



Assessed Need and Concern Documentation

Care Coordination Training Module #1

Care Coordinator Role

An important role of the Care Coordinator is to conduct a Health Risk Assessment and develop an Individualized Care Plan with the member based on their identified needs and preferences. The Care Coordinator will provide ongoing monitoring and updating of the Care Plan. (Medica MOC).



DHS Audit Protocol

EW and Non-EW:

The CCP addresses assessed needs in areas of life identified for the person. All enrollee's assessed needs and concerns related to primary care, acute care, long-term services and supports, mental health, behavioral, and service needs and concerns are addressed in the care plan; or statement as to why an assessed need(s) was not included on the CCP.

DHS Audit Protocol

SNBC/ISNBC:

The care plan addresses member's assessed needs and preferences and reflects a person-centered, interdisciplinary, holistic, and preventive focus.

Method for measuring outcome achievement:

Care plan addresses member's health care needs, concerns, primary care, acute care, behavioral health care needs, and chronic conditions as identified in the HRA or a statement as to why an assessed need(s) was not included in the care plan.

Assessed need and concern documentation

If the assessment identifies an unmet need, concern, or preference, a goal **MUST** be created OR there must be a statement as to why it is not included on the care plan.

This statement must be specific to the assessed need and may be located on the assessment, or care plan.

Auditors will also give credit if we find applicable information in case notes, but it is preferred that Care Coordinators are documenting this on the HRA or care plan.



Unmet ADL need

Bathing

How well can you bathe or shower yourself?* Bathing or showering by yourself means washing all parts of the body including your hair and face. Would you say that you:

- 00 - Need no assistance
- 10 - Yes, needs assistance, met by current supports or help from others or equipment
- 11 - Yes, needs assistance NOT met by current supports or help from others or equipment
- 12 - Chose not to answer

COMMENTS

Bob reports he is having a hard time bathing due to right shoulder pain. He is unable to wash himself fully due to limited range of motion.

Bathing

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- 00 - Need no assistance
- 10 - Yes, needs assistance, met by current supports or help from others or equipment
- 11 - Yes, needs assistance NOT met by current supports or help from others or equipment
- 12 - Chose not to answer

COMMENTS

Bob reports he is having a hard time bathing due to right shoulder pain. He is unable to wash himself fully due to limited range of motion. CC educated Bob on service and DME options which Bob declines. Bob has been educated on the risks of declining services.

SMART goal example:

Bob will have Home Health Aide service in place for bathing assistance by June 1.

No goal would be needed as it is clearly documented that member declines to address this concern.

Pain

F.4b Pain Screening

PAIN SCREENING	DATE
Bob Johnson	5/9/2023
Are you experiencing any pain now or in the last 2 weeks? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Has your pain affected your function or quality of life (e.g., activity level, mood, relationships, sleep or work)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
How often do you experience pain (Constantly, Daily, Once a Week or Not Often)? Daily	
At its worst, how severe is your pain (1 to 10 with 10 being the worst)? 9	
Have you talked to your doctor or someone else about the cause of your pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <u>Dr. Anderson (PCP)</u> When? <u>April 2023</u>	
Have you talked to someone about how to handle your pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <u>Dr. Anderson (PCP)</u> When? <u>April 2023</u>	
Pain management plan: <u>Hx of cortisone injections. Takes Ibuprofen daily.</u>	

SMART goal example:

Bob will self-report a decrease in his pain by 1-2 points on a scale of 1-10 by target date.

F.4b Pain Screening

PAIN SCREENING	DATE
Bob Johnson	5/9/2023
Are you experiencing any pain now or in the last 2 weeks? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Has your pain affected your function or quality of life (e.g., activity level, mood, relationships, sleep or work)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
How often do you experience pain (Constantly, Daily, Once a Week or Not Often)? Daily	
At its worst, how severe is your pain (1 to 10 with 10 being the worst)? 9	
Have you talked to your doctor or someone else about the cause of your pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <u>Dr. Anderson (PCP)</u> When? <u>April 2023</u>	
Have you talked to someone about how to handle your pain? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <u>Dr. Anderson (PCP)</u> When? <u>April 2023</u>	
Pain management plan: <u>Hx of cortisone injections. Takes Ibuprofen daily.</u>	

Comments on Health Concerns/Community Support Plan Implications:

Include the person's health related goal in Community Support Plan. Include supports needed for progress toward the goal.

Bob reports that his primary source of pain is his right shoulder. He has discussed pain concerns with his PCP and has seen an orthopedic specialist in the past. They explained to Bob that the next step to address shoulder pain would be surgery which Bob declines. Bob declines a goal related to pain.

No goal needed as it is clearly documented that member declines to address this concern.

Chronic Condition

Physical Health (check all that apply)

None, I am physically healthy

Chronic Bronchitis or Chronic Obstructive Pulmonary Disease (COPD)

Asthma

Heart Failure

Chest Pain (angina)

High Blood Pressure

Seizures

Kidney Disease with or without dialysis

Infectious Disease such as HIV/AIDS, Hepatitis, Tuberculosis (TB)

I would like help managing this condition:

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Blood Pressure: (Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bob reports his Blood Pressure has been high at recent appointments. He continues to work with his provider.
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SMART goal example:
Bob will self-report that his Blood Pressure is less than 140/80 by target date.

Physical Health (check all that apply)

None, I am physically healthy

Chronic Bronchitis or Chronic Obstructive Pulmonary Disease (COPD)

Asthma

Heart Failure

Chest Pain (angina)

High Blood Pressure

Seizures

Kidney Disease with or without dialysis

Infectious Disease such as HIV/AIDS, Hepatitis, Tuberculosis (TB)

I would like help managing this condition:

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Blood Pressure: (Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Bob has a history of high blood pressure. It is presently managed with medication.
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No goal needed as it is clearly documented the member feels the condition is managed.

Substance Use

My Alcohol/Tobacco/Substance Use

- F.11 Do you drink any alcoholic beverages including beer and wine or do you never drink alcohol? Drinks alcohol Never drinks alcohol (**SKIP # 12 & 13**)
- F.12 On average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day? NA (**Probe for frequency**)
- F.13 Has alcohol caused you any problems? Yes No
(IF YES:) Please describe. NA
- F.14 Do you smoke or use tobacco? Yes No
If yes, how much do you smoke or use and how often? (**Probe for frequency per day.**)
1 pack/day
- F.15 Do you use any other substances such as marijuana, cocaine or amphetamines?
 Yes No If yes, which? NA

Assessor:

- F.16 Are you concerned about the person's alcohol/tobacco/substance use? Yes No
If yes, any next steps? (e.g. Cessation materials provided)
CC provided information on Medica Tobacco Cessation program and will complete referral.

Comments/Plan Implications for Substance Abuse

Bob reported he would like to "cut back" on smoking and has considered quitting altogether. He is willing to consider the Tobacco Cessation Program. He reported he would like to cut back to around a 1/2 pack per day.

SMART goal example:

Bob would like to self-report a decrease in his smoking to a half pack per day in the next 6 months.

My Alcohol/Tobacco/Substance Use

- F.11 Do you drink any alcoholic beverages including beer and wine or do you never drink alcohol? Drinks alcohol Never drinks alcohol (**SKIP # 12 & 13**)
- F.12 On average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day? NA (**Probe for frequency**)
- F.13 Has alcohol caused you any problems? Yes No
(IF YES:) Please describe. NA
- F.14 Do you smoke or use tobacco? Yes No
If yes, how much do you smoke or use and how often? (**Probe for frequency per day.**)
1 pack/day
- F.15 Do you use any other substances such as marijuana, cocaine or amphetamines?
 Yes No If yes, which? NA

Assessor:

- F.16 Are you concerned about the person's alcohol/tobacco/substance use? Yes No
If yes, any next steps? (e.g. Cessation materials provided)
NA

Comments/Plan Implications for Substance Abuse

Bob reports he has smoked for many years and has no intentions to quit at this point. He declines any supports related to quitting or reducing how often he is smoking.

No goal needed as it is clearly documented that member declines to address this concern.

Medication Management

F.8 Assessor: Are you concerned that person is: (Check if Yes)

<input checked="" type="checkbox"/> Not taking meds on time?	<input type="checkbox"/> Taking prescriptions from too many physicians?
<input checked="" type="checkbox"/> Not taking proper number of meds?	<input type="checkbox"/> Using outdated meds?
<input checked="" type="checkbox"/> Not getting Rx properly filled?	<input type="checkbox"/> Refusing to take meds?
<input type="checkbox"/> Not getting meds needs reevaluated?	<input type="checkbox"/> Having other medication problems?
<input type="checkbox"/> Not getting meds due to cost?	(SPECIFY) _____
<input type="checkbox"/> Affected by drug side effects?	<input type="checkbox"/> Info re: Prescription Drug Program given

Comments on Medications/Support Plan/Supervision Implications

Member reports that he sometimes "forgets" to take his medications. He is currently taking his medications out of the bottle. At times he cannot remember whether he has taken them during the day or not. Bob would benefit from weekly set up of medications and a Pill Minder.

SMART goal example:
Bob will report taking his medications as ordered through the target date.

My Medications	I need help with my medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A (no medications used) If yes, create a goal
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F.7 How do you remember to take your medications? *(Do not read list. Check all that apply.)*

Calendar
 Egg Carton, Envelopes
 Informal caregiver gives them
 RN setup
 Pill Minder
 Follows directions on label
 Other (Specify) _____

F.8 Assessor: Are you concerned that person is: (Check if Yes)

<input checked="" type="checkbox"/> Not taking meds on time?	<input type="checkbox"/> Taking prescriptions from too many physicians?
<input checked="" type="checkbox"/> Not taking proper number of meds?	<input type="checkbox"/> Using outdated meds?
<input checked="" type="checkbox"/> Not getting Rx properly filled?	<input type="checkbox"/> Refusing to take meds?
<input type="checkbox"/> Not getting meds needs reevaluated?	<input type="checkbox"/> Having other medication problems?
<input type="checkbox"/> Not getting meds due to cost?	(SPECIFY) _____
<input type="checkbox"/> Affected by drug side effects?	<input type="checkbox"/> Info re: Prescription Drug Program given

Comments on Medications/Support Plan/Supervision Implications

Member reports that he sometimes "forgets" to take his medications. He is currently taking his medications out of the bottle. At times he cannot remember whether he has taken them during the day or not. Bob would benefit from weekly set up of medications and a Pill Minder. Bob stated he can come up with his own system to better remember to take his medications as ordered. He declines a goal for this area.

No goal needed as it is clearly documented that member declines to address the concern.

Managing and Improving My Health

Managing and Improving My Health

Screening for my health	Check if educational conversation took place with me	Goal is needed	Check if N/A, contraindicated, declined	Notes
Annual Preventive Health Exam	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Bob reports it has been around 2 years since he had his last annual physical.

SMART goal example:

Bob will schedule and attend his Annual Preventative Exam in the next 3 months.

Managing and Improving My Health

Screening for my health	Check if educational conversation took place with me	Goal is needed	Check if N/A, contraindicated, declined	Notes
Annual Preventive Health Exam	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Bob reports it has been around 2 years since he had his last annual physical. He does not feel it is needed at this time and declines to schedule or create goal.

No goal needed as it is clearly documented that member declines to address the concern.

Mental Health

Mental Health Diagnosis
(If applicable):

Depression and PTSD

N/A

Managed by a Health Professional? Yes No
(Psychiatrist, Psychologist, Primary Care Physician)

Need Goal? Yes No Declined

Emotional Health

How would you rate your emotional health?*

- 05 - Poor
 06 - Fair
 07 - Good
 08 - Excellent
 12 - Chose not to answer

- In the past three months, have you been stressed or anxious?
 Yes No Chose not to answer
- In the past three months, have you had little interest or pleasure in doing things that you normally like?
 Yes No Chose not to answer
- In the past three months, have you been feeling down, depressed, or "blue" more than usual?
 Yes No Chose not to answer
- In the past three months have you been limited in your social activities with family, friends, neighbors, or groups (not related to transportation)?
 Yes No Chose not to answer

SMART goal example:

Bob will participate in 1 activity per week that he enjoys to help improve his mood over the next 12 months.

Mental Health Diagnosis
(If applicable):

Depression and PTSD

N/A

Managed by a Health Professional? Yes No
(Psychiatrist, Psychologist, Primary Care Physician)

Need Goal? Yes No Declined

Emotional Health

How would you rate your emotional health?*

- 05 - Poor
 06 - Fair
 07 - Good
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- In the past three months, have you been stressed or anxious?
 Yes No Chose not to answer
- In the past three months, have you had little interest or pleasure in doing things that you normally like?
 Yes No Chose not to answer
- In the past three months, have you been feeling down, depressed, or "blue" more than usual?
 Yes No Chose not to answer
- In the past three months have you been limited in your social activities with family, friends, neighbors, or groups (not related to transportation)?
 Yes No Chose not to answer

No goal needed as the member identified no concerns despite Mental Health diagnoses.

Additional Assessment Areas to Consider

- An Identified Future Plan that a goal can assist in accomplishing.
- A nutrition concern that is not currently managed.
- A Person Centered Need that is not currently met. (D & E on LTCC or Education/Employment/Family Planning)
- An Identified Member goal/concern for their health.
- Multiple ER visits, hospitalizations, or recent SNF discharge.
- Social Determinants of Health not currently met including: Food, Housing, Transportation.
- Concerns of abuse, neglect, exploitation by self or others identified.

Resources

SMART Goal Trainings and Resources: [Training | Medica](#)

SMART Goals

SMART Goals Series #1 [↗](#)

[↓](#) [Summertime Skills #1 \(PDF\)](#)

[↓](#) [SMART Goals Example Guide \(PDF\)](#)

[↓](#) [SMART Goals FAQ \(PDF\)](#)

SMART Goals Series #2 [↗](#)

[↓](#) [Summertime Skills Series #2 \(PDF\)](#)

SMART Goals Series #3 [↗](#)

[↓](#) [Summertime Skills Series #3 \(PDF\)](#)

SMART Goals Refresher Training [↗](#)

[↓](#) [SMART Goals Refresher Training \(PDF\)](#)

DHS Audit Protocol

Questions??

If you have questions regarding this audit element, please reach out to your auditor or email MedicaSPPRegQuality@Medica.com.





THANK YOU

MISSION

To be the trusted health plan of choice for customers, members, partners and our employees.

VISION

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

VALUES

Customer-Focused • Excellence • Stewardship • Diversity • Integrity