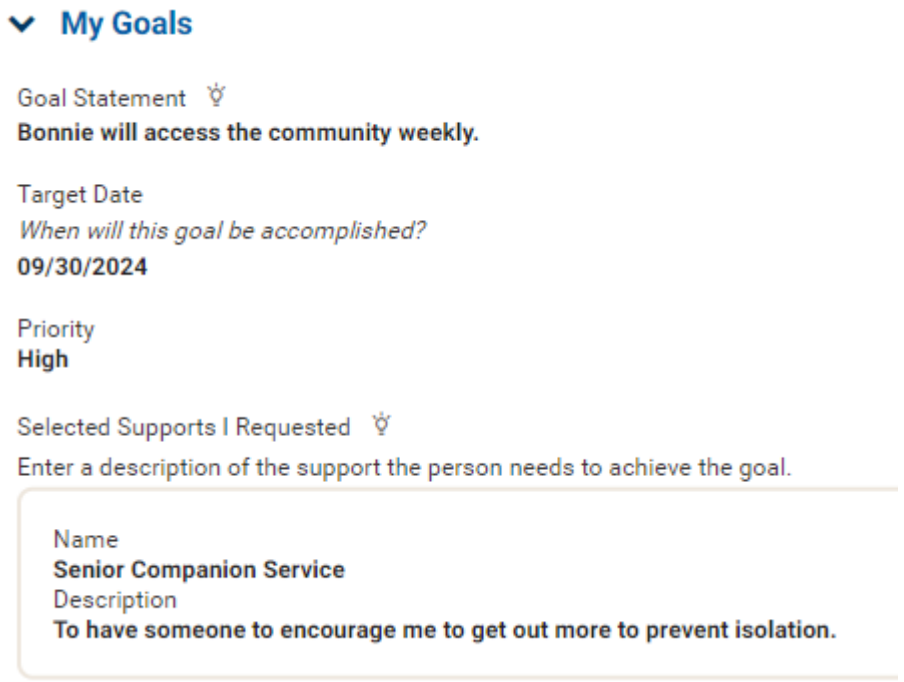
Care plans/support plan goals must be written in a SMART, person-centered format.

SMART Goals

Care Plan Goals must include:

- Identified member-centered goals and member specific interventions.
- Action steps & who is responsible for each intervention. What will the member need to accomplish the goal and how will the CC help the member achieve the goal?
- Use plain language when creating the goals and interventions so it can be easily understood by the member, authorized family member or legal guardian.
- Avoid “blanket” goals like the member will not have any ER or hospitalization visits.

Rank by Priority	My Goals	Support(s) Needed	Target Date
☐ Low ☐ Medium ☒ High	Bob will schedule an appointment for an annual physical by target date.	Care Coordinator will provide contact information for local in-network clinics. Bob will call clinic and schedule appointment. Bob will contact Provide-a-ride for transportation to appointment.	10/31/23

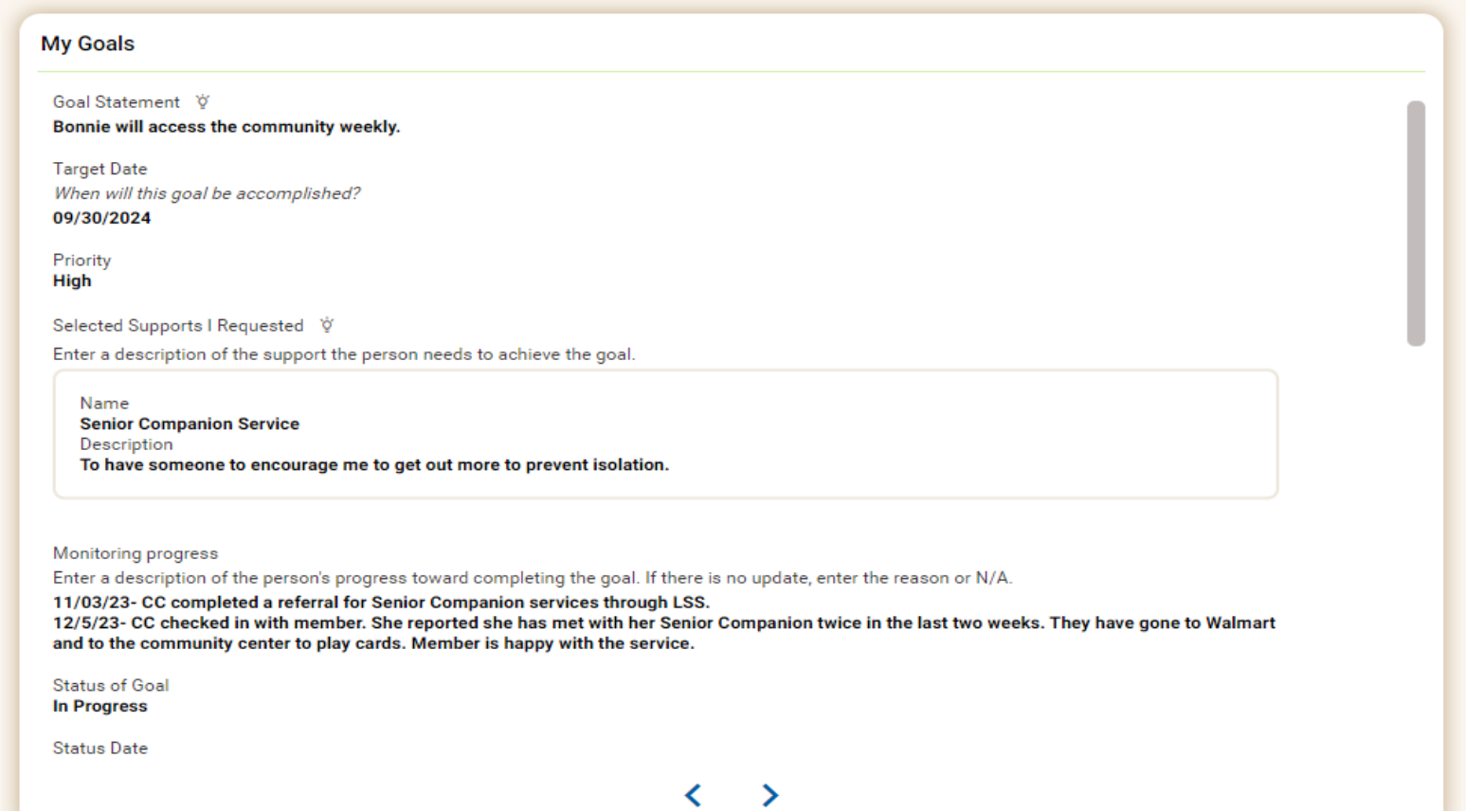


SMART Goals

- **<u>Target Dates/Status Dates</u>** may be short term or long term, depending on the identified need.
- “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.
- If you are creating a short-term goal, make sure you are addressing it by the identified target date.

Goal Progress

- Monitoring progress/revising support plan of each goal should occur during the planned follow up and/or as needed throughout the year.
- The Care Coordinator should have a discussion with the member about each goal and the member's progress & response toward meeting a goal.
- If a goal is not being met, identify possible barriers/issues and consider if current interventions need to be modified to assist the member in meeting the goal.
- Goal Monitoring and Outcomes should be documented on the Care Plan or Support Plan. This is the document that follows the member.



My Goals

Goal Statement
Bonnie will access the community weekly.

Target Date
When will this goal be accomplished?
09/30/2024

Priority
High

Selected Supports I Requested
Enter a description of the support the person needs to achieve the goal.

Name
Senior Companion Service
Description
To have someone to encourage me to get out more to prevent isolation.

Monitoring progress
Enter a description of the person's progress toward completing the goal. If there is no update, enter the reason or N/A.
11/03/23- CC completed a referral for Senior Companion services through LSS.
12/5/23- CC checked in with member. She reported she has met with her Senior Companion twice in the last two weeks. They have gone to Walmart and to the community center to play cards. Member is happy with the service.

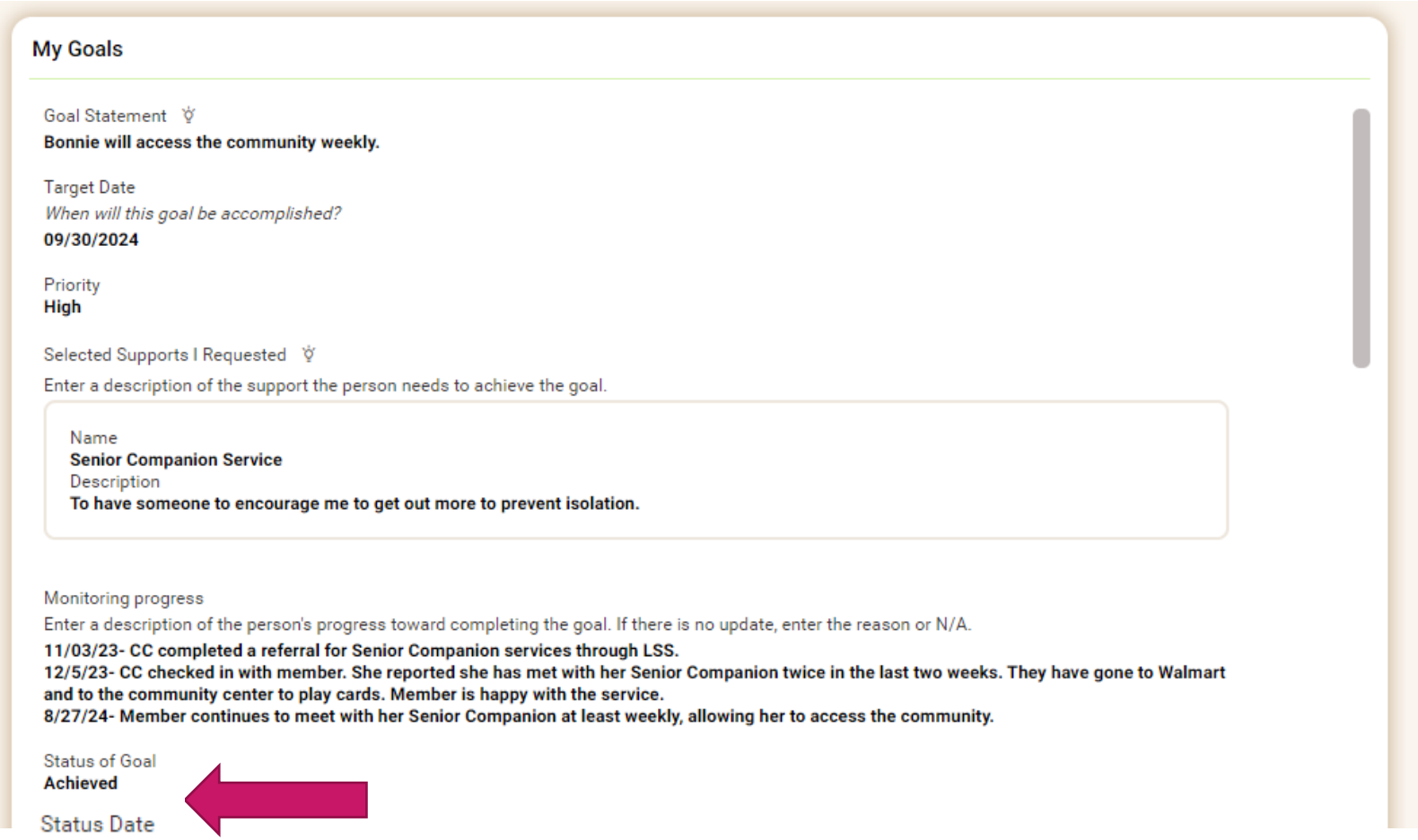
Status of Goal
In Progress

Status Date

My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date
Bob will schedule an appointment for an annual physical by target date.	Care Coordinator will provide contact information for local in-network clinics. Bob will call clinic and schedule appointment. Bob will contact Provide-a-ride for transportation to appointment.	10/31/23	8/7/23- Bob reported he called Essentia Proctor and has appt scheduled 8/31/23.

Goal Outcomes

- Evaluation of goal outcomes/status of goal 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; in MnCHOICES it would be achieved, in progress or closed).
- The date to evaluate outcomes/status date of goal will be the date of the next follow-up contact, identified target date, or at a minimum would be the next scheduled reassessment date.



My Goals

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8/27/24- Member continues to meet with her Senior Companion at least weekly, allowing her to access the community.

Status of Goal
Achieved

Status Date
08/27/2024

My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
Bob will schedule an appointment for an annual physical by target date.	Care Coordinator will provide contact information for local in-network clinics. Bob will call clinic and schedule appointment. Bob will contact Provide-a-ride for transportation to appointment.	10/31/23	8/7/23- Bob reported he called Essentia Proctor and has appt scheduled 8/31/23. 10/7/23-Bob confirmed he attended appt and is established with PCP.	Goal Met 08/2023

Follow Up Plans

- Care Plans must include a schedule for a follow-up plan and ongoing contact.
- The follow-up plan/meeting schedule contacts should be member specific and may occur with the member and/or authorized family members or legal guardians based on member request, identified risk, needs, and frailty.
- If the scheduled follow-up does not occur the CC must document the reason.
- Medica requires contact every 6 months at minimum, following each notice of transition, or as indicated from ECC/Impact Report.

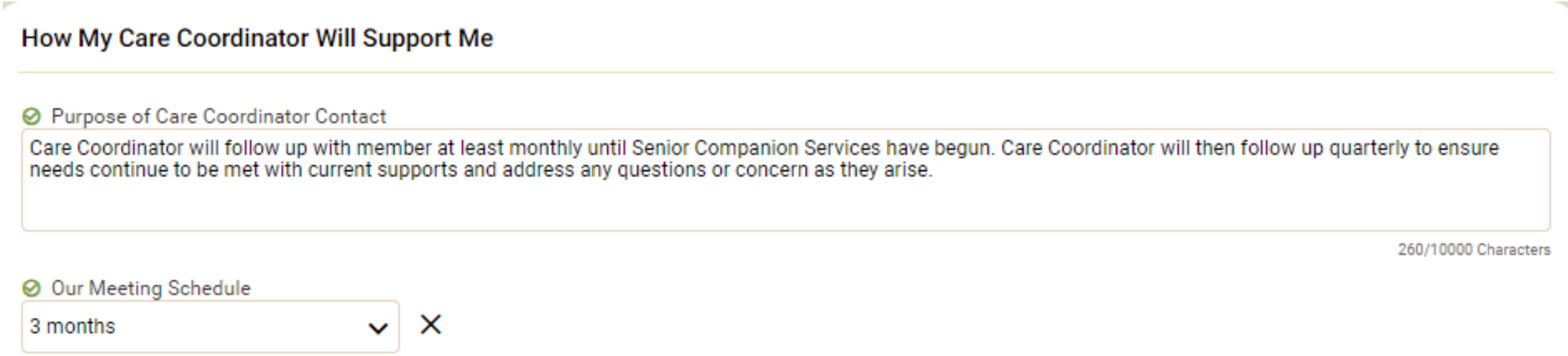
Example Follow Up Plans

My follow up plan:

Care Coordinator/Case Manager follow-up will occur:

- ☐ Once a month
- ☒ Every 3 months
- ☐ Every 6 months
- ☐ Other

Purpose of Care Coordinator contact: Care Coordinator will follow up with Bob at least every 3 months to ensure he has the supports needed to schedule his annual physical, take his medications as ordered, and transportation needs are met. Care Coordinator will also address any other needs or concerns as they arise.



Resources

The following additional resources can be located on the CC Hub:

- Care Plan Instructions/Collaborative Care Plan Instructions (Assessment & Care Plan Section)
- SMART Goal Training Series, Smart Goal Example Guide, Smart Goal FAQ (Training Section)
- MnCHOICE Help Center search “support plan”

If you have questions regarding this audit element, please reach out to your auditor or email MedicaSPPRegQuality@Medica.com.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To be the trusted health plan of choice for customers, members, partners and our employees.

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To be trusted in the community for our unwavering commitment to high-quality, affordable health care.

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Customer-Focused • Excellence • Stewardship • Diversity • Integrity