CENTER FOR DEVELOPMENT & DISABILITY

Medically Fragile Case Management Program
2300 Menaul NE
Albuquerque, NM 87107
505-272-2910 (Metro Office)
505-272-8100 (Fax)
CDD-MedFrag@salud.unm.edu

INDIVIDUALIZED SERVICE PLAN

Initial: ☐ **Reassessment: ☐**

NAME: **DOB:** **MEETING DATE:**

MCO Provider:

Private Insurance:

Medicare: Yes ☐ No ☐

SSI: Yes ☐ No ☐

NOME: Yes ☐ No ☐ (Not otherwise Medicaid eligible = Do they need the waiver to be eligible?) {Waiver clients only – remove completely if EPSDT}

SSDI: Yes ☐ No ☐

ISP Cycle Dates:

Program: Medically Fragile Waiver ☐ or Medically Fragile Non-Waiver EPSDT ☐

Six-Month Review Completed By: For Initial ISP only – *CM mark your submission calendar when this is due.* **(Remove completely if not Initial ISP.)**

Household Members:

Name	Occupation	General Health

Legal Guardian(s):

Primary Language:

What is your spiritual preference?

Ethnicity (Do you consider yourself Hispanic or Latino)**: Yes ☐ No ☐ Don't want to answer ☐**

Race: (*enter a choice from list*)
(*American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White or Anglo)*

If you are American Indian/Native American, what tribe(s) or pueblo(s)? (Remove if it does not apply.) (*Pueblo*: list pueblo, *Navajo*, *Apache*: list tribe, *Other*: list)

TEAM MEMBERS

Name	Duration/Frequency	Funding

PRENATAL HISTORY

HEALTH HISTORY

CURRENT STATUS
Primary Diagnosis/ICD-10 Code:

Have parents/legal guardian discussed DNR?
or
Has individual discussed Advanced Directives? (Remove the one that isn't answered)

Medical Power of Attorney (POA)? Yes ☐ No ☐
If yes, name and title of Medical POA**:**

(insert page break)

MEDICAL FRAGILITY ASSESSMENT FACTORS

A. MEDICATION ADMINISTRATION:

- **Scheduled -**

Name	Dosage	Frequency	Route

- **PRN -**

Name	Dosage	Frequency	Route

B. MEDICAL CARE and SUPERVISION:

- **Hospitalizations -**

Date	Hospital	Reason/Treatment

- **Medical Care Contacts –**

Date	Physician/Specialty	Reason/Treatment

C. NUTRITION and FEEDING:

- **Airway Safety (History of Aspirations) -**
- **Feeding Route -**
- **Time to Feed -**
- **Feedings per Day -**
- **Additional Skilled Care -**
- **Behavioral Component -**

HEIGHT: WEIGHT: BMI:

- **Nutritional Status (BMI percentage) – Describe here if healthy weight, underweight or overweight. Delete "BMI" if you do not do one.**

D. RESPIRATORY:

(The following information must be included for someone non-ventilator dependent if they have respiratory issues))

1. **Ventilation –**
2. **Oxygen Requirements –**
3. **Suctioning –**
4. **Airway Clearance –**
5. **Skilled Assessment -**

(The following information must be included if client requires a ventilator)

D-1 Ventilator Status
D-2 Frequency of Suctioning (type)
D-3 Airway Clearance
D-4 Respiratory Status/Skilled Assessment

E. NEUROLOGICAL:

1. **Seizures -**
2. **Spasticity -**

F. OTHER COMPLEX MEDICAL/SKILLED CARE TREATMENTS:

G. MEDICAL IMPACT BASED ON ABILITY FOR SELF CARE:

H. FAMILY SUPPORT ISSUES: (Do not list all bullets unless you address them for a score.)

- **Financial concerns -**
- **Health concerns for other family members -**
- **Sleep for caregivers -**
- **Family stability -**

- **Support systems (extended family & community) -**
- **Meeting care needs of other family members -**
- **Behavioral -**
- **Every day household care needs/chores -**
- **Coordination of all the care needs for the recipient -**
- **Miscellaneous -**

I. SLEEP PATTERN:

J. ALLERGIES:

K. IMMUNIZATIONS:

L. VISION:

M. DENTAL:

DEVELOPMENTAL TESTING

(insert page break)

DD ASSESSMENT FACTORS

A. SENSORIMOTOR DEVELOPMENT:
1. **Mobility -**
2. **Toileting -**
3. **Hygiene -**
4. **Dressing -**

B. AFFECTIVE DEVELOPMENT:

C. SPEECH & LANGUAGE DEVELOPMENT:
1. **Expressive -**
2. **Receptive -**

D. AUDITORY FUNCTIONING:

E. COGNITIVE DEVELOPMENT:

F. SOCIAL DEVELOPMENT/SOCIAL SKILLS:
1. **Interpersonal Skills -**
2. **Social Participation -**

G. ADL/INDEPENDENT SKILLS:
1. **Home Skills -**
2. **Community Skills –**

H. CHALLENGING BEHAVIOR:
1. **Harmful Behavior -**
2. **Disruptive Behavior -**
3. **Socially Unacceptable/Stereotypic Behavior -**
4. **Uncooperative Behavior -**

INDIVIDUALIZED SERVICE PLAN

The following Individualized Service Plan (ISP) serves as a guideline for care. This ISP does not constitute physician orders. This ISP will vary, as recipient's care needs change. Recipient's family is encouraged to use this document to write in changes over the ISP cycle year. The IDT – interdisciplinary team - is made up of recipient, his/her family, case manager, MCO Care Coordinator; health care providers, nursing agency and community providers – such as the early intervention team, school, therapists and anyone else the individual and/or family designates to be a part of the ISP meeting and plan.

(Case manager will document recipient's ability or inability to participate.)

(Recipient's name) has participated in the development of his/her Individualized Service Plan.
OR
(Recipient's name) is not able to participate in the development of his/her Individualized Service Plan due to_____.

Case manager has discussed with the (recipient and/or family) parent that they have the option of receiving psychosocial and/or behavioral counseling. The (recipient and/or family) has/have chosen to_____.

(Recipient's) Strengths:

(Recipient's) Needs:

Family Strengths:

Family Needs:

MEDICALLY FRAGILE CASE MANAGEMENT
INDIVIDUALIZED GOAL AND OBJECTIVES

GOAL: Maintain Recipient's quality of life in their home environment.

In order to meet the stated goal, the RN/case manager uses person centered planning that is family directed. The Medically Fragile Case Management Program provides ongoing RN case management services. RN Case Management services include the following:

- Monthly contact with **Recipient's** family.
- Every other month face-to-face contact with **Recipient** and family.
- Monthly contact with MCO providers.
- Monthly contact with nursing agencies.
- Contact with DME providers as needed.
- Contact with therapy service providers as needed.
- Contact with schools **(FIT or elementary etc)** as needed.
-

Objective: Timely access to appropriate medical management.		
Outcome: Recipient will access appropriate medical management during this Individualized Service Plan (ISP) cycle.		
Strategy/Person Responsible	**Evaluation Method**	**Evaluation Indicator**
Family will schedule and attend appointments with Recipient's medical specialists as recommended to manage complex care needs. The PCP will be seen annually and PRN to address primary care needs.	Chart review Family self-report	RN CM will collect information regarding appointments through medical record review and family self-report. RN will document upcoming visits to medical specialists including resources required for visit on a monthly basis. ISP will document ability to access medical providers.
Family will access appropriate medical discipline depending on Recipient's needs. For example, he/she will see PCP for typical childhood illness such as cold. Recipient will go to the urgent care when unable to get appointment with primary care provider and will use emergency room when in critical medical crisis.	Chart Review Family self-report	RN CM will collect information regarding appointments through medical record review and family self-report. Number and reason for visits to emergency room and admissions to hospital will be documented in monthly note and ISP.
MFCMP RN CM will keep an updated list of Recipient's medical	Chart review	Team member list included in annual ISP.

team including names, contact information, appointment list, and any special transportation and/or appointment needs.		
MFCMP RN CM will communicate with Recipient's PCP informing them that Recipient is receiving ongoing case management services from the MFCMP.	Chart review PCP engagement	RN, CM will contact the PCP annually and PRN to obtain input for care plan and necessary medical records. PCP will provide documents necessary to complete annual level of care.
Family or MFCMP RN CM will notify MCO Care Coordinator if assistance is needed to obtain prior authorizations to see medical specialists.	Chart review Family self-report	Family self-reporting during monthly visit with RN, CM. RN/CM will follow up with MCO as needed.
Family will notify MCO care coordinator in advance of appointments if they need assistance with arranging travel to medical providers.	Chart Review Family self-report	MFCMP RN CM will have monthly contact with MCO. MCO will assist with arranging transportation to appointments. Family self-report during monthly visit with RN, CM.

Objective: Access community based support system including MCO services, in-home skilled care services, and educational services and therapies services when appropriate.		
Outcome: Recipient will have access to a community-based support system during this ISP cycle.		
Strategy/Person Responsible	**Evaluation Method**	**Evaluation Indicator**
MCO has preferred DME company that will provide the supplies and equipment Recipient requires to maintain care at home.	Chart review Family self-report	MFCMP RN CM will discuss ease of access to supplies and equipment at each monthly meeting. MFCMP RN CM will have monthly contact with MCO.
MCO Care Coordination will be available to Recipient when assistance is needed to access medications, DME, therapy or physician referral.	Chart review Family self-report	Family will contact MCO care coordinator when assistance is needed to access medications, DME, therapy or physician referral. MFCMP RN CM will have monthly contact with MCO care coordinator.
Family and MFCMP RN, CM will discuss Recipient's skilled care needs and determine a schedule to	Chart review Family self-report	Annual Level of Care will be completed to assess Recipient's degree of need.

meet those needs based on level of eligibility.		MFCMP RN CM will have monthly contact with family regarding skilled care needs in home.
MFCMP RN CM will communicate with nursing agency to monitor in-home skilled services on a monthly basis and as needed.	Chart review	MFCMP RN CM will have monthly contact with nursing agencies to review agency's ability to meet level of provider services as well as care plan activities.
The nursing agency will complete the nursing care plan (485) per licensing regulations as required. MFCMP RN CM will make recommendations regarding plan of care.	Chart review Family self-report	MFCMP RN CM will monitor skilled care needs during monthly visit, and assess if additional care and/or education is needed. Nursing agency will monitor skilled care needs during supervisory visits per licensing regulations, and contact RN CM if agency is unable to meet care plan expectations, or additional client/family needs are identified. Nursing agency representative will attend annual ISP meeting.
RN, CM will assist Recipient to access federally mandated education.	Chart review Family self-report	Family will report that Recipient's educational needs are being met. MFCMP RN CM will attend Individual Educational Plan (IEP) meetings per parent request.
Client will receive medically necessary therapies including OT, PT, SLP and behavioral health services.	Chart review Family report	Family will contact PCP and request referrals for therapies. MFCMP RN CM will communicate with service providers to identify services available to Recipient. Therapy service providers will develop a plan of care for Recipient. MFCMP RN CM will obtain therapy reports and integrate into client's plan of care as able. Service provider reports will be filed in Recipient's e-chart.

Objective: Access to specialized equipment to care for Recipient at home.		
Outcome: Client will have access to specialized equipment.		
Strategy/Person Responsible	**Evaluation Method**	**Evaluation Indicator**
MFCMP RN CM and family will identify equipment priorities for Recipient**.**	Chart review Family report	Equipment obtained
MFCMP RN CM will complete assessment of home safety and equipment needs.	Family report Chart review Vendor documentation of education (in home)	Equipment vendors provide necessary equipment to family. Equipment vendors will complete equipment operation instruction with family. Family demonstrates awareness of safe operation and maintenance expectations for equipment. Annual MFCMP Safe Home Evaluation will be completed to identify areas of need.
Family or MFCMP RN CM will notify MCO care coordinator if assistance is needed to obtain prior authorizations to obtain equipment.	Chart Review Family Report	Family self-reporting during monthly visit with MFCMP RN CM. MFCMP RN CM will follow up with MCO as needed.
RN, CM will include Specialized Medical Equipment in Recipient's MAD-046 budget. **{Waiver clients only – remove completely if EPSDT}**	Chart review Family report **{Waiver clients only – remove completely if EPSDT}**	Family will obtain equipment for Recipient utilizing SME funds. **{Waiver clients only – remove completely if EPSDT}**

Objective: Participation in state and federal health programs.		
Outcome: Recipient will participate in state and federal health programs during this ISP cycle.		
Strategy/Person Responsible	**Evaluation Method**	**Evaluation Indicator**
Recipient's family will maintain his/her NM Medicaid insurance for MFCMP and Medically Fragile Wavier services.	Monthly ISD portal check Family self-report	Family will complete annual Medicaid re-certification paperwork.
MFCMP RN CM will assess Recipient's level of care and submit a Comprehensive Individual	Chart review	MFCMP RN CM will submit Comprehensive Individual

Assessment and Family Centered Review annually. **{Waiver clients only – remove completely if EPSDT}**		Assessment and Family Centered Review annually. **{Waiver clients only – remove completely if EPSDT}**
MFCMP RN CM will develop and coordinate an ISP annually.	Chart review	MFCMP RN CM will submit ISP annually.
MFCMP RN CM will assess Recipient's level of care needs and progress toward objectives monthly.	Chart review	RN will complete monthly visit to assess care needs, coordinate needed actions, and measure progress toward objectives.

Objective: Recipient's family will access natural community supports.		
Outcome: Family will verbalize knowledge of available community supports and ability to access them.		
Strategy/Person Responsible	**Evaluation Method**	**Evaluation Indicator**
MFCMP RN CM will work with family to develop a plan to increase community inclusion and participation.	Chart review Family self-report	MFCMP RN CM will identify supports available in the community. Family will verbalize understanding of available community supports. Family will report ability to access community supports.
MFCMP Family Specialist will be available to assist family to access available supports.	Chart review Family self-report	MFCMP Family Specialist will work directly with family and MFCMP RN to assist Recipient's family to increase inclusion and participation in the community.

Progress toward goal and objectives will be addressed at the monthly visit.

CARE ACTIVITY
The CARE ACTIVITY describes what each member of the team will be doing to address the goals listed.

MEDICAL
(Doctor's name) is (Recipient's name) primary care physician. The PCP will continue to provide medical support by office visit or by phone as necessary to maintain recipient's care at home. The PCP will coordinate and provide referrals to medical specialists and assist with justifications and authorizations for therapy, equipment, and treatments as needed.

HOME HEALTH SERVICES
(PDN = Private Duty Nurse = RN or LPN), (HHA = Home Health Aide)

Private Duty Nursing: Duties of the PDN include but are not limited to:
1. Implement nursing agency plan of care as ordered by the physician.
2. Administer medications, exercises, therapy, or treatments as ordered by the physician.
3. Provide consistent nursing care to assist and support the family including a written emergency care plan.
4. Observe for signs of dehydration, lethargy, and poor skin turgor.
5. Promote and maintain nutritional intake that will allow for optimal weight and health status.
6. Continually provide a safe environment. Be mindful of Recipient's high risk for falls and injuries during transfers, bathing, and repositioning.
7. Assist the family with coping and long-range management, planning, and adaptation to Recipient's needs.
8. The nurse will notify the family immediately and physician (if indicated) of unusual changes in Recipient's status, especially symptoms or respiratory distress, deteriorating motor/neurological condition, or renal function.
9. Any problems or concerns will be communicated to the MFCMP case manager as soon as possible.

Nursing Supervision: The home health agency will conduct and document a supervisory visit per state licensing regulations.

(This is not required, but highly recommended when there are only HHA services in the home - it is an option for the family.)
Nursing Assessment: Nursing assessment provided because (*recipient's name*) has HHA services only. Assessments provided (describe: *every month, every other month etc.*) per the recipient's budget.

Home Health Aide (HHA): The family understands the role and limitations of HHA care and are in agreement with the care based on these criteria. Designated care activities of the family and agency includes: (a) development of a client specific safety/emergency response plan, and (b) training of the HHA by the family and agency in the emergency/safety plan.

Family Member as Home Health Aide (HHA): The family understands the role and limitations of HHA care and are in agreement with the care based on these criteria. Designated care activities of the family and agency includes: (a) development of a client specific safety/emergency response plan, and (b) training of the HHA by the family and agency in the emergency/safety plan.

The home health aide will provide routine maintenance of recipient's environment as instructed by the family. After thorough orientation and instruction, the home health aide may assist with recipient's personal care, positioning, and routine management under the support of skilled nursing in the home and mother. Remain observant of changes in condition and report to family and RN supervisor. The case manager will add specific information regarding the HHA duties customized for the client.

(The following is added if the client has PCS.)
Personal Care Services (PCS): The (pick one: Molina, BCBS, Presbyterian, United) care coordinator is responsible for the PCS assessment and oversight.

FAMILY
The recipient/family understands the importance of maintaining Medicaid eligibility and that eligibility must re-determined at least once a year. It is the family's responsibility to notify their Income and Support office (ISD) of any change in address. It is the family's responsibility to complete the annual NM Medicaid paperwork. If the paperwork is not completed on time, recipient may lose his/her Medicaid eligibility.

The family is responsible to: You can customize this section and add bullets as needed.
- Notify the case manager if your child is hospitalized.
- Complete re-certification paperwork.
- Participate in monthly visits with the case manager.
- Make sure their child has an annual appointment with the PCP – physician.

Transition Plan: (e.g. transition from FIT to pre-school to happen on___. Enter info as appropriate.)

Recipient is on the Medically Fragile Case Management Program. He/she will remain on program as long as he/she meets criteria for eligibility, which is determined on an annual basis.

DD Waiver Registration Date:

DD Waiver Determination: (Pending – to be determined, Match-on hold, etc.)

HIPAA Education Date: (Original signed document will be scanned to e-chart and then mailed with ISP to parents.)

School: *Enter name of school, not just the school district.*

Early Childhood Intervention: EI Outcomes/Strategies completed as indicated in the IFSP.

Occupational Therapy (home-based/center-based):

Physical Therapy (home-based/center-based):

Speech Language Therapy (home-based/center-based):

Behavior Support Consultation, Psychosocial Counseling:

Nutritional Counseling:

Medical Supply Company: Insert Equipment Table here

Article	Source	Funding

Specialized Medical Equipment and Supplies (SME): The SME allowance is in addition to any medical equipment and supplies furnished under the NM Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. The case manager will assist the family in determining what equipment and/or supplies are eligible for this fund. The SME allowance cannot exceed $1000.00 per ISP cycle year and requires prior authorization. All requests must be submitted for approval a minimum of **60-days** prior to the end of the ISP cycle. Additionally, all requests for **iPad or computer** purchases require a letter of justification from a physician, therapist, or teacher specifying how the equipment will be used by the participant. **The Waiver participant must be able to operate the device independently and be the sole user.** *(NOTE: iPad applications cannot be purchased, nor can families be reimbursed for iPad application purchases.)* All requests for computers require approval from DOH/DDSD and must be submitted 60 days prior to the end of the current ISP cycle.

Add this paragraph if family does not want SME. (Do not put it on the MAD046 if this paragraph is inserted.)
The family is aware of the SME benefit and has chosen not to submit a request at this time. The family will contact the MFCMP case manager if this benefit is needed during the current ISP cycle as outlined above.

MCO Care Coordination: The care coordinator will be the family's contact at (*Blue, Presbyterian, or Western Sky Community Care)* MCO. She/he will assist ***(Recipient's name)*** family with getting prior authorizations as needed for providers, supplies, equipment, and medication. The care coordinator will assist with out-of-state travel as needed. The care coordinator will communicate with family per MCO's guidelines and as needed.

RN/Case Management: The RN/case manager through the Medically Fragile Case Management Program will coordinate ***(Recipient's name)*** services through the Medically Fragile Waiver including nursing, therapeutic services, durable medical equipment and supplies, and other needs as identified by the family, healthcare team, and delineated in the ISP and IEP **(*IEP added only if the child has one*).** The case manager will make bimonthly face-to-face home visits and communicate by telephone on the months the face-to-face visits are not held. The case manager will be available by telephone on an as-needed basis. Reevaluate plan on an ongoing basis, making adjustments as necessary and coordinate a formal reevaluation in six months with the entire team if indicated. The client's eligibility and this ISP will be reassessed annually.

The case manager will communicate on a regular basis with the MCO care coordinator. The MCO care coordinator will be invited to the annual ISP meeting.

SAFE HOME EVALUATION

General description of home and geographic area:

Lived at current residence how long?

Physical Address ☐ Own or ☐ Rent
*(Enter address information here***)**

Mailing Address ☐ Check if same as physical address
*(Enter mailing address information here***)**

Telephone Number(s):

E-mail:

Are you at risk to lose your current living situation? **☐ Yes ☐ No**

- ☐ **Plumbing**
  - ☐ **City**
  - ☐ **Septic**
- ☐ **Utilities**
  - ☐ **Electric**
  - ☐ **Gas**
  - ☐ **Other:**
- ☐ **Heating/Cooling**
- ☐ **Yard**
- ☐ **Ramps**
- ☐ **Bathroom Equipment**
- ☐ **Handicapped Accessible Bathroom**
- ☐ **Handicapped Accessible Access to Home**
- ☐ **Fire Extinguisher**
- ☐ **Smoke Detectors**
- ☐ **CO Alarm**

Are there any risks that need immediate intervention including:

- ☐ **Broken Windows**
- ☐ **Trip/Fall Dangers**
- ☐ **Fire Hazards**
- ☐ **Other:**
- ☐ **Broken Flooring**
- ☐ **Pests/Infestations**
- ☐ **Mold**

Comments:

Are there pet(s) in the home? ☐ Yes ☐ No If yes, please specify type and number of pet(s):

Are there smokers in the home? ☐ Yes ☐ No

Emergency back-up contacts and numbers:

Name	Phone Number	Relationship

Have you notified police, fire and utility companies that an individual with medical needs lives in the home? ☐ Yes ☐ No

Emergency phone numbers readily posted to include fire, police, doctor, utility company, and crisis hotline? ☐ Yes ☐ No

Plan for potential power outage:

Plan for function failure of medical equipment:

Are there any disaster risk factors including fabricated, wild fire, high winds, flooding, etc.?

What does family do in an emergency?

Emergency evacuation plan:

Do you have an emergency "Go Bag" or written list of equipment and medication necessary in an evacuation?

Closest hospital?

Distance to PCP? Number of visits a year?

Distance to specialists? Number of visits a year?