

Programs of All-Inclusive Care for the Elderly (PACE)

Chapter 8 – IDT, Assessment & Care Planning

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(Rev. 2, Issued: 06-09-11)

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10 - Introduction - Section 1 Interdisciplinary Team (IDT)

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The intent of this portion of the chapter is to clarify the regulatory requirements for the Interdisciplinary Team (IDT) as defined by the PACE regulations. CMS developed a guidance to provide an in-depth description of PACE care planning that provides additional clarification regarding IDT requirements for the PACE program. Care Planning Guidance for PACE Organizations, September 1, 2010 is available at: http://www.cms.gov/PACE/09_AdditionalResources.asp#TopOfPage.

10.1 - Interdisciplinary Team Composition

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT is critical to the success of the PACE program. Each of the eleven (11) IDT roles must be fulfilled by specific individuals who are employed or contracted by the PACE organization.

The IDT is composed of, but not limited to, at least the following members:

- Primary Care Physician;
- Registered Nurse;
- Master's Level Social Worker;
- Physical Therapist;
- Occupational Therapist;
- Recreational Therapist or Activity Coordinator;
- Dietitian;
- PACE Center Manager;
- Home Care Coordinator;
- Personal Care Attendant or his or her representative;
- Driver or his or her representative.

The IDT members must be legally authorized (licensed, certified, registered) to practice in the State in which they provide services and possess the ability to actively participate as an effective member of the team in the development and monitoring of each participant's plan of care. The IDT members may be employed or contracted staff.

However, if the PACE organization uses contracted IDT members, they must meet the same personnel requirements and perform the same responsibilities as employed IDT members. All members of the IDT must primarily serve PACE participants. PACE organizations may apply for a waiver to contract with community-based primary care physicians when the organization can demonstrate that extenuating circumstances warrant this arrangement. If CMS grants this waiver, and the community-based physicians are contracted as the IDT physician, they must provide all the additional services required in that role.

[42 CFR §§ 460.64, 460.102(b) and (d)(3); Section 903 of BIPA]

10.2 - Basic Information for an Established IDT

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and participants and their caregivers consistent with the requirements for confidentiality in 42 CFR § 460.200(e). The IDT approach involves timely and effective communications, interactive problem-solving, and the exchange of information between team members, contractors, participants and their caregivers in order to create mutual goals for the participant, while maintaining participant confidentiality. See [Chapter 12 Medical Records and Participant Information](#) for further information. Each team member is responsible for informing the IDT of the medical, functional, and psychosocial condition of each participant in an ongoing manner.

[42 CFR § 460.102(d)(2)(i)]

The following questions should be answered during the team meetings:

- What information is shared? And when?
- What is the interaction of the other team members?
- When there is an initial or periodic assessment:
 - Does the team consider a home assessment by the therapist if the participant has a functional disability or is compromised?
 - Does the team consider a plan of care for all of the diagnoses that effect the participant's health or well being?
 - Does the physician appear to be involved in the participant's care in other settings (inpatient or nursing facilities)?
 - Is there any contract staff providing care or services?

- Do they attend the meetings; if not, how is their input obtained?

10.3 - Requirements for the IDT

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE organizations must establish an IDT at each center to comprehensively assess and meet the individual needs of each participant and assign each participant to an IDT functioning at the PACE center that the participant attends. The IDT is responsible for the initial and periodic assessments, plan of care, and coordination of 24-hour care delivery. Each team member is responsible for: (1) regularly informing the IDT of the medical, functional, and psychosocial condition of each participant; (2) remaining alert to pertinent input from other team members, participants, and caregivers; and (3) documenting changes of a participant's condition in the participant's medical record consistent with documentation policies established by the medical director. Additionally, IDT members must serve primarily PACE participants.

As part of the initial assessment, eight of the eleven IDT members (Primary Care Physician, Registered Nurse, Master's Level Social Worker, Physical Therapist, Occupational Therapist, Home Care Coordinator, Dietitian, and Recreational Therapist or Activity Coordinator) evaluate the participant in person, at appropriate intervals and develop a discipline-specific assessment of the participant's health and social status. At the recommendation of individual team members, other professional disciplines (e.g., Speech-Language Pathology, Dentistry, or Audiology) may be included in the comprehensive assessment process.

[42 CFR §§ 460.102(a) and (d), 460.104(a); 71 FR 71288 (Dec. 8, 2006)]

20 - Introduction - Section 2 Participant Assessment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

This portion of Chapter 8 focuses on Participant Assessment Requirements and providing additional guidance related to the participant assessments.

20.1 - PACE Organization Responsibilities

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE organization must have a care management strategy to address the major health needs of the participant for the interim period between official enrollment and initial comprehensive assessment leading to the development of the initial care plan. The interim care management strategy may be documented in the discipline-specific progress notes or other section of the medical record identified by the organization and documented in policy and procedures.

PACE organizations must have policies and procedures that delineate how the IDT will operate, how they will conduct participant assessments, and how they will incorporate the results of assessments into a continuously updated care plan for each participant.

Specifically, the policies and procedures must address, at a minimum, the following elements:

- The mechanisms and timeframes for IDT interaction;
- The organization's process for initial assessment includes:
 - Discipline-specific assessment information and at what intervals assessments are made;
 - Criteria to determine when additional disciplines (e.g., Speech Therapist, medical specialists, clinical pharmacists, dentists, etc.) would be included in the assessment;
 - Required elements of the initial and periodic assessments, i.e., physical and cognitive function and ability, medication use, participant preferences for care, socialization and availability of family support, current health status and treatment needs, nutritional status, participant behavior, psychosocial status, medical and dental status, and participant language;
 - Home assessment including home access and egress, ability to perform ADLs in the home environment, need for assistive devices, ability to summon immediate emergency assistance, relationship with co-habitants and neighbors;
 - Identification of conditions that overlap disciplines (e.g., blindness, deafness, psycho-behavioral problems, etc.) and require interdisciplinary interventions and measurable outcomes;
- The process for reassessments includes:
 - Frequency at which scheduled reassessments are performed;
 - Circumstances that would prompt an unscheduled reassessment (e.g., significant change in health status);
 - Persons performing the reassessment;
 - Process for communicating the compiled reassessment information to the team;
 - Process for resolving participant requests for reassessments in a timely manner;
 - Team roles and functions;

- Timeline;
- Documentation of resolution.

[42 CFR §§ 460 Preamble Discussion, 460.102, 460.104(d); 71 FR 71331 (Dec. 8, 2006)]

20.2 - Timing of Assessments

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

20.3 - Pre-Enrollment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT must perform any pre-enrollment assessments in person, and cannot substitute assessments completed by non-PACE community providers or reports contained in copied medical records. The PACE organization also cannot supplant the initial comprehensive assessments with any pre-enrollment screening undertaken to determine a prospective enrollee's suitability for PACE services as well as eligibility for PACE enrollment.

CMS recognizes that some PACE organizations may choose to perform some or all IDT assessments prior to enrollment, and allows pre-enrollment assessments to fulfill the initial assessments requirement when certain contingencies are met:

- The health status of the enrolled participant has not changed since the pre-enrollment assessments;
- If the participant's health status has changed, the participant is reassessed per 42 CFR § 460.104 and an initial care plan developed per 42 CFR § 460.106.

The Medicare Health Outcomes Survey-Modified (HOS-M) assesses annually the frailty of the population in PACE organizations in order to adjust plan payment rates. Initial eligibility for payment purposes is based on community-residing participants who do not have end-stage renal disease (ESRD) and are 55 or over. Refer to [Chapter 10](#) of this PACE Manual for more information regarding HOS-M.

[42 CFR § 460.180]

20.4 - Initial Assessment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The interdisciplinary team (IDT) must conduct an initial, in person comprehensive assessment for each PACE participant. The initial assessment must be completed promptly following enrollment with individual team members' assessments scheduled at appropriate intervals taking into account the participant's level of health. If the comprehensive assessment cannot be completed by the effective date of enrollment, the

organization must explicitly document the reason for the delay in the progress notes and care plan and perform the comprehensive assessment within a few days.

CMS believes timely health assessments and care planning are imperative to sustain continuity of care. Therefore, if essential members of the IDT or other identified healthcare experts required to complete the initial comprehensive assessment are not available to conduct the assessment in the established time frame due to prolonged absence (vacant IDT position, extended leave, or illness lasting three or more weeks), the remaining IDT members should develop the care plan and revise it as soon as the missing required initial health assessment is completed, and document in the progress notes the reason for the delay in developing a complete care plan.

[42 CFR § 460.104(a)]

20.5 - Assessment of Multiple New Participants

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

When a PACE organization enrolls three or more new PACE participants in one month, the organization may conduct the initial comprehensive assessment for the new PACE participants over a four-week (i.e., twenty business days) time period in which the IDT identifies and prioritizes the assessments by highest acuity of care (i.e., sickest first).

If essential members of the IDT or other identified healthcare experts required to complete the initial comprehensive assessment are not available to conduct the assessment in the established time frame, the remaining IDT members should develop the care plan and revise it as soon as the missing required initial health assessment is completed, and document in the progress notes the reason for delay of care plan development. Following completion of the assessments for an individual participant, the IDT will promptly consolidate the discipline-specific results into a single plan of care.

20.6 - Assessment Process

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

20.7 - Initial Assessment

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The initial comprehensive health assessment must be conducted in person by eight of the eleven IDT members for each new participant. Each IDT member uses a discipline-specific standardized health risk assessment form developed or adopted by the PACE organization. When completed, the discipline-specific health risk assessment form is filed in the medical record section designated by PACE organization policy, for example, in a separate tab containing all discipline-specific assessments; or, in the respective discipline section of the medical record along with the discipline-specific progress notes. CMS expects clinical documentation to meet professional health information management standards. Specifically, clinical documentation must: a) identify and communicate patients' problems, needs and strengths; b) monitor their condition on an ongoing basis;

and c) record treatment and response to treatment for each participant. PACE organizations must periodically review medical records to assure that clinical documentation reflects good clinical practice and conforms to high standards of communicating clear, complete, and accurate information at the level expected from trained and licensed health care professionals. Good clinical practice dictates not only the documentation of treatment and services, but also the outcomes and efficacy in resolving the problem. Further information regarding medical records can be found in [Chapter 12](#).

A comprehensive assessment criterion includes, but is not limited to, the following:

- Physical and cognitive function and ability;
- Medication use;
- Participant and caregiver preferences for care;
- Socialization and availability of family support;
- Current health status and treatment needs;
- Nutritional status;
- Home environment, including home access and egress;
- Participant behavior;
- Psychosocial status;
- Medical and dental status;
- Participant language and cultural needs.

[42 CFR §§ 460 Preamble Discussion, 460.104(a)(2) and (4); 71 FR 71311 (Dec. 8, 2006)]

20.8 - Semiannual Reassessments

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT primary care physician, registered nurse, master's level social worker, and recreational therapist/activity coordinator must all, at a minimum, conduct periodic health reassessments on a semiannual basis. Other IDT members or specialty practitioners actively involved in the development or implementation of the participant's care plan must also conduct the semiannual reassessment. The pertinent practitioners conduct the reassessment in person, and meet to consolidate the reassessment findings into the care plan. At least semi-annually, the IDT must reevaluate the plan of care, including defined outcomes, and make changes as necessary.

Intervals	Performed	Minimum disciplines involved
Semi-annual	<ul style="list-style-type: none"> In-person At least every 6 months More often if participant's condition dictates 	<ul style="list-style-type: none"> PCP, RN, SW, Recreational Therapist or Activity Coordinator Other team members actively involved in development or implementation of Plan of Care

[42 CFR §§ 460.104(c)(1); 460.106(d)]

20.9 - Annual Reassessments

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The physical therapist, occupational therapist, dietitian, and home care coordinator, at a minimum, must conduct, on at least an annual basis, an in person reassessment. Other pertinent IDT members or specialty practitioners actively involved in the participant's care plan should also conduct an in-person annual reassessment. The IDT members who do the periodic reassessment must meet to consolidate the findings into the revised care plan.

Intervals	Performed	Minimum disciplines involved
Annual	<ul style="list-style-type: none"> In-person At least annually More often if participant's condition dictates 	<ul style="list-style-type: none"> PT, OT, Dietitian, Homecare Coordinator

[42 CFR § 460.104(c)]

20.10 - Periodic and Unscheduled Health Reassessments

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

In addition to the semiannual and annual reassessments described above, two situations should trigger participant reassessment. First, if a participant experiences a significant change in health or psychosocial status, the eight IDT members (primary care physician, registered nurse, master's level social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, and home care coordinator) must conduct an in-person reassessment. Secondly, when a participant or his or her designated representative believes that the participant needs to initiate, eliminate, or continue a particular service, the IDT members will determine the pertinent practitioners to conduct the in-person reassessment. The PACE organization must have explicit procedures for timely resolution of requests by a participant or his or her designated representative to initiate, eliminate, or continue a particular service. The IDT must notify the participant or designated representative of its decision to approve or deny the request from the participant or designated representative as expeditiously as the participant's condition requires, but no later than 72 hours after the date the IDT receives the request for reassessment. However, the IDT may extend the 72-hour timeframe for notifying the

participant or designated representative of its decision to approve or deny the request by no more than 5 additional days if the participant or designated representative requests the extension or the IDT documents its need for additional information and how the delay is in the interest of the participant. The PACE organization must explain any denial of a request to the participant or designated representative orally and in writing. The PACE organization must provide the specific reasons for the denial in understandable language. The PACE organization is responsible for: (1) informing the participant or designated representative of his or her right to appeal the decision; (2) describing both the standard and expedited appeals processes, including the right to, and conditions for, obtaining expedited consideration of an appeal of a denial of services; and (3) describing the right to, and conditions for, continuation of appealed services through the period of an appeal. If the IDT fails to provide the participant with timely notice of the resolution of the request or does not furnish the services required by the revised plan of care, this failure constitutes an adverse decision, and the participant's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR § 460.122.

Intervals	Performed	Minimum Disciplines Involved
Unscheduled	<ul style="list-style-type: none"> • In-person • Change in participant status (health or psychosocial) • At the request of the participant or designated representative 	<ul style="list-style-type: none"> • PCP, RN, SW, Recreational Therapist/Activity Coordinator, PT, OT, Dietitian, and/or Homecare Coordinator as needed • Other team members actively involved in development or implementation of POC

[42 CFR § 460.104(d)]

20.11 - Recommendations for the Assessment Process

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

20.12 - Changes to Plan of Care and Documentation

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Team members who conduct a reassessment must meet the following requirements:

- Reevaluate the participant's plan of care;
- Discuss any changes in the plan with the IDT;
- Obtain approval of the revised plan from the IDT and the participant (or designated representative); and
- Furnish any services included in the revised plan of care as a result of a reassessment to the participant as expeditiously as the participant's health condition requires.

IDT members must document all assessment and reassessment information in the participant's medical record.

[42 CFR § 460.104(e) and (f)]

30 - Introduction - Section 3 - Care Planning

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

30.1 - PACE Care Planning Overview

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE care planning is the process by which a participant's IDT holistically assesses the participant's medical, functional, psychosocial, and cognitive needs, and develops a single comprehensive plan of care to address the identified needs. The IDT members who conduct the extensive discipline-specific assessments collectively discuss the participant's identified needs and design and monitor the individualized care plan.

[42 CFR §§ 460.104; 460.106(b)]

30.2 - PACE Care Planning and the Interdisciplinary Team

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

PACE care planning is the responsibility of the IDT members that deliver direct care to participants in the PACE center they attend and/or in alternative settings such as their homes or inpatient facilities when dictated by their healthcare needs. A key component of the PACE model is IDT members' identification of participant needs in all care domains (medical, psychosocial, physical, cognitive, functional, and end-of-life), and the IDT's coordinated response to these needs. Each member of the team acts within his/her authorized scope of practice, in accordance with participant preferences, working in unison with other IDT members to meet the identified needs and achieve each participant's optimal outcomes. Optimal outcomes will differ for each participant, but the plan of care is the roadmap to meet the participant- and team-defined outcomes as measured after implementation of focused interventions over a prescribed period of time.

Each participant is assigned, at enrollment, to an IDT team that operates at the PACE center the participant attends. The intent of having this broad-based team is to maximize the expert services dedicated to the holistic care of each participant.

[42 CFR §§ 460.104; 460.106]

30.3 - Plan of Care Development

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

30.4 - Single Plan of Care

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT will promptly consolidate the eight discipline-specific assessments into a single individualized plan of care for each participant. The full IDT team collectively develops the care plan through discussion and consensus at a formal care planning meeting. The IDT must implement, coordinate, and monitor the plan of care whether the services are furnished by PACE employees or contractors. When goals and interventions for a particular problem are overlapping, the team may decide to combine actions into team interventions and outcomes to achieve a single goal. They may conversely find that a problem is unique and needs to be addressed by a specific discipline. Whether a problem manifests as multi-faceted or singular in nature, the IDT incorporates the problems into a single plan of care that is collectively monitored and evaluated by the team. Although the PACE center director, driver, and personal care attendant do not perform assessments, they contribute valuable information about participants and should be included in care planning discussions.

[42 CFR §§ 460.104(b); 460.106]

30.5 - Participant/Caregiver Involvement in Care Planning Process

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT must develop, review, and reevaluate the plan of care in collaboration with the participant or caregiver, or both, to ensure that there is agreement with the plan of care and that the participant's concerns are addressed. The IDT may subsequently need to reconvene to incorporate information obtained from the participant and/or caregiver related to care plan changes requested by the participant.

[42 CFR § 460.106(e)]

30.6 - Contents of the Care Plan

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The initial care plan must specify the care needed to meet the participant's medical, functional, emotional, social, and cognitive needs identified in the initial comprehensive health assessment. For each need identified, the plan must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes. All care plans should include the aforementioned basic five components; however, experienced PACE organizations may design more sophisticated care plan models that incorporate these five basic components with other features such as long-term and short-term goals that enhance care management.

The PACE plan of care is the IDT's framework for managing the overall health status of each participant. The problems identified in the initial health risk assessment and the IDT's coordination of care will be the plan's focus. In general, the plan includes:

- Active chronic problems for which the IDT members have designed interventions that they will be monitoring and evaluating over a set time frame. When the IDT members achieve the care goals for an active problem, they may classify the problem as maintenance care. Maintenance care may be addressed in the care plan or in the discipline-specific progress notes depending on the organization's policy;
- Problems that cross domains of care and require interdisciplinary coordination;
- Exacerbation of problems that were previously controlled and/or classified as maintenance care, but disease progression and/or other intervening conditions resulted in a change that now requires team monitoring and evaluation of interventions;
- Significant changes that indicate a decline or improvement in health status that:
 - Will not normally resolve without intervention by providers, require standard disease-related clinical interventions, or are not self-limiting;
 - Impacts more than one area of the patient's health status; and
 - Requires interdisciplinary review and/or revision of the care plan.

Each PACE organization must define what care is integrated into the participant's plan of care, and what discipline-specific care is appropriately documented and monitored by the respective discipline specialist in the progress notes.

As PACE organizations develop care planning policy and procedures that unequivocally define what problems are incorporated in the single care plan versus which problems may be documented solely in discipline-specific progress notes, the following criteria are suggested:

- Long-standing stability (e.g., controlled over several months or years) versus liability (e.g., uncontrolled or prone to exacerbations);
- Brevity of therapeutic regimen to achieve resolution (e.g., brief regimen of one-two weeks) versus chronicity of therapeutic regimen with uncertain course until resolution (e.g., repeated changes in therapeutic agents to achieve resolution);
- Maintenance condition monitored by a sole discipline versus active condition that has potential to result in a change in health status, change in medication, or expanded therapeutics requiring interdisciplinary monitoring;

- Stable residential, social network and caregiver support versus residential or psychosocial transitions requiring interdisciplinary monitoring.

[42 CFR § 460.106(b)]

30.7 – Progress Notes

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

Progress notes detail the care delivered by practitioners performing within their scope of practice as they manage day-to-day participant encounters or follow up on care provided during previous encounters. Progress notes may be formatted as the traditional “SOAPE” note commonly used by many clinical professionals, a narrative description of care rendered, or other format designed for narrative text entry in an electronic medical record. The progress note format is prescribed in the PACE organization’s policy and procedures for medical record documentation.

The progress note not only gives sufficient information to enable other providers to know what care has been given, but also explains the details of the encounter and the clinical judgment applied so that subsequent care enhances therapy without redundancy or contravention. For example, a progress note would refer to subjective information reported by the participant (e.g., complaints, concerns, effectiveness of ongoing therapy, etc.), objective findings noted by the provider (e.g., vital signs, weight, examination of body systems, random blood sugar test, etc.), the assessment of the findings (e.g., diagnosis, presumptive condition, etc.), the therapeutic approach taken (e.g., medication, procedure, lifestyle activity, self-management strategy, etc.), and a discussion about how the participant was educated about the treatment approach and agreement/disagreement with the treatment planned (e.g., demonstration of self-management technique, discussion about disease stages, explanation of medication side effects, etc.). A narrative progress note may document an exchange between providers (e.g., documentation of a discussion with the hospitalist managing the case of a hospitalized participant, summary of a meeting with a nursing facility’s care planning team for a participant placed in a skilled nursing facility, description of a home care coordinator’s visit to the contracted home care facility to review contractor records, etc.) or between IDT members and the participant’s family or other caregivers (e.g., discussion of a proposed change in a participant’s care plan, discussion of a grievance filed by the participant and/or family, etc.). Consider the following three examples.

In example 1, the physician or mid-level practitioner (nurse practitioner or physician assistant) documents in a medical “SOAPE” note the subjective complaints, objective measurement of vital signs and a body system-by-system assessment, existing or new diagnoses, therapeutics, orders for diagnostic tests or specialty services, and participant education for a participant’s chronic care visit to manage multiple co-morbid chronic conditions.

In example 2, the registered nurse documents in the nursing “SOAPE” notes subjective complaints, vital signs, the wound appearance (depth, width, color, drainage, degree of

granulation, warmth/coolness, etc.), nursing diagnosis, and sterile or non-sterile technique used when packing and dressing a decubitus ulcer during a skilled nursing visit for wound care.

In example 3, the physical therapist documents in the physical therapy narrative progress note a participant's self-report of walker use in the home, results of range of motion and strength measurement, and performance of strength-building exercises during a therapy session. Progress notes summarize the chronological clinical care and underlying clinical judgment applied by the individual clinician.

30.8 - Monitoring Participant Health Status

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT members must continuously monitor the participant's medical, functional, emotional, social, and cognitive status. IDT members monitor health status by direct observation when providing services, informal observation in the PACE center or alternative settings, self-report by participants, feedback from caregivers, reports from network providers, or communication among IDT members. When significant health or psychosocial status changes occur, the eight IDT members must reassess the participant and initiate or expand an already scheduled care planning meeting to discuss the significant change(s), the reassessment results, and, if warranted, revise the participant's care plan following the discussion. Significant changes are defined as a "decline" or "improvement" in the last assessed health status that meets all three conditions:

- Will not normally resolve without intervention by staff or by implementing standard disease-related clinical interventions and is consequently not "self-limiting";
- Impacts more than one domain of the participant's health;
- Requires interdisciplinary review and/or revision of the care plan.

[42 CFR §§ 460.104(d)(1) and (e); 460.106(c)(2)]

30.9 - Documentation of Plan of Care

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The IDT members consolidate the contents of the PACE care plan into a single comprehensive document that is filed in the care plan section of the participant's medical record. The care plan clearly displays, at a minimum, the problem being addressed, interventions, measurable outcomes, time lines, and persons responsible for each intervention. It is continuously updated as the team monitors the participant's health status.

[42 CFR § 460.106(f)]

30.10 - Plan of Care Revision

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

The PACE care plan is continuously updated as the team monitors the participant's health status. The IDT members must minimally reevaluate the single comprehensive plan of care for each participant on a semiannual basis. The team should conduct the reevaluation in collaboration with the participant and caregivers whenever feasible. Involvement of the participant and caregivers in care planning assures that the participant's care preferences are addressed and informed participation in care is maximized.

Updates are made directly to the care plan in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems may be retained for monitoring or relocated to the discipline-specific progress notes if the team classifies it as maintenance care. The rationale for eliminating or relocating a resolved problem to maintenance care in the progress notes section must be documented in the care plan.

[42 CFR §§ 460.104(c)(1) and (e); 460.106(d)]

30.11 - Continuous Plan of Care Monitoring and Evaluation

(Rev. 2, Issued: 06-09-11; Effective: 06-03-11; Implementation: 06-03-11)

An integral part of implementing the care plan is the IDT's continuous monitoring of the participant's health and psychosocial status as well as the effectiveness of the plan of care. Continuous monitoring is achieved through the assessment/reassessment of participant needs, provision of services, formal evaluation of the efficacy of services provided, informal observation, input from participants or caregivers, and communication among IDT members and all other providers. Timely, accurate, and complete written and verbal communication among PACE stakeholders is paramount to quality and safe participant care. The interdisciplinary care team approach and the perpetual care planning process are the gold standards that make PACE an effective model for the care of frail elders.

[42 CFR § 460.106(c)(2)]

To obtain more information pertaining to the Care Planning Guidance, visit <http://www.cms.gov/pace/>.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2PACE	06/09/2011	Initial Publication of Manual	06/03/2011	NA
R1_SO	06/03/2011	Initial Publication of Manual - Rescinded and replaced by Transmittal 2	06/03/2011	NA

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