



## **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 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.

The Care Coordinator will include the family in identifying the patient's care needs and Partner for Children waiver services. The patient and family 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, 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.

The following sections F-CAP sections must be submitted with the 60 day partial reviews; attach any other sections that have additional changes or updates:

- Section 3-A Physical Exam
- Section 4 Health and Safety Assessments
- Section 6 Goals of Care by Care Coordinator/Family Centered Team Meeting
- Section 7 Services

A complete F-CAP must be completed every 6 months.

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, CCS #, CIN, date of birth (DOB), date of F-CAP, and initial, 60-day re-assessment, 6 month full review, and interim assessment. The patient name, CCS #, CIN, date of birth (DOB), date of F-CAP will populate to the remaining pages once the document is saved and reopened.

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

**CCS #:** Enter the CCS number associated with the patient.

**CIN:** Enter the CIN associated with the patient.

**DOB:** Enter the patient's date of birth.

**Date of F-CAP:** Enter the date of the F-CAP.

**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.

**6 month full review:** Enter a check mark on each page, if completion of that F-CAP page is for the 60 month full review.

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

**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.



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## **Section 1-A. Patient Information - Demographic**

**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.

**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 1-B. Patient Information – Social**

**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, 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.

**Family Coping:** Describe how the patient/family has been dealing with the patient's illness.

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

## **Section 2-A. Medical Information - Diagnosis/Providers**

**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:** Check the box which represents the insurance the patient/family has. If the family has medical managed care, please list the name of the care plan.

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

**Medical Home:** Enter the name and **phone** of the patient's usual source of care.

**Primary Managing Physician:** Enter the name and **phone** of the patient's primary managing 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/Specialty:** Enter the name and **phone** number, and **specialty** of the SCC physician following the patient.

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

**Special Care Center Social Worker:** Enter the name and **phone** number of the SCC social worker 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 5. Care Goals.)

**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.

**Therapist:** Indicate what type of therapist. Enter the **name** and **phone** number.

**MTU:** Enter the MTU contact **name** and **phone** number.



**Mental Health Professional:** Indicate the type of mental health professional. Enter the ***name*** and ***phone*** number.

**Upcoming Appointments:** Enter any upcoming appointments for the patient.

## **Section 2-B. Medical Information – Providers/Suppliers**

**Durable Medical Equipment (DME) Supplier:** Enter the ***names*** of the DME provider ***equipment supplied***, and ***phone*** numbers.

**Contact Name:** Enter the ***names*** and ***phones*** number of the contact person of the DME supplier.

**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.

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

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

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

## **Section 2-C. Medical Information – Hospitalizations**

**Last Hospitalization:** Describe the patient's last hospitalizations including the ***dates***, ***reason*** for stay, and name of ***hospital***. (For initial FCAPs, provide a one year history. All other FCAPs provide a 6-month history)

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

## **Section 2-D. Medical Information – Health 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 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 and surgical history including psychiatric history and treatment from the medical reports received as well as the patient and Family's response to this question.

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

**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***.

## Section 2-E. Medical Information – Medication History

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

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



## **Section 3-A. Health & Symptom Assessments – Physical Exam**

**Temp:** Provide temperature.

**Heart Rate:** Provide heart rate.

**Resp:** Provide respiratory rate.

**B/P:** Provide blood pressure.

**Height:** Provide height in centimeters or inches (whichever is appropriate).

**Weight:** Provide weight in kilograms or pounds (whichever is appropriate).

**Head Cir:** Provide head circumference in centimeters.

**Abd:** Provide abdomen circumference in centimeters.

**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.

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

## **Section 3-B. Health & Symptom Assessments – Review of Systems**

**Review of Systems:** Complete the Review of Systems area by documenting in each area, check all applicable boxes. Describe any abnormalities or concerns in the comment areas.

## **Section 3-C. Health & Symptom Assessments – Review of Systems/Nutrition Status**

**Review of Systems:** Complete the Review of Systems area by documenting in each area, check all applicable boxes. Describe any abnormalities or concerns in the comment areas.

**Diet:** Complete the diet area by checking all applicable boxes.

**Nutritional 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.

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

### **Section 3-D. Health & 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/Notes:** Care Coordinator enters any comments or notes in this area.

### **Section 3-E. Health & Symptom Assessments – Symptom Assessment Tool**

**Symptom Assessment Tool:** Check the appropriate box to indicate if symptom is present or not.

Describe the **subjective** and **objective** assessment of symptom: include **location, radiation, duration, and frequency**. Rate the **intensity** of pain using the picture or 1 to 10 scale. If **unable to rate** symptom please explain. Describe **precipitating factors, alleviating factors** and **problems** identified.

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



## **Section 4-A. Health and Safety Assessments – Risks/Environment (Part 1)**

**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 individual and their **relationship** to the patient.

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

**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 dependent, 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/Family Information” Section 1 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 4-B. Health and Safety Assessments – Home Environment (Part 2)**

**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.

**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 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 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.

**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.

**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 at home.

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

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



## **Section 5-A. Perception of Illness/Health Care Goals – Patient**

To complete Section 5 of the F-CAP, and other sections, the Care Coordinator may obtain 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, 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.

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

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

**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. Are they able to discuss their understanding and acceptance towards the prognosis, is their demeanor angry, tearful, friendly, open, and what gives them strength?

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

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

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



## **Section 5-B. Perception of Illness/Health Care Goals – Patient Desires**

### **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.

**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; is the patient concerned with the differences?

**Desired place of residence:** Describe where the patient would like to live.

**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/and/or pet to be with patient, 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.

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



## **Section 5-C. Perception of Illness/Health Care Goals – Family**

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

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

## **Section 5-D. Perception of Illness/Health Care Goals – 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 7 "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/Palliative Care Education:** For all that apply, check the box to indicate the appropriate type of family training/education requested or declined. Describe other types of training/education 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.

**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 effective 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.

**Desires for End of Life Goals, if appropriate:** Describe the family's goals for end of life.

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



## **Section 5-E. 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/Notes:** Care Coordinator enters any comments or notes in this area.



## **Section 6-A. Goals of Care – Care Coordinator (Sec. 1-3)**

Section 6 is designed to summarize all previous plans and goals identified throughout the comprehensive care plan F-CAP. Enter goals and the plan to obtain goals, for each section listed below, including patient, family and Circle of Support. 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.

**Section 1. Patient/Family and Social Information:** Describe goals and plans from this section.

**Section 2. Medical Information:** Describe goals and plans from this section including the following:

Identification of any medical equipment required.

Goals and plans for any DME required.

**Section 3. Health & Symptom Assessments:** Describe goals and plans from this section.

Based on the Physical Examination and Review of Systems, describe specific goals, related to nutrition, medical treatment, and pain management relating to all areas of the physical examination. For example: dressing changes three times a week for four weeks.

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

## **Section 6-B. Goals of Care – Care Coordinator (Sec. 4-5, Other)**

**Section 4. Health and Safety Assessments:** Describe goals and plans from this section.

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 may include referral to Child/Adult Protective Services and Licensing and Certification or community and other appropriate resources.

**Section 5. Perception of Illness/Health Care Goals:** Describe goals and plans for the perceptions and health care goals for each individual listed below, as applicable.

**Other issues not identified/addressed in Sections 1-5:** Describe any other goals and plans for the patient not already described in the sections above.

**Transition Plan discussed:** Check the appropriate box to indicate if the Transition Plan was discussed with the patient and Family and Circle of Support. Also, please indicate the reason the patient is transitioning off PFC.



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.

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

### **Section 6-C. Goals of Care – Care Coordinator (Outcomes)**

Document outcomes of interventions/services **from previous F-CAPs**; include timeline and follow-up plan if applicable.

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

### **Section 6-D. Goals of Care – Family Centered Team Meeting**

**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.

**List the overall team goals that integrate the patient, family, and Circle of Support desires/goals, as well as any additional goals that may have not been addressed elsewhere in the F-CAP. The Family Centered 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.

<p><b>Summary: Care coordination is anticipated to be: high complexity, high risk, or support and management:</b> 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></p>	<p>Complex coordination required with multiple disciplines, patient and family, frequent team meeting, outside 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.</p>
<p><b>High Risk</b></p>	<p>Patient/Family 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.</p>
<p><b>Support and Management</b></p>	<p>Patient and Family are stable with current plan of care, and require minimal support, management and coordination. F-CAP revised every 60 days.</p>

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



## **Section 7-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 EPSDT or CCS:** Check the appropriate box to indicate if **EPSDT** or **CCS** is authorizing the EPSDT supplemental services private duty in home nursing.

**EPSDT Case Manager Name:** Enter the name and **phone** number of the EPSDT 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 PFC Waiver Services**

List the current PFC Provider **agency name**, **phone** number, as well as the **care coordinator**, and **phone** number. Check the appropriate boxes for services being received as well as **frequency**, **duration**, and **notes**.

### **Current Community Services**

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



## **Section 7-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 sent to family:** Enter the date the F-CAP was sent to the family.

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



## **Section 8-A. Family Resources – Goals Summary**

**This page is designed to be kept in the PFC home binder/folder or other retrievable place**

**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. 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, including follow-up plan if applicable:** 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 8-A. Family Resources – 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. 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/education. Our Family Counselor means the psychologist, MFT, ACSW or LCSW providing counseling to the family.