Summary of Changes to Iowa Care Planning Tool: Specialized and Rehabilitative Services

Changes to the language of Specialized Services in the Care Planning Tool took effect on 3/1/2016.

Changes to the language of Rehabilitative Services in the Care Planning Tool took effect on 3/8/2016.

General Care Planning Guidance

Many care plans are submitted with all of the PASRR-identified services clustered together. This makes it difficult to determine whether the care plan is compliant. **Please list each PASRR-identified service as a separate line item in the care plan.**

Having the PASRR Summary of Findings in front of you as you create the care plan makes it easier to include all PASRR-identified services in the care plan.

Language for Care Plan Compliance

Exact specifiers of the required elements for care plan compliance are now found in the "Intervention" column for Specialized and Rehabilitative Services. The elements in the brackets have been made even more specific to take the guess work out of creating a compliant care plan.

> **Provider:** the exact name and credentials to ensure that the appropriate professional is delivering these services. Cue "when we say psychiatrist, we mean psychiatrist!"
>
> **Agency Name:** If the exact name of the provider is not yet known, you may enter the name of the agency/organization where the service is scheduled. It will still be important to ensure that the service is scheduled with an appropriately credentialed professional.
>
> **Exact Date of Appointment:** Describes the date of the scheduled appointment for this service. This is not the same as the date you entered this into the care plan, or scheduled the appointment. This is the date of the service.
>
> **Anticipated Frequency:** How often will the service be delivered? Evaluations typically occur "one time." Other services, such as psychotherapy or medication management may occur weekly, monthly, every two months, quarterly, etc.
>
> **Expected Duration:** How long will the service be delivered. Evaluations are typically delivered "once." Psychotherapy might be time limited…how many sessions are to be delivered? How long will the resident be under the care of the psychiatrist?

There are specifiers in the "Intervention" column for all specialized and rehabilitative services that will prompt you to specify the location and modality of the service. While these are not mandatory elements of a compliant care plan, it might make it easier to distinguish which services are being provided in the facility from those delivered outside of the facility. For those facilities in rural areas, the specification for

"modality" might prompt you to consider options other than "face to face" visits, where appropriate. There are many services that can be delivered via telehealth when it is difficult to find available providers.

Language that Supports the Coordination of Care

In the "Goal" area, you may find guidance on what to do with the findings from PASRR-identified evaluations. For example, findings from the psychiatric evaluation should be communicated to the primary care provider. Any additional services that are ordered as a result of the evaluation should be included in the care plan.

Note the language in the "Goal" section for Individual and Group Therapy. "My attendance and progress in individual therapy will be communicated to my Primary Care Provider and to my Psychiatrist. Staff will encourage communication from the therapist to my care team by facilitating releases of information."

For several items, especially those that are comprised of an evaluation or a "plan" (e.g. Behaviorally Based Treatment Plan) there is language in the goal section to prompt the user to (1) update the care plan with any new services that were identified as a result of the evaluation and (2) share this information with the clinical team and anyone else for whom a release of information was signed.

In the "Person/Position Responsible" Area, there is language that considers who will be responsible for facilitating the communication of evaluations to the behavioral health care team, e.g. "Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional."

Areas Where Additional Specifiers are Requested

ADL Training: NF staff will assist in the identification of needed ADL assistance/skills, indicate who/how ADL skills training and support will be implemented and any specific issues that the training will focus upon: (Specify: self-care, bathing, dressing, dental care, eating, social skills, personal care skills, communication, self-advocacy skills or others).

Behaviorally Based Treatment Plan (under "Persons/Position Responsible"): Specify responsibilities of specific staff for having knowledge of my behavior management plan, helping me be accountable to commitments made within the plan, where the plan is located, strategies for implementing the plan, discussions that will happen when things are not working well with regard to the plan, etc."

Crisis Intervention/Safety Plan: "I will utilize my crisis intervention/safety plan when (Specify: I am expressing suicidal ideation, attempting to harm myself, threating/attempting to harm others, or any other specific at risk behaviors that we may have identified for me)."

I am in need of Assistive Devices: "I am in need of the following Assistive Devices or Technology (Specify types: cane, walker, wheel chair, adaptive products, communication equipment, etc.)"

Community Living Skills Training: "Once identified, indicate who/how community living skills training will be implemented and any specific issues that the training will focus upon: (Specify: adaptive behavior skills, communication skills, social skills, personal care skills, self-advocacy skills or others)."

Areas Where Links to Additional Resources or Tips are Provided

Crisis Intervention/Safety Planning

Safety Planning Resources:
http://www.namihelps.org/NAMIAdultMHCrisisPlanningMay2013Y.pdf

http://www.sprc.org/library_resources/items/patient-safety-plan-template

Crisis Plan Resource:

http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf

Behavioral Health Advanced Directives

http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf

Options Counseling: "NF staff will facilitate referral to the Aging and Disability Resource Center (ADRC) through telephone or web contact with LifeLong Links, so that I may meet with an Options Counselor and explore options including those for services to move toward community placement. LifeLong Links: 1-866-468-7887, or via the web: www.lifelonglinks.org"

Integrated Health Home referral: "Managed Care Organizations that will be managing Medicaid beginning in April 2016 can assist the NF in locating any nearby Integrated Health Home providers so that choices can be identified and arrangements can be made to begin receiving services. You may contact IME Member Services or your MCO for information on how to facilitate a referral for Iowa Medicaid members."

Self-Health Care Management: "Assessment for appropriate services can begin by contacting a local Integrated Health Home (IHH) program, Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC), or prior community service providers."

Language that Describes Documents for ServiceMatters

Each "Intervention" area contains a sentence that describes what reports or documents will demonstrate that the specialized services are delivered. We will ask for these during the service matters review process. This is designed to help you know what documents to prepare in order to make the review process more efficient.

When an Individual Declines a Service

There is now a care plan entry for use when the individual declines participation in a service. It is at the very end of the care planning tool. (Line 113, in RED).

There are three things that we expect you to do when an individual declines a service:

1. Education of individual/guardian on a regular basis.
2. The NF must identify and implement appropriate alternatives to meet the needs that each declined PASRR identified service would have addressed.
3. Identify the agency or name of professional that will provide the service, when the individual chooses to participate.

Tip: Search for “decline” instead of “refuse”