COMPASS Person-Centered Service Plan Guide:

The Participant's Person-Centered Service Plan (PCSP) is an individualized, comprehensive document developed by the participant, their chosen representative(s), and the Supports Coordinator prior to the provision of services. The Person-Centered Planning (PCP) process utilizes information gathered from the InterRAI-HC Assessment, the CAPS and Triggers report, and the PCSP Quality Assurance Report, and involves listening to and supporting the participant based on their strengths, abilities, aspirations and preferences, to make decisions for maintaining a life that is meaningful to them.

The Supports Coordinator will establish a written PCSP for each participant. The PCSP identifies the participant's strengths, weaknesses, preferences, service needs, prioritized goals, expected outcomes, and planned interventions and reflects the goals and interests of the participant. **This document MUST also include ALL services provided to, or needed by, the participant regardless of funding source.**

Participants should be involved in the care planning process to the extent they prefer. Participants also have the ability to invite any informal supports, family members, friends or community supports to be present and involved in any aspect of the care planning process. A caregiver who is involved in the plan's development process may contribute to the discussions about goals and other aspects of the process, but may not define goals for an individual.

- See the *MI Choice Waiver Policies & Procedures Manual* for further information regarding the COMPASS Person Centered Service Plan
- See the *COMPASS Assessment and PCSP Guide* for specific instructions on entering a PCSP.

The COMPASS PCSP is divided into two sections – **PCSP Goals and PCSP Interventions**. Each PCSP goal is determined by the participant and is linked to the specific issue(s) established during the Assessment process that it will be addressing. Each PCSP Intervention is identified by the participant and is linked to the specific issue(s) established during the Assessment process to help achieve the chosen goals. Each Goal and Intervention that is added to the PCSP must be linked to an issue(s) in the "Issues Addressed" section

PCSP Goals:

PCSP Goals define what the participant wants to happen and to achieve. It is the foundation of person-centered care planning and addresses the desired outcome of the individual.

The Supports Coordinator will assist the participant with identifying their own goals that are specific to the issues that have been identified during the assessment. Additional goals may be identified and added during a PCSP review or monitoring call.

Adding a Goal:

In the Goal section of the Navigation panel the Supports Coordinator will select add and enter the name of the goal. The goal should be broad and defined in "I" language. It should be written in a way that is understandable to the client.

- Examples of Goals:
    - *I want to have my personal and household needs met.*
    - *I want to increase my social activity.*
    - *I want to decrease my hospital visits.*

Desired Outcomes:

- Desired outcomes provide a description of why the participant has the goal and the specific actions that will be taken by the participant and their supports to achieve the goal.
- The Supports Coordinator will assist the participant with identifying what steps need to be taken to achieve the goal. The desired outcomes should be specific and defined in "I" language.
- Examples of Desired Outcomes:
    - *To have assistance with my daily care and remain as independent as possible.*
    - *To get regular wound care, heal my skin and prevent infection.*
    - *To have a lifeline in case I fall or have an emergency.*

Issues Addressed:

- The issues have been identified and populated with the sections that have been marked "Yes" in "Include in PCSP" within the assessment.
- Select the sections of the Assessment that apply to the current goal being added.
- It is recommended to keep goals limited to address only one issue, but it is not required. This makes the PCSP report easier to read for all parties involved.

Issue Description:

- Provides the description of the issue that was created in the "Include in PCSP" section of the Assessment. It is auto-populated from the selections made in the "Issues Addressed" section. It will display the section selected from the Assessment along with the corresponding description.
- This section is not editable here.

Priority:

- How the participant prioritizes and ranks their goals based on their own preferences.
- Ask the participant how they would rank their goal based on the following available options:
  - Less Important (Low)
  - Important (Medium)
  - More Important (High)

* **The PCSP needs to reflect variety in priority ranking based on the participant's preferences and needs. All goals can not be at the same priority level.**

Start Date:

- Ask the participant when they would like to begin the goal. The start date may be the date of the Assessment, of the formal Person-Centered Planning (PCP) meeting (if scheduled), or upon participant request.
- The Start Date is not dependent on availability of services.
- Note that if the Goal has a Start Date that is greater than the Assigned Assessment Date it will not be displayed in the dated Assessment upon finalization, however, it will be displayed in the Next Assessment.

Goal Review:

- The Goal Review is an evaluation completed by the Supports Coordinator with the participant to determine the current status and progress of the goal, and if the interventions that were put in place are working.
- Interventions may need to be updated, changed or added as needed to better assist the participant in achieving the goal.
- Document the effectiveness of the current intervention and how it is assisting the participant in reaching their goal. Briefly describe the progress, or lack thereof, that is being made. The goal review cannot be cloned from previous reviews. It must be re- evaluated with each PCSP review.

- If the intervention is unsuccessful in helping the participant in reaching their goal then document the changes that are to be made. This may include altering the goal, deleting the intervention, or adding an additional intervention. Supports Coordinators should utilize the following "smart phrases" in their goal review to maintain consistency in charting:
    - *"The intervention has been unsuccessful in helping the participant reach their goal. Adjustments to the plan will include:"*
    - *"Barriers to achieving the goal include:"*

Resolved Date:

- If during the goal review the participant determines that the goal has been achieved a resolved date can be entered.

PCSP Interventions:

PCSP Interventions are services and actions that are being added to the PCSP to address the Issues that were identified by the Supports Coordinator and participant. The Supports Coordinator will assist the participant during the Assessment with identifying the interventions that will be put in place to help achieve the chosen goals. The participant needs to agree to the interventions, and they should provide a direct path to the desired outcomes.

Adding an Intervention:

In the PCSP Interventions section of the Navigation panel the Supports Coordinator will select the type(s) of intervention to be added from the five options listed below:

- Purchased WA (Waiver)
- Purchased Other (Non-Waiver)
- Informal
- Self
- Arranged

Additional interventions may be identified and added during a PCSP review or monitoring call, but they cannot be duplicated.

Purchased WA (Waiver):

Purchased Waiver Interventions are those that are authorized to be paid for using MI-Choice Waiver funding and are for participants who are either have a status of *Waiver-Pending* (WA-P) *Waiver-Yes* (WA-Y), or *C-Waiver* (UPHP C-WA).

Based on the Interventions identified with the participant, determine from the following drop- down menu which are to be Purchased Waiver:

- Adult Day Care
- Assistive Technology
- Chore Services
- Community Health Worker
- Community Living Supports (*ECLS Services for C-Waiver*)
- Community Transportation
- Counseling
- Environmental Accessibility Adaptations
- Fiscal Intermediary Services
- Goods and Services
- Home Delivered Meals
- Nursing
- Personal Emergency Response System (PERS)
- Private Duty Nursing (PDN)
- Residential Services
- Respite
- Specialized Medical Equipment and Supplies
- Supports Brokerage
- Supports Coordination – **Supports Coordination is a required intervention on all MI Choice Waiver care plans.** (*Supports Coordination is not a billable service for C-Waiver participants and should be entered under Purchased-Other*)
    - *See asterisk within this section for additional direction.
- Training
- Vehicle Modifications

Enter the Intended Start Date for the Intervention. Note that if the Intervention has a Start Date that is greater than the Assigned Assessment Date it will not be displayed in the dated Assessment upon finalization, however, it will be displayed in the Next Assessment.

Intervention Description:

* (Intervention Description is only available when "Supports Coordination" has been selected as an Intervention)

- This is a description of the specific interventions and tasks identified during the PCP process, which will be carried out by the Supports Coordinator.

- Examples may include:
    - *Notify informal support of the tasks and duties assigned to them.*
    - *Provide Supports Coordination Services including monitoring the person-centered service plan.*
    - *Provide assistance with Medicaid Re-Determinations and Paperwork as needed/requested.*

Issue Addressed:

- These are the issues that have been identified and populated within the sections of the COMPASS Assessment that have been marked "Yes" in "Include in PCSP". They will appear in the box labeled "Select Assessment Sections with Issues". Select the issues that the intervention will address.

Issue Description:

- This provides the description of the issue that was created in the "Include in PCSP" section of the Assessment. It is auto-populated from the selections made in the "Issues Addressed" section. It will display the section selected from the Assessment along with the corresponding description.

- This section is not editable here.

Participant Preference:

- Identifies what the participant states they need from the intervention.

- Assist the participant with identifying the Agency they would prefer to provide the service.

- Using "I" language describe the service and the agency that will be providing it.

- Examples include:

    - *I prefer to have Best Lawn Care provide weekly lawn care in the summer.*
    - *I prefer to have Community Action Agency assist me with personal and household care Monday's and Wednesday 11:00am – 2:00pm.*
    - *I would like a lifeline through Alert Medical*

Communication Plan**:**

*(Communication Plan is only available when "Supports Coordination" has been selected as an intervention)

- Indicates the participant's preferences regarding communication with the Supports Coordinator. This is where the participant specifies how often they would like to be contacted, assessed, and have their PCSP reviewed.

- Review the following Communication Plan questions with the participant:

    - *How often should the SC contact you (number of days)?* This field will update the Monitoring Contact Due on the Compass Dashboard.

        - The standard time frame is every 30 days, but participants can elect to shorten or extend the time frame, if needed, to serve the participants needs. The participant must be contacted no less frequently than every 90 days.
        - The *Monitoring Contact* Due will be reset on the Compass Dashboard when either a Monitoring Contact or Person-Centered Planning Meeting Progress Note has been entered, or an Assessment has been finalized.

- *How often should the SC assess you?* This field will update the Next Assess Due on the Compass Dashboard.

    - Supports Coordinators must complete a comprehensive in-person reassessment with all new participants within 90 days of the initial assessment. Following the 90-day reassessment Supports Coordinators must complete a comprehensive in-person reassessment with all participants no less than annually (360 days).
    - The *Next Assessment Due* will be reset on the COMPASS Dashboard each time an Assessment is finalized.

- *How often should the SC have a person-centered planning meeting?* This field will update the Person-Centered Planning Due on the COMPASS Dashboard

    - The PCSP must be reviewed and updated with the participant as frequently as necessary or preferred, but at least 90 days after the initial assessment, then every 180 days thereafter.
    - The *Person-Centered Planning* Due on the COMPASS Dashboard will reset each time a Person-Centered Planning Meeting is entered in the Progress Notes or an Assessment has been finalized.

- *Who would you prefer the SC communicate with about your services and supports if anyone other than you?* Leave blank if no one else.

    - Enter the name of the person the participant prefers the SC to communicate with. This person should be added as an Informal Support in the COMPASS Assessment and to the PCSP.

- *Informal Supports Communication Plan:*

    - Have the participant select from the following options:

        - SC will communicate with all informal supports regarding their role in care
        - Participant/Guardian/Legal Representative will take responsibility to communicate with all informal supports regarding their role in care
        - Other
            - If "Other" is selected, provide a clear description in the box provided.

- *Would you like a copy of your PCSP mailed to your primary care physician?*

    - Check the appropriate box, "yes" or "no", based on the Participants preference.

- *Would you like a copy of your PCSP mailed to any of your other physicians?*

    - Check the appropriate box, "yes" or "no", based on the participants preference.
    - If "yes" is selected provide a clear explanation in the box provided.

Intended Start Date:

- This field identifies the intended date the intervention will begin. It is auto-populated from the "Add Purchased WA" section. Although this is auto-populated, it can be edited here if needed.

Resolved Date:

- This is the date the Intervention has been completed. During the Goal Review the Supports Coordinator and Participant will determine if an Intervention can be resolved.
- Under *Purchased Waiver* Supports Coordination will only be resolved upon the participant's case closure or if their status changes to something other than WA-Y, WA-P or WA-I.

Purchased Other (Non-Waiver):

These are Interventions that are arranged for participants, and paid for through other allocated UPCAP funds such as, but not limited to, 202 & 221 funds. They require the Supports Coordinator to create and submit a work order for the services. These participants have a status other than *Waiver-Pending* (WA-P) or *Waiver-Yes* (WA-Y).

The following is a list of Statuses that could potentially fall under this category:

- AASA/CM AASA Care Management
- AASA/TCM AASA Targeted Care Management
- NFT Nursing Facility Transition
- Veterans Veterans Administration
- UPHP-AHH UPHP Adult Home Help
- LCM-I Long term Care Management Ineligible

Based on the Interventions identified with the participant, determine which of those will be covered utilizing other available funds allocated through UPCAP. The following interventions are available under *Purchased Other* and will appear in the drop-down menu:

- Assistive Technology
- Adult Day Care
- Chore Services
- Community Health Worker
- Community Living Supports
- Community Transportation
- Counseling
- Environmental Accessibility Adaptations
- Fiscal Intermediary Services
- Goods and Services
- Home Delivered Meals
- Nursing
- Personal Care Services – *C-Waiver PCA Only*
- Personal Emergency Response System (PERS)
- Private Duty Nursing (PDN)
- Residential Services
- Respite
- Specialized Medical Equipment and Supplies
- Supports Brokerage
- Supports Coordination – **Supports Coordination is a required intervention on all care plans.** *See asterisk within this section for additional direction.
- *Supports Coordination for C-Waiver Participants should be added here*
- Training
- Vehicle Modifications

Enter the Intended Start Date. Note that if the Intervention has a Start Date that is greater that the Assign Assessment Date it will not be displayed in the dated Assessment upon finalization, however, it will be displayed in the Next Assessment.

Intervention Description:

*(Intervention Description is only available when "Supports Coordination" has been selected as an intervention.)

- This section identifies the specific interventions and tasks that the Supports Coordinator is taking responsibility for. The Supports Coordinator will consult with the Participant to identify the specific tasks the Supports Coordinator will assist with and provide for the Participant.

- Examples may include:

    - *Notify informal support of the tasks and duties assigned to them.*
    - *Provide Supports Coordination Services including monitoring the person-centered service plan.*
    - *Provide assistance with Medicaid Re-Determinations and Paperwork as needed/requested.*

Issue Addressed:

- These are the issues that have been identified and populated within the sections of the COMPASS Assessment that have been marked "Yes" in "Include in PCSP". They will appear in the box labeled "Select Assessment Sections with Issues". Select the issues that the intervention will address.

Issue Description:

- This provides the description of the issue that was created in the "Include in PCSP" section of the Assessment. It is auto-populated from the selections made in the "Issues Addressed" section. It will display the section selected from the Assessment along with the corresponding description.

- This section is not editable here

Participant Preference:

- Identifies what the Participant states they need from the intervention.

- Assist the Participant with identifying the Agency they would prefer to provide the service.

- Using "I" language describe the service and the agency that will be providing it.

Communication Plan**:**

*(Communication Plan is only available when "Supports Coordination" has been selected as an intervention)

- Indicates the participant's preferences regarding communication with the Supports Coordinator. This is where the participant specifies how often they would like to be contacted, assessed, and have their PCSP reviewed.

- Review the following Communication Plan questions with the participant:

    - *How often should the SC contact you (number of days)?* This field will update the Monitoring Contact Due on the Compass Dashboard.

        - The standard time frame is every 30 days, but participants can elect to shorten or extend the time frame, if needed, to serve the participants needs. The participant must be contacted no less frequently than every 90 days.
        - The *Monitoring Contact* Due will be reset on the Compass Dashboard when either a Monitoring Contact or Person-Centered Planning Meeting Progress Note has been entered, or an Assessment has been finalized.

    - *How often should the SC assess you?* This field will update the Next Assess Due on the Compass Dashboard.

        - Supports Coordinators must complete a comprehensive in-person reassessment with all new participants within 90 days of the initial assessment. Following the 90-day reassessment Supports Coordinators must complete a comprehensive in-person reassessment with all participants no less than annually (360 days).
        - The *Next Assessment Due* will be reset on the COMPASS Dashboard each time an Assessment is finalized.

    - *How often should the SC have a person-centered planning meeting?* This field will update the Person-Centered Planning Due on the COMPASS Dashboard

        - The PCSP must be reviewed and updated with the participant as frequently as necessary or preferred, but at least 90 days after the initial assessment, then every 180 days thereafter.
        - The *Person-Centered Planning* Due on the COMPASS Dashboard will reset each time a Person-Centered Planning Meeting is entered in the Progress Notes or an Assessment has been finalized.

    - *Who would you prefer the SC communicate with about your services and supports if anyone other than you?* Leave blank if no one else.

        - Enter the name of the person the participant prefers the SC to communicate with. This person should be added as an Informal Support in the COMPASS Assessment and to the PCSP.

- *Informal Supports Communication Plan:*
    - Have the participant select from the following options:
        - SC will communicate with all informal supports regarding their role in care
        - Participant/Guardian/Legal Representative will take responsibility to communicate with all informal supports regarding their role in care
        - Other
            - If "Other" is selected, provide a clear description in the box provided.
- *Would you like a copy of your PCSP mailed to your primary care physician?*
    - Check the appropriate box, "yes" or "no", based on the Participants preference.
- *Would you like a copy of your PCSP mailed to any of your other physicians?*
    - Check the appropriate box, "yes" or "no", based on the participants preference.
    - If "yes" is selected provide a clear explanation in the box provided.

<u>Intended Start Date:</u>

- This field identifies the intended date the intervention will begin. It is auto-populated from the "Add Purchased Other" section. Although this is auto-populated, it can be edited here if needed.

<u>Resolved Date:</u>

- This is the date the Intervention has been completed. During the Goal Review the Supports Coordinator and Participant will determine if an Intervention can be resolved.
- If a Participant's status has been switched to WA-Y or WA-P the resolved date will be the day prior to the start date of WA-Y or WA-P. Waiver services would then be switch to "Purchased Waiver".
- See additional notes on cloning at the end of the COMPASS PCSP Guide.

Informal Interventions:

Interventions that are arranged for the Participant, but are not paid for by MI-Choice Waiver funds or other UPCAP funds. These Interventions are provided by the Participant's caregivers and/or community supports that have been identified in the Caregiver section and Community Supports section of the Assessment.

The tasks and interventions provided by informal supports are identified during the completion of the Caregiver and Community Support sections of the Assessment. The Supports Coordinator will select a Provider from the drop-down list and enter a start date. The Providers information will then be auto-populated.

The option to add a Caregiver or Community Support to the PCSP *Informal Interventions* is also available within COMPASS record for both Caregivers and Community Supports. While in the specific COMPASS record the Supports Coordinator has the option to select the "**Copy to Informal Intervention**" tab, and the data will be auto-populated to the PCSP. See the COMPASS Assessment and PCSP User Guide for further details.

Any Informal or Community Supports added to *Informal Interventions* will auto-populate to the COMPASS Back-Up Plan.

Issue Addressed:

- These are the issues that have been identified and populated within the sections of the COMPASS Assessment that have been marked "Yes" in "Include in PCSP". They will appear in the box labeled "Select Assessment Sections with Issues". Select the issues that the intervention will address.

Issue Description:

- This provides the description of the issue that was created in the "Include in PCSP" section of the Assessment. It is auto-populated from the selections made in the "Issues Addressed" section. It will display the section selected from the Assessment along with the corresponding description.

- This section is not editable here

Provider Phone Number:

- The phone number of the selected Caregiver or Community Support that has been selected. This is auto-populated from the Caregiver section of the Assessment.

- The section is not editable here, but will be updated when the Caregiver or Community Support record is edited.

Tasks:

- The tasks and/or duties that the Caregiver or Community Support will be providing forthe participant. This is auto-populated from the Caregiver section of the Assessment.

- This section is not editable here, but will be updated when the Caregiver or Community Support record is edited.

- The record must be specific and list the type of assistance the informal supportis providing, along with the amount and frequency.

Intended Start Date:

- This field identifies the intended date the intervention will begin. It is auto-populated from the date entered when the Informal Intervention was added. Although this is auto- populated, it can be edited here if needed.

Resolved Date:

- This is the date the Intervention has been completed. During the Goal Review the Supports Coordinator and Participant will determine if an Intervention can be resolved.

Self-Interventions:

These are considered **self-management plans**, and describe the interventions and tasks the Participant is taking responsibility for and agreeing to do for themselves. These should not be behavior, safety or educational things which are covered in the handbook and signed by all participants (i.e., lock dog up, treat worker with respect, etc.).

The Supports Coordinator will assist the Participant with identifying tasks that they can perform and/or take responsibility for.

- Examples of Self Interventions:
  - *Appointments*
  - *VA Benefits*
  - *SS Card*

The Supports Coordinator will add the *Self Intervention* in the navigation panel by entering a short Intervention name and the Intended Start Date.

Intervention Description:

- Assist the Participant with identifying the specific interventions they are going to perform and/or take responsibility for.

- Enter a description of the specific self-intervention including the amount, type and frequency.

- Examples of Intervention Descriptions:
  - *I will continue paying for my PERS unit privately*
  - *I will schedule and attend my Dental/Vision/Hearing appointments as needed and recommended.*
  - *I will actively pursue Veterans Administration Benefits.*
  - *I will work on getting a replacement Social Security Card.*

Issue Addressed:

- These are the issues that have been identified and populated within the sections of the COMPASS Assessment that have been marked “Yes” in “Include in PCSP”. They will appear in the box labeled “Select Assessment Sections with Issues”. Select the issues that the intervention will address.

Issue Description:

- This provides the description of the issue that was created in the “Include in PCSP” section of the Assessment. It is auto-populated from the selections made in the “Issues Addressed” section. It will display the section selected from the Assessment along with the corresponding description.

- This section is not editable here.

Intended Start Date:

- This field identifies the intended date the intervention will begin. It is auto-populated from the date entered when the Self Intervention was added. Although this is auto-populated, it can be edited here if needed.

Resolved Date:

- This is the date the Intervention has been completed. During the Goal Review the Supports Coordinator and Participant will determine if an Intervention can be resolved

Arranged Interventions:

Arranged Interventions are those that are being paid for or provided by sources other than the MI-Choice Waiver Program, UPCAP, Informal or Community Supports. These interventions do not require a work order. The Supports Coordinator will assist the participant with identifying which services are to be provided under *Arranged Interventions.*

Select the Intervention(s) from the provided drop-down list. If "Other" is selected, the Arranged intervention can be specified in the Additional Description box available in the next step. The following is a list of possible Arranged Interventions:

- Community-based food assistance
- Disease-specific support or advocacy
- Durable Medical Equipment
- Faith/religion based services and supports
- Hearing services and supports
- Health insurance or benefit assistance services (i.e. MMAP)
- Home health aide services
- Hospice services and supports
- Housing assistance, services, or support
- Incontinence supplies
- Independent Living Services
- Legal services
- Low cost or free community-based services
- Mental health services
- Non-emergency medical transportation
- Occupational therapy services
- Other
- Other Physician
- Palliative Care
- Pharmacy
- Physical therapy services
- Prescription assistance services
- Primary Physician
- Services and supports for the Aged
- Services and supports for the Blind
- Skilled Care
- Skilled nursing services
- Social worker services
- Speech language pathology therapy services
- State Emergency Relief services
- Supplemental Nutrition Assistance Program (SNAP) services
- Tribal Services
- Veterans supports and services (examples: DME, nursing, counseling, transportation)
- Vision services

Additional examples of Arranged Services would include:

- Grant services
- Usual and Customary Care provided to a participant receiving Residential Services through the MI-Choice Waiver

Enter the Intended Start Date. Note that if the Intervention has a Start Date that is greater that the Assigned Assessment Date it will not be displayed in the dated Assessment upon finalization, however, it will be displayed in the Next Assessment.

The participant's primary care physician, medical providers, and pharmacy must be included on the PCSP and Back- Up Plan populated in COMPASS. Make sure to include **ALL** current Medical Providers, including primary physician, specialists, DME providers, and pharmacies, on the PCSP as well.

The option to add a Medical Provider, Pharmacy, and/or Durable Medical Equipment to the PCSP *Arranged Interventions* is also available within the COMPASS record for each of these providers. When in any of these three records the Supports Coordinator has the option to select the "**Copy to PCSP**" tab, and the data will be auto-populated to the PCSP. Each of these may be added manually as well. See the COMPASS Assessment and PCSP User Guide for further details.

Any services that have been added to *Arranged Interventions* will auto-populate to the Service Provider section of the COMPASS Back-Up Plan, identifying the name of the Provider and the service being provided.

Additional Descriptor:

- This is used to identify "Other" interventions. It also delineates specific skilled care, hospice, DME items, and medical providers such as a podiatrist, neurologist, etc. that could be added multiple times. When an Additional Descriptor is completed for an Arranged Intervention the text will display in the Navigation Panel instead of the intervention name.

- Additional Descriptors can be left blank if the Arranged Intervention is clearly defined when originally added.

Intervention Description:

- This section provides a detailed description of the *Arranged Interventions* the participant needs or is receiving. The Supports Coordinator will enter the specific intervention to be provided including the amount, type and frequency of the service.

- The Supports Coordinator may need to collaborate with the agencies providing the intervention to obtain all necessary information for the Intervention Description.

- *For Food Benefits:*
  - Include ALL food benefit sources, including food commodities, food pantries, and SNAP benefits.
  - If the participant receives SNAP Benefits, make sure to add Michigan Department of Health and Human Services (by county) as the provider.
  - Be sure to include the frequency at which the food benefits are received – monthly, weekly, quarterly, etc.
  - Issue: Assistance Paying for Food
  - Goal Examples:
    - I want to maintain my independence while remaining safe
    - I want to maintain optimal nutrition
    - I want to improve nutrition

- *For Medical Providers:*

  - Include ALL current medical providers, including specialists
  - The participant's primary physician should be listed under "Primary Physician" and all other medical providers should be added separately under "Other Physician".
  - Be sure to include the type of medical provider (i.e. chiropractic care; podiatry; etc) under "Additional Descriptor"
  - The frequency at which they provide care to the participant (i.e. every 6 months; annually, etc) and any other important information regarding the services provided should be entered under "Intervention Description".
  - Issue: Requires ongoing medical treatment
  - Goal Examples:
    - I want to maintain optimal health
    - I want to improve my health

- *For Pharmacies:*

  - Include ALL pharmacies utilized by the participant
  - If the participant uses more than one pharmacy, add the pharmacy most often used under the "Pharmacy" option. For additional pharmacies, select "Other" and enter in the name of the pharmacy under Additional Descriptor
  - Issue: Requires Medications
  - Goal Examples:
    - I want to maintain optimal health
    - I want to improve medication adherence

- *For DME*:

    - Include all of the DME that has been entered in the participants COMPASS record of Durable Medical Equipment.
    - Use phrasing such as “Participant will utilize the following DME as needed for safety:”

- *For Incontinence Supplies:*

    - The specific type of supplies that are being provided *must* be identified along with the *amount* provided on a monthly basis. If you are unable to get the order information from the agency, ask the participant and document the type and amount of supplies reported, even if information is general. Documenting that the participant is “eligible” with no further information is not acceptable to meet required standards.
    - Document all attempts in Compass that are made to obtain the required information.

- *For Skilled Services:*

    - List the amount, type and frequency of the specific Skilled Service, matching the tasks to the 485 skilled care plan.
    - Specific services must be added individually under its own Arranged Intervention or under Additional Descriptor. These would include things such as nursing, home health aide, physical therapy, etc.

<u>Issue Addressed:</u>

- These are the issues that have been identified and populated within the sections of the COMPASS Assessment that have been marked “Yes” in “Include in PCSP”. They will appear in the box labeled “Select Assessment Sections with Issues”. Select the issues that the intervention will address.

<u>Issue Description:</u>

- This provides the description of the issue that was created in the “Include in PCSP” section of the Assessment. It is auto-populated from the selections made in the “Issues Addressed” section. It will display the section selected from the Assessment along with the corresponding description.

- This section is not editable here.

Provider Type:

- Identifies the type of Provider being utilized for the Arranged Intervention.

- Select one of the following Provider Types from the Agent Provider list:

    - No Selection
    - Arranged Provider
    - Medical Provider
    - Pharmacy Provider
    - DME Provider
    - Other
        - If "Other" is chosen you will you will be provided with a place to enter the name of the provider. If the provider is going to be ongoing, complete and submit a Provider Request form, which is available on the UPCAP website, to your Case Tech. The Case Tech will add the provider to Compass, and the Supports Coordinator will then be able to locate and add the provider from the Agent Provider list.

Provider Phone:

- The Provider phone number will auto-populate if the provider is listed in Compass. This field is not editable within this section, but will be updated when the provider record is updated.

- If "Other" is selected the Supports Coordinator is able to free-text and edit the Provider and Provider Phone fields at any time.

Intended Start Date:

- This field identifies the intended date the intervention will begin. It is auto-populated from the date entered when the Arranged Intervention was added. Although this is auto- populated, it can be edited here if needed.

Resolved Date:

- This is the date the Intervention has been completed. During the Goal Review the Supports Coordinator and Participant will determine if an Intervention can be resolved.

Additional Information:

Intervention Start and Stop Dates:

Each individual intervention should have its own start and stop date. Examples include, but are not limited to: “Skilled Nursing”, the purchase of “Good and Services”, “Training”, Specialized Medical Equipment and Supplies”. Note that Compass does not allow for duplicate interventions to be open at the same time. Depending on the situation, the intervention would either have to be stopped and restarted, or an additional service would be added to an existing intervention. An example of adding to an existing intervention would be: a piece of DME that has been added to a current order.

Cloning Interventions:

In the situation where a participant’s care plan needs to be updated and interventions will be switching between Purchased Waiver and Purchased Other, Cloning can be used to make the update. Cloning allows this process to be easier to maintain accurate interventions. When cloning an intervention, the system will clone all fields with the exception of the Resolved Date.

* See the COMPASS Assessment & PCSP User Guide for further details. This is found in the “Help” drop down menu in COMPASS Navigator.

PCSP Quality Assurance Report:

This can be generated from the participants COMPASS file under reports. This report will show the question responses that are considered to be “not normal” as well as show the Relevant History and section’s Descriptions of Conditions Noted Above for the Supports Coordinator to review.

CAPS Report:

The CAPS (and Triggers) Report can be generated from the participants COMPASS file under reports. Through Inter-RAI-HC Assessment process key factors in the person’s life, including aspects of function, health, social support, service use, and quality of life are addressed. This report is populated identifying any problems and potential areas of need that were identified during the assessment process.

Temporary Door Criteria:

Participants who qualify only under Door 3, 4 or 5 may have greater potential for discharge from the MI-Choice Waiver program. They require ongoing assessment and follow up monitoring and may only require services for a limited time***. Care planning for these applicants must include restorative nursing interventions and a specific discharge plan, except for those receiving end-of-life care.*** Restorative nursing interventions are discussed in the Michigan Medicaid Nursing Facility Level of Care Determination Process Guidelines.

- Example of Goal:
    - *My Discharge Plan*
- Example of Desired Outcome:
    - *Safely discharge to community resources in the event my personal care and homemaking needs can be met through alternate community resources or informal supports.*
- Intervention can be listed under Supports Coordination – Examples:
    - *Supports Coordinator to monitor for ongoing MI-Choice Waiver eligibility.*
    - *Monitor services and interventions that focus on maintaining and promoting the participants physical, mental and/or psychosocial function.*
    - *Assist Participant with arrangement of community resources and services in the event of closure from the MI-Choice Waiver program due to no longer meeting Nursing Facility criteria.*

Effective Date:

- 08/25/2023

Document History:

- Revised 04/30/2024 – Internal Quality Committee
    - Updated to include newly approved Waiver Services
    - Updated with direction re: issues/goals for physicians/pharmacies on PCSP
- Revised 03/18/2024 – Internal Quality Committee Annual Review
    - Updated to include new guidance from MDHHS re: physicians/pharmacies on PCSP
    - Updated to clarify ALL services must be reflected on PCSP
- Revised 9/26/2023 – Internal Quality Team
    - Updated to include C-Waiver direction
    - Updated to include more clarification regarding priority ranking for participant goals.