



## PARTNERS FOR CHILDREN

### Family-Centered Action Plan (F-CAP) Instructions



Instructions for completion of the Family-Centered Action Plan (F-CAP) for Partners for Children (PFC) California Department of Health Care Services Pediatric Palliative Care Waiver comprehensive care plan.

#### **General Instructions**

The F-CAP process is designed to integrate the patient and Family Unit's goals and medical objectives to ensure that the patient can successfully and safely live in the community.

It is anticipated that completion of the F-CAP will be accomplished in more than one visit. The Care Coordinator has the flexibility to gain information and insights through conversations, observations, appropriate timing and sensitivity with the patient and Family Unit.

The Care Coordinator will include the Family Unit in identifying the patient's care needs and Partner for Children waiver services. The patient and Family Unit may select and invite individuals of their choice (Circle of Support) to actively participate throughout the development of the F-CAP process. With input from the patient's Family Unit, the Care Coordinator will obtain information about the patient's needs, desires, preferences, and goals. Risk factors will be identified, analyzed, and addressed as the F-CAP is developed. The completed physician approved F-CAP will be forwarded to the CCSNL for review and approval. The Care Coordinator will ensure the family and signing physician receive a copy of the F-CAP. The F-CAP will be updated as indicated, or at least every 60 days.

Following each evaluation visit, the Care Coordinator will update the F-CAP based on the assessment, status of the patient and evaluation of the effectiveness of the services provided. For minimal changes to the F-CAP between each 60 day review, only the pages that have changes need to be revised and sent to the CCSNL with the new dates at the top. If it is determined that the existing F-CAP no longer meets the needs of the patient, the Care Coordinator, consulting with the treating physician, must submit the updated physician-approved full F-CAP to the CCSNL. The Care Coordinator is responsible for assuring that services are provided in accordance with the F-CAP.

#### **F-CAP Instructions**

F-CAP Header:

Each page of the F-CAP there is space designated for the patient name, date page completed, initial, 60-day re-assessment, and interim assessment.

**Patient Name:** Enter the patient's name on each page of the F-CAP.

**Date page completed:** Since the F-CAP may take more than on visit to complete and with updates individual pages may change, enter the date the individual F-CAP page was completed (mm/dd/yyyy), on each page.

**Initial:** Enter a check mark on each page, if completion of that F-CAP page is for first completion of the F-CAP.

**60 day re-assessment:** Enter a check mark on each page, if completion of that F-CAP page is for the 60 day re-assessment.

**Interim assessment:** Enter a check mark on each page, if completion of that F-CAP page is for an interim assessment.

## Table of Contents

Section	Sub-Section	Page
<b>Section I. Patient Information</b>		4
	Section I-A. Patient Information - Identifying Information	3
	Section 1-B. Patient Information - Diagnosis/Providers	5
<b>Section II. Health and Symptom Assessments</b>		7
	Section II-A. Health and Symptom Assessments - Communication/History	7
	Section II-B. Health and Symptom Assessments - Physical Assessment	8
	Section II-B, C, D. Health and Symptom Assessments - Assessment of Systems	8
	Section II-E. Health and Symptom Assessments - Pain Assessment Tool	8
	Section II-F. Health and Symptom Assessments - Nutritional Risk Screen	9
<b>Section III. Family/Social Information</b>		10
<b>Section IV. Health and Safety Assessments</b>		11
	Section IV-A. Health and Safety Assessments - Risks/Home Environment (Part 1)	11
	Section IV-B. Health and Safety Assessments - Home Environment (Part 2)	12
<b>Section V. Perception of Illness/Health Care Goals</b>		14
	Section V-A. Perception of Illness/Health Care Goals - Patient	14
	Sections V-B through V-E. Perception of Illness/Health Care Goals - Family or Circle of Support	15
	Sections V-F through V-H. Perception of Illness/Health Care Goals - Siblings	16
	Section V-I. Perception of Illness/Health Care Goals - Decisions	17
<b>Section VI. Patient, Family, and Circle of Support Desires</b>		18
	Section VI-A. Patient, Family, and Circle of Support Desires - Patient	18
	Section VI-B. Patient, Family, and Circle of Support Desires - Family	19
	Section VI-C. Patient, Family, and Circle of Support Desires - Circle of Support	20
<b>Section VII. Care Goals by Care Coordinator</b>		22
	Section VII-A. Care Goals by Care Coordinator - Sec I-III	22
	Section VII-B. Care Goals by Care Coordinator - Sec IV	22
	Section VII-C. Care Goals by Care Coordinator - Sec V and Other	23
<b>Section VIII. Integration of All Goals</b>		25
<b>Section IX. Services</b>		27
	Section IX-A. Services - Current	27
	Section IX-B. Services - Requested	28
<b>Section X. Additional Resources</b>		29
	Section X-A. Additional Resources - Goals Summary	29
	Section X-B. Additional Resources - Family Phone Sheet	29

## **Section I. Patient Information**

**Care Coordinator:** Enter the **name** of the Care Coordinator working with the patient, and who completed the F-CAP, the name of the **Agency** employed by; and the Care Coordinator's **phone** number.

**California Children's Services (CCS) Nurse Liaison (CCSNL):** Enter the **name**, **county** and **phone** number of the CCSNL.

**Patient's PFC Enrollment Date:** Enter the date (mm/dd/yyyy) the patient was enrolled in PFC.  
**Date CCSNL forwarded patient information to Agency:** Enter the date (mm/dd/yyyy) and the Agency received the patient's information from the CCS program.

### **Section I-A. Patient Information - Identifying Information**

**Patient Name:** Enter the patient's name, last name first.

**Preferred Name:** If different from first name, enter the name the patient prefers to be called.

**DOB:** Enter the patient's date of birth (mm/dd/yyyy).

**Sex:** Check the appropriate gender box for the patient: **Male** or **Female**.

**Marital Status:** Check the appropriate marital status box: **Single**, **Married**, or **Other**.

**Race:** Check the appropriate race identification (**Caucasian**, **Hispanic**, **Black**, **Asian**, or **Other**)

**Primary Language:** Enter the primary language spoken by the patient. Include if patient is too young for language or language is not developed yet.

**Need for Interpreter:** Check the appropriate box, if interpreter is needed and check the "Ordered" box if interpreter services were ordered.

**Use of Language Line:** Indicate, by checking the appropriate box if use of Language Line is needed.

**Other Languages spoken in the home:** Enter the name of other languages spoken in the home.

**School/Day Care:** Enter the name and **grade** of the school or day care the patient attends.

**Mother Name:** Enter the name, **age**, **address**, **phone** number, **cell** number, and **email** address if appropriate, of the patient's Mother.

**Father Name:** Enter the name, **age**, **address**, **phone** number, **cell** number, and **email** address if appropriate of the patient's Father.

**Other family member caring for patient:** Enter the **name**, **relationship**, **age**, **address**, **phone** number and **cell** number of any other family member caring for the patient.

**Legal Guardian:** Enter the **name**, **relationship**, **age**, **address**, **phone** number and **cell** number of the patient's legal guardian, if different from the parents.

**Foster Care:** Check the appropriate box to indicate if patient is in Foster Care. If yes, enter the **name** and **phone** number of the patient's Foster Care Case Worker.

**Emergency Contact:** Enter the **name**, **relationship**, **age**, **address**, **phone** number and **cell** number of the patient's emergency contact.

## **Section I. Patient Information**

**Email Addresses for the patient/family:** If the patient/family wishes, enter the email addresses.

**Comments/Notes:** Care Coordinator enters any comments or notes in this area.

### **Section I-B. Patient Information - Diagnosis/Providers**

#### **Diagnosis**

**Waiver Diagnosis:** Enter the name and **ICD-9** code of the primary waiver diagnosis.

**Other Diagnosis:** Enter the name and **ICD-9** code of another diagnosis.

**Other Diagnosis:** Enter the name and **ICD-9** code of another diagnosis.

#### **Health Insurance**

**CCS #:** Enter the patient's 7 digit CCS number.

**Medi-Cal #:** Enter the patient's Medi-Cal number.

**Other Insurance:** If the patient has other insurance, enter the **name** of the Health Insurance Company including **Policy Number** and **Group** Number.

#### **Health Care Providers**

**Primary Care Physician:** Enter the name and **phone** of the patient's primary care physician.

**Special Care Center:** Enter the name and **phone** number of the CCS-approved Special Care Center (SCC) following the patient.

**Special Care Center Physician:** Enter the name and **phone** number of the SCC physician following the patient.

**Other Physician:** Enter the name and **phone** number of any other physician following the patient.

**Palliative Care Team/Service in Hospital:** Enter the name of the Palliative Care Team that follows the patient when in the hospital, if appropriate, and a **phone** number.

**Contact Name:** Enter the name and **phone** number of the contact person of the Hospital based Palliative Care Team. (Describe the hospital Palliative Care Team plan for patient in Section VII. Care Goals.)

#### **Other Agencies, Business or Providers**

**Intermittent Home Health Agency (HHA) Provider:** If receiving services through an HHA, enter the agency **name** and **phone** number.

**Contact Name:** Enter the name and **phone** number of the contact person of the HHA.

**Durable Medical Equipment (DME) Supplier:** Enter the **name** of the DME provider and **phone** number.

**Contact Name:** Enter the name and **phone** number of the contact person of the DME supplier.

## **Section I. Patient Information**

**Pharmacy(s):** Enter the **names** of the pharmacies involved in the patient's care and **phone** number.

**Contact Name:** Enter the name and **phone** number of the contact person of the pharmacy.

**Mental Health Professional:** Enter the name, phone number and licensure of the mental health professional that the patient/family is receiving services from.

**Comments:** Enter comments.

**Refer to Section VII. Care Goals of the F-CAP to document goals and plans generated from Section I Patient Identifying Information.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section II. Health and Symptom Assessments**

### **Section II-A. Health and Symptom Assessments - Communication/History**

#### **Communication**

**Patient has the ability to express needs and wants:** Check the appropriate box that indicates if the patient is able to express needs and wants.

**If patient is not yet able to express needs and wants,** enter the **name** and **relationship** of the individual who speaks on behalf of the patient.

#### **Medical History**

**Is a physician available for home visits:** Check the appropriate box to indicate if a physician is available for home visits. If yes, enter the **name** and **phone** number of the physician.

**Date(s) of home visit:** Enter the date(s) of the most recent home visit.

**History of current illness:** Briefly describe the patient's history of current Partners for Children eligible waiver illness from the medical reports received. Patient/Family Unit may provide good information about the family's perception of what is happening now in the context of the history of the illness.

**Medical/ Surgical History:** Describe the patient's medical history, surgical history including psychiatric history and treatment from the medical reports received as well as the patient and Family Units response to this question.

**Last Hospitalization:** Describe the patient's last hospitalizations including the **dates**, **reason** for stay, and name of **hospital**.

**List current medical treatments:** List and describe any medical treatments currently receiving and include the **type**, **frequency** and **duration** of treatment.

**List current medications:** List all current medications, include name of the **medication**, **dosage** and **frequency**.

**List all allergies:** List all known **allergies**, including food, drug, skin, environmental etc. . . . Include **reaction** to each allergen listed.

**Immunizations current:** Check the appropriate box to indicate if immunizations are current. If not current, state **why**.

**List current medical equipment in the home:** List all current medical equipment in the home.

**Refer to Section VII of the F-CAP to add any medical equipment not in the home and needed:** For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section II. Health and Symptom Assessments**

### **Section II-B. Health and Symptom Assessments - Physical Assessment**

**Physical Assessment:** This Section is completed by a Registered Nurse (RN). Enter a brief summary of the patient's general physical assessment which includes intravenous access (both peripheral and central lines); mental status and any changes; pain and symptom management - what is being used and if it is effective; functional and activity limitation; and rehabilitation potential. A broader physical assessment is captured in the Review of Systems Section below.

### **Section II-B, C, D. Health and Symptom Assessments - Assessment of Systems (Parts 1, 2 and 3)**

**Assessment of Systems:** Complete the Assessment of Systems area by documenting in each area, check all applicable boxes. There are boxes to check if no abnormalities are identified and if the patient or parent on behalf of the patient denies any problems. Describe any abnormalities or concerns in the comment areas.

### **Section II-E. Health and Symptom Assessments - Pain Assessment Tool**

#### **Pain Assessment Tool:**

Check the appropriate box to indicate if pain is present or not.

Describe the **subjective** and **objective** assessment of pain: include **location, radiation, duration, and frequency**.

Rate the **intensity** of pain using the picture or 1 to 10 scale. If **unable to rate** pain, please explain.

Describe **precipitating factors, alleviating factors** and **problems** identified.

**Comments:** Enter comments in this area.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section II Health and Symptom Assessment.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section II. Health and Symptom Assessments**

### **Section II-F. Health and Symptom Assessments - Nutritional Risk Screen**

#### **Nutritional Risk Screen**

Complete the Nutrition Risk Screen area by documenting in each area; check all applicable boxes.

#### **Nutrition Status**

Identify each category as **low risk**, **moderate risk**, or **high risk**: weight, appetite, hydration, suck/swallow/breathing, ability to chew/swallow, and ability to orally feed.

Specifically **describe any impairment** with suck, swallow, breathing or the ability to chew or swallow and the effect on the nutritional status.

**Special feeding needs:** Identify and describe any special feeding needs.

**Integument System:** Assess and document the status of the integument system including any signs or symptoms of nutritional deficiency (skin, hair).

**Identify any other signs of nutritional deficiency not indicated above:** describe these other signs.

**Currently followed by Dietician through the SCC:** Check the appropriate box if the patient is followed by the Registered Dietitian in the SCC or physician office. Include the **name** of the RD or SCC.

**Comments:** Describe any abnormalities or concerns in the comment area.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section II Health and Symptom Assessment.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

### **Section III. Family/Social Information**

#### **Section III. Family/Social Information**

**Primary Caregiver:** Enter the primary caregiver **name**, **relationship to patient**, and **age**.

**List each child living in the home:** List the **name**, **relationship to patient**, and **age** of each child residing in the home under age 18.

**List each adult living in the home:** List the **name**, **relationship to patient**, and **age** of each adult residing in the home over age 18.

**List other Circle of Support Individuals:** List the **names**, **relationships to patient**, and **ages** of each Circle of Support individual.

**Spiritual beliefs/Religious affiliations:** Describe the patient's spiritual beliefs and religious affiliations; indicate if different from the rest of the Family Unit, and if the patient identifies the difference as a concern.

**Traditional health belief system:** Describe the patient's traditional health belief system. For example: use of shaman, homeopathic medicine, alternative medicines, eastern medicine, etc.

**Contextual and cultural issues:** Describe any contextual and cultural issues that may influence PFC services ordered or provided. For example: patient is male and cultural beliefs allow for hands on services to be provided by a male only, sibling or one parent died of cancer (or patient's illness), patient lives in an upstairs dwelling.

**Other:** Describe any other concerns.

**Comments:** Enter comments in this area.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section III Family / Social Information.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section IV - Health and Safety Assessment**

### **Section IV-A. Health and Safety Assessments - Risks/Home Environment (Part 1)**

#### **Health and Safety Assessment**

The purpose of the health and safety assessment is to evaluate for health safety risk and risk of abuse, neglect, exploitation, and potential for violence in the home. The Care Coordinator will document all reported or observed critical events or incidents that may affect the health, safety, and welfare of the patient. Examples of critical events or incidents include: patient abuse (verbal, sexual, physical, or mental) or neglect; incidents posing an imminent danger to the patient; fraud or exploitation (including misuse of patient's funds and/or property); or an unsafe environment.

**Health and safety risk factors:** Check each appropriate box for risk factors in the home. Check the appropriate box if a **restraining order** is current and in place. Enter the **name** of the restrained and their **relationship** to the patient.

**Education by Care Coordinator on risk of abuse, neglect and exploitation:** Check the appropriate box to indicate if education on the risk of abuse, neglect and exploitation was provided to patient and/or Family Unit. Complete this task at least every 60 days and more often if appropriate. If no, explain **why not**.

**Other/Notes:** Enter other pertinent comments, notes or observations.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section IV Health and Safety Assessment.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

#### **Home Environment Assessment**

**Home Environment:** The purpose of the home environment assessment is to assure a safe environment that meets the needs of the patient and family. It will assure that patient care areas can facilitate and accommodate everything necessary to provide care in the home that is comfortable and safe. This includes the use, maintenance and cleaning of all medical devices, equipment, and stored supplies. All medical equipment must be in working order at all times. The assessment will also assure that safety and preventative measures are in place. This requires making sure primary and back-up utilities, fire safety systems and devices are installed and in working order. These include grounded electrical outlets, smoke detectors, fire extinguishers and phone services. If applicable, there needs to be evidence that local emergency and rescue services and public utility services have been notified that a person with special needs resides in the home. All other services and supports need to be in place, or have been ordered and will be in place, at the time the patient is placed in the home or at the start of care. This includes documentation that the caregivers have been trained to support the care needs of the patient.

## **Section IV - Health and Safety Assessment**

### **Home Environment/Neighborhood**

**Condition:** Check the appropriate box(s) that best describes the condition of the home where care will be provided: neat, orderly/ clean, disorderly/clean, unsanitary, damp, mold, smoky, warm, or cold.

**Primary and Back-Up utilities:** Check the appropriate box to indicate if the utilities are adequate or inadequate. For example: patient resides in a rural area and is machine dependant, is there a second source of utility such as a generator and fuel for the generator?

**Heating/cooling:** Check the appropriate box to indicate if the home has adequate heating and cooling.

**Electrical:** Check the appropriate box to indicate if the home has adequate and safe electrical connections including grounded electrical outlets.

**Refrigeration:** Check the appropriate box to indicate if the home has adequate refrigeration.

**Water/plumbing:** Check the appropriate box to indicate if the home has adequate water and plumbing.

**Pests /Rodents:** Check the appropriate box to indicate if pests and/or rodents are present in the home.

**Phone:** Check the appropriate box to indicate if a land line phone is present and in working order. Cell numbers are listed in the "Patient Identifying Information" Section I of the F-CAP.

**Safety Devices are installed and in working order:** Check the appropriate box to indicate if the following devices are in working order: Fire alarm, Carbon Monoxide and Fire Extinguisher.

## **Section IV-B. Health and Safety Assessments - Home Environment (Part 2)**

### **Home Environment Assessment (cont.)**

**Home is a multi-unit dwelling:** Check the appropriate box to indicate if home is a multi-unit dwelling and what **floor** of the building the home is located on, including **stairs** to the home or inside the home.

**Wheelchair accessible:** Check the appropriate box to indicate if home is wheelchair accessible and if **ramps** are installed or available.

**Home well maintained:** Check the appropriate box to indicate if the overall home is well cared for. Free of barriers to care, for example: car parts are not kept inside in an open area.

**Local emergency responders aware of patient:** Check the appropriate box to indicate if local EMS has been notified that a person with special needs resides in the home, if applicable.

**Public utilities aware of patient:** Check the appropriate box to indicate if public utilities have been notified that a person with special needs resides in the home, if applicable.

## **Section IV - Health and Safety Assessment**

### **DME**

**Medical equipment in working order:** Check the appropriate box to indicate if any medical equipment in the home is in working order.

**Family knowledgeable in use of medical equipment:** Check the appropriate box to indicate if the family is trained and knowledgeable in the use of the medical equipment in the home.

**Family aware of any potential hazards related to certain DME such as an oxygen tank:** Check the appropriate box to indicate if the family is aware of any potential hazards related to certain DME.

**Home can safely accommodate all medical devices, equipment storage and supplies:** Check the appropriate box to indicate if the home can safely accommodate all the medical devices, equipment storage and supplies.

### **Other**

**Pets or other animals:** Check the appropriate box to indicate if there are pets or other animals in the home. List the **type/species** and **number** present.

**Are pets contained in yard or crate/cage:** Check the appropriate box to indicate if pets are contained in yard or crate/cage.

**Internet:** Check the appropriate box to indicate if the internet is available to patient/ Family Unit at home.

**Rural/outlying area transportation issues:** Describe any transportation issues for the patient, specifically if residing in a rural or outlying area.

**Comments:** Describe any concerns, and add comments.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section IV Health and Safety /Home Environment Assessment:** specifically plans to address deficiencies in the Home/Environment, and if applicable, an Emergency Back-up plan. For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section V. Perception of Illness/Health Care Goals**

To complete Section V of the F-CAP, and other sections, the Care Coordinator has the flexibility to gain information specifically on the psycho-social/spiritual aspects of the patient, family and siblings through conversations, observations, appropriate timing, sensitivity and insight with the patient, Family Unit, and Circle of Support. Gathering the information for this section may require more than one visit and it may change as the trajectory of the patient's illness and condition changes. In addition, this section captures the patient's perception of illness and health care goals as well as the parents, grandparents, Circle of Support, siblings and others to understand their perceptions of the patient's illness and express their health care goals.

Moreover, this section gathers information on the patient's, family, Circle of Support and sibling perception of the prognosis, the trajectory of illness, if they worry about self and others, and includes psychosocial and behavior indicators. The Health Care Goals portion captures the desires for quality of life, how information would like to be received and if comfortable talking about end of life issues.

### **Section V-A. Perception of Illness/Health Care Goals - Patient**

**For infant, toddler or patient unable to respond, refer to parental comments.**

**Patient perception of illness:** Check each box that describes the patient's perception of their illness, and if worried about self or others. If worried about another indicate who and why. Their understanding and acceptance towards the prognosis, are they able to discuss, is their demeanor angry, tearful, friendly, open, and what gives them strength?

**Unable to assess:** Check the box and enter the reason why unable to assess the patient.

**Health Care Goals:** Check the box that best describe the patient's health care goals.

**Comments:** Describe any comments, impressions, observation and concerns.

**Information of preference if bad news:** Check the box that describes the patient's preference for hearing bad news. Enter the name of the person **who** is requested to assist if applicable.

**Important factors in health care decision making:** Check the box that describes factors that will influence the patient's decision making.

**If illness terminal, talking about end of life:** Check the box that describes the patient's reaction to/preference for talking about end of life.

**Comments/Impressions/Observations:** Enter any further information important to this section.

## **Section V. Perception of Illness/Health Care Goals**

**Describe the plan and goals in Section VII of the F-CAP.** Refer to Section VII of the F-CAP to document goals and plans generated from Section V. Perception of Illness and Health Care Goals.

### **Sections V-B through V-E. Perception of Illness/Health Care Goals - Family or Circle of Support**

**Perception of illness/health by:** Check the appropriate box to indicate which family member or Circle of Support is responding to this section. This section repeats several times to provide opportunity for Mother, Father, Grandmother, Grandfather and Circle of Support to respond as appropriate. Sibling response follows the family and Circle of Support Section.

Check each box that describes the individual's perception the patient's illness, and if worried about self or others. If worried about another indicate who and why. Their understanding and acceptance towards the prognosis, are they able to discuss, is their demeanor angry, tearful, friendly, open, and what gives them strength?

**Unable to assess:** Enter the reason why unable to assess the individual.

**Health Care Goals:** Check the box that best describe the individual's health care goals for the patient.

**Comments:** Describe any comments, impressions, observation and concerns.

**Information of preference if bad news:** Check the box that describes the individual's preference for hearing bad news. Enter the name of the person **who** is requested to assist if applicable.

**Important factors in health care decision making:** Check the box that describes factors that will influence the individual's decision making.

**If illness terminal, talking about end of life:** Check the box that describes the individual's reaction to/preference for talking about end of life.

**Comments/Impressions/Observations:** Enter any further information important to this section.

**Describe the plan and goals in Section VII of the F-CAP.** Refer to Section VII of the F-CAP to document goals and plans generated from Section V. Perception of Illness and Health Care Goals.

## **Section V. Perception of Illness/Health Care Goals**

### **Sections V-F through V-H. Perception of Illness/Health Care Goals - Siblings**

#### **Perception of Illness/ Health Care Goals - Siblings:**

**Sibling:** Enter a check mark in the appropriate box to identify which sibling is responding to this section. This section repeats several times to provide opportunity for older siblings, younger siblings, a twin, or other to respond to this section as appropriate.

**Sibling's positive and negative adjustment of illness:** Check the appropriate box to indicate the relative age of the sibling responding to this section. This section repeats several times to provide opportunity for multiple siblings to respond as appropriate.

Check each box that describes the sibling's adjustment to illness, and if worried about self or others. If worried about another indicate who and why. Their understanding and acceptance towards the prognosis, are they able to discuss, is their demeanor angry, tearful, friendly, open, and what gives them strength? Identify sibling support, resources, communication within and outside of the family, understanding and adjustment of patient's illness, increased sibling rivalry, feeling of rejection, loneliness, isolation, sadness, confusion and anxiety.

**Unable to assess:** Enter the reason why unable to assess the sibling.

**Health Care Goals:** Check the box that best describe the sibling's health care goals for the patient.

**Comments:** Describe any comments, impressions, observation and concerns.

**Information of preference if bad news:** Check the box that describes the sibling's preference for hearing bad news. Enter the name of the person **who** is requested to assist if applicable.

**Important factors in health care decision making:** Check the box that describes factors that will influence the sibling's decision making.

**If illness terminal, talking about end of life:** Check the box that describes the sibling's reaction to/preference for talking about end of life.

**Comments/Impressions/Observations:** Enter any further information important to this section.

**Describe the plan and goals in Section VII of the F-CAP.** Refer to Section VII of the F-CAP to document goals and plans generated from Section V. Perception of Illness and Health Care Goals.

## **Section V. Perception of Illness/Health Care Goals**

### **Section V-I. Perception of Illness/Health Care Goals - Decisions**

#### **Decision for Life Sustaining/Prolonging Treatment (check all that apply):**

Check the box if the patient/family want Cardio-Pulmonary Resuscitation (CPR) started.

Check the box if the patient/family wishes to allow a natural death with no CPR.

Check the box to refer to a completed Physician Orders for Life-Sustaining Treatment (POLST) or equivalent (Advanced Directive or DNR) for additional information.

Check the box if the POLST Form or equivalent is kept in the home chart to give to the local Emergency Medical Services (EMS) as needed. Check the box if a copy is obtained for the Care Coordinator.

Check the box if an Advanced Directive has been completed and a copy obtained for the Care Coordinator.

Check the box if there is no decision made by the patient/family.

Check the box if this conversation has not taken place.

**Funeral Home/Mortuary:** If the patient/family has a preference, enter the name of the funeral home/mortuary, **phone** number, and **name** and **phone** number of the contact person. Indicate in comments if this conversation has not taken place.

**Comments:** Enter comments in this area.

**Refer to Section VII of the F-CAP to document goals and plans generated from Section V. Perception of Illness and Health Care Goals.** For easy access and identification, all goals and plans are described in one area of the F-CAP.

## **Section VI. Patient, Family, and Circle of Support Desires**

### **Section VI-A. Patient, Family, and Circle of Support Desires - Patient**

#### **Patient Desires**

This section is designed to **describe**/document the patient's desire to address each area/domain including medical indications, patient preferences, quality of life, contextual issues, emotional, economic discussion and plan for each desire addressed, if applicable. In addition include other patient desires as requested.

For each area, include outcomes and follow-up **plan** as appropriate. Indicate if a **service** is requested and who the **provider** is (if appropriate, enter the services on the request for services in Section IX "Services").

**Desires for management of pain:** Describe the patient's desire for management of pain. For example: desires to be cognitively aware but free of pain.

**Desires for management of physical symptoms:** Describe the patient's desire for management of physical symptoms.

**Desires to express feelings:** Describe the patient's desire for expressing feelings. For example: how the patient expresses feelings - keeps to self, talk with a few identified individuals, shows signs of anger or frustration when unable to express feelings and how to provide the opportunity to express feelings.

**Desires to express spiritual matters:** Describe the patient's desire for expressing spiritual matters. For example: is there a specific person the patient would like to talk with regarding spiritual matters, are there specific spiritual rituals or ordinance they would like have done or participate in. The patient's spiritual beliefs may be different from the Family Unit; is the patient concerned with the differences?

**Desired place of residence:** Describe the patient's desire for where they live during their illness.

**Desires to accomplish academic goal:** Describe the patient's desire to accomplish an academic goal. For example: finish the school year, graduate from grade school, middle school or high school.

**Desires to accomplish social goal (legacy):** Describe the patient's desire for creating a legacy. For example: making a scrap book, memory book, video, letters, write a book, etc.

**Desires for End of Life Goals, if appropriate:** Describe the patient's goals for end of life. For example: would like sibling to be with patient, would like a specific pet to be with them, or other end of life desires.

**Desired place of death:** Describe the patient's preference of where the desired place of death is. For example: desires to be at home, in the family room with a specific person(s) or pet, or in the hospital, if appropriate. Indicate if this conversation has not taken place.

## **Section VI. Patient, Family, and Circle of Support Desires**

**Specific Requests:** Describe any specific request of the patient at the time of death or any other preferences.

**Comments:** Enter comments or concerns in this area.

### **Section VI-B. Patient, Family, and Circle of Support Desires - Family**

#### **Family Desires**

**Desires to support patient's wishes:** Check the appropriate box to indicate if the Family desires to support the patient's wishes and explain if unable to support the patient's desires or have concerns. In this Section of the F-CAP include the plan for each desire addressed, if applicable. In addition include other Family desires as requested. Indicate if a **service**, such as bereavement counseling, is requested and who the provider is (if appropriate, enter the services on the request for services in Section IX "Services"). Include outcomes and follow-up **plan** as appropriate.

**Management of patient's pain:** Describe the Family desire to manage the patient's pain (may differ from patient's request).

**Management of patient's physical symptoms:** Describe the Family desire to manage the patient's physical symptoms (may differ from patient's request).

**Desire sibling support (community services):** Describe the Family preference for sibling community support (may differ from patient's request), and identify the type and frequency of support requested. Please note: community services are not authorized by the CCSNL.

**Desires emotional support for family members:** Describe the Family preference for emotional support for family members (may differ from patient's request).

**Desires spiritual support:** Describe the Family preference for spiritual support and identify the type of provider or delivery of spiritual support (may differ from patient's request). Indicate how, if the patient's spiritual support is different from the Family or Circle of Support will they respect the patient's wishes.

**Desires Family Training:** For all that apply, check the box to indicate the appropriate type of family training requested or declined. Describe other types of training requested, and include the desired goals, services requested, if appropriate and provider.

**Desires respite care:** Check the appropriate box to indicate if in home respite or out of home respite is requested. Enter the name of the provider agency/facility for out of home respite.

## **Section VI. Patient, Family, and Circle of Support Desires**

**Desires grief /bereavement services:** After the Care Coordinator has explained the bereavement benefit, indicate if grief / bereavement services are requested. If the benefit is requested, indicate what phase of the illness trajectory the family anticipates will be most affective for the patient and family. Include plan and provider. **Please note:** For bereavement services, at least one visit must be made before the patient's death in order for the service to continue for the family after the patient's death.

**Comments:** Enter comments or concerns in this area.

### **Section VI-C. Patient, Family, and Circle of Support Desires - Circle of Support**

#### **Circle of Support Desires**

**Desires to support patient's wishes:** Check the appropriate box to indicate if the Circle of Support desires to support the patient's wishes and explain if unable to support the patient's desires or have concerns. In this section of the F-CAP include the plan for each desire addressed, if applicable. In addition include other Circle of Support desires as requested. Indicate if a **service**, such as bereavement counseling for a caregiver, is requested and who the provider is (if appropriate, enter the services on the request for services in Section IX "Services"). Include outcomes and follow-up **plan** as appropriate.

**Management of patient's pain:** Describe the Circle of Support desire to manage the patient's pain (may differ from patient or family requests).

**Management of patient's physical symptoms:** Describe the Circle of Support desire to manage the patient's physical symptoms (may differ from patient or family requests).

**Desire sibling support (community services):** Describe the Circle of Support preference for sibling community support (may differ from patient or family requests), and identify the type and frequency of support requested. Please note: community services are not authorized by the CCSNL.

**Desires emotional support for family members:** Describe the Circle of Support preference for emotional support for family members (may differ from patient or family requests).

**Desires spiritual support:** Describe the Circle of Support preference for community spiritual support and identify the type of provider or delivery of spiritual support (may differ from patient or family requests). Indicate how, if the patient's spiritual support is different from the Circle of Support will they respect the patient's wishes.

**Desires Family Training:** Family Training is only available to Circle of Support members who are caregivers for the patient. For all that apply, check the box to indicate the appropriate type of family training requested or declined. Describe other types of training requested, and include the desired goals, services requested, if appropriate and provider.

## **Section VI. Patient, Family, and Circle of Support Desires**

**Desires respite care:** Enter a check mark in the appropriate box to indicate in home respite or out of home respite. Enter the name of the agency/facility for out of home respite.

**Desires anticipatory grief services/bereavement services:** Bereavement services are only available to Circle of Support members who are caregivers for the patient. After the Care Coordinator has explained the bereavement benefit, indicate if grief / bereavement services are requested. If the benefit is requested, indicate what phase of the illness trajectory the family anticipates will be most affective for the patient and family. Include plan and provider.  
***Please note:*** For bereavement services, at least one visit must be made before the patient's death in order for the service to continue after death to the family.

**Comments:** Enter comments or concerns in this area.

## **Section VII. Care Goals by Care Coordinator**

Section VII is designed for all previous plans and goals identified throughout the comprehensive care plan F-CAP to be documented here. Enter goals and the plan to obtain goals, for each section listed below, including patient, family and Circle of Support participation. For example: For the Patient Identifying Information section, the plan might include, follow-up with family next visit to obtain the last name and phone number of the mental health professional following the patient. The goal is to have complete patient identifying information. Add comments if applicable.

### **Section VII-A. Care Goals by Care Coordinator - Sec I-III**

**Section I. Patient Identifying Information:** Describe goals and plans from this section.

**Section II. Health and Symptom Assessments:** Describe goals and plans from this section including the following:

Identification of any medical equipment required.

Goals and plans for any DME required.

Based on the physical assessment and Assessment of Systems, describe specific goals, including nutrition, medical treatment, and pain management goals relating to all areas of the physical assessment. For example: dressing changes three times a week for four weeks. Add these goals to the overall plan of care goals in Section VIII. Integration of All Goals.

**Goals identified in the assessment for training needs, including on-going education regarding medical treatment:** Enter identified training needs, including on-going education regarding medical treatment, include goals and plans to meet this need. For example: training needed to educate and train the patient and family on the care of the central line.

**Section III. Family Social Information:** Describe goals and plans from this section.

### **Section VII-B. Care Goals by Care Coordinator - Sec IV**

**Section IV. Health and Safety:** Describe goals and plans from this section, including the following.

Goals and or plans for any Health and Safety risk factors: (including short and long term goals/plans).

**Proposed intervention:** Enter the proposed plan and intervention including mitigation of any environmental risk factors identified during the assessment. This will include referral to Child/Adult Protective Services and Licensing and Certification or community and other appropriate resources.

## **Section VII. Care Goals by Care Coordinator**

**Plan, including short and long term plan:** Describe the plan for addressing and resolving any health and safety risk factors identified in the health and safety assessment; include short and long term goals.

**Identify any safety measures required to protect against injury to the patient:** Describe any safety measures required to protect against injury to the patient. For example: addition of side rails to the bed, consideration of moving bedroom to main floor, etc.

**Home Environment Assessment:** Describe goals and plans from this section.

**Emergency Back-up plan:** Identify what the emergency back up plan is for the patient, and home.

**Describe the Plan to address deficiencies in Home/Environment and include both short and long terms goals/plan:** Identify plan and specific goals. For example: home to be sprayed for insects, home to be trapped for rodents, water heater broken – new water heater to be delivered and installed by (community non-profit organization) on October 1, etc. . . .

## **Section VII-C. Care Goals by Care Coordinator - Sec V and Other**

### ***Section V-(A-H). Perception of Illness and Health Care Goals***

Describe goals and plans for the perceptions and health care goals for each individual listed below, as applicable, include relationship to patient:

Patient Plan

Family Plan

Mother

Father

Grandmother

Grandfather

Circle of Support

Siblings

Older sibling

Younger sibling

Twin

Other

### ***Section V(-I). Decisions***

Include any plan or goals for the **decision** for Life Sustaining/Prolonging Treatment. Include short and long term goals if appropriate; for example patient and family have not signed a POLST or equivalent document and are interested in obtaining more information, or would like to think about their response and would like to address this issue at the next visit.

## **Section VII. Care Goals by Care Coordinator**

**Other Goals/Plan:** Describe any other goals and plans for the patient not already described in the sections above.

**Rehabilitation potential:** Document rehabilitation potential, and indicate if not applicable, include goals and plan.

**Discharge and Referral Goal/Plan:** If appropriate, describe discharge and referral plan if the patient and family choose to dis-enroll from the PFC.

**Transition Plan discussed:** Check the appropriate box to indicate if the Transition Plan was discussed with the patient and Family Unit and Circle of Support.

A Transition Plan is indicated when a child nears the age of 20, and will require coordination into adult care or when transitioning off of PFC for any reason. Transition of a patient off of PFC may be needed if the patient moves from a county where the PFC is active to a county not participating in PFC. In that case, the CCSNL will assist the patient and family in the dis-enrollment process and work with the Care Coordinator in facilitating the transfer to the new county and connecting the patient and family with resources that are available there. Transition assistance may also be needed if a patient and their family decide to enroll in hospice, in which case the CCSNL and Care Coordinator will work with the hospice agency to ensure the smooth transition to that service. Transition will occur as the patient approaches their 20 birthday to prepare or update the Adolescent Transition Health Care Plan with patient/family to identify any needs prior to the age of 21 years. This may include setting up a transition planning meeting with the patient/family and include the Care Coordinator in the discussion.

**Discussed with CCSNL:** Check the appropriate box to indicate if the Transition Plan was also discussed with the CCSNL.

**Transition goals:** Describe goals and plans for transition.

## **Section VIII. Integration of All Goals**

### **Section VIII. Integration of All Goals**

#### **By Multidisciplinary Team, Patient, Family and Circle of Support**

The purpose of Section VIII “Integration of All Goals,” is to bring together all the goals and plans thus far identified in the F-CAP and integrate into a comprehensive care plan for the child and family. This includes identifying and resolving any differences or overlap in the plan and goals.

The multidisciplinary team consists of the patient, the patient’s parent or legal guardian, the patient’s choice of additional family members/friends/caregivers (Circle of Support), the Care Coordinator and other professionals providing services to the patient.

**List the overall team goals that integrate the patient, family, and Circle of Support desires/goals. As well as any additional goals that have not been addressed elsewhere in the F-CAP. *The Multidisciplinary Team goals should always reflect the patient and family goals.*** Describe the integrated goals for this patient, family and Circle of Support.

**Identify any differences and conflicts in care goals between multiple team members including any treatment goals:** Describe any differences and conflicting care goals between multiple team members, patient, family and Circle of Support including any physical assessment treatment goals.

**Plan for resolution of goal differences identified above:** Identify the plan of action for resolution and follow-up of differences and conflicts in care.

**Summary: Care coordination is anticipated to be: high complexity, high risk, or support and management:** Check the box that best describes the anticipated level of care coordination required based on the Care Coordinator’s evaluation and assessment.

<b>High complexity</b>	Complex coordination required with multiple disciplines, patient and family unit, frequent team meeting, out side agencies involvement such as visiting school, or Home Health Agency (if Care Coordinator is from a Hospice Agency). Requires changes or updates to F-CAP more than every 60 days.
<b>High Risk</b>	Patient/Family Unit identified as high risk, either due to medical care needs, therapies requested/provided, end of life needs or identified as high risk for abuse neglect and exploitation. Requires extensive support and management.
<b>Support and Management</b>	Patient and Family Unit are stable with current plan of care, and require minimal support, management and coordination. F-CAP revised every 60 days.

## **Section VIII. Integration of All Goals**

**Family members and Community Support Members who participated in this conference.** Enter the **names** and **relationship** to the patient of all individuals who participated in the conference, including face-to-face, in writing, or phone.

**Comments:** Enter comments or concerns in this area.

## **Section IX. Services**

### **Section IX-A. Services - Current**

#### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Nursing (Private Duty) In Home Nursing Services**

**Currently receiving EPSDT Supplemental in home nursing services:** Check the appropriate box to indicate if the patient is receiving EPSDT supplemental in home nursing (private duty/shift/nursing) services.

**Requesting EPSDT supplemental nursing services:** Check the appropriate box to indicate if supplemental in home nursing services are requested during the F-CAP completion and add request to the Services Requested Section of the F-CAP.

**Services Authorized through Medical Case Management (MCM), or CCS:** Check the appropriate box to indicate if **MCM** or **CCS** is authorizing the EPSDT supplemental private duty in home nursing services.

**MCM Case Manager Name:** Enter the name and **phone** number of the MCM Nurse Case manager.

**Number of hours receiving per week if known:** Enter the appropriate number of shift nursing services hours the patient is currently receiving by an LVN, RN and **RN Supervision per month**. For example 40 hours of LVN services and 2 hours per month of RN Supervision.

**Name of HHA or Individual Nurse Provider (INP) providing the EPSDT supplemental nursing services:** Enter the name and **phone** number of the Home Health Agency or INP providing the supplemental nursing services to the patient.

**Another child in the family is also receiving these services:** Check the box if there is another child in the family receiving these services.

#### **Current Medi-Cal State Plan Services**

List current Medi-Cal State Plan **services** including **frequency, duration, provider name** and **phone** number, if known.

#### **Current Community Services**

List current community **services** including the **frequency, duration, and provider name**.

## **Section IX. Services**

### **Section IX-B. Services - Requested**

#### **PFC Services Requested**

List Partners for Children services requested. Check the box for extension if currently receiving the services and an extension is requested. Include **code**, description of **service**, **from/to dates**, **frequency/duration**, **units**, **provider name** and **provider NPI number**.

#### **Medi-Cal State Plan Service Requested**

List Medi-Cal State Plan Services requested. Check the box for extension if currently receiving the services and an extension is requested. Include **code**, description of **service**, **from/to dates**, **frequency/duration**, **units**, **provider name** and **provider NPI number**.

#### **Community Services Requested**

List Community services requested. Check the box for extension if currently receiving the services and an extension is requested. Include **date**, **service description**, **frequency**, **duration** and **provider name** (individual or agency/group providing the service). The CCSNL is not responsible for authorization of these services.

#### **Signatures**

Enter the names of the Care Coordinator, CCSNL, patient (if applicable), parent/legal guardian, and approving physician. Have each individual sign and date in the appropriate box.

**Date F-CAP faxed or emailed to CCSNL:** Check the appropriate box to indicate faxed or emailed and enter the date the F-CAP was sent to the CCSNL.

**Date F-CAP mailed to family:** Enter the date the F-CAP was mailed to the family.

**Date F-CAP mailed to Health Care provider (PCP or SCC):** Enter the date the F-CAP was mailed to the Health Care Provider (PCP or SCC).

## Section X. Additional Resources

### Section X-A. Additional Resources - Goals Summary

**Goals identified:** The purpose of this area is to provide a summary of the identified goals if this would be helpful as a resource page for the patient/Family Unit. This page is designed to be kept in the PFC home binder/folder, refrigerator or easily retrievable place. This may be more helpful for updates and interim changes. Describe a summary of the goals. Include who the **provider** is, what the **planned intervention** including the day of the week/month the provider will provide the service.

**Document outcomes of interventions/services from previous F-CAP, include follow-up plan if applicable:** This document is a resource page for the patient/Family Unit. This page is designed to be kept in the PFC home binder/folder, refrigerator or easily retrievable place. Enter brief description of **goals** from initial or up-dated F-CAP include the **intervention or service** requested to reach goal and indicate the **effectiveness** of the intervention or service; if applicable describe the **follow-up plan**.

### Section X-B. Additional Resources - Family Phone Sheet

#### **Phone Numbers General Instruction Sheet:**

The Contact Sheet, entitled "Phone Numbers" is a resource page for the patient/family. This page is designed to provide contact information, 24 hour agency call line number and complaint/grievance contact information. This form is to be given to the Partners for Children patient and a copy in the Partners for Children Care Coordinator/agency and California Children's Services (CCS) records via the CCSNL. This page may be kept i.e. in the PFC home binder/folder or on the refrigerator. The Care Coordinator should help keep the contact information updated for both the client/family and the CCSNL. Therapist(s) means the therapist providing the expressive therapy: massage therapist, child life, art therapist, etc. Our Family Training RN means the agency RN providing family training. Our Family Counselor means the MFC or LCSW providing counseling to the family.