



2017 PCMH Care Plan Guidance Document

Activity I:

At least 80 percent of high-priority beneficiaries (identified in Section 241.00), whose care plan, as contained in the medical record, includes:

1. Documentation of a beneficiary's appropriate problem list
 - Review document for a problem list
 - Problems could be listed under a "Problem List" heading; they could also be listed somewhere else in the document (Example: it may be located in the PMH or under the chief complaint)
 - All active, significant clinical conditions/problems should be listed
 - All problems that are no longer active should be documented as "Resolved" or removed from list.
2. Instructions for follow-up
 - Documentation should include the timing of future follow-up visits (related to the problem)
 - Somewhere in the documentation of the visit, there should be a follow-up for the patient; there doesn't have to be a follow-up for each problem – just one follow-up
 - A follow-up appointment has to include a specific time frame. These are examples of what would not meet the measure: (Follow-up PRN, follow-up left to the patient's discretion such as follow-up if symptoms persist or don't improve)
3. Assessment of progress to date
 - Documentation **and** problem-based assessment including (stability or change of condition)
 - Review documentation for a brief assessment of each problem and the stability of that problem; this can be located anywhere in the visit documentation or under a specific section
 - Problems that are listed as "resolved" will not require an assessment
4. Updated at least twice within a 12-month period



- Documented update to the plan of care, which would include active problems
- The first care plan submitted must be completed in the current performance year
- The second care plan submitted (update) could be face-to-face or a telephone call. The updated care plan should be done within 12 rolling months of the first one and would include active problems.
- Of the two care plans submitted, the first date of the performance year is considered the first care plan and the second date will be considered the update
- Care plans will not be considered for review if they are not in the correct performance year

Indicate if:

- At least 80 percent of the top 10 percent of high-priority beneficiaries have a care plan in the medical record
- Each attested care plan includes all four required elements

Validation:

For validation, 20 percent of the high-priority beneficiaries selected as having a care plan in the medical record will be randomly selected for care plan review. To pass this activity, at least 80 percent of care plans must include all four of the required elements stated above.

Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of completion can be provided upon request

QA team will review and validate care plans based on the requirements stated in the 2017 PCMH Program Policy Addendum

Addendum to Care Plans:

- Adding an addendum is acceptable if timely
 - Addendum should be created no later than two weeks after the visit
- Example of an acceptable addendum:
 - Office visit is conducted on 12/8/16; care plan/visit note did not address follow-up
 - Addendum to the 12/8/16 visit is created on 12/15/16 stating the patient is to return to the office in 3 weeks
- Example of an unacceptable addendum:



- Office visit completed on 7/22/16; care plan/visit note did not address follow-up
- Addendum to office visit is created on 12/15/16

Care Plan Tips:

- CPC+ practices are also required to complete care plans
- Care plan may be initiated by the physician, APN or RN
 - The physician should sign off on the care plan
- For established HPBs, a new care plan does not need to be created at the beginning of each performance year
- For established HPBs, there should be at least two updates within a 12-month period
- For new HPBs, there should be an initial care plan and an update within a 12-month period
- Updates may be completed either by an office visit or by phone
- Templates may be used
 - Be sure to address all care plan elements
 - If all elements are not included on a template, you may submit any supporting documentation
- An office visit note, progress note, or SOAP note that includes all care plan elements may be used but these notes are required
- Remember to address all problems that are listed on the care plan or note
- Deadline to attest to and select HPBs with a care plan is 12/31/2017