

## Care Plan Tool

### NJ FamilyCare Community Based Palliative Care

Palliative care is extra support for people with serious illnesses. It helps manage symptoms, reduce stress, and works alongside other treatments. An interdisciplinary care team (IDT) listens to what matters to the member and supports their choices—so they can focus on quality of life.

The Community Based Palliative Care (CBPC) benefit provides team-based support for people with serious disease and helps members manage symptoms and navigate the care system. CBPC is not hospice care. Members do not need a terminal diagnosis to receive services and may continue curative or disease-directed treatments while enrolled in the benefit.

### Provider Guidance

This care plan documents the interdisciplinary, person-centered palliative care approach for members enrolled in the Community-Based Palliative Care (CBPC) benefit. It is completed by the CBPC interdisciplinary team, led by the Lead IDT Clinician, in collaboration with the member and, when appropriate, their caregiver or family.

The care plan must be completed within the member's first month of enrollment and updated through ongoing IDT discussions as the member's needs, goals, or condition change. If the Lead IDT Clinician did not complete the initial in-person assessment, the care-planning interaction with the member must occur in person. Upon finalization, the care plan must be signed by the Lead IDT Clinician, MCO Care Manager (if applicable), member, and caregiver (if applicable). The care plan should also be shared with clinicians involved in the member's care (e.g., curative care provider, member's primary care physician) upon completion and whenever updated (e.g., as chart note).

Providers should submit material care plan changes to the member's MCO via the MCO Care Manager (CM) within 5 business days. For both FFS and MCO members, the care plan should be stored in the member's EHR for review by the IDT and MCO CM, if applicable, at monthly IDT meetings.

### This form is used to:

- Translate assessment findings into an individualized, interdisciplinary plan of care
- Document the member's goals, preferences, and priorities for palliative care
- Identify symptoms, functional needs, psychosocial concerns, and social factors affecting quality of life
- Outline planned supports, referrals, resources, and follow-up activities across care domains
- Support coordination among the IDT, the member, caregivers, and the MCO Care Manager
- Provide documentation of care planning for ongoing service delivery and program oversight

### General Guidance

- Use legible handwriting or fill electronically
- All sections must be completed unless marked as 'if applicable' or 'optional'

- Complete all fields, using 'N/A' where appropriate
- Attach supporting documentation where prompted (e.g., clinical tools, labs, functional assessments)

## Section-by-Section Guidance

### SECTION A: ADMINISTRATIVE INFORMATION

- Provide member, caregiver, provider entity, and Lead IDT Clinician information

### SECTION B: QUALIFYING CLINICAL CONDITION & FUNCTIONAL DECLINE

- Document the member's qualifying clinical condition and other providers (i.e., PCP, Specialists) and describe functional decline or disease impact using common assessment tools (e.g., ADLs/ IADLs, PPS, KPS, ECOG, FAST)

### SECTION C: MEDICATIONS

- List current medications; document palliative-specific medication changes or deprescribing considerations

### SECTION D: CARE COORDINATION & SUPPORT SERVICES

- Indicate referrals, services, equipment, and support needed to address the member's medical and non-medical needs

### SECTION E: INTERDISCIPLINARY TEAM (IDT) INVOLVEMENT

- Identify required and optional IDT members are involved in the member's care, meeting frequency, and whether the member consents to telehealth and has access to telehealth services

### SECTION F: ADVANCE CARE PLANNING (ACP) & GOALS REVIEW

- Document the member's goals, code status, advance care planning discussions or documents

### SECTION G: PALLIATIVE CARE PLAN OF CARE

- Describe the symptom-based plan addressing physical, psychosocial, spiritual, and social needs, including follow-up and planned interventions

### SECTION H: AUTHORIZATION & SIGNATURES

- Obtain required signatures to finalize the care plan

## Required Attachments

- Most recent Comprehensive Medical Assessment Tool (CMAT)
- Functional assessment tools (if used)
- Recent clinical notes (if needed for justification)
- Advance directive or POLST forms (if on file)

SECTION A: ADMINISTRATIVE INFORMATION		
<b>Member Details</b>		
Member Name: (last, first, mi)		Medicaid ID #:
Health Plan <input type="checkbox"/> Aetna Better Health of New Jersey <input type="checkbox"/> Fidelis Care <input type="checkbox"/> Fee-For-Service (FFS) <input type="checkbox"/> Horizon NJ Health <input type="checkbox"/> UnitedHealthcare (UHC) <input type="checkbox"/> Wellpoint		
Date: (mm/dd/yyyy)	DOB: (mm/dd/yyyy)	Age: <input type="checkbox"/> Adult (19 years or older) <input type="checkbox"/> Child (0-18 years)
Primary Spoken Language:		Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Member's Emergency Contact</b>		
Name:		
Relationship:		Cell Phone Number:
<b>Lead IDT Clinician</b>		
Name:		NPI #:
Business Phone:		Medicaid ID #:
<b>Provider Entity Information</b>		
Name:		
Business Phone:		Medicaid ID #:
Organization Address:		
Street Address	City	State    Zip Code
SECTION B: QUALIFYING CLINICAL CONDITION & FUNCTIONAL DECLINE*		
*For provider: please attach any completed functional evaluation tools to this form		
<b>Primary Disease Diagnosis(es)</b>		
Diagnosis	Primary ICD 10 Code	Date of Onset
<b>Functional Decline Description and Measurement</b>		
Measurement Tool:	Measurement:	
<b>Primary Care Provider</b>		
Name:		Phone:
		Medicaid ID #:

<b>Specialty Provider(s)</b>	
Name:	Phone:
	Medicaid ID #:
Name:	Phone:
	Medicaid ID #:
Name:	Phone:
	Medicaid ID #:
<b>SECTION C: MEDICATIONS</b>	
Current Medications:	
Palliative-Specific Medications Added:	
Deprescribing Conditions:	
<b>Allergies</b>	
Drug Allergies: <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No	Food Allergies: <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No
Specification: (if applicable)	Specification: (if applicable)
<b>SECTION D: CARE COORDINATION &amp; SUPPORT SERVICES</b>	
Home Health Referral:	<input type="checkbox"/> Yes (specify to the right) <input type="checkbox"/> No
	Date Referral Made: (if applicable) Follow Up Made: (if applicable)
Other Referrals Made:	<input type="checkbox"/> Hospice <input type="checkbox"/> HCBS <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Case Management <input type="checkbox"/> Other: _____
Durable Medical Equipment (DME) Needs:	<input type="checkbox"/> Oxygen <input type="checkbox"/> Wheelchair <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Feeding Tube <input type="checkbox"/> Catheter <input type="checkbox"/> Ventilator <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Other: _____
Select All Member Needs:	<input type="checkbox"/> Community Resources <input type="checkbox"/> Concurrent Care Services <input type="checkbox"/> Caregiver Support <input type="checkbox"/> Social Work & Counseling Services <input type="checkbox"/> Other: _____
Specify which Social Work or Counseling Services are needed: (if applicable)	

<b>Expedited Approvals Needed</b>	
Approvals Needed for DME & Supplies? <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No	
Type of DME/Supplies: (if applicable)	Timeframe: (if applicable)
Approvals Needed for Medications? <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No	
Type of Medication(s): (if applicable)	Timeframe: (if applicable)
SECTION E: INTERDISCIPLINARY TEAM (IDT) INVOLVEMENT	
Frequency of IDT Meetings: <i>(at least monthly)</i>	
Telehealth Access	<input type="checkbox"/> Telehealth is accessible and reliable to the member <input type="checkbox"/> Telehealth is not accessible and reliable to the member
Telehealth Consent	<input type="checkbox"/> Member agrees to use telehealth for permitted CBPC interactions <input type="checkbox"/> Member does not agree to use telehealth for CBPC interactions
Required IDT Staff: Mark Yes/No to indicate whether practitioner is on member's IDT	
Lead IDT Clinician (MD, DO, NP, or PA) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
name	phone <span style="float: right;">Medicaid ID #</span>
Registered Nurse (RN) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
name	phone <span style="float: right;">Medicaid ID # (optional)</span>
Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
name	phone <span style="float: right;">Medicaid ID #</span>
Chaplain <i>*may be excluded upon member request</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
name	phone <span style="float: right;">Medicaid ID # (optional)</span>
Child Life Specialist (CLS) <i>*only required for pediatric members; optional otherwise</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
name	phone <span style="float: right;">Medicaid ID # (optional)</span>

<b>Optional Staff</b>		
Nurse Practitioner (NP/APN) or Physician Assistant (PA) – non-lead / non-rendering <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
name	phone	Medicaid ID #
Licensed Practical Nurse (LPN) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
name	phone	Medicaid ID # <i>(optional)</i>
Certified Nursing Assistant (CNA) or Home Health Aide (HHA) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
name	phone	Medicaid ID # <i>(optional)</i>
Community Health Worker <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
name	phone	Medicaid ID # <i>(optional)</i>
Pharmacist <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
name	phone	Medicaid ID # <i>(optional)</i>
<b>SECTION F: ADVANCE CARE PLANNING &amp; GOALS REVIEW</b>		
<b>Member Care Goals:</b> (Use SMART – specific, measurable, achievable, relevant, and time-bound goal statement)		
<b>Family/Caregiver Goals:</b> (Use SMART – specific, measurable, achievable, relevant, and time-bound goal statement)		
Code Status:	<input type="checkbox"/> Full Code <input type="checkbox"/> Do not Resuscitate (DNR) <input type="checkbox"/> Do not Intubate (DNI) <input type="checkbox"/> Do not Hospitalize (DNH) <input type="checkbox"/> Allow Natural Death (AND)	
Health Power of Attorney Identified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Advance Care Planning Discussion Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No Advance Directive on File: <input type="checkbox"/> Yes <input type="checkbox"/> No

POLST on File:		<input type="checkbox"/> Yes	Next Advance Care Planning Date:	<input type="checkbox"/> 6 Months	<input type="checkbox"/> 1 Year
		<input type="checkbox"/> No		<input type="checkbox"/> Other Date: _____	
Transition Planning Needs:		<input type="checkbox"/> Transportation	<input type="checkbox"/> Member and Family Communication		
		<input type="checkbox"/> Provider Coordination	<input type="checkbox"/> Medication Review		
		<input type="checkbox"/> DME	<input type="checkbox"/> Other: _____		
Summary of Follow-up Plan/Visit Frequency and Problem List Actions					
Key Priorities to be Addressed at the Next Visit					
<b>SECTION G: PALLIATIVE CARE PLAN OF CARE</b>					
<b>Pain Management Plan</b>					
Applicable Interventions:		<input type="checkbox"/> Pharmacologic (e.g., opioids, NSAIDs, adjuvant medications) <input type="checkbox"/> Non-pharmacologic (e.g., physical therapy, acupuncture, massage) <input type="checkbox"/> Interventional (e.g., nerve blocks, palliative radiation) <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A			
Frequency of Services Needed:		Duration of Services Needed:		Follow-Up Needed:	
Follow-Up Date:		Outcomes from Plan:			
<b>Dyspnea Management Plan</b>					
Applicable Interventions:		<input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Non-invasive ventilation (e.g., BiPAP) <input type="checkbox"/> Bronchodilators or steroids <input type="checkbox"/> Breathing techniques (e.g., pursed-lip breathing) <input type="checkbox"/> Opioids (e.g., low-dose morphine) <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A			
Frequency of Services Needed:		Duration of Services Needed:		Follow-Up Needed:	
Follow-Up Date:		Outcomes from Plan:			

<b>GI Symptom Management Plan</b>		
Applicable Interventions:	<b>Nausea/Vomiting:</b>	<input type="checkbox"/> Antiemetics <input type="checkbox"/> Dietary modifications <input type="checkbox"/> Other: _____
	<b>Constipation:</b>	<input type="checkbox"/> Fiber intake <input type="checkbox"/> Hydration <input type="checkbox"/> Laxatives <input type="checkbox"/> Other: _____
	<b>Diarrhea:</b>	<input type="checkbox"/> Hydration <input type="checkbox"/> Anti-diarrheal agents <input type="checkbox"/> Probiotics <input type="checkbox"/> Other: _____
	<b>Anorexia/Cachexia:</b>	<input type="checkbox"/> Appetite stimulants <input type="checkbox"/> Nutritional counseling <input type="checkbox"/> Other: _____
		<input type="checkbox"/> N/A
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	
<b>Psychological Symptom Management Plan</b>		
Applicable Interventions:	<b>Depression:</b>	<input type="checkbox"/> Antidepressants <input type="checkbox"/> Therapy/Counseling <input type="checkbox"/> Other: _____
	<b>Anxiety:</b>	<input type="checkbox"/> Anxiolytics <input type="checkbox"/> Relaxation Techniques <input type="checkbox"/> Other: _____
	<b>Delirium:</b>	<input type="checkbox"/> Antipsychotics <input type="checkbox"/> Environmental Modifications <input type="checkbox"/> Other: _____
	<b>Grief/Existential Distress:</b>	<input type="checkbox"/> Spiritual Care <input type="checkbox"/> Psychosocial Support <input type="checkbox"/> Other: _____
		<input type="checkbox"/> N/A
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	
<b>Other Symptom Management Plan</b>		
Applicable Symptoms:	<input type="checkbox"/> Fatigue (e.g., energy conservation strategies, stimulants) <input type="checkbox"/> Insomnia (e.g., sleep hygiene, medications) <input type="checkbox"/> Pruritus (e.g., antihistamines, skin care) <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A	
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	

<b>Social Factors and Resource Plan</b>		
Applicable Factors:	<input type="checkbox"/> Living Situation <input type="checkbox"/> Food Insecurity <input type="checkbox"/> Transportation <input type="checkbox"/> Safety <input type="checkbox"/> Education <input type="checkbox"/> Mental Health <input type="checkbox"/> Disabilities <input type="checkbox"/> Utilities <input type="checkbox"/> Financial Strain <input type="checkbox"/> Employment <input type="checkbox"/> Family and Community Support <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A	
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	
<b>Referrals to Other Programs or Services Offered</b>		
Type of Service:		
Provider Name:		
Provider Address:		
street address	city	state    zip code
Outcome Achieved:		
<b>Resources Provided</b>		
Type of Resource:		
Outcome Achieved:		
<b>Upcoming Dates</b>		
Next IDT Meeting Date and Time:	Next Member Follow-up Date:	
<b>SECTION H: AUTHORIZATION &amp; SIGNATURES</b>		
Lead IDT Clinician Signature	Date: (mm/dd/yyyy)	
MCO Care Manager Signature: (if applicable)	Date: (mm/dd/yyyy)	
Member Signature:	Date: (mm/dd/yyyy)	
Caregiver Signature: (if applicable)	Date: (mm/dd/yyyy)	