OVERVIEW

A plan of care must be developed for all Home Help cases. The plan of care is developed throughout the assessment in the Michigan Adult Integrated Management System (MiAIMS) comprehensive assessment.

The plan of care directs the movement of the individualized care and progress toward goals identified jointly by the client and adult services worker (ASW).

Philosophy

A plan of care is person-centered, and strength based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of care.

Participants in the plan should involve not only the client, but also guardians, family, significant others, and the caregiver, if appropriate.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Michigan Department of Health and Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services.
- Promoting client independence and self-sufficiency.

A plan of care is to be completed on all new cases, updated as often as necessary, but minimally at the six-month review.

Plan of Care Development

Address the following factors in the development of the plan of care:

- The specific services to be provided, by whom, and the approved hours.

- Discuss and document an emergency backup plan in the event the primary caregiver becomes unavailable or unable to complete services.

Example: Examples of documentation are as follows:

- Maternal aunt Becky Smith at (555) 555-5555, will be an emergency backup caregiver.
- Client does not have a primary caregiver identified at case opening and/or case review. ASW should document the options that have been explored with the client and that a backup caregiver plan has not been established.
- Client has an agency provider; ASW should document if a discussion was completed with the agency to verify if a backup provider would be sent to client's home in the event the primary agency caregiver was not able to provide care.
- Client does not have a backup caregiver plan and is unable to be left alone safely. ASW should document the options that were discussed with the client in the event the client feels they are in danger or unsafe.

Note: All back up caregiver plans must be developed with the client and/or guardian.

- The extent to which the client does not perform activities essential to caring for themselves. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the client and the **caregiver**, if appropriate, in developing a plan to achieve this goal.
- The availability or ability of a **responsible relative** of the client to perform the tasks the client does not perform. A responsible relative is defined as an individual's spouse or a parent of an unmarried child under age 18. Authorize Home Help **only** for those services or times when the responsible relative is **unavailable** or **unable** to provide care; see ASM 120, Adult Services Comprehensive Assessment.

  Example: Client's spouse is unavailable to provide care due to employment. Their work schedule is Monday-Friday, 7:00 a.m. to 6:00 p.m. The client's spouse would be responsible for house cleaning, shopping, and laundry and the meals that are prepared during the times they are available.
- Document if a service animal will be used for specific personal care needs; see ASM 137, Service Animal.

- Home Help may be approved when the client is receiving other home care services **if** the services are not duplicative (same service for the same time period); see ASM 125, Coordination with Other Services.

Good Practices

Plan of care development practices will include the use of the following skills:

- **Listen actively** to the client.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for **congruency** between case assessment and plan of care.
- Provide the necessary supports to **assist** clients **in applying for resources**.
- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

CONTACT

For questions contact MDHHS-Home-Help-Policy@michigan.gov.