INSTRUCTIONS FOR INSPIRE (SNBC) CARE PLAN

INFORMATION ABOUT ME
Name: Enter member's name.
My DOB: Enter member's date of birth.
Health Plan ID Number: Enter member's HealthPartners Member ID number.
SNBC Enrollment Date: Enter the date member enrolled with HealthPartners SNBC.
Care Plan Completion Date: Enter the date the care plan is completed.
Phone #: Enter member's phone number.
My Address: Enter member's address.
Assessment Date: Enter the date the assessment was completed.
Assessment Type: Choose the type of assessment that was completed.
Emergency Contact Name/Phone #: Enter member's emergency contact information.
If applicable, Legal guardian/representative Name/Phone#: Enter member's legal guardian/representative information.
Was Advance Directive/Health Care Directive Discussed? Document that a discussion occurred by checking yes or no. If no discussion occurred, document reason.
My Primary Language is: Check appropriate box. If the member's language is not on the list, check "Other" and document their language in this section. Include interpreter information.
MY INTERDISCIPLINARY CARE TEAM (ICT)
Care Coordinator/Case Manager: Enter HealthPartners SNBC Care Coordinator name and phone number.

Primary Physician: Enter the name, phone number, and fax number of member's primary care provider.
Clinic: Enter the name of the member's primary care clinic.
If applicable, County Waiver CM Information: Enter Name, Phone, Fax, and E-mail of the County Waiver Case Manager if member is open to a waiver.
Date care plan was shared with County Waiver CM: Enter date that care plan was shared with the Waiver Case Manager.
Waiver Type: Indicate type of waiver member is on, if applicable.
Disability Type: Indicate member's disability type.
Mental Health Targeted Case Manager: Check yes or no. If yes, enter name and phone number
Other Interdisciplinary Care Team Members: Enter names of additional ICT members and their relationship to the member. Examples of other team members may include but is not limited to other physicians, specialists, psychiatrist, psychologist, etc. Document yes or no if the care plan is shared with these ICT members.

What's Important to Me: Describe what is most important to the member, their wishes, dreams, and goals in life. Complete the first row at the initial/annual assessment. Updates should be dated and entered in the second row. Updates include any relevant updates throughout the year.
My Strengths: Enter member's supports and describe what works best for the member. Include a list of the member's skills, talents, and/or interests. Complete the first row at the initial/annual assessment. Updates should be dated and entered in the second row. Updates include any relevant updates throughout the year.

My Supports and Services: Enter any requests that member has asked for assistance with. Enter any supports or services that member has requested. Complete the first row at the initial/annual assessment. Updates should be dated and entered in the second row. Updates include any relevant updates throughout the year.
Check if an educational conversation took place: CC/CM should have an educational conversation with the member or member's authorized representative about applicable conditions and/or regularly scheduled screenings. Check each box to show that an educational conversation took place for each applicable condition or screening.
Goal is Needed: If the member needs assistance with a risk or identified need, check the appropriate box and create a goal in Section VI.
Check if N/A, Contraindicated, Declined: Check applicable box if the Condition/Screening or goal is not applicable, contraindicated, or declined.
Notes: Free text area for any additional applicable information such as date of the screening or reason for declining a goal.
Diabetic routine checks as recommended by physician: CC/CM should inquire whether a member with diabetes has routine diabetic checks with their doctor. If not, CC/CM should encourage the member to schedule a visit and create a goal to address this in Section VI. CC/CM should review and discuss with member patient education topics such as the importance of an eye exam, diet (i.e. Cholesterol) and knowing their A1C level.
Medication Adherence: Check if educational conversation took place. If there are concerns regarding member not taking medications as prescribed mark goal is needed. Create goal in Section VI. Refer to Medication Therapy Management (MTM) if appropriate.
Other: Enter any other test or condition not addressed in this section.

Mental Health Diagnosis: If member declines to have goal included on his/her care plan, please indicate that you are aware of the mental health need and that you will continue to address it. This can be captured in case notes.

Disease Management Referral: Check yes, declined, or N/A. If yes, include the diagnosis. *All health plans have different diseases and processes for their Disease Management Programs; please check with the member's health plan for direction.*
My Goals: List appropriate member centered goals to meet the risks identified on the HRA. Goals should be SMART (Specific, Measurable, Attainable, Relevant and Time bound. n
My Intervention: Document any intervention(s) related to achieving this goal: What will the member need to do to accomplish the goal and how will the CC/CM help the member achieve the goal?
Target Date: List the target date (month/year) for completion of the goal. "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.
Monitoring Progress/Goal Revision Date: This column can be used to document progress during the follow up contact and/or as needed throughout the year. The CC/CM should have a discussion with the member about each goal and the member's progress toward meeting a goal. This discussion should include determining if the goal was met or not met and an evaluation of whether the goal will be discontinued, modified, or carried forward. The CC/CM should document the date (month/year) of the review and the outcome (e.g., discontinued, modified, or carried forward) in this column. If priorities change, please note. Reminder: The plan of care is a "living document" that should be updated per frequency identified in section VIII. My Follow Up Plan. Best Practice Recommendation: The CC/CM should document their monitoring of the care plan and/or updates directly on the care plan. If CC/CM uses case notes to document progress on goals, the progress regarding each goal should be clearly indicated in the case notes.

Date Goal Achieved/Not Achieved: This column is used to document the date (month/year) the goal was achieved or if not achieved, the date (month/year) it was reviewed. This column may also be used to document progress notes and the final outcome (e.g., goal discontinued, modified, or carried forward to next year's care plan).
Initial/Annual: Describe any barriers to meeting goals. **Update:** Complete and date at time of designated follow up.
CC/CM Follow-up Plan: Check box to indicate how frequently you will be following up with the member. If other, describe. Must be a minimum of every 6 months. You will be audited according to what you select.

Essential Services Backup Plan: Essential services are services that if the member did not receive them, the member's health or ability to remain safety in their home would be compromised. What is their back up plan if essential services providers do not show up? Example, the member is receiving essential services such as Meals-on-Wheels, if that is their only source of nutrition, describe how this need will be met.
I have been given a choice of different types of services that can meet my needs: The member/authorized representative checks yes or no
I have been offered a choice of providers from available providers: The member/authorized representative checks yes or no.
I have annually received my appeal rights: Inform member/authorized representative that their annual appeal rights are sent with any DTR and with their annual Evidence of Coverage (EOC). The member/authorized representative should check yes or no. CC/CM can direct member/authorized representative to customer service if they need a copy of the appeal rights documents.

I am aware that healthcare information about me will be kept private (Data Privacy rights): Inform member/authorized representative that their privacy rights are sent annually. The member/authorized representative should check yes or no. CC/CM can direct members/authorized representative to customer service if they need a copy of their EOC, which contains data privacy information.
I have discussed my plan of care with my care coordinator/case manager and have chosen the services I want. The member/authorized representative checks yes or no.
I agree with the plan of care as discussed with my care coordinator/case manager. The member/authorized representative checks yes or no.
Member/Authorized Representative Signature and Date. CC/CM must obtain signature from member or authorized representative.
Member/Authorized Representative Printed Name: Enter or Print name of member or authorized representative that signed above.
Care Coordinator/Case Manager Signature and Date. CC/CM signs care plan.
Care Plan Mailed/Given to me on: Enter the Date Care Plan was Mailed/Given to the Member.
Care Plan or Summary Mailed/Given to My Doctor: Enter the Date Care Plan or Summary was Mailed/Given to PCP. Enter the method that care plan was shared (Verbal, Phone, Fax, Electronic Medical Record).
Member Name and HealthPartners ID: Enter member name and Health Partners ID