NEW JERSEY HUMAN SERVICES

NJ FAMILYCARE

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'

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- 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

Member Details

Member Name: (last, first, mi)		Medicaid ID #:
Health Plan	☐ Aetna Better Health of New Jersey ☐ Fidelis Care ☐ Fee-For-Service (FFS) ☐ Horizon NJ Health ☐ UnitedHealthcare (UHC) ☐ Wellpoint	
Date: (mm/dd/yyyy)	DOB: (mm/dd/yyyy)	Age: ☐ Adult (19 years or older) ☐ Child (0-18 years)
Primary Spoken Language:		Interpreter Needed: ☐ Yes ☐ No

Member's Emergency Contact

Name:	
Relationship:	Cell Phone Number:

Lead IDT Clinician

Name:	NPI #:
Business Phone:	Medicaid ID #:

Provider Entity Information

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

Primary Disease Diagnosis(es)

Diagnosis	Primary ICD 10 Code	Date of Onset

Functional Decline Description and Measurement

Measurement Tool:	Measurement:

Primary Care Provider

Name:	Phone:
	Medicaid ID #:

Specialty Provider(s)	
Name:	Phone:
	Medicaid ID #:
Name:	Phone:
	Medicaid ID #:
Name:	Phone:
	Medicaid ID #:

SECTION C: MEDICATIONS
Current Medications:
Palliative-Specific Medications Added:
Deprescribing Conditions:

Allergies	
Drug Allergies: ☐ Yes (specify below) ☐ No	Food Allergies: ☐ Yes (specify below) ☐ No
Specification: (if applicable)	Specification: (if applicable)

SECTION D: CARE COORDINATION & SUPPORT SERVICES		
Home Health Referral:	☐ Yes (specify to the right) ☐ No	Date Referral Made: (if applicable) Follow Up Made: (if applicable)
Other Referrals Made:	☐ Hospice ☐ HCBS ☐ Behavioral Health ☐ Case Management ☐ Other: ________________	
Durable Medical Equipment (DME) Needs:	☐ Oxygen ☐ Wheelchair ☐ Tracheostomy ☐ Feeding Tube ☐ Catheter ☐ Ventilator ☐ Hospital Bed ☐ Other: _________	
Select All Member Needs:	☐ Community Resources ☐ Concurrent Care Services ☐ Caregiver Support ☐ Social Work & Counseling Services ☐ Other: ________________	
Specify which Social Work or Counseling Services are needed: (if applicable)		

Expedited Approvals Needed	
Approvals Needed for DME & Supplies? ☐ Yes (specify below) ☐ No	
Type of DME/Supplies: (if applicable)	Timeframe: (if applicable)
Approvals Needed for Medications? ☐ Yes (specify below) ☐ No	
Type of Medication(s): (if applicable)	Timeframe: (if applicable)

SECTION E: INTERDISCIPLINARY TEAM (IDT) INVOLVEMENT	
Frequency of IDT Meetings: *(at least monthly)*	
Telehealth Access	☐ Telehealth is accessible and reliable to the member ☐ Telehealth is not accessible and reliable to the member
Telehealth Consent	☐ Member agrees to use telehealth for permitted CBPC interactions ☐ 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)			☐ Yes ☐ No
name	phone	Medicaid ID #	
Registered Nurse (RN)			☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*	
Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT)			☐ Yes ☐ No
name	phone	Medicaid ID #	
Chaplain **may be excluded upon member request*			☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*	
Child Life Specialist (CLS) **only required for pediatric members; optional otherwise*			☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*	

Optional Staff		
Nurse Practitioner (NP/APN) or Physician Assistant (PA) – non-lead / non-rendering		☐ Yes ☐ No
name	phone	Medicaid ID #
Licensed Practical Nurse (LPN)		☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*
Certified Nursing Assistant (CNA) or Home Health Aide (HHA)		☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*
Community Health Worker		☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*
Pharmacist		☐ Yes ☐ No
name	phone	Medicaid ID # *(optional)*

SECTION F: ADVANCE CARE PLANNING & GOALS REVIEW

Member Care Goals: (Use SMART – specific, measurable, achievable, relevant, and time-bound goal statement)	
Family/Caregiver Goals: (Use SMART – specific, measurable, achievable, relevant, and time-bound goal statement)	

Code Status:	☐ Full Code ☐ Do not Resuscitate (DNR) ☐ Do not Intubate (DNI) ☐ Do not Hospitalize (DNH) ☐ Allow Natural Death (AND)				
Health Power of Attorney Identified:	☐ Yes ☐ No	Advance Care Planning Discussion Completed:	☐ Yes ☐ No	Advance Directive on File:	☐ Yes ☐ No

POLST on File:	☐ Yes ☐ No	Next Advance Care Planning Date:	☐ 6 Months ☐ 1 Year ☐ Other Date: ___________
Transition Planning Needs:	☐ Transportation ☐ Provider Coordination ☐ DME	☐ Member and Family Communication ☐ Medication Review ☐ Other: _________________________	
Summary of Follow-up Plan/Visit Frequency and Problem List Actions			
Key Priorities to be Addressed at the Next Visit			

SECTION G: PALLIATIVE CARE PLAN OF CARE

Pain Management Plan

Applicable Interventions:	☐ Pharmacologic (e.g., opioids, NSAIDs, adjuvant medications) ☐ Non-pharmacologic (e.g., physical therapy, acupuncture, massage) ☐ Interventional (e.g., nerve blocks, palliative radiation) ☐ Other: _________________________ ☐ N/A	
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	

Dyspnea Management Plan

Applicable Interventions:	☐ Oxygen therapy ☐ Bronchodilators or steroids ☐ Opioids (e.g., low-dose morphine) ☐ N/A	☐ Non-invasive ventilation (e.g., BiPAP) ☐ Breathing techniques (e.g., pursed-lip breathing) ☐ Other: _________________________
Frequency of Services Needed:	Duration of Services Needed:	Follow-Up Needed:
Follow-Up Date:	Outcomes from Plan:	

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

Social Factors and Resource Plan				
Applicable Factors:	☐ Living Situation	☐ Food Insecurity	☐ Transportation	☐ Safety
	☐ Education	☐ Mental Health	☐ Disabilities	☐ Utilities
	☐ Financial Strain	☐ Employment	☐ Family and Community Support	
	☐ Other: ______________________		☐ N/A	
Frequency of Services Needed:	Duration of Services Needed:		Follow-Up Needed:	
Follow-Up Date:	Outcomes from Plan:			

Referrals to Other Programs or Services Offered				
Type of Service:				
Provider Name:				
Provider Address:	street address	city	state	zip code
Outcome Achieved:				

Resources Provided
Type of Resource:
Outcome Achieved:

Upcoming Dates	
Next IDT Meeting Date and Time:	Next Member Follow-up Date:

SECTION H: AUTHORIZATION & SIGNATURES	
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)