INTERIM REPORT ON THE VARIETY AND MERITS OF CARE PLAN TEMPLATES AND REGULATIONS IN USE, INCLUDING IMPLICATIONS FOR INFORMATION TECHNOLOGY

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ALTARUM

SOLUTIONS THAT MATTER. HEALTH CARE THAT WORKS.

Table of Contents

Report on the Variety and Merits of Care Plan Templates

INTRODUCTION

Our scan of contemporary use of forms and formats for care plan documentation shows a wide variety of approaches, none of which use something close to the proposed eLTSS standards and all of which use substantial narrative elements. The most complete and up-to-date set of care plan records that we have yet seen is done longhand on a typewritten sheet by a single care coordinator responsible for over one hundred high-need patients seen at one hospital. None of it is digitized or analyzed in any way.

The electronic record systems that we reviewed have at best the minimal information needed for a C-CDA transmission—mostly limited to immediate and near-term needs. None so far record the caregiver role or identification, the prognosis, or the actual advance directive.

Some institutional rules have substantially adverse effects on the documentation of the care plan. In one care system, there really is a team to provide services for complicated and vulnerable elderly persons. They get together and formulate a care plan. But each clinical provider can document only the elements in their scope of work—and they must document the progress and changes to the plan. So, within a short time, the record has updates from a dozen service providers, often multiple times. Quickly, the care plan is some composite of all this writing, but no one brings it all back together except for the clinician(s) in the lead on this patient, who know all the changes, but can't write them down in a coherent way.

Mostly, though, really good multidisciplinary clinical teams know their patients and their situations well, but document only a skeletal summary. That summary generally includes diagnoses, basics of the living situation, medications, treatments, and supportive services in use or recommended. The various biases, regular and irregular omissions, and lack of long-term perspectives in this work are substantial, as summarized below.

CARE PLAN EXISTENCE

- In geriatric specialty care settings, comprehensive care plans (at least for current issues) are generally well-known to someone.
- But not necessarily to everyone on the team.
- Care plans are rarely documented well.
- Documentation includes many errors and omissions from the start.
- Documentation usually becomes out of date as changes are implemented piece-meal.
- Time horizon is variable and generally no more than a few months.

CARE PLANS AND PATIENTS

- Care plans are often profoundly shaped by the willingness of the elderly person or the caregiver to accept, or even to explore, personal priorities and the services that would help.
- Many difficult situations resulted from the patient/family choosing to stay with a hazardous plan until it failed.
- Sometimes, this was from denial or serious lack of understanding or lack of the ability to understand—but often, it was just hoping to keep going in the established way without having to deal with changes.

CARE PLANNING AND THE PROVIDER TEAM

- Care plans are also profoundly constrained by the awareness of the effective care team of the available resources. Whatever the team has learned to work, in whatever way they have learned it, is what they offer.
- Occasionally, a solution is creative and novel, but mostly what's offered is what has worked in the past and what is believed to be available.
- Care teams claim to wish they had up-to-date and readily available access to the array of possible services, but they do not consult with the sources that they now have available (such as AAA for clinicians, or PCP for social services providers).

ELEMENTS OFTEN KNOWN BUT NOT DOCUMENTED

- Highly charged interpersonal issues—adverse family dynamics, assessment of dysfunctional personality (elder or family or caregiver) (usually well-known in the team—but delicately documented), suspicion of abuse or neglect.
- Spiritual issues (only sometimes known).
- Explicit prognoses—for survival or function or both—really rarely mentioned unless the patient has an aggressive cancer or is a candidate for hospice—otherwise rarely brought up in case presentation or documented in the record.
- Housing and support system when not traditional family—usually well known in the team but not documented (couch surfing, living in a car, sleeping on the couch or recliner, etc.).
- Errors and other elements that might precipitate legal liability.

ELEMENTS NOT KNOWN OR DOCUMENTED BUT QUICKLY ARISING IN DISCUSSION

- What services would make the situation better but are not available (or are perceived to be unavailable).

- What back-up is needed for an unplanned urgent situation.
- Focus is on health care services available in the particular patient's insurance plan or by having come to a particular hospital—however, teams can split availability of many supportive services by geography.

ELEMENTS THAT RESPONDENTS FIND PERPLEXING

- What information is needed by a community entity that takes responsibility for monitoring and improving the local service supply system.
- Could there BE such an entity that takes on leadership in monitoring and improving.
- But clinicians appear to be willing to report shortcomings in service quality or supply IF there were a responsive entity trying to match the needs.

Technical Report on Information Technology Standards for Care Plans

Les Morgan

INTRODUCTION

This document summarizes our preliminary research into Information Technology (IT) issues related to the variety and merits of care plan templates. In IT terminology, the word *templates* is best understood to refer to *standardized record formats* and associated *content standards* for data. This report will mainly focus on such standardized record formats and content standards, but will briefly touch on other issues that affect the overall usability of such data in clinical settings.

The scope of the review is bounded by a basic question: What is a "care plan" and how does that concept differ from a "shared care plan", a "clinical record", an "episode of care", a "transition of care", or other terms, which all may require access to some or all the information that could inform a "care plan" in an individual provider setting? For purposes of this review we will focus on what is needed for development of a *shared care plan*, which requires the exchange of confidential client information across providers.[1, 2]

In addition to care plan standards *per se*, any exchange of such data must comply with telecommunications standards, HIPAA[3], FERPA[4], 42 CFR Part 2[5] , 42 CFR Part 483 Subpart B[6], and 45 CFR Parts 160-164[7] requirements. Additional standards for vocabulary and content are needed so information that is exchanged can be semantically intelligible between communicating parties. There must also me some way to correctly match patient data with the right person, leading to a need for

[1] For a helpful review of the issues in creating a shared care plan, see: Vermont Health Care Innovation Project. *Shared Care Plans & Universal Transport Protocol: Final Report*. (May 2016), p. 3. URL checked 15 October 2017: http://healthcareinnovation.vermont.gov/content/shared-care-plans-universal-transfer-protocol-final-report-may-2016

[2] For an environmental scan of shared care planning processes and approaches see the presentation by Annette Dabbs to the HL7 LHS Workgroup. Her research is informing the development of the HL7 FHIR Care Team Resource. URL checked 17 October 2017: http://wiki.hl7.org/index.php?title=2017-10-06_Learning_Health_Systems_Call

[3] HIPAA (Health Insurance Portability and Accountability Act of 1996) is a United States Federal law that provides data privacy and security provisions for safeguarding medical information.

[4] FERPA (Family Educational Rights and Privacy Act of 1974) is a United States federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

[5] 42 CFR Part 2 refers to the Confidentiality of Substance Use Disorder Patient Records. It applies to records of Federally funded drug and alcohol abuse treatment. See: https://www.law.cornell.edu/cfr/text/42/part-2 (URL checked 12 October 2017).

[6] 42 CFR Part 483 Subpart B refers to Medicare and Medicaid Nursing Home Regulations, covering personal and clinical records of a person admitted to a nursing home.

[7] 45 CFR Parts 160-164 refer to General Administrative Requirements.

standards for personal identifiers. With multiple providers involved, issues of care plan governance, responsibility for data accuracy and currency, and clear rules about how data can be modified are essential, enforced by appropriate legal agreements.

Consent forms, with some means of revoking such consent, also must be exchanged in addition to "care plan data". Many other types of records may need to be linked to the same patient case file, but standards for those ancillary data types are not part of this report. Examples of such ancillary records include detailed medical reports, lab reports, medication summaries, etc., all of which have their own IT standards that are distinct from "care plans".

It is important to keep in mind that standards for structured information are helpful for capturing clinical data but have limited ability to capture non-clinical and non-codifiable patient identified data. The importance of free text in care planning is clear from our clinical interviews. Methods for mining free text that permit extraction of structured data are developing, but their actual use in clinical settings is in its infancy.

The following acronyms are used frequently when discussing IT standards and are defined here for the convenience of the reader:

- HL7: An international not-for-profit Standards Development Organization (SDO).
- ONC or ONC IT (The Office of the National Coordinator for Health Information Technology): A staff division of the Office of the Secretary, within the U.S. Department of Health and Human Services. ONC is responsible for certification of health information technology in the United States.
- CDA (Clinical Document Architecture): Released in 1999. Clinical summary documents are based on this architecture.
- CCR (Continuity of Care Record): Released in 2004. This record contains patient summary information.
- CCD (Continuity of Care Document): Released in 2007. This is an interoperability solution that resulted as a combination of CDA and CCR.
- CCDA or C-CDA (Consolidated Clinical Document Architecture): Released in 2011. This is the most recent consolidation of CCD document templates.
- FHIR (Fast Healthcare Interoperability Resources, pronounced "fire"): The latest standard to be developed under the HL7 organization.[8]

MAJOR DRIVERS OF CARE PLAN STANDARDIZATION

The widespread use of Electronic Health Records (EHRs) has been accelerated by CMS and ONC rules that specify data collection and exchange requirements for providers that are covered by those regulations.

[8] FHIR Release 3 (STU). FHIR Overview. URL checked 17 October 2017: https://www.hl7.org/fhir/overview.html

- Under the ONC IT HIT Certification Program, complete EHR systems and EHR modules must have specific capabilities and functions to be certified.[9] Certification requirements are complex and change over time. The Certified Health IT Product List is a database that can be searched to determine certification status for specific Vendor systems.[10]
- Within CMS, the Medicare and Medicaid EHR Incentive Programs Stage 2 outlined both incentive payments for early adoption, and negative payment adjustments (disincentives) for late adoption or non-compliance.[11, 12] The Medicare EHR Incentive Program for returning eligible professionals (EPs) ended with the 2016 reporting period. Starting in 2017, Medicare eligible clinicians now report to the Quality Payment Program.[13] which offers tracks for Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). These programs mandate the use of a certified EHR system, but regulations recognize that implementation levels vary, offering a system of graduated incentives for use of the most current technology.

SPECIFIC CARE PLAN DATA STANDARDS

There are many care plan standards available. Most of are derived from the two base content standards: C-CDA and FHIR. These standards have a modular character that allows system designers to implement specific classes of data structures that work together as part of a family of standards called the HL7 Clinical Document Architecture (CDA). HL7 is an international not-for-profit Standards Development Organization (SDO) whose mission is to provide a comprehensive framework for the exchange and management of health information. Its members include most of the major IT vendors providing solutions to the healthcare sector. Compliance with HL7 standards is essential to business success for many of these vendors. CDA is a base standard which provides a common architecture, coding, semantic framework, and markup language for the creation of electronic clinical records of many types. CDA was developed to address the specific problem of "standards proliferation", in which multiple SDOs (HL7, IHE, HITSP, etc.) were developing multiple and diverging approaches for template requirements, making interoperability more difficult. HL7 has established a Care Plan Model.[14]

In the United States, ONC IT encourages providers and vendors to implement clinical documents that meet both Meaningful Use (MU)[15] and C-CDA data requirements, but recognizes that MU standards

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[9] Reference: *ONC Health Information Technology : Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition*; Revisions to the Permanent Certification Program for Health Information Technology Final Rule 170.314.

[10] *Certified Health IT Product List*. URL checked 17 October 2017: https://chpl.healthit.gov/#/search

[11] Reference: CMS Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2 Final Rule 495.6.

[12] Centers for Medicare and Medicaid Services. *Electronic Health Records (EHR) Incentive Programs*. URL checked 17 October 2017: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

[13] Quality Payment Program. URL checked 17 October 2017: https://qpp.cms.gov/

[14] For the HL7 Care Plan Model see: *HL7: Care Plan*. URL checked 15 October 2017: http://wiki.hl7.org/index.php?title=Care_Plan; and: FHIR Release 3: 9.5 Resource CarePlan. URL checked 15 October 2017: https://www.hl7.org/fhir/careplan.html

[15] The term "Meaningful Use" has been superceded by newer regulations, but is used here because it still appears in much documentation.

should be a floor on electronic capability, not a ceiling. The basic ONC IT guidance is that providers should begin by choosing the C-CDA templates that best fit their workflow, then add whatever additional CDA components may be needed to meet MU requirements. Systems may choose to implement whatever CDA data types they need to meet specific business needs. Adopting more than just the minimum MU standards can be a source of competitive advantage for providers and vendors that are early adopters.

ONC IT EHR CERTIFICATION CRITERIA

Most of the technical requirements now in effect for care plans in the United States refer to a version of the ONC IT *EHR Certification Criteria*, which are updated regularly. The *2014 Edition EHR Certification Criteria*, Categories & Criteria section, placed emphasis on standards for Care Coordination [§ 170.314(b)[16, 17]] and Patient Engagement [§ 170.314(e)[18]]. Criteria for meeting these standards include four basic information types:[19]

Transition of Care 170.314(b)(1)&(2)

- When transitioning a patient to another care setting, the provider should transmit a summary care record
- Record Type: Transition of Care/Referral Summary

Data Portability 170.314(b)(7)

- When a patient transitions from provider or setting to another, a medication reconciliation should be preformed
- Record Type: Export Summary

View/Download/Transmit 170.314(e)(1)

- Patients must be able to view & download their own medical info & also be able to transmit that info to a 3rd party
- Record Type: Ambulatory or Inpatient Summary

Clinical Summary 170.314(e)(2)

- Provide clinical summaries for patients for each office visit
- Record Type: Clinical Summary

[16] URL checked 19 October 2017: https://www.healthit.gov/sites/default/files/170.314(b)(2)ToC_CreateandTransmit_2014_TP-v1.5.pdf

[17] URL checked 19 October 2017: https://www.healthit.gov/sites/default/files/170.314(b)(1)Receive_Display_Incorporate_2014_TP-v1.5.pdf

[18] URL checked 19 October 2017: https://www.healthit.gov/sites/default/files/170.314e1vdt_2014_tp_approved_v1.4_onc.pdf

[19] This summary table is adapted from: *Implementing Consolidated-Clinical Document Architecture (C-CDA) for Meaningful Use Stage 2*. ONC Implementation and Testing Division April 5, 2013. URL checked 15 October 2017: https://www.healthit.gov/sites/default/files/c-cda_and_meaningfulusecertification.pdf

The common MU dataset that is required by the ONC IT *2014 Edition Certification Guide* includes some data elements that refer to a care plan, but they are high-level summaries, not a detailed care plan record structure. The data elements called "Care Plan" and "Care Team Members" are part of the Transition of Care: Care Coordination 170.314(b) record type.

None of these standardized data records in the 2014 certification standard is equivalent to what would be considered a "care plan" for purposes of our study. However, the drive to get these standardized data records into operational use—and shared between systems—addressed some of the most urgent felt needs of medical providers. Since adoption of innovative technology takes time, money, and a great deal of effort, these four types of standardized data record still are not fully-implemented in all care settings, but they have become the baseline standards for exchange of electronic medical data in the United States.

The ONC IT *2015 Edition Certification Guide* (required Release 2.1) includes a standardized Care Plan document template [§170.315(b)(9) Care Plan].[20] In that template, the user must record care plan information that includes the following:

- Patient Name
- Goals
- Health Concerns
- Health Status Evaluations and Outcomes, and
- Interventions

ONC IT Care Plan Listening Sessions conducted with 12 EHR Vendors in May 2017 found that:

- All vendors have implemented HL7 C-CDA based document templates, but the majority are using the older Release 1.1 instead of ONC IT 2015 required Release 2.1 which includes a standardized Care Plan document template [§170.315(b)(9) Care Plan].
- The HL7 C-CDA Care Plan document is considered a starting point for effective care planning but remains limited in robustness of data elements for longitudinal and holistic care and ability to support emerging extended care team models.
- HL7 C-CDA and FHIR Care Plan standards need to be further harmonized to enable systems that use one type to communicate with other systems using another type.
- New CMS Medicare and Medicaid programs such as CPC+, APM, and longitudinal care management payment codes such as Medicare Chronic Care Management are driving care plan technology development and adoption.

PILOT PROGRAMS DEMONSTRATING STANDARDS

Two noteworthy pilot projects illustrate how existing C-CDA and FHIR standards can be used in practical settings.

[20] 2015 Edition §170.315(b)(9) Care Plan. URL checked 16 October 2017: https://www.healthit.gov/sites/default/files/170_315b9_care_plan_v1_0_1.pdf

Greater New York Hospital Association (GNYHA) Delivery System Reform Incentive Program (DSRIP) electronic Care Plan & Learning Collaborative[21]

- DSRIP was initiated in 2015 to support continued health systems transformation between performing provider systems (PPS) (including primary care, Emergency Departments, hospitals, community based organizations and behavioral health organizations) and quality entities (QE) in the greater New York area serving the State's Medicaid population.
- Participating entities are implementing care plan governance and workflow guidelines and piloting deployment of the C-CDA Care Plan Document template (standard) across multiple organizations to support the capture and exchange of care plans.

Pharmacist eCare Plan[22, 23]

- Community Care of North Carolina (CCNC) together with the North Carolina Community Pharmacy Enhanced Services Network (CPESN) are testing and implementing an electronic pharmacy care plan—a shared document detailing a patient's current medication regimen and health concerns, pharmacy interventions and the patient's health outcomes over time. To date, CCNC has received over 2,000 e-Care Plans from participating entities.
- The Pharmacy eCare Plan is designed using both C-CDA and FHIR Care Plan standards.

SPECIALIZED CARE PLAN REQUIREMENTS

Some care plan requirements apply in specific domains. This summary notes some examples briefly.

Chronic Care Management

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.[24] In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions. Some CCM payment codes cover the development and ongoing use of a care plan.

- CCM CPT 99490 “Chronic care management services” includes a requirement that a comprehensive care plan be established, implemented, revised, or monitored.
- Complex CCM CPT 99487 “Complex chronic care management services” includes a requirement for establishment or substantial revision of a comprehensive care plan. The supplemental Complex CCM CPT 99489 can be charged for each additional 30 minutes of time.

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[21] URL checked 16 October 2017: http://www.gnyha.org/whatwedo/finance-insurance-gme/nys-finance-issues/dsrip

[22] URL checked 16 October 2017: http://www.pharmacyhomeproject.com/the-project/cpesn/ecare-plan

[23] URL checked 16 October 2017: https://www.healthit.gov/techlab/ipg/node/4/submission/1376

[24] For details on CPT codes and other general information see: Department of Health and Human Services, Centers for Medicare & Medicaid Services. Chronic Care Management Services. URL checked 17 October 2017: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

The CCM concept of a Comprehensive Care Plan is "A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed)". Providers must give the patient and/or caregiver a copy of the care plan, and must ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care. Details of how these things are done will depend on the features of the certified EHR used by the provider.

Technical requirements for these care plans are addressed under "Structured Recording of Patient Health Information", which directs that recording of the patient's demographics, problems, medications, and medication allergies be done using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year.

Comprehensive Primary Care Plus (CPC+)

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.[25] CPC+ seeks to improve quality, access, and efficiency of primary care. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States.

Participation in the CPC+ model includes detailed specifications for IT systems, including technical requirements for establishing a patient focused care plan to guide care management.[26] To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9), within the first two years of the program.

To support Track 2 practices, health IT Vendors must provide the Centers for Medicare & Medicaid Services (CMS) with Letter(s) of Support [LOS(s)] and sign a Memorandum of Understanding (MOU). CMS provides a list of vendors who have voluntarily submitted information, but inclusion in that document does not confirm that a specific Vendor's products will meet the CPC+ health IT requirements.[27]

Nursing Homes

CMS has released the interpretative guidelines (IG) for new regulations that will be effective for Nursing Home surveys after Nov 28, 2017. A new requirement concerns the baseline care plan which

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[25] *Comprehensive Primary Care Plus*. URL checked 17 October 2017: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

[26] *CPC+ Certified Health IT Requirements (REVISED)*. URL checked 17 October 2017: https://innovation.cms.gov/Files/x/cpcplus-hit-track2reqs.pdf

[27] *Health IT Vendors in CPC+*. URL checked 17 October 2017: https://innovation.cms.gov/Files/x/cpcplus-hittracker.pdf

must be developed and implemented within 48 hours of admission.[28] The baseline care plan serves until a comprehensive care plan is developed. The format and location of the baseline care plan are at the facility's discretion. Specific content is described in the regulatory language.

Skilled Nursing Facilities (SNF)

By law, SNFs must develop a plan of care (care plan) for each resident.[29, 30, 31] A 2013 report by the Inspector General found that Skilled Nursing Facilities often fail to meet care planning and discharge requirements.[32]

HCPCS

Patients that require complex and multidisciplinary care modalities under care of home health agencies or hospices must have care plans involving regular physician review. HCPCS codes G0181 (home health) and G0182 (hospice) cover these care planning functions.[33] Content and documentation for the plan of care is discussed in the regulations.

PACE

Programs of All-Inclusive Care for the Elderly (PACE) are required to have care plans for all participants. Contents of the care plan are specified in section 30.6 of the regulations, which read as follows:[34]

"30.6 - Contents of the Care Plan. 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

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[28] Judy Wilhide. *Discussion of the Interpretative Guidelines for F655, Baseline Care Plan*. July 26, 2017. URL checked 17 October 2017: https://www.leadingage.org/regulation/discussion-interpretative-guidelines-f655-baseline-care-plan

[29] Centers for Medicare and Medicaid Services. *Medicare Coverage of Skilled Nursing Facility Care*. URL checked 16 October 2017: https://www.medicare.gov/Pubs/pdf/10153.pdf

[30] *Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance*. Section 30.2.3.1 - Management and Evaluation of a Patient Care Plan. URL checked 17 October 2017: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf

[31] *What's a care plan in skilled nursing facilities?* URL checked 17 October 2017: https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-snf.html

[32] Department of Health and Human Services. Office of the Inspector General. *Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Requirements*. OEI-02-09-00201. February, 2013. URL checked 17 October 2017: https://oig.hhs.gov/oei/reports/oei-02-09-00201.pdf

[33] CMS Manual System. Pub 100-04 Medicare Claims Processing. July 14, 2006. URL checked 17 October 2017: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R999CP.pdf

[34] Programs of All-Inclusive Care for the Elderly (PACE). *Chapter 8 – IDT, Assessment & Care Planning* (Rev. 2, Issued: 06-09-11). URL checked 17 October 2017: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c08.pdf

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."

ONC IT 2017 INTEROPERABILITY STANDARDS ADVISORY

Adoption of better care plan structures has been identified by ONC IT as an important interoperability need in its 2017 Interoperability Standards Advisory.[35] In the 2017 Advisory, three distinct types of care plan were highlighted for attention, each with an analysis of current standards, adoption rates, and key issues.

1. Interoperability Need: Documenting and Sharing Care Plans for a Single Clinical Context

This data type is Federally required, and adoption levels are good, but ONC IT noted the following Limitations, Dependencies, and Preconditions for Consideration regarding the Care Plan data type for a single clinical context:

"The care plan as expressed in the C-CDA standard does not attempt to represent the longitudinal care plan; rather it represents a "snapshot" of a care plan at a single point in time for transmission to other providers and teams to ensure continuity of care. The Care Plan Domain Analysis Model is used as a reference model for C-CDA care plan documents in the context of the longitudinal care plan." (page 32).

2. Interoperability Need: Domain or Disease-Specific Care Plan Standards

This data type is not Federally required and adoption levels are poor.

3. Interoperability Need: Sharing Patient Care Plans for Multiple Clinical Contexts

This data type is not Federally required and adoption levels are poor. The emerging standard is the HL7 Fast Healthcare Interoperability Resources (FHIR), DSTU 2.[36] The emerging implementation specification is IHE Dynamic Care Planning (DCP), Rev 1.1 Trial Implementation.[37]

EMERGING TRENDS: INTEGRATION OF HEALTH DATA WITH SOCIAL SERVICE DATA

ONC IT Care Plan Listening Sessions found that EHR Vendors see tremendous value in capturing social and behavioral determinants of health in care plans but are not yet doing so in a structured or standardized way. Several non-EHR Vendors have come forward into that market space, providing

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[35] Office of the National Coordinator for Health IT. *2017 Interoperability Standards Advisory: Care Plan (Section II-B)*. URL checked 15 October 2017: https://www.healthit.gov/sites/default/files/2017_isa_reference_edition-final.pdf

[36] FHIR, DSTU-2. URL checked 15 October 2017: https://www.hl7.org/fhir/DSTU2/

[37] *IHE Patient Care Coordination Technical Framework Supplement: Dynamic Care Planning (DCP)*. URL checked 15 October 2017: http://www.ihe.net/WorkArea/DownloadAsset.aspx?id=1535

systems that are designed specifically for social service, mental health, and substance abuse treatment providers to handle specialized care coordination needs.

The growing interest in social determinants of health, and integration of health care data with social service data, may result in the emergence of hybridized systems that attempt to reach across multiple care domains in ways we have not yet seen. The cost driver for such systems, in at least some cases, will be an attempt to manage the special needs of at-risk patients who require multiple types of support—a requirement that is like the needs of frail elders who are living with increasing levels of disability. Some of the community-based initiatives that are now being launched may provide useful paradigms and systems that can be adapted to the needs of elders, even if that is not part of their current focus. Two important initiatives highlight these trends: the Accountable Health Communities (AHC) model and the eLTSS Initiative.

Accountable Health Communities (AHC) Model

In 2016, the Centers for Medicare & Medicaid Services (CMS) released a Funding Opportunity Announcement (FOA) for applications for the Center for Medicare and Medicaid Innovation's (Innovation Center) Accountable Health Communities (AHC) model. Over a five-year period, CMS will implement and test the three-track AHC model to support local communities in addressing the health-related social needs of Medicare and Medicaid beneficiaries by bridging the gap between clinical and community service providers. Social needs include housing instability, food insecurity, utility needs, interpersonal violence and transportation.

In April 2017, CMS' Accountable Health Communities Model selected 32 participants to serve as local "hubs" linking clinical and community services.[38] To be successful, these hubs will need advanced care coordination systems that can span a wide range of provider types. Here are two examples of how AHC bridge organizations will operate:

- In the AHC Assistance Track, Community Health Network Foundation in Indianapolis will partner with the Eastside Redevelopment Committee, an organization representing 50 businesses and community-based organizations focused on improving health through high-quality support services, educational programs, and workforce development. Together, they will serve residents of East Indianapolis, a community where 40% of the population received Indiana Medicaid services in 2015 and the emergency room utilization rate was above the national average. Through their participation in the AHC Assistance Track, they hope to reduce health care costs for high-risk beneficiaries who receive navigation services.
- In the AHC Alignment Track, the Oregon Health & Science University (OHSU) will seek to reduce healthcare utilization and cost to beneficiaries across nine rural counties in Oregon by working with over 50 clinical sites, community service providers, and local health departments. In Oregon, the AHC model is targeting over 300,000 Medicare and Medicaid beneficiaries. OHSU will coordinate the model activities through the Oregon Rural Practice-

[38] *CMS' Accountable Health Communities Model selects 32 participants to serve as local 'hubs' linking clinical and community services*. URL checked 16 October 2017: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-04-06.html

based Research Network, a statewide network of primary care clinicians, community partners, and academicians dedicated to studying the delivery of health care to rural residents and to reducing rural health disparities.

eLTSS Initiative

The electronic Long-Term Services & Supports (eLTSS) Initiative is an ONC IT-CMS partnership that is focused on identifying and harmonizing electronic standards that can enable the creation, exchange and re-use of interoperable service plans for use by health care and community-based long-term services and supports providers, payers and the individuals they serve.[39] These plans can help to improve the coordination of health and social services that support an individual's mental and physical health. This initiative is driven by the requirements of the CMS Testing Experience and Functional Tools (TEFT) in community-based long-term services and supports (CB-LTSS) Planning and Demonstration Grant Program created in the Affordable Care Act (ACA).

The eLTSS Initiative published the final eLTSS Dataset in September 2017. It includes both core and non-core data elements. This dataset was developed and vetted through two rounds of piloting, harmonization, and disposition activities. The eLTSS dataset has not yet been adopted as a standard, but is continuing to move through the standards process. Additional technical standards (including vocabulary, terminology, and content standards) still need to be identified to support the interoperable electronic capture and exchange of the eLTSS dataset. That effort is being led by the TEFT grantee in the state of Georgia as the next phase of the eLTSS Initiative.

[39] Much of the material in this section is drawn from: *ONC Tech Lab Standards Coordination Home: eLTSS Home*. URL checked 16 October 2016: https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home

Appendix A: Results of ONC IT Care Plan Listening Sessions (May 2017)

[The following summary is adapted from material provided by ONC IT]

In May of 2017, ONC IT conducted a series of four care plan listening sessions with12 different technology solution providers. Each vendor was asked to present on their electronic care planning capabilities and participate in an open discussion with other participants and ONC IT staff. The sessions provided valuable insight into the state of electronic care plan capture, exchange and sharing and use of health IT standards. Key takeaways from the four sessions were:

Care plan ownership and management varies depending on the type of care team engaged and the care setting

Care plan is not physician driven; physicians are interested in parts of the care plan and are dependent on broader care team to manage care plan

Majority of vendors are “learning” alongside their clients on how best to implement electronic care planning

New CMS Medicare and Medicaid Innovation programs such as CPC+ and longitudinal care management payment codes such as Medicare Chronic Care Management are driving care plan technology development and adoption

Standards are helpful for capturing clinical data but limit ability to capture non-clinical and non-codifiable patient identified data

All vendors have implemented HL7 C-CDA based document templates with majority using Release 1.1 instead of ONC IT 2015 required Release 2.1 which includes standardized Care Plan document template

The HL7 C-CDA Care Plan document is considered a starting point for effective care planning but remains limited in robustness of data elements for longitudinal and holistic care and ability to support emerging extended care team models

HL7 C-CDA and FHIR Care Plan standards need to be further harmonized to enable systems that use one type to communicate with other systems using another type

Vendors see tremendous value in capturing social and behavioral determinants of health in care plans but are not yet doing so in a structured or standardized way

Appendix B: Chronic Care Management Regulations

Chronic Care Management (CCM) Services (Medicare Learning Network Dec 2016)

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare beneficiaries with multiple chronic conditions: CPT 99490 - 20 minutes of clinical staff time per calendar month, provided under the supervision of a physician or other QHCP (qualified health care professional). Recognizing there were Medicare beneficiaries of increased complexity requiring more than 20 minutes of clinical staff time, beginning in 2017 CCM services were expanded to include: CPT 99487 - 60 minutes of clinical staff time per calendar month; and CPT 99489 – each additional 30 minutes per calendar month.

A care plan is among the required elements to bill Medicare for CCM services includes:

- The creation, revision, and/or monitoring of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports – for all health issues with particular focus on the chronic conditions being managed.
- Must at least electronically capture care plan information, with timely availability of care plan information to individuals involved in the patient's care within and outside the billing practice as appropriate. Electronic care plan sharing can include by fax.
- A copy of the plan of care must be given to the patient and/or caregiver.

A comprehensive care plan for all health issues is felt to typically include, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

Appendix C: Hospice Regulations

Regulations for Medicare payment for hospice services includes completion of a "plan of care" and supporting documentation – regulations outlined below. In this case I got the details from the book for surveyors for hospice accreditation.

Hospice: Survey & Certification - Guidance to Laws & Regulations (CMS

This page provides basic information about being certified as a Medicare and/or Medicaid hospice provider and includes links to applicable laws, regulations, and compliance information.

Survey & Certification - Guidance to Laws & Regulations

State Operations Manual: Appendix M - Guidance to Surveyors: Hospice

§418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services

From Clinical Record Review: Review the plan of care to identify whether the IDG used the comprehensive assessment and assessment updates to make sound care planning decisions appropriate to the patient/family needs. (p14)

Attending physicians can often provide a history of the patient's disease process and family dynamics that can help the hospice make better care planning decisions that address all areas of need related to the terminal illness and related conditions, resulting in improved patient outcomes. (p40)

L526 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.54(c)(2) - **Complications and risk factors that affect care planning**. (p42)

L529 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.54(c)(5) - Severity of symptoms. Procedures and Probes §418.54(c)(1) - (5) Ask clinical staff to describe how they obtain all relevant information necessary to complete the comprehensive assessment. Is there evidence in the clinical record and during home visits that the reasons for admission, complications and risk factors **that could affect care planning**, functional status, imminence of death, and symptom severity have been identified and are being addressed? (p42)

L533 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.54(d) Standard: Update of the comprehensive assessment … Hospices are free to choose their own method for documenting updates to the assessment. The hospice should evaluate and document the patient's response to the care, treatment and services provided, and progress toward desired outcomes. The purpose of updating the assessment is to ensure that the hospice IDG has the most recent accurate information about the patient/**family in order to make accurate care planning decisions**. Assessment updates should be easily identified in the clinical record … (p46)

L535 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.54(e)(2). Interview key staff and have them explain the hospice's system of documentation and retrieval of patient specific data elements. Ask to see a copy of the data elements that comprise the hospice's comprehensive assessment. Have the hospice explain how they **use these data elements in care planning**, coordination of services and in their quality assessment and performance improvement (QAPI) program. (p47-48)

L536 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services. (p48)

L541 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(a)(1) - Determine through interview, observation and record review that all disciplines comprising the IDG contribute to the patient's comprehensive and ongoing assessments and **care planning process**. (p51)

Procedures and Probes §418.58 … Focus on areas such as how and why the hospice chose its quality measures, how it ensures consistent data collection**, how it uses data in patient care planning**, and how it aggregates and analyzes data. … (p60-61)

L762 (Rev. 104, Issued: 03-07-14, Effective: 03-07-14, Implementation: 03-07-14) §418.112(b) Standard: Professional management … Hospice is responsible for providing all hospice services including: • Ongoing assessment, care planning, monitoring, coordination, and provision of care by the Hospice IDG … (p155

L779 (Rev. 104, Issued: 03-07-14, Effective: 03-07-14, Implementation: 03-07-14) … Procedures and Probes §418.112(e)(1)(ii) … If there are problems identified regarding failure to communicate with facility staff, interview the hospice designated IDG member, and the **facility care plan coordinator** for the patient, in order to determine: … (p164-165)

§418.56(c) Standard: Content of the Plan of Care

§418.56(d) Standard: Review of the Plan of Care

§418.112(d) Standard: Hospice Plan of Care

A – Patient Care - Is there evidence during the survey that: … The hospice involves the patient and/or family in developing the **plan of care**. (Interviews with staff, patients and family can be helpful in determining how the hospice involves patient/families in developing the plan of care.) (p12)

2. Clinical Record Review … Determine if the **plan of care** is current and reflects the participation of all members of the IDG. (p14) … Review a sample of clinical notations by all personnel providing services. Determine if the **plan of care** and frequency of visits by hospice personnel support the findings of the comprehensive assessment and updates to the assessment. Did the agency's interventions follow the plan of care? Was the documentation specific to changes in the patient/family's status? (p14-15)

D - Hospice Home Visit Procedures … Implements the plan of care; (p15)

3 - Visit Procedure … Request a copy of the most recent plan of care for each patient selected for a home visit. (p17)

E - Follow-Up Procedures … Check any specific patient/family complaints concerning the hospice's delivery of items and services with the hospice to be sure that there are no misunderstandings and that the patient's plan of care is being followed. (p19) … If hospice deficiencies are identified as a result of a home visit and/or clinical record review … deficiencies could include, but are not limited to: … Failure to develop and implement a plan of care that meets the needs identified in the initial or comprehensive assessment; (p19)

L513 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.52 (c)(2) - Be involved in developing his or her hospice plan of care; (p35)

L521 §418.54 - The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related

conditions. … The comprehensive patient assessment must accurately reflect the patient's current health status and **include information to establish and monitor a plan of care**. (p38)

L522 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.54(a) Standard: Initial assessment … The purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs. … The initial assessment is necessary to gather the essential information necessary to begin the plan of care and provide the immediate necessary care and services. (p39)

L543 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(b) Standard: Plan of care. All hospice care and services furnished to patients and their **families must follow an individualized written plan of care** established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. (p51)

L545 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(c) Standard: **Content of the plan of care.** The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Procedures and Probes §418.56(c) • Determine through interview/observation and record review if the plan of care identifies all the services needed to address problems identified in the initial, comprehensive and updated assessments. • Is there evidence of patients receiving the medication/treatments ordered? • Are plans of care individualized and patient-specific? • Does the plan of care integrate changes based on assessment findings? • Is there documentation to support that the development of the plan of care was a collaborative effort involving all members of the IDG and the attending physician, if any? The attending physician and the IDG members do not have to sign the plan of care but there must be documentation of their involvement. (p52)

L548 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(c)(3) - **Measurable outcomes anticipated from implementing and coordinating the plan of care**. The outcomes should be a measurable result of the implementation of the plan of care. The hospice should be using data elements as a part of the plan of care to see if they are meeting the goals of care. Are the outcomes documented and measurable? Look for movement towards the expected outcome(s) and revisions to the plan of care that have been made to achieve the outcomes. (p55)

L551 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(c)(6) - The interdisciplinary group's documentation of the **patient's or representative's level of understanding, involvement, and agreement with the plan of care**, in accordance with the hospice's own policies, in the clinical record. While the patient/family must be included in developing/updating the plan of care, they do not need to be present during IDG meetings. (p56)

L552 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(d) Standard: **Review of the plan of care.** The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as

frequently as the patient's condition requires, but no less frequently than every 15 calendar days. Communication with the attending physician may be through phone calls, electronic methods, orders received, or other means according to hospice policy and patient needs. (p56)

L553 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(d) - A **revised plan of care** must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Ask the hospice to describe the plan of care review process. How does the hospice IDG (in collaboration with the individual's attending physician, if any) ensure that each patient's individualized plan of care is reviewed, and revised if warranted, no later than 15 days from the previous review? (p57)

L555 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.56(e)(2) - Ensure that the care and services are provided in accordance with the plan of care. (p57)

L594 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.64(c) Standard: Medical social services. Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services. (p76)

L672 (Rev. 69, Issued: 12-15-10, Effective: 10-01-10, Implementation: 10-01-10) §418.104(a) Standard: Content. Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. (p113)

Appendix D: PACE (Program for All Inclusive Care of the Elderly) Regulations

PACE - Chapter 8 - IDT, Assessment & Care Planning (CMS)
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. (p12)
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 … (p12)
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 …
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 …
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.

(p13-15)

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)] (p16)

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)] (p17)

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)] (p17)
To obtain more information pertaining to the Care Planning Guidance, visit http://www.cms.gov/pace/. ***[This link takes you to a page that no longer exists]***

Appendix E: Long Term Care Facilities Regulations

Nursing Homes: Survey & Certification - Certification & Compliance (CMS)

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, a state surveyor completes at least a Life Safety Code (LSC) survey, and a Standard Survey.

Electronic Code of Federal Regulations - Subpart B—Requirements for Long Term Care Facilities

§483.21 Comprehensive person-centered care planning

(**a**) ***Baseline care plans.*** (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR [Pre-Admission Screening & Annual Resident Review] recommendation, if applicable.

(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.

(ii) A summary of the resident's medications and dietary instructions.

(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

(b) ***Comprehensive care plans.*** (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
(2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to—
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) Be culturally-competent and trauma-informed.

(c) *Discharge planning*—(1) *Discharge planning process.* The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at §483.15(b) as applicable and—
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient

assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

(2) *Discharge summary.* When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

[81 FR 68858, Oct. 4, 2016]

Nursing Homes: Survey & Certification - Guidance to Laws & Regulations (CMS)

Consolidated Medicare and Medicaid requirements for participation (requirements) for Long Term Care (LTC) facilities (**42 CFR part 483, subpart B**) were first published in the Federal Register on **February 2, 1989 (54 FR 5316).** The requirements for participation were **recently revised** to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. The revisions were published in a final rule that became **effective on November 28, 2016**.

List of Revised Ftags effective November 28, 2016

483.21 Comprehensive Resident Centered Care Plans:

- F655 Baseline Care Plan
- F656 Develop/Implement Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons
- F660 Discharge Planning Process
- F661 Discharge Summary

What's a care plan in a nursing home? (from Medicare.gov - information for beneficiaries)

Nursing home staff gathers health information and prepares care plan with patient (when able) and/or family or other person acting on patient's behalf (with permission). Basic care plan includes a health assessment that must be completed within 14 days of admission, at least every 90 days after first review or more often if medical status changes; ongoing regular assessments of conditions to monitor for changes and adjustments of care plan as needed. Nursing homes are required to submit this information to the federal government who uses this information for quality measures, nursing home payment and state inspections. Depending on patient needs, care plan "may" include: personal or health care services needed; type of staff required to provide needed services; frequency of needed services; equipment or supplies needed (e.g., wheelchair;

feeding tube); diet and food preferences; **how care plan will help you reach patient's goals**; whether patient will be returning to the community and, if so, a plan to help meet that goal.
Evaluation of the Quality Indicator Survey (QIS) - final report Dec 2007 The basic rule that we developed was that a resident must **fail** an indicator in assessment, **care planning** or care plan revision, and provision of care to site an Ftag. Ftags were cited as greater than isolated if more than two residents met the above criteria in specific areas of care. (p3) QIS survey process deficiencies, such as assessment (F272) and care planning (F279) deficiencies, were more frequently accompanied by their related outcome tags than were Standard survey deficiencies, but, for outcome deficiencies (e.g., pressure ulcer development, F314), Standard surveys were more frequently accompanied by related process deficiencies than were QIS outcome deficiencies. (p7)