CARE PLANNING
ARE WE KEEPING THE PACE

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• When and how the care plan was developed,
• All changes made to the care plan at any point,
• Progress notes, treatments, evaluations, of the care plan,
• IDT recommendations and notes related to the care plan,
• Assessments that were used in constructing or revising the care plan,
• Documentation that the participant was appropriately involved in making the care
Plan of Care (POC) Focus

- Problems identified in the initial and updated health risk assessments
- IDT’s coordination of care
- Ongoing adjustments to the POC to meet changing and current needs

Refer to Pages 3 and 7 of the CMS Care Plan Guidance
PACE CARE PLANNING

- Is the process by which a participant’s assigned IDT, holistically assesses for needs of the participant, and develops a single comprehensive plan of care to address these identified needs
- MEDICAL
- FUNCTIONAL
- PSYCHOSOCIAL
- COGNITIVE
- EMOTIONAL
- END OF LIFE
CARE PLAN

- C Continuous
- A Assessments
- R Regarding changes
- E Elderly
- P Promoting
- L Life
- A Altering
- N Needs to stay in community
IDT

CONTRACTED PROVIDERS

DIETARY

RECREATION THERAPY

SOCIAL WORK

PCP

PT

OT

LIFE SPECIALIST

CONTRACTED PROVIDERS

NURSING

DIETARY

PARTICIPANT AND CARE GIVER
WHAT IS THE CARE PLANS PURPOSE

- ROAD MAP
- GUIDE
- PERSONAL DIRECTORY
- FRAMEWORK FOR MANAGING THE OVERALL HEALTH STATUS OF EACH PARTICIPANT
COMPONENTS OF THE CARE PLAN

01 IDENTIFIED PROBLEMS OR CONCERNS

02 MEASURABLE GOALS TO BE ACHIEVED

03 INTERVENTIONS TO ACHIEVE THOSE GOALS

04 TIME FRAMES
Information for Building the Care Plan

• Identify:
  • participant’s specific needs/problems
  • participants goals and preferences
  • relevant medical diagnosis
  • participant’s strengths
  • community supports
  • safety concerns
  • relevant psycho-social issues
  • cognitive issues
  • cultural considerations
  • Coordination of care with contracted providers
Things that may change the Road Map

1. Change in caregiver status
2. Change in physical condition
3. Change in cognition
4. Changing in housing
Unscheduled Reassessments

• A significant change in health status
  • All eight IDT members must reassess in person
  • Update the care plan within thirty (30) days
• A participant or caregiver requests a reassessment to verify the need to initiate, eliminate, or continue a particular service (service request)
  • IDT members will determine the pertinent practitioners to conduct the in-person reassessment
  • Things being reported as Level 2's should prompt at minimum a review of the care plan
Keeping the Care Plan current

- Continuous monitoring
- Update the Care Plan as goals are met, revised or need updating
- Report changes or new problems to IDT
  - Anticipate problems
  - Intervene early to minimize problems
- Revise Care Plan when changes:
  - Will not resolve without intervention
  - Impact more than one domain of health
  - Require IDT review to evaluate for need in change of plan
SHOULD THEIR CARE PLANS BE THE SAME
Steps to finding participant specific goals

1. Define the problem and does the participant see it as a problem
2. Be objective & describe what's observed
3. State how it limits or jeopardizes well being
4. Try to determine the underlying causes participant non adherence, change is support
5. Consider input from all team and staff members including participant and care givers
6. Develop long and short term goals considering how achievement of goals can be measured
7. Set realistic time for evaluation of effectiveness of the plan
Documentation should include

The medical record must demonstrate the following items:

• Medical records must contain evidence that assessments were conducted
• 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