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**By Jennifer Osburn,**
RN, HCS-D, COS-C
Clinical Learning Solutions Manager

# A Clinician's Guide to Creating a Compliant Care Plan

**Pulling together the professional and comprehensive assessments and translating this information into a CMS-compliant, patient-specific, individualized Plan of Care can be an overwhelming and daunting task for the home health clinician. However, it does not have to be.**

When you understand what is required and engage your training in the professional process, you better understand how to tailor your findings into actionable goals and interventions.

Since the Conditions of Participation mandate that the patient receive all treatments and services outlined on the Plan of Care, getting this right is imperative. In this document, we will walk through this process to instill new habits that will soon become second nature.

## 1) Discern the reason the person was referred to home health services.

This information is usually found in the referral documents, including the face-to-face encounter documentation. You want to know the primary problem that initiated the referral, so you know the focus of care. This helps prioritize care and will help identify if the goals are met or not.

## 2) Double check this against the primary problem observed during assessment in the home.

If the physician/provider referred you for COPD but you find a problematic wound, for example, you will need to have a conversation with the provider regarding what your primary reason for care may be.

The content of the comprehensive assessment as mandated by CMS includes the following items which will help guide your formation of the patient's plan of care:

- An accurate reflection of the patient's current health, psychological, functional, and cognitive status. This includes relevant past medical history, active health and medical problems; functional capacity within the community including patient's relationships, living environment, impact on the delivery of services, and ability to participate in his or her own care; functional status includes level of ability to function independently in the home, such as ADLs; and cognitive status refers to an evaluation of the degree of the patient's ability to understand, remember, and participate in developing and implementing the plan of care.
- The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward the achievement of goals identified by the patient and measurable outcomes identified by the HHA.

Examples of patient strengths include awareness of disease status, knowledge of medications, motivation and readiness for change, motivation to perform the Home Exercise Program (HEP) and so on. Measurable outcomes show a change in health status, functional status, or knowledge that happens over time in response to the professional's intervention.

Examples include end-result functional and physical health improvement or stabilization, health care utilization measures and potentially avoidable events.

- The patient's continuing need for home care, including eligibility for the home health benefit.
- The patient's medical, nursing, rehabilitative, social, and discharge planning needs.
- A review of all medications the patient is currently using to identify issues.

Potential issues include adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

- The patient's primary caregiver(s), if any, and other supports including their willingness and ability to provide care and availability and schedules.
- The patient's representative (if any).
- Incorporation of the current version of OASIS.

## 3) Decide which co-morbid conditions are also currently problematic vs. those that have the potential to be.

Often home health patients have multiple comorbid and chronic diseases as well as the acute problem that prompted the referral. A proper assessment of required treatments, patient knowledge and compliance, and control status will help you determine which of these illnesses are more acute and require more attention from the skilled professional(s) involved.

## 4) Think about what the physician and patient hope to achieve through this admission for services. What is the physician/provider trying to achieve through the care being delivered by your agency? Healing a wound? Increasing mobility? Preventing complications? Patient knowledge and compliance about a particular problem?

- Once you know what they believe is the goal of care, you will be able to pinpoint your route to achieve those goals. Also, find out what the patient hopes to achieve during their admission, and if needed discuss more realistic goals. Once you know this information and can relate back to their focus from time to time, you have built-in patient buy in.

## 5) Roadmap the steps it will take to get to that destination.

- Now that you know where you are going professionally, decide the route it will take to get there.

## 6) Plan for stops in the journey and potential bumps in the road.

- What are the potential issues that may crop up? Potential for infection? Potential for falls? Potential fluid volume overload? Is there an actual issue with finances keeping the patient from affording their heart medications or insulin? How will you overcome these roadblocks?
- These items and actions become your planned interventions: assessment, teaching, management and evaluation, or hands on care.

## 7) Decide how you will measure success, and how often you will check progress.

- How do you know the plan is working? You will need patient-specific, measurable parameters for the goals you have set so you can refer to these and measure progress along the way. What landmarks or gauges are you watching to ensure the patient is moving toward completion of goals? Wound measurements? Signs and symptoms?
- Increase in flexion or extension? Ability to perform ADLs with improved safety and endurance? Be specific about what is to be accomplished.

## 8) Ensure the list of CMS-required components are included on the Plan of Care.

The Conditions of Participation require that the following items be included on the patient's individualized plan of care:

- All pertinent diagnoses. This means all known diagnoses that are unresolved at time of assessment.
- The patient's mental, psychological, and cognitive status. What is the patient's orientation status to time, place, and person?
- The types of services, supplies, and equipment required.

**TIP** **Best Practice includes use of a specific tool, such as the CLOX Test or another standardized tool, to thoroughly assess the patient's cognitive status.**

**Be sure you are using a tool designed for use in the patient demographic you are seeing. Psychosocial or psychological status may include interpersonal family relationships, financial status, homemaker/household needs, vocational rehab needs, family social problems or transportation needs.**

**Be sure to note these issues in the assessment as well as on the plan of care, as these impact the patient's progress to goals.**

- The frequency and duration of visits to be made. Once you have your goals and interventions decided, estimate the number of visits it will take to deliver these interventions. Be sure you have an appropriate number of interventions versus visits; it is not feasible to complete 90 interventions in 6 visits, for example.
- Prognosis. A forecast of expected course of the disease or ailment.
- Rehabilitation potential. What is the expected potential that the services being delivered will restore the patient's health status?
- Functional limitations. What circumstances are impacting the patient's ability to perform activities of daily living? List those here.
- Activities permitted. What is the patient allowed to do in his or her home?
- Nutritional requirements. The physician- ordered diet and nutritional supplements.
- All medications and treatments. This includes all prescribed, over the counter, herbals, and supplemental medications by any route as well as any medical treatments such as oxygen or specialized wound care items and dressings.
- Safety measures to protect against injury. List the measures recommended to increase the patient's safety in the home, such as removing throw rugs and electrical cords, installing grab bars in the bathroom and so on.
- A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors.

List the characteristics that increase a patient's risk to use the emergency department and/or be readmitted to the hospital for treatment.

- Patient and caregiver education and training to facilitate timely discharge. What specifically are you planning to teach the patient and caregiver(s) or representatives before the patient is discharged with goals met? List these topics here.
- Patient-specific interventions and education. What other patient-specific treatments, procedures, and education will be necessary to achieve the goals you and the patient have established. BE sure these are individualized to the patient rather than cookie-cutter statements such as "teach on disease process and medications." You want to illustrate a clear picture as to which specific aspects of the disease and which medication knowledge deficits are to be covered.

- Measurable outcomes and goals identified by the HHA and the patient. To be measurable, there must be a defined parameter to identify the goal is met. Example: Patient's weight will remain between 135 and 138 throughout the episode through daily weights, prescribed cardiac drugs and low sodium diet.
- Information related to any advanced directives. List any patient directives here including power of attorney, living will, DNR, and so on.
- Any additional items the HHA or physician may choose to include. Check your agency's policies for additional items that may be included on the plan of care as well.

## Plan of Care Interventions and Goals Worksheet Example: Patient with Cellulitis of LLE and IV Therapy. Also has Diabetes Type 2.

| Ranking | Problem (actual or potential) | Goal | Intervention | Comments |
|---|---|---|---|---|
| 1 | Infection of LLE | Infection will resolve w/in 21 days with IV antibiotic therapy | SN: perform and teach IV administration to wife each visit until wife is independent | |
| 4 | Potential for fluid volume overload | Patient will have no s/s of fluid overload AEB no edema, stable weight, decreased leg circumference | SN to measure leg circumference every visit. Teach to weigt daily and when to report to SN. | |
| 3 | Potential for complication of IV therapy: infiltration of peripheral line | Patient will have no s/s of infiltration AEB: no pain, redness, or swelling around the insertion site | SN to teach patient and wife s/s of infiltration of line and when to report to SN | |
| 5 | Potential for complication of IV therapy: phlebitis of vein | Patient will have no s/s of phlebitis AEB: no pain, redness, swelling or warmth near the insertion site | SN to teach patient and wife s/s of phlebitis of vein and when to report to SN | |
| 6 | Potential for complication of IV therapy: infection of IV site | Patient will have no s/s of infection of IV site AEB: no pain, redness, swelling, or drainage of pus at the insertion site | SN to teach patient and wife s/s of site infection and when to report to SN | |
| 2 | Potential for hyperglycemia due to infection, stress, and diabetes | Patient's glucose will remain between 110-200 throughout the 21-day IV treatment and then 100-170 afterward. | SN to review patient's glucometer readings every visit and note ranges. Instruct on s/s of hyperglycemia to report | Patient demonstrated independence with checking glucose at SOC visit. |
| Other problems and goals will be entered in this same manner and then ranked according to acuity/potential. | | | | |

## Plan of Care Interventions and Goals Worksheet

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