



Care Planning Guidance for PACE Organizations

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Care planning for PACE organizations is a unique process in which an interdisciplinary team assesses participant needs, develops a comprehensive plan of care, and holistically manages the care of frail elderly individuals. Interdisciplinary care planning is a cornerstone of the PACE model of care.

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I. PACE Care Planning Overview

PACE care planning is the process by which a participant's Interdisciplinary Team (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. The care plan delineates problems, interventions, and measurable outcomes to improve, maintain, recover or reset a participant's baseline health status and preferences for health care. When a care plan is properly executed, the assessments and care planning flow together in a seamless perpetual process that:

- Takes into account each participant as a human being with unique characteristics, needs, and documented preferences;
- Anticipates potential problems by identifying individual risks and how these risks can be minimized to foster the participant's highest feasible level of well-being;
- Develops and implements a plan of care that integrates discipline-specific assessments and allows for coordinated and continuous evaluation of the efficacy of care; and
- Comprehensively re-evaluates the participant's status at prescribed intervals as well as at episodic reassessments prompted by changes in the participant's health status. Note: Significant changes in health status compel a timely reassessment which cannot be deferred to a prescribed interval such as semi-annual or annual reassessments (see the discussion on monitoring participant health status, page 12).

CMS developed this guidance for use in conjunction with the final PACE rule, 42 CFR 422, published December 8, 2006, to provide an in-depth description of PACE care planning that guides implementation of the regulations. This document examines each aspect of care planning in sufficient depth to clarify CMS expectations and assist PACE organizations as they self-assess and improve their own care planning process. CMS believes a collaborative team-driven approach to managing care is the hallmark of the PACE experience.

II PACE Care Planning and the Interdisciplinary Team (§460.102)

A. Interdisciplinary Team

PACE care planning is the responsibility of the Interdisciplinary Team (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. The traditional medical model of care, while common in most acute care settings, does not drive the PACE IDT operations or the care planning process. A key component of the PACE model is IDT members' identification of participant needs in all care domains (medical, psychosocial, 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 member- 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 IDT is comprised of eleven members, namely, a primary care

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physician, registered nurse, master's level social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietitian, home care coordinator, PACE Center manager, personal care attendant or representative, and driver or representative. These IDT members are responsible for health assessments, care planning, delivery of 24-hour care, informing and receiving information from other IDT members on participants' condition, documenting care in participants' medical records, and primarily serving PACE participants. The intent of having this broad-based team is to maximize the expert services dedicated to the holistic care of each participant. Therefore, CMS expects that each of these eleven (11) IDT roles be fulfilled by separate individuals who are employed or contracted staff and work full- or part-time. One individual must not fill several IDT roles. For example, a single registered nurse must not simultaneously fill the role of IDT registered nurse, home care coordinator, and PACE center manager, which would essentially dilute the total team membership to eight individuals. The eleven IDT members must primarily serve PACE participants, but may work less than full-time at the PACE center as long as they perform all of the required IDT functions listed above.

Eight of the eleven IDT members (physician, registered nurse, master's level social worker, physical therapist, occupational therapist, home care coordinator, dietitian, and recreation coordinator) must conduct comprehensive initial health assessments as well as periodic and unscheduled reassessments. All members must primarily serve PACE participants although POs may apply to CMS and qualify for a waiver when extenuating circumstances warrant special consideration.

B. PACE Physician

The PACE physician has additional regulatory responsibilities. The physician must deliver primary medical care, manage medical situations, and oversee the participant's use of medical specialists and inpatient care. The delivery of primary medical care by the physician may be **supplemented, but not supplanted**, by duly-licensed and State-authorized mid-level practitioners (i.e., nurse practitioners and physician assistants). Mid-level practitioners may deliver clinical care (assess, diagnose, and treat acute, chronic, and emergent disease and conditions; perform preventive health screening; and, as permitted by the Medical Director and documented in policy, perform minor procedures such as suturing, excising minor lesions, incision and drainage of lesions, etc.) to PACE participants within the scope of practice authorized by the State in which they deliver primary care. They may also serve, but **will not replace** the physician on the IDT or perform participant assessments/reassessments in lieu of the physician.

C. Employed or Contracted IDT Members

The IDT members may be employed or contracted staff. However, if the PACE organization (PO) uses contracted IDT members, they must meet the same personnel requirements and perform the same responsibilities as employed IDT members. CMS expects the PO to perform oversight activities for all contracted IDT members to assure that they perform all IDT responsibilities. Formal oversight activities should be documented in policy and include activities such as periodic observation of service delivery, review of service documentation, assurance of participation in refresher training, review of applicable credentials, assessment of communication with other IDT members, investigation of complaints made by participants against respective staff members, and evaluation of participation in the QAPI program.

POs may apply for and receive a waiver to contract with community-based primary care physicians when the organization can demonstrate that extenuating circumstances warrant this

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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, namely, conducting comprehensive initial health assessments and periodic reassessments, developing and monitoring the care plan, providing 24-hour care, informing and receiving information from other IDT members on participants' condition, documenting care in participants' medical records, and participating in the development and evaluation of QAPI activities. The PO's Medical Director must conduct and document formal oversight activities on both the clinical and IDT role performance for each of the community-based physicians contracted as the IDT physician.

III. Initial Comprehensive Health Assessment for Care Planning (§460.104)

A. Policies and Procedures

POs should have policies and procedures that delineate how the IDT will operate, how they will conduct participants' assessments beginning with the initial comprehensive health assessment, and how they will incorporate the results of the initial and subsequent assessments into a continuously updated care plan for each participant. Specifically, the policies and procedures should address, at a minimum, the following elements:

- The mechanisms and timeframes for IDT interaction
- The organization's process for initial assessment including
 - discipline-specific assessment information and at what intervals assessments are made
 - criteria to determine when additional disciplines (i.e. 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 multidisciplinary interventions and measurable outcomes
- The process for reassessments including
 - frequency at which scheduled reassessments are performed
 - circumstances that would prompt an unscheduled reassessment (i.e., 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 (see §460.104(d) for regulatory specifications)
 - team roles and functions
 - timeline
 - documentation of resolution

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B. Home Assessment

CMS believes the home assessment must be thorough and encompass not only the safety of the home environment, but also the capacity of the participant to have an optimal quality of life while in the home environment. Each IDT member must incorporate an assessment of how the participant will function in the home. For example, the dietitian must not only assess nutritional status, but also the participant's ability to do meal planning, prepare meals, and sustain adequate nutritional intake at home. The registered nurse must assess any barriers to self-administration of medications and adherence to therapeutic regimens in the home. The occupational therapist must assess the participant's capacity to perform activities of daily living in the home where the physical layout, location of cabinets and shelving, design of existing furniture, etc., may present barriers to independence. The social worker must determine the participant's ability to perform instrumental activities of daily living in the home such as contacting family, friends, or neighbors when needed, dealing with utility companies when service is interrupted, and accessing finances to run the household. The IDT's comprehensive assessments must evaluate competencies in all settings pertinent to a given participant – home, community, PACE center.

C. Timing of the Initial Assessment

PACE care planning begins with the initial comprehensive health assessment promptly performed in person for each enrolled PACE participant. The eight IDT members who conduct the initial assessment in person are the primary care physician, registered nurse, master's level social worker, dietitian, physical therapist, occupational therapist, activities coordinator, and home care coordinator. The discipline-specific assessment includes, but is not limited to, 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 access and egress, participant behavior, medical and dental status, and participant language and cultural needs. When the IDT identifies other healthcare specialists that must conduct additional assessments outside the IDT members' expertise or scope of practice, these specialists must also promptly perform the assessment in person...

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:

1. The health status of the enrolled participant has not changed since the pre-enrollment assessments.
2. If the participant's health status has changed, the participant is reassessed per §460.104 and an initial care plan developed per §460.106 within thirty (30) calendar days of enrollment.
3. The timing of the initial assessments does not adversely affect capitated payment to the organization.

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. Initial comprehensive assessments are performed in person and independent of any pre-enrollment eligibility screening. The initial assessment and development of the initial care plan should be

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completed within thirty (30) calendar days of enrollment (see further discussion about development of the initial care plan below in section 5). 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. When a PACE organization enrolls several new PACE participants in one month, the organization should prioritize the initial comprehensive assessment for the new PACE participants by highest acuity of care (i.e., sickest first).

D. Care Management Prior to Care Plan Development

Completion of the initial comprehensive assessment and development of the initial single care plan for a given participant may take several weeks. 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.

IV. Documentation of Initial Comprehensive Health Assessment

Eight IDT members (physician, registered nurse, master's level social worker, physical therapist, occupational therapist, activities coordinator, home health coordinator, and dietitian) must conduct the initial comprehensive health assessment in person 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 PO policy, e.g., in a separate tab containing all discipline-specific assessments, in the respective discipline section of the medical record along with the discipline-specific progress notes, etc.

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. POs 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.

V. Plan of Care Development (§460.106)

A. Single Plan of Care

The eleven IDT members consolidate the eight discipline-specific assessments into a single individualized plan of care for each participant within thirty (30) days of enrollment. The full IDT team collectively develops the care plan through discussion and consensus at a formal care

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planning meeting. The team may find during their discussion that several problems have a related cause and appear to be a singular problem for the participant. For example, a morbidly obese participant may have musculoskeletal pain (knees and lower back), uncontrolled hypertension and blood sugar levels, physical inactivity, lack of participation in group activities, and depression. 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. For example, consider a participant who is questioning lifelong religious or spiritual convictions and whose needs would best be addressed by a chaplain or spiritual adviser, or a participant unable to pay his utility bills and for whom the social worker intercedes to secure a utilities subsidy. 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.

When the team has identified problems, conditions, limitations, maintenance levels, or areas for improvement, they should be stated in functional or behavioral terms. For example, the problem statement should specify how the condition is a problem for the participant, how the condition limits or jeopardizes the participant's ability to do their activities of daily living, or in what way the condition affects their well-being. For example, the IDT team assesses a new enrollee having a diagnosis of schizophrenia and a long-standing history of treatment with antipsychotic medications as displaying behaviors suggestive of either non-efficacious therapy or non-compliance with the medication regimen. In the care plan, they do not identify the problem as medication non-compliance or non-efficacy; preferably, they briefly describe the baseline behaviors to be changed by the interventions they will implement over the prescribed period of time in sufficient detail to enhance outcome measurement. Thus, they describe the problem as follows: Participant exhibits a flat affect, does not mingle with other participants despite staff modeling, and states that the other participants are spying on her. The IDT may develop interventions such as directly observed medication administration, change of therapeutic agents, one-on-one psychotherapy, small group activities, etc., and reevaluate in 2-3 months. The post-intervention behaviors can then be compared to the pre-intervention behaviors. If a PO uses automated care planning software, it may need to tailor the problem description to comply with the software format; however, CMS highly encourages POs to enhance the details of the care plan as much as possible to facilitate the measurement of intervention efficacy for each participant.

B. Participant / Caregiver Involvement in Care Planning Process

IDT members may participate in care planning meetings in person, telephonically, through video-conferencing, or other technology that enables real time discussion and timely documentation of the care plan. The IDT members should encourage the attendance of the participant and/or caregiver for the team discussion when appropriate, but may develop a proposed care plan that is subsequently discussed with the participant and/or caregiver prior to implementation. If the participant and/or caregiver do not attend the care planning meeting, the IDT should meet with them before the meeting to identify and ensure participant input into goals, needs, preferences, etc., and after the meeting to review the care plan. 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.

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The IDT members must develop and present a care plan that maximizes participant involvement, incorporates preferences for care, and guarantees informed consent for treatment. As evidence of participant involvement in care planning, the following documentation should be noted in the participant's medical record:

- If the participant and/or caregiver are present in person or telephonically at the care planning meeting, their discussion points should be included in the care plan.
- If the participant and/or caregiver do not attend the care planning meeting, a designated IDT member must conduct a meeting in person or telephonically with the participant and/or caregiver (preferably a family meeting) to discuss the proposed care plan and the participant's care preferences, questions, and concerns.
 - If the IDT member meets with the participant and/or caregiver prior to the team's care planning meeting, the discussion points documented in the IDT member's progress notes should be read, discussed, and assimilated in the single care plan.
 - If the IDT member meets with the participant and/or caregiver subsequent to the care planning meeting, the discussion points, including the participant's care preferences, must be documented in the team member's progress notes and incorporated in the care plan within ten business days.
- All IDT members attending the care planning meeting telephonically or through other technology must document care planning participation in their discipline-specific progress notes, and review and authenticate concurrence with the care plan within ten business days of the plan's implementation.
- All IDT members as well as the participant and/or caregiver should indicate concurrence with the care plan through signature (wet or electronic) as defined by the organization in its care planning policy and procedures. A print copy used to obtain required signatures should be scanned into an electronic medical record unless the automated system has electronic signature functionality which is authorized in its organizational policy.

C. Access to Qualified Specialist for Routine or Preventive Women's Health Service

The IDT physician or alternative IDT member identified in the organization's care planning policy should inform female participants that they are entitled to choose a qualified specialist for routine or preventive women's health services from the PACE organization's network. In some PACE organizations, the physician makes this notification during intake, the enrollment process, or at the initial physician assessment. If notification has not been made prior to development of the care plan, §460.104(b) requires the IDT team to make this notification during the care plan development or when the proposed care plan is subsequently presented to the participant and/or care giver for discussion, revision, and incorporation of the participant's preferences.

D. Contents of the Plan of Care

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. CMS expects all care plans to have these basic five components; however, experienced POs may design more sophisticated care plan models that incorporate these five basic components with other features such as long-term and short-term

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goals that enhance care management. Several examples of care plan formats are displayed below in Appendix A.

The staff responsible for conducting an intervention and monitoring the outcome may be an employed or contracted staff, but the IDT members are collectively responsible for implementing, coordinating, and monitoring the care plan. They should develop and implement the initial care plan by consensus within thirty (30) days of enrollment.

E. Differentiating Progress Notes and Care Plan Contents

The participant medical record is the single comprehensive record of care rendered to an individual participant. The medical record must be complete, accurate, readily accessible, systematically organized, and maintained and housed at the PACE Center where the participant receives services. Each participant record must contain all of the essential components listed in §460.210(b) including the eight IDT discipline-specific initial assessments and all reassessments, discipline-specific progress notes, and the participant's single plan of care.

1. Progress Notes

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 the 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 (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,

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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.

2. Plan of Care

By contrast, the PACE plan of care is the team's framework for managing the overall health status of each participant. The problems identified in the initial health risk assessment and the team'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 multidisciplinary 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. Defining what the organization considers a significant change in health status is an essential part of developing care plan policy and procedures. A full IDT reassessment of a significant change would not be required in a case where the patient's condition is expected to return to baseline within a short period of time such as one or two weeks. For example, a physician or mid-level practitioner treating and monitoring a participant for a minor skin infection would document care in the medical progress note. However, the clinician who is treating and monitoring the same participant for a facility-acquired methicillin-resistant

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Staphylococcus aureus (MRSA) would include this problem in the single care plan because management crosses disciplines, care settings, and requires team monitoring. A condition is defined as “self-limiting” when the condition will normally resolve without further intervention or implementation of standard disease-related clinical interventions. For example, a 5% weight loss for a patient with the flu would not normally meet the requirements for a “significant change in health status” reassessment. In general, a 5% weight loss may be an expected outcome for a participant who experienced nausea and diarrhea for a few days. In this situation, providers would monitor the participant’s status and attempt various interventions to rectify the immediate weight loss that they would document in progress notes. If the participant did not become dehydrated and started to gain weight after the symptoms subsided, a comprehensive reassessment or change in the care plan would not be warranted. The amount of time that would be appropriate for PACE providers to monitor a participant depends on the clinical situation and severity of symptoms experienced by the participant. Generally, if the condition has not resolved within approximately 2 weeks, IDT providers should begin a comprehensive reassessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the patient needs. However, it is essential that providers document their clinical decision-making in the progress notes to demonstrate evidence that the participant’s needs were identified and addressed according to the organization’s policy and procedures.

As PACE organizations develop care planning policy and procedures that unequivocally define what problems are incorporated in the single care plan verses 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 lability (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 multidisciplinary monitoring
- stable residential, social network, and caregiver support versus residential or psychosocial transitions requiring multidisciplinary monitoring

F. Monitoring Participant Health Status

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 status changes occur, the pertinent IDT members must reassess the participant within one week (i.e., five business days) 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 within one week (i.e.,

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five business days) 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

VI. Documentation of Plan of Care (§460.106)

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. 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.

VII. Periodic and Unscheduled Health Reassessments (§460.104)

A. Semiannual Reassessments

The IDT primary care physician, registered nurse, master’s level social worker, and activities coordinator must all minimally conduct periodic health reassessments on a semiannual basis. Other IDT members or specialty practitioners actively involved in the participant’s care plan should also conduct the semiannual reassessment. The pertinent practitioners conduct the reassessment in person and meet to consolidate the reassessment findings into the care plan within thirty (30) calendar days.

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 POC

B. Annual Reassessments

The physical therapist, occupational therapist, dietitian, and home care coordinator must all minimally conduct an annual reassessment in person. 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 annual reassessment must meet to consolidate the findings into the revised care plan within thirty (30) calendar days.

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 • Other team members actively involved in development or implementation of POC

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C. Unscheduled Reassessments

In addition to the semiannual and annual reassessments described above, two situations should trigger participant reassessment. First, if a participant experiences a significant change (as defined above in section 5) in health status, the eight IDT members (physician, registered nurse, master’s level social worker, physical therapist, occupational therapist, recreation coordinator, dietitian, and home care coordinator) must conduct an in-person reassessment and update the care plan within thirty (30) days. IDT members must not wait until the next scheduled reassessment to update the care plan since the care plan must accurately reflect the participant’s current status. Secondly, when a participant or caregiver requests a reassessment to verify the need to initiate, eliminate, or continue a particular service, the IDT members will determine the pertinent practitioners to conduct the in-person reassessment.

When a participant experiences a significant change in health status or requests a reassessment that results in comprehensive reassessments by required IDT members, the next semi-annual reassessment should be scheduled six months from the date of this unscheduled reassessment. Thus, any unscheduled reassessment essentially resets the timing of the subsequent semi-annual reassessment from the six-month anniversary of the last scheduled reassessment to the six-month anniversary of the unscheduled reassessment.

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

VIII. Plan of Care Revision (§460.106)

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.

IX. Plan of Care for Participants in Contracted Facilities

When a participant’s care needs cannot be accommodated in the PACE center clinic and the organization extends its care options by contracting providers to deliver specialized services, the IDT does not “hand off” the participant’s care - it expands the care team by collaborating with contracted specialists and placing participants in more appropriate healthcare settings to

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meet new needs. This concept is clearly supported by PACE regulations governing contracted services which require the PACE organization to maintain responsibility for the participant's care whether the care is delivered by the PACE organization or contractors. For example, when the PO solicits services by a contractor or contracted facility, it must specify in the contract that the contractor furnishes only those services authorized by the PACE IDT and agrees to be accountable to the PO [§460.70(d)(5)]. The implication for care planning is that the PO must implement, coordinate, and monitor the IDT-derived plan of care whether a contractor renders services in the PACE center, a community-based office/clinic, or in a contracted facility.

POs cannot be reticent about exerting their contractual and regulatory authority to actively engage in the care of PACE participants placed in contracted facilities. CMS expects the PO to establish a good working relationship with the contracted facility staff and develop a collaborative care plan that meets the participant's needs and facilitates both organizations to jointly manage care as an enhanced care team. Although the PACE care plan is developed collectively, it is the operational plan for the participant as the PO retains its authority and responsibility to guide care. Following the recommendations of contracted facility specialists is unequivocally appropriate, but not being involved in care decisions for all services falls short of the team's ultimate responsibility.

The expectation that the PO retains responsibility for the care plan when a participant is placed in a contracted care facility is not a negative reflection on the quality of services or competency of the contracted facility staff. The expertise of the contractor is established through the contracting process, and the mutual respect and professional collaboration between the PO and the contractor is cultivated by a close working relationship. The crux of the requirement is compliance with PACE regulations that require retention of authority by the PO over the 24-hour care of its participants.

Examples of care planning collaboration include regularly scheduled joint care planning meetings, periodic update calls (e.g., nurse-to-nurse, physician-to-physician, therapist-to-therapist conferences) or update reports that are transmitted over secured fax or e-mail lines, and joint team meetings for key risk areas such as wound care teams. These examples of standing communication mechanisms are particularly important when a fragile participant is receiving care in a contracted facility and changes in status are labile.

X. Documentation of Other Care (§460.210)

A PACE organization must maintain a single, comprehensive medical record for each participant in accordance with accepted professional standards. At a minimum, the medical record must contain the following documentation of all care and services rendered to the participant by employed and contracted providers and IDT members:

- Appropriate identifying information.
- Documentation of all services furnished, including the following:
 - A summary of emergency care and other inpatient or long-term care services.
 - Services furnished by employees of the PACE center.
 - Services furnished by contractors and their reports.
- Interdisciplinary assessments, reassessments, plans of care treatment, and progress notes that include the participant's response to treatment.
- Laboratory, radiological and other test reports.
- Medication records.
- Hospital discharge summaries, if applicable.

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- Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin).
- Enrollment Agreement.
- Physician orders
- Discharge summary and disenrollment justification, if applicable.
- Advance directives, if applicable.
- A signed release permitting disclosure of personal information.

Documentation of the care plan in the medical record must demonstrate the following items:

- Medical records must not only contain evidence that assessments were conducted (initial assessments, semiannual and annual reassessments, unscheduled reassessments for health status changes), but also clearly specify how care plans relate to assessment results
- How participants/caregivers are involved in the development of their own plan of care
- Collaboration among all disciplines and the participant/caregiver
- How the participant's concerns were addressed

X. Continuous Plan of Care Monitoring and Evaluation

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. Appendix B illustrates the PACE communication paradigm that begins with the identification of needs by the multiple discipline-specific assessments, converges to the IDT's/participant's consolidation of interventions in the care plan, and embraces the interaction of all providers involved in care delivery. Appendix C depicts how each component of the PACE care planning process interrelates in a continuous flow of assessment, intervention, evaluation, revised intervention, and reevaluation resulting in life-long comprehensive 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.

Appendix A – Sample Care Plan Formats

The sample care plan formats illustrated below are intended to depict the type of information required for an effective interdisciplinary team care plan that complies with the requirements outlined in Section §460.106 of the PACE Regulations. Acceptable care plan formats are widely available.

NOTE: These examples are not intended to be all inclusive, nor are the interventions and outcomes meant to be used as standard interventions and outcomes for the identified problems. CMS expects PACE organizations to use standardized health information abbreviations recommended by professional health information management associations and documented in local policy for care plan and medical record documentation.

Case Presentation for Sample Care Plan #1:

The participant is a 63 year old male having diagnoses of type II diabetes mellitus, peripheral vascular disease, chronic renal insufficiency, diabetic retinopathy, schizophrenia, and right lower extremity below-the-knee amputation. He has been on dialysis since 2007. The participant was recently diagnosed with severe major depression without suicidal ideation. His co-morbidities are stable and his diabetes satisfactorily controlled as indicated by an HgbA_{1c} of 5.1. His psychiatrist has added a second anti-depressant, Abilify, to his current regimen of fluoxetine because his depressive symptoms are unrelieved with monotherapy. The IDT team is concerned that Abilify may destabilize his diabetes. In Sample Care Plan Format #1, the care plan addresses the participant's potential for labile hyperglycemic blood levels due to the addition of a second anti-depressant agent that is known to raise blood sugar levels in some diabetics.

Sample Care Plan Format #1				
Problem: Participant is well-controlled for diabetes, but has depressive symptoms unresolved by fluoxetine regimen. The addition of the antidepressant Abilify puts participant at risk for diabetic instability.				Initiated 9-4-09.
Measurable Outcome	Intervention	Time Line	Staff Responsible	Measurable Outcome Met / Not Met
Maintain stable diabetic status with glycosylated hemoglobin (HgbA _{1c}) at 6.0 or below, and blood glucose < 110 mg/dl in the morning and <140 mg/dl in the evening	1. Monitor HgbA _{1c} levels	1. Monthly for 3 months, then quarterly for 3 months	1. Physician	Met as of 11-13-09: HgbA _{1c} drawn on 9-09 (5.1), 10-09 (5.2), and 11-09 (5.4). Next draw to be done in 2-10
	2. Instruct participant on self-monitoring blood glucose levels each morning and each evening. Reinforce as necessary.	2. At initial care plan visit and reinforce each month	2. Physician and Home Care Nurse	Met as of 11-13-09 – Participant educated 9-4-09 and reeducated 10-2-09 and 11-6-09. Continue at 12-09 visit.
	3. Reinforce importance of	3. At initial care plan	3. Home Care Nurse	Met as of 11-13-09 –

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	maintaining diet and not missing meals.	visit and reinforce each month		Participant educated about diabetic diet and regular meals on 9-4-09, 10-2-09, and 11-6-09. Continue at 12-09 visit.
	4. Monitor meal intake.	4. Monitor weekly for 6 weeks, then every two weeks for 2 months.	4. Home Care Nurse	Met as of 11-13-09 – See weekly food diaries filed in medical record. Continue random checks one week per month until 2-10 visit.
	5. Monitor blood glucose levels. Report blood glucose value > 130 in the morning and > 180 in the evening to physician	5. Monitor weekly for 6 weeks, then every two weeks for 2 months, then monthly for 3 months	5. Home Care Nurse	Met as of 11-13-09 – See blood glucose flow sheet filed in the medical record. Continue daily check until 2-10 visit.
	6. Instruct participant to report incidents of hyper/hypoglycemia by telephone to Home Care Nurse	6. At initial care plan visit and reinforce each month. Monitor weekly for 6 weeks, then every two weeks for 2 months.	6. Home Care Nurse	Met as of 11-13-09 – Instructed on signs & symptoms of hyper- / hypoglycemia on 9-4-09. Called weekly by Home Care Nurse to ask about symptoms – no abnormal glycemic symptoms reported. See Home Care Call Log and progress notes in medical record. Continue random calls one week per month until 2-10 visit.

Evaluation: Care plan reviewed 11-13-09. All measurable outcomes met during past quarter. Continue all interventions as noted above until next care plan review in 2-10.

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Sample Care Plan Format #2

Case Presentation for Sample Care Plan #2:

The participant is a 63 year old male having diagnoses of type II diabetes mellitus, peripheral vascular disease, chronic renal insufficiency, diabetic retinopathy, schizophrenia, and right lower extremity below-the-knee amputation. He has been on dialysis since 2007. The participant has recently been diagnosed with severe major depression without suicidal ideation. His co-morbidities are stable and his diabetes satisfactorily controlled as indicated by an HgbA_{1c} of 5.1. His psychiatrist has added a second anti-depressant, Abilify to his current regimen of fluoxetine because his depressive symptoms are unrelieved with monotherapy. The IDT team is concerned that Abilify may destabilize his diabetes. Sample care plan format #2 addresses the participant's recent diagnosis of depression and the lack of efficacy of a single anti-depressant agent.

Sample Care Plan Format #2					
Problem: Participant is on monotherapy for major depressive disorder, but is experiencing an acute exacerbation of depressive symptoms as evidenced by a score of 30 on the Beck Depression Scale-II (BDI-II) and IDT members' observations of disinterest in performing activities of daily living (ADLs), withdrawal from usual degree of social interaction, and less frequent contacts with his social support network.					Initiated 9-4-09.
Long-term Care Goal A	Intervention	Measurable Outcome	Time Line	Staff Responsible	Measurable Outcome Met / Not Met
Stabilization of Mental status	1. Psychiatric Consult	1. Complete consult and review/ recommendations. Incorporate into care plan as IDT deems appropriate.	1. Within 3 weeks (Note: Use clinical judgment to set exact date)	1. Physician	
	2. Abilify 2mg daily titrated upwards by 2 mg weekly to 10 mg	2. Participant complies with prescribed medication regimen as confirmed by verbal report and consumption of expected number of tablets.	2. Medication administered for 8 weeks	2. Physician	
	3. Evaluate for improvement and by retesting depression scores quarterly. Adjust Abilify as necessary after reassessment	3. Return of baseline affect, resumption of baseline ADLs, and resumption of baseline social interaction as evidenced by a rating of 13 or below on the BDI-II.	3.a. Evaluation of antidepressant medication efficacy within 2-4 weeks (Note: Use clinical judgment to set exact date)	3.a. Psychiatrist	
			3.b. Medical and medication evaluation within 2-3 months	3.b. Physician	

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			(Note: Use clinical judgment to set exact date)		
			3.c. Clinical visit every 2 weeks.	3.c. Psychiatric Nurse Practitioner	
			3.d. Baseline status achieved by March 2010.	3.d. Physician and Psychiatric Nurse Practitioner	
	4. Evaluate insomnia and adjust Trazadone as needed.	4. Baseline sleep pattern of 7 hours with 1 to 2 interruptions.	4. Monitor weekly for 6 weeks, then every two weeks for 2 months.	4.. Physician and Registered Nurse	
	5. Evaluate hygiene and grooming. Report deterioration to team.	5. Participant will maintain baseline status of good personal hygiene, clean clothing, and groomed hair and nails.	5. Weekly for 2 weeks, then every other week for 2 weeks, then monthly for 3 months.	5. Home Care Nurse and Social Worker	
	6. Provide individual counseling sessions	6. Return of baseline affect, resumption of baseline ADLs, and resumption of baseline social interaction as evidenced by a rating of 13 or below BDI-II.	6. Weekly for 6 weeks, then every other week for 8 weeks, then monthly for 3 months.	6. Psychiatric Nurse Practitioner	
Short-term Care Goal A.1	Intervention	Measurable Outcome	Time Line	Staff Responsible	Measurable Outcome Met / Not Met
Maintain good family support systems	Provide support and education on depression to sister.	Sister will be able to describe signs and symptoms of depression and at least 3 signs of improvement, lack of improvement, or regression. Sister will request additional support as needed.	Call sister weekly for 2 weeks, then every other week for 2 weeks, then monthly for 3 months.	Social Worker	

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Short-term Care Goal A.2	Intervention	Measurable Outcome	Time Line	Staff Responsible	Measurable Outcome Met / Not Met
Renew social interaction with acquaintances.	Encourage participant to interact with at least one friend.	Participant will resume monthly outing.	By October 30, 2009	Social Worker	
	Encourage participant to interact with 2 or more friends.	Participant will resume weekly small group card games	By Jan 30, 2010.	Recreational Therapist	
Evaluation:					

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Sample Care Plan #3

Case Presentation for Sample Care Plan #3

The participant is an 84 year old female having diagnoses of congestive heart failure and pneumonia who was hospitalized for one week. At the time of discharge, she was unable to resume her baseline ambulatory status due to her de-conditioned state. The care plan addresses the participant's ambulatory status.

Sample Care Plan Format #3					
Problem: Participant assessed in August 2009 to ambulate independently with a straight cane for a daily half-mile walk, but is now experiencing muscle weakness status-post hospitalization that limits her ambulation with a straight cane to less than 20 feet.					Initiated 10-4-09.
Care Goal	Intervention	Measurable Outcome	Time Line	Staff Responsible	Measurable Outcome Met / Not Met
Independent ambulation-300 feet with straight cane.	1.a. Progressive strengthening exercises to bilateral lower extremities 3X week in the clinic.	1. Increase strength from P+ to G+ on standardized strength scale.	1. 4 weeks	1.a Physical Therapist	
	1.b. Modified strength exercises to bilateral lower extremities daily in the home.			1.b. Home Health Aide	
	2.a. Ambulation training with rolling walker 3X week in the clinic.	2. Increase ambulation from 20 feet to 150 feet.	2. 6 weeks	2.a. Physical Therapist	
	2.b. Ambulation with rolling walker twice daily in the home			2.b. Home Health Aide	

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	3.a. Ambulation training with straight cane 2X week in the clinic	3. Increase ambulation with straight cane from 150 feet to 300 feet.	3. 6 weeks	3.a. Physical Therapist	
	3.b. Ambulation with straight cane twice daily in the home			3.b. Home Health Aide	
Evaluation:					

Appendix B
Care Plan Process Communication Paradigm

**Discipline-specific Assessment
and Care Planning**

**Interdisciplinary Team and
Participant / Caregiver
Consolidated Care Plan**

Medical Record

Direct Care Providers

Center Staff
(employed &
contracted)

Home
Environment
Staff
(employed &
contracted)

**Community-based
Contracted Staff**

- Skilled nursing facilities
- Home care services
- Dialysis facilities
- Transportation services
- Acute care facilities
- Residential facilities
- Medical specialists
- Rehabilitation facilities

Appendix C Care Planning Process Flow Chart

