

How to Use the Service Coordination Plan

To support Accountable Care Collaborative: Medicare-Medicaid Enrollees

INTRODUCTION

The federal government requires Regional Care Collaborative Organizations (RCCOs) to work directly with each beneficiary enrolled in the Accountable Care Collaborative: Medicare-Medicaid Enrollees (ACC: MME) Program and complete a Service Coordination Plan (SCP).

- Clients determined to be **high-risk** must have a SCP completed **IN PERSON within 90 days of enrollment** in the ACC: MME.
- **All other clients** must have a SCP completed **within 120 days of enrollment** in the ACC: MME, by phone or in person at the RCCO's discretion.
- The SCP is required to be **reviewed no less frequently than every six months**.

The goal of the SCP is to promote proactive, person-centered, strength-based coordination of services and supports, including:

- Physical and behavioral health needs for clients with complex conditions,
- System-level oversight and support for clients receiving case management from other agencies.

The SCP documents the client's long and short-term goals, and it becomes the blueprint for meeting those goals and improving health outcomes. The RCCOs and PCMPs will use a SCP that contains required, standardized elements to collaborate with the client and to identify and coordinate among the client's other service providers.

The SCP is intended to complement, rather than duplicate, other assessments or care plans currently in place (e.g., through HCBS waiver programs). To prevent duplication, strengthen relationships, and improve coordination in serving program enrollees, RCCOs and delegated care coordinators are expected to follow established written protocols describing the process for collaborating with SEPs, CCBs, BHOs, hospitals, home health organizations, disability organizations, skilled nursing facilities, hospice organizations, and other community resources.

RCCOs are responsible for ensuring SCP completion and timely review and updates, even when care coordination is delegated to a PCMP or other contractor, as well as for providing training and guidance as needed. Whether or not the RCCO or its delegate choose to use the SCP document, CMS and the Department require documentation that each of the domains was reviewed and completed accordingly.

PERSON-CENTERED, APPROPRIATE CARE

The Department, RCCOs, and PCMPs will promote the coordination of all necessary covered benefits and additional supports to clients in a manner that is sensitive to the client's functional and cognitive needs, language and culture, and personal preferences and choices. Additionally, care coordination must allow for caregiver involvement and take into account appropriate care settings, with a preference for the home and community when preferred by the client.

Clients have the right to review and/or obtain copies of their SCP at any time.

GENERAL PROCESS FOR COMPLETING A SCP

First, determine if the client receives on-going case management services and identify the organization(s) providing those services.

For clients receiving on-going case management services:

1. Determine who is providing services for the client and request applicable information to assist with SCP completion.
2. To the extent that the cooperating providers deem the requested information to be within treatment, payment, or health care operations (TPO), or the client has agreed to provide a HIPAA-compliant waiver, obtain copies of any service plans, care plans or assessments.
3. Review the shared documents for SCP applicable information.
4. Complete as much of SCP as possible from available information.
5. Speak with the client and, with their input, identify any gaps in services.
6. With client, determine long and short-term goals and action steps.
7. Document information as appropriate on the SCP.

For clients not receiving on-going case management services:

1. Gather data and information from available sources, including information from the Benefits Utilization System (BUS) and/or the Statewide Data and Analytics Contractor (SDAC).
2. Complete as much of the SCP as possible from available information.
3. Speak with the client and, with their input, identify any gaps in services.
4. With client, determine long and short-term goals and action steps.
5. Document information as appropriate on the SCP.

SCP UPDATE REQUIREMENTS

The Service Coordination Plan **must be updated by the RCCO or designee at least every six months regardless of client status.** The Department also expects the SCP to be updated upon:

1. A significant change in the client's needs,
2. A critical incident, such as:
 - a. Emergency room visit
 - b. Unexpected hospitalization
 - c. Injury
 - d. Abuse or neglect
3. Any care transition (e.g., discharge from hospital, discharge from rehab at skilled nursing facility, etc.).
4. Client, family or provider request

OBTAINING CLIENT INFORMATION VIA EXISTING DATA-SOURCES

In some cases, information in the SCP will be obtained via the Benefits Utilization System (BUS) and/or the Statewide Data and Analytics Contractor (SDAC).

Note: only clients enrolled in Home and Community Based Waiver Services (HCBS) will have information in the BUS.

DESCRIPTION OF FIELDS AND EXPECTATIONS FOR COMPLETING A SERVICE COORDINATION PLAN

CLIENT SUMMARY PAGE

ADMINISTRATIVE INFORMATION

DATE ENROLLED: Enter the date the client was enrolled into the RCCO.

DATE OF SCP: Enter the begin date of the Service Coordination Plan.

DATE OF SCP REVIEW: Enter the date the SCP is reviewed.

RCCO: Enter the name of the RCCO.

SCP AUTHOR: Enter the name of the person completing the SCP.

SCP Author Organization: Enter the name of the organization for which the author works.

REASON FOR SCP: Enter the reason for the SCP (choose one): new, six-month review, critical incident, care transition (e.g., hospital discharge, move from facility into community, etc.), change in condition, change in goals, resolution of goals, or resolution of action steps.

1. WHICH DESCRIPTION BEST FITS THE CLIENT'S OVERALL STATUS: Choose the most appropriate description of the client's current health status and prognosis.

2. HIGH-RISK PRIORITIZATION: Note if the client is or is not prioritized as "High Risk."

3. CLIENT SUMMARY AND NEXT STEPS: This section is completed AFTER the SCP is thoroughly created and reviewed, as it records a high-level summary of the assessment that includes brief notes about the client's current condition and supports, including: physical, behavioral, social supports, major stressors or barriers, and information about next steps.

BASIC DEMOGRAPHICS

4. Client Information Section (most of this information is found in SDAC, BUS and/or monthly reports provided from the Department).

a. LAST NAME: Enter the client's last name.

b. FIRST NAME: Enter the client's first name.

c-f. STREET ADDRESS, CITY, ZIP, and COUNTY: Enter the client's primary address information.

g. EMAIL: Enter the client's primary email address.

h. TELEPHONE NUMBER AND ALTERNATE NUMBER: Enter the client's preferred and, if applicable, alternate phone number. Designate each number as Home, Cell, Work or Other.

i. DOB: Enter the client's date of birth in the following format: 01-01-2001.

j. GENDER: Enter the client's gender (i.e., Female, Gender queer/Androgynous, Intersex, Male, Transgender, Transsexual, Cross-dresser, Female to Male-FTM, Male to Female-MTF, or Other).

k. MARITAL STATUS: Enter single, married, domestically partnered, or divorced.

l. CLIENT ID: Enter the client's Medicare and Medicaid identification numbers.

- m. **COMMUNICATION REQUIREMENTS:** Enter requirements necessary for effective communication with the client (i.e., speak loudly, translation needed, assistive technology needed, etc.).
- n. **PREFERRED LANGUAGE:** Enter the client's preferred language.
- o. **PREFERRED MEANS OF COMMUNICATION:** Check the appropriate box: Home Phone, Cell Phone, Work Phone, Email, Mail, In Person, Through Caregiver or Legal Guardian, or Other.

5. CLIENT CONTACT HISTORY

If initially unable to contact a client, RCCOs or their designee are required to attempt to contact the client at least three times during every six-month period.

- a. **CLIENT CONTACTED, DOES NOT WANT PLAN (EXPLAIN):** If a client has been successfully contacted and states that they do not want a SCP created on their behalf, the SCP author must explain why the client made that choice.

NOTE: Clients who decline a SCP must still be contacted every six months for mandatory follow-up.

- b. **CLIENT CONTACT INFORMATION NOT VALID:** Select this if the SCP author determines that the client's contact information is not valid. The SCP author must then work with medical providers and/or other case managers/care coordinators to try and obtain correct contact information. If correct contact information is not located, the SCP author must regularly review SDAC data to determine if the client received services and/or updated contact information.
- c. **ATTEMPTED CONTACT, NO RESPONSE:** The SCP author must attempt contact three times when attempting to reach a client. If unsuccessful, the SCP author is expected to try again, in six months, to contact the client.

6. CASE MANAGERS/CARE COORDINATION AGENCY

- a. **DOES CLIENT CURRENTLY RECEIVE ON-GOING CASE MANAGEMENT SERVICES?**

Select YES if the client does currently receive on-going case management services (e.g., SEP/CCB case manager, CMHC case manager, etc.). Select NO if the client does not currently receive on-going case management services.

If the client does currently receive on-going case management services, the SCP author contacts case managers to review existing service plan/care plan/assessment and evaluate what role the RCCO or designee will play in care coordination. **A summary of this process and the outcomes must be documented in the Assessment Narrative section, "Gaps in Care, Duplication of services and Areas to Address," particularly the RCCO or designee's responsibility related to care coordination for the client.**

When clients are receiving on-going case management, the RCCOs or designees are still expected to contact the client personally to introduce themselves and the ACC: MME Program and discuss any services or supports the client needs that are not being addressed by the other case managers.

NAME/AGENCY/PHONE/EMAIL: If the client is currently receiving case management services, the RCCO or designee will talk with the client and existing case managers to identify who has the most frequent contact with the client and is most appropriate to serve as the client's primary contact/case manager. This "lead" care coordinator should be entered in the first row. Then enter the names of any other care coordinators involved in the client's care. Also enter the applicable agency, phone number and email addresses.

ASSESSMENTS/CARE PLANS, RELEASE OF INFORMATION: Document if assessments/care plans have been requested or obtained, and indicate if the appropriate permissions (release of information, etc.) are in place.

7. MEDICAL HISTORY

The purpose of this section is to capture key medical information recorded in the SDAC and/or electronic health record. Depending on the licensure and knowledge of the care coordinator, this information is used to identify potential concerns about medications and treatments. At a minimum, this information is used to:

- Guide coordination of physical and behavioral health treatment;
- Prevent unnecessary emergency room visits and hospitalizations;
- Address barriers to appropriate care, including primary care and specialty care visits;
- Assist with medication management; and
- Flag clients taking medications that are associated with abuse or overdose.

The SCP author is expected to contact the appropriate case managers and/or medical professionals to discuss any concerns.

a. DIAGNOSES: Enter the client's diagnoses as reported in claims data and/or shared by providers or case managers. This should be a comprehensive list of the actual diagnoses made by health care providers; this is not the place to record what the client believes to be their primary diagnoses.

b. PROGNOSIS: Enter the prognosis for each diagnosis according to the best information available.

c. IS THIS LIST COMPLETE: Select YES or NO.

8. RECENT HOSPITALIZATION AND EMERGENCY DEPARTMENT VISITS: For recent hospitalizations and emergency department visits, enter the date and reason. Note if a care transition plan was generated and disseminated. Finally, note any follow-up visit(s).

9. MEDICATIONS: Enter the client's list of medications based on data in the SDAC or available from providers. An attached list is acceptable, provided the SCP refers to the attachment.

a. IS THIS LIST COMPLETE: Select YES or NO.

10. MEDICATION QUESTIONS/CONCERNS: Record any questions and/or concerns related to access, conflicting prescriptions, over or under utilization, adherence, cost, etc.

11. BARRIERS TO APPROPRIATE CARE: Record any questions and/or concerns related to access to primary or specialty providers, transportation, follow up, etc.

CLIENT GOALS

12. PERSON(S) INVOLVED IN CREATING PLAN: Select all clients who contributed in the creation of the plan and goals: Client, Family Member, Legal Guardian, Authorized Representative, Other.

13. CLIENT'S LONG-TERM GOAL(S):

Using person-centered language, enter the client's long-term goal.

Considerations:

- What would they like to happen as a result of their care?
- What would they like to be able to do that they cannot currently do?
- What is the most important thing they want to achieve related to their chronic disease?

Be sure take a holistic approach and consider all aspects of the clients' health, including behavioral and physical health.

Examples of long-term goals:

- "I want to be able to travel to Florida for a family reunion next year."
- "I want to feel happy."
- "I want to feel stronger so that I can move into the community."

14-16. CLIENT'S SHORT-TERM GOAL(S):

a. GOAL: The client's identified short-term goal(s) should be specific, measurable, attainable, relevant, time-based, and must be mutually agreed upon between the client and the SCP author.

Add as many or as few short-term goals as needed and desired by the client.

Examples:

- "Client wants to cut back on smoking over the next three months."
- "Client wants to understand how to use her blood pressure medication by the end of January."
- "Client wants to be able to communicate with PCMP and address questions and concerns at next medical appointment."

Coordinators should facilitate formation of realistic goals. For example, someone with a terminal illness may not be able to meet a goal to "live another 20 years," but they might have obtainable goals related to quality of life.

b. CLIENT OBJECTIVES: Enter the objectives that will assist the client to attain the short-term goal(s), and enter the start date for those objectives. Enter as many or as few objectives as needed to assist the client to reach the short-term goal being addressed.

START DATE: Enter the starting date of the goal.

STATUS UPDATE: Enter the date when the goal was updated.

c. CARE COORDINATOR/CASE MANAGER ACTION STEPS: List the identified action steps that the client, the SCP author, their personal care worker or other caregivers, or health care providers can

take to achieve the client's short-term goal(s). These interventions should be established mutually with the client.

For example, the interventions(s) for the above goal(s) might be:

- Client and Care Coordinator will discuss strategies to decrease or quit smoking.
- Client will ask their doctor about using blood pressure medication at next visit.
- Client and Care Coordinator will prepare list of questions to bring to the next doctor appointment.

d. OUTCOME: As needed, update the outcome by selecting either Completed, Revised, No longer pertinent, or Client request to discontinue, and then add the date.

Goals that continue from one review period to the next should be copied and continued with modifications, as needed, for specific action steps.

e. UPDATES: Record any helpful narrative when the SCP is revised, updated, or when new information becomes available.

17. CLIENT ASSENT: After the long and short-term goals have been identified, the client signs to indicate their participation in, and agreement with, the goals. Indicate if the client was contacted in person or by phone and add the date when the client reviewed and agreed to the goals and objectives.

PROVIDER INFORMATION

18. PRIMARY CARE MEDICAL PROVIDER (PCMP)

a. CLINIC NAME: As appropriate, determine what clinic the client goes to for medical and/or behavioral services.

b. PROVIDER NAME: Enter the name of the physician.

c-g. PHYSICIAN CONTACT INFORMATION: Enter the physician's contact information, including: phone, street address, city, zip and email address.

h. ATTRIBUTED TO ACC: Select YES if the client's physician is attributed to the ACC (PCMP). Select NO if the client's physician is not attributed to the ACC (PCP).

i. DATE OF LAST VISIT: Enter the date of the client's last visit with the physician.

j. WHO DOES THE CLIENT CONSIDER THEIR PRIMARY PROVIDER TO BE: As appropriate, determine who the client considers to be their PCMP/PCP. If there is a discrepancy, the SCP author should review SDAC claims history and talk with case managers or providers to identify who is actually providing the majority of primary physical or behavioral health care services. If the ACC attributed PCMP is truly not the primary provider and the client-identified primary providers is eligible to serve as a PCMP, the RCCO should work with the client to change the attribution.

k. REFERRALS AND SPECIALISTS INVOLVED WITH CLIENT CARE: Determine if the physician has made any referrals. If so, enter the date of the referral, the provider's name and the date of the visit, if that visit occurred. If referral visits have not been completed, the SCP author will assist the client to follow-through on referrals.

19-21. PROVIDER(S): Select N/A if there are no other specialists, physical, or behavioral healthcare providers involved in the client’s care.

a-h. If applicable, enter the Provider Type (e.g., OT, SLP, Behavioral Health, etc.), the Provider Name and contact information, including: phone, street address, city, zip and email address. Also, enter the date of the client’s last visit with the provider.

i. ADVICE AND RECOMMENDED FOLLOW-UP: Record any known advice or recommendations regarding follow-up from the provider. Determine if the client has completed the follow-up and assist the client with all uncompleted items.

j. ADDITIONAL SERVICES RECOMMENDED: Record any known services or referrals the provider recommends. Determine if the client has completed the services/referrals and assist the client with all uncompleted items.

22. ADDITIONAL PROVIDERS:

Select N/A if no other providers are involved in the client’s care. Otherwise, record the Type, Name, Agency, and Release of Information (ROI). Select N/A if there are no applicable ROIs related to the client’s care coordination needs. Otherwise, record the date of the release

ASSESSMENT NARRATIVE

After carefully reviewing any and all existing assessments, and having met with or spoken to the client, the SCP author summarizes elements of the client’s needs, concerns or considerations in the appropriate section of the Assessment Narrative. For those domains that are not applicable to the client, select N/A. This information is then be used to guide the conversation with the client about their long and short-term goals.

a. CULTURAL/SPIRITUAL CONSIDERATIONS: Enter any cultural and/or spiritual considerations pertinent to understanding the client’s health within the context of their life and environment.

b. LANGUAGE/COMMUNICATION: Enter any linguistic or communication considerations (e.g., monolingual Spanish, uses TTY, etc.).

c. URGENT NEEDS: Enter any urgent needs. Note any barriers to care or access.

d. TRANSPORTATION REQUIREMENTS OR PREFERENCES: Select N/A if there are no transportation requirements or preferences. Otherwise, select the applicable options. If the client’s requirements or preferences do not appear as a choice, select “Other” and then enter the appropriate information. Note any barriers to care or access.

e. TRANSPORTATION ASSISTANCE NEEDED: Select NA if there are no transportation assistance needs identified. Otherwise, select the applicable options. If the client’s transportation assistance needs do not appear as a choice, select “Other” and then enter the appropriate information. Note any barriers to care or access.

f. EMPLOYMENT/SCHOOL INFORMATION: Enter any employment or school information. Note any barriers to care or access.

- g. PHYSICAL DISABILITY:** Select and describe any physical disabilities, if applicable.
- h. INTELLECTUAL DISABILITY, INCLUDING DELIRIUM AND DEMENTIA:** Describe any intellectual, cognitive, or memory related disability, if applicable.
- i. ASSISTIVE TECHNOLOGY NEEDS:** Select NA if the client has no assistive technology needs. Otherwise, select the applicable options. If the client has assistive technology needs that have not been addressed, state what is still needed. Note any barriers to care or access.
- j. EXISTING MENTAL HEALTH/SUBSTANCE USE DISORDER:** Enter any existing mental health/substance use disorders. Note any barriers to care or access.
- k. PREFERENCE FOR LIVING ARRANGEMENT:** Enter the client’s preferences for living arrangements. Note any barriers to care or access.
- l. COMMUNITY RESOURCES USED:** Enter a list of all community resources the client currently utilizes. Document any discussed resources the client might additionally utilize. Note any barriers to care or access.
- m. FOOD:** Enter any relevant information about food/nutritional issues. . Note any barriers to care or access.
- n. CHILD AND OTHER DEPENDENT CARE:** Enter any relevant information about children or other dependents. Note any barriers to care or access.
- o. FAMILY AND OTHER CLOSE CONNECTIONS:** Enter any relevant information about family or other close connections. Note any barriers to care or access.
- p. OTHER:** Enter any information pertinent to the SCP that has not been captured above.
- q. GAPS IN CARE, DUPLICATION OF SERVICES AND AREAS TO ADDRESS:** Provide a summary of all the areas in the Assessment Narrative that a client requires assistance. Identify any gaps in services or duplication in services here. Indicate actions the SCP author and the client will take to address issues.

ADDITIONAL CLIENT INFORMATION

24. FAMILY/FRIEND/AUTHORIZED REPRESENTATIVE SUPPORT

Select NA if this section is not applicable to the client.

a-c. Otherwise, note if the client “Lives with family/friend,” or if the “Family/friend lives close by.” Then note if the “Family/friend is available to assist with” elements of care, and if so, enter what kinds of assistance they are able to provide (e.g., transportation to doctor appointments, bill paying, etc.).

e-i. Enter the Primary Family/Friend’s Name and contact information, including street address, phone, and email. Also indicate if a Release of Information has been obtained by the client in order to share information with this family/friend/authorized representative.

25. DECISION MAKER INFORMATION

Enter NA if this section is not applicable to the client.

a-b. Otherwise, enter the legal guardian's Name and Phone Number, if applicable.

c-d. Enter the Power of Attorney's name or Medical Power of Attorney's name, if applicable.

e. Enter any information about Advanced Directives, if applicable.

f-h. Enter the Name, Phone, and email address of a client-identified emergency contact.

26. **IMPORTANT INFORMATION NOT CAPTURED IN THE SERVICE COORDINATION PLAN**

Enter any information not captured in the SCP that is needed to help address barriers or gaps to appropriate care and services. Include any information that is needed to help clients engage in their care and reach their health care goals.