

Care plan guidance document

METRIC A:

Percentage of high-priority beneficiaries (identified in Section 241.00) whose care plan as contained in the medical record includes:

1. Documentation of current problem

- a. Each visit-related encounter document should include a list of current problems.

2. Plan of care integrating contributions from health care team (including behavioral health professionals) and from the beneficiary

- a. A visit-related encounter (or dated entry into a plan of care flowsheet or template) should include an entry that clearly summarizes the plan of care for the patient. Ideally, this should be a problem-based detail of the plan of care occurring twice during the 12-month timeframe.
- b. The problem assessment of diagnosis from the current problems could be included in the visit note in the “plan” section or as stand-alone documentation in a separate care plan template.
- c. If using separate documentation, make sure to include the date the plan is updated.
- d. The “Plan” or the “Assessment and Plan” section of the visit documentation must include statements of specific, problem-related plan information.
 - i. For example, “Plan: follow up on diabetes in four months with repeat A1C.”
- e. Statements should include an approximate or absolute time and a follow-up item (e.g., lab, visit, referral, etc.).
 - i. **Example: Assessment and Plan**
 1. **Type II Diabetes Mellitus:** Improved after recent increase in insulin dosing. Continue current insulin and metformin doses. Refer to patient educator for help with diet. Follow up in the clinic in six months with Hgb A1C and microalbumin.
 2. **Essential Hypertension:** Stable blood pressure, at target, no change in medications. Continue home blood pressure checks. Target is systolic <130. Patient will report blood pressure via secure messaging.

Example of “stand-alone” care plan:

DATE:	01/08/2014	03/22/2014	06/10/2014
PROBLEM 1	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus
PHASE OF CARE	Elevated home blood sugars	F/U office visit for disease management	Care coordination visit and diabetes teaching
MEDICATIONS	Glucophage XR 850mg — Continued	Glucophage XR 850mg — Continued	Glucophage XR 850mg — Continued
DISCIPLINES	PCP, Dietetics	APN	APN, Case Manager
TESTS	A1C: 9.6	A1C: 8.3	A1C: 7.5
STATUS	Unstable; will recheck in three months, recheck A1C, dietetics: for healthy diet teaching	Improved; recheck in three months, check A1C, Lipids, microalbumin and CMP for yearly labs	Improving; await lab results, case manager will follow up for additional diabetic teaching

3. Instructions for follow-up

- a. Documentation mentioned in the visit/encounter of an existing future visit linked to a problem under management.
 - i. **For example, noting the patient has a future visit scheduled with a patient educator for diabetes management.**
- b. Documentation could be contained within a completed assessment and plan would be acceptable, as would evidence in the chart.
 - i. **Example: Follow up in six months, patient is doing well.**

4. Assessment of progress to date

- a. The encounter document should contain a problem-based assessment for all problems that were addressed during the visit.
- b. Clear documentation in the plan of care (EHR activity [telephone encounter/care plan update] or in a progress/visit note) identifying the course of a specific problem being tracked.
- c. Documentation should include reference to the problem stability.
 - i. **For example, problem is “improving, deteriorating or stable.”**
- d. If the patient’s problem is not clearly managed in a separate EHR activity (stand-alone care plan), then the “Plan” section of the encounter/visit documentation must clearly state or update the status of each problem.
 - i. **For example: Assessment**
 1. **Type II diabetes, improved control after changes in insulin dosing.** Hypertension that is at the treatment target. No changes in medications. Will draw lipid, CMP, A1C and complete a microalbumin in three months.
 2. **Type II diabetes mellitus:** Improved after recent increase in insulin dosing. Will follow up in six months for A1C.
 3. **Essential hypertension:** Stable blood pressure, at target, no change in medications. K+ level drawn today and results will be reported to patient via patient portal.

NON-COMPLIANT PATIENTS:

- If a patient misses a follow-up appointment, the clinic can utilize outreach to follow up.
- A telephone note can be used to address and update the care plan, but it must contain a specific timeframe for followup to re-engage the patient.
- If the patient is non-compliant and the clinic is utilizing outreach to follow up, there should be documentation showing a good faith effort has been made to reach the patient and reschedule them.



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