Policy:	PA.2002
Title:	**Care Planning**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	10/01/2013
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Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines how the CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Interdisciplinary Team (IDT) will incorporate results of initial and subsequent assessments into a continuously updated Plan of Care for each Participant.

II. POLICY

A. The IDT must develop, evaluate, and if necessary, revise a comprehensive person-centered Plan of Care for each Participant. IDT members shall identify Participant needs in all care domains, including medical, psychosocial, cognitive, functional, and end-of-life, and determine the IDT's coordinated response to those needs. The IDT is responsible for care planning for PACE Participants in the PACE Center and/or in alternative settings, including their homes or inpatient facilities, as dictated by their healthcare needs.

B. PACE care planning is the process by which the IDT conducts a holistic assessment of each Participant as a human being with unique characteristics, needs and documented preferences, and develops a single comprehensive Plan of Care to address the identified needs in conjunction with program resources. Each Plan of Care must take into consideration the most current assessment findings and identify the services to be furnished to attain or maintain the Participant's highest practicable level of well-being. The Plan of Care shall delineate problems, interventions, and measurable outcomes to improve, maintain, recover, or reset a Participant's baseline health status and preferences for health care. The Plan of Care anticipates potential problems by identifying potential risks and integrates discipline-specific assessments to allow for a coordinated and continuous evaluation of care efficacy.

III. PROCEDURE

A. Development of Plan of Care

1. Initial Plan of Care: In accordance with this Policy and CalOptima Health Policy PA.2001: Interdisciplinary Team (IDT) & Participant Assessments, CalOptima Health PACE shall develop a comprehensive Plan of Care for each Participant based on the initial comprehensive assessment findings within thirty (30) calendar days of the date of enrollment.

2. Semi-annual Plan of Care evaluation: At least once, every one-hundred eighty (180) calendar days from the date the latest Plan of Care was finalized the IDT must complete a reevaluation of, and if necessary, revisions to each Participant's Plan of Care.

3. Change of status Plan of Care evaluation:

    a. IDT must complete a re-evaluation of and if necessary, revisions to a Participant's Plan of Care within fourteen (14) calendar days after CalOptima Health PACE determines, or should have determined, that there has been a change in the Participant's health or psychosocial status, or more expeditiously if the Participant's condition requires.

    b. If a Participant is hospitalized within fourteen (14) calendar days of the change in participant status, the IDT must complete a reevaluation of, and if necessary, revisions to the Plan of Care as expeditiously as the Participant's condition requires but no later than fourteen (14) calendar days after the date of discharge from the hospital.

4. After scheduled and unscheduled assessments of Participants, the IDT is responsible for promptly consolidating discipline-specific assessments into a single Plan of Care for each Participant through discussion in team meetings and consensus of the IDT.

5. As part of the Plan of Care, the IDT is responsible for informing female Participants that they are entitled to choose a qualified specialist for women's health services from CalOptima Health PACE's network to furnish routine or preventive women's health services.

6. The PACE Center Manager, with consensus from the IDT, shall request inclusion of additional disciplines in the assessment and Plan of Care development, as indicated for the conditions presented by the Participant. These disciplines may include, but are not limited to:

    a. Speech Therapy;

    b. Medical Specialties;

    c. Behavioral Health;

    d. Clinical Pharmacy; and

    e. Dentistry.

7. The IDT must develop, review, and reevaluate the plan of pare in collaboration with the Participant or caregiver, or both. If a Participant or caregiver chooses not to participate in the care planning process, it should be documented that PACE IDT attempted to engage them in the process.

8. The IDT must review and discuss each Plan of Care with the Participant or the Participant caregiver or both before the Plan of Care is completed to ensure that there is agreement with the Plan of Care and that the Participant's concerns are addressed.

9. The Social Worker is responsible for securing Participant or caregiver concurrence with the Plan of Care. The concurrence shall be documented by a signature, or by a progress note detailing the discussion and agreement.

B. Contents of the Plan of Care

1. The Plan of Care shall identify all of the Participant's current medical, physical, emotional, and social needs, including all needs associated with chronic diseases, behavioral disorders, and psychiatric disorders that require treatment or routine monitoring.

2. At a minimum, each Plan of Care must address the following elements:

    a. Vision;

    b. Hearing;

    c. Dentition;

    d. Skin integrity;

    e. Mobility;

    f. Physical functioning, including activities of daily living;

    g. Pain management;

    h. Nutrition, including access to meals that meet the participant's daily nutritional and special dietary needs;

    i. The participant's ability to live safely in the community, including the safety of their home environment;

    j. Home care;

    k. Center attendance;

    l. Transportation; and

    m. Communication, including any identified language barriers.

3. CalOptima Health PACE must identify each intervention (the care and services) needed to meet each medical, physical, emotional, and social needs. It does not have to identify the medications needed to meet the Participant's needs if a comprehensive list of medications is already documented elsewhere in the Medical Record.

4. CalOptima Health PACE utilizes the most appropriate interventions for each care need that advances the Participant toward a measurable goal and outcome.

5. CalOptima Health PACE must identify how each intervention will be implemented, including

    a. A timeframe for implementation;

    b. Identify a measurable goal for each intervention; and

    c. Identify how the goal for each intervention will be evaluated to determine whether the intervention should be continued, discontinued, or modified.

6. CalOptima Health PACE must take the Participant's preferences and goals of care into account.

7. When the IDT members achieve the care goals for an active problem, they may reclassify the problem as maintenance care, which shall then be monitored and documented by the specific discipline in the progress notes.

8. If the IDT determines that certain services are not necessary to the care of the Participant, the reasoning behind this determination must be documented in the Participants Plan of Care.

9. The IDT shall not incorporate the following in the Plan of Care, but will document in discipline-specific progress notes:

    a. Maintenance care as monitored by a sole discipline;

    b. Conditions of long-standing stability that are controlled over at least several months;

    c. Conditions with a brief therapeutic regimen to achieve resolution (e.g., brief regimen of one-two weeks) and that are not chronic;

    d. Residential, social network and caregiver support that is considered stable and not transitional; and

    e. Conditions which are "self-limiting" in that they will normally resolve without further intervention or implementation of standard disease-related clinical interventions.

10. All IDT members must indicate concurrence with the Plan of Care through signature or e-signature.

C. Implementation of the Plan of Care

1. The IDT must implement, coordinate, and monitor the Plan of Care whether the services are furnished by PACE employees or contractors.

2. The IDT must evaluate and monitor the Participant's medical, physical, emotional, and social needs as well as the effectiveness of the Plan of Care, through the provision of services, informal observation, input from Participants or caregivers, and communications among members of the IDT and other employees or contractors.

3. PACE must arrange and schedule all care planned services in a timely manner as outlined in CalOptima Health Policy PA.1007: Delivery of PACE Services.

D. Documentation

1. The IDT must document the Plan of Care, and any changes made to it, in the Participant's medical record, in accordance with the requirements of CalOptima Health Policy PA.6001: Medical Records Maintenance, and applicable CalOptima Health PACE and discipline-specific documentation standards and guidelines.

2. The IDT ensure that the most recent Plan of Care is available to all employees and contractors within the organization as needed.

3. Updates made directly to the Plan of Care shall be done in a manner to preserve the history of the Participant's care and to enable the IDT to trace the effectiveness of interventions over time.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for PACE
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Policy PA.1007: Delivery of PACE Services
D. CalOptima Health Policy PA.2001: Interdisciplinary Team (IDT) & Participant Assessments
E. CalOptima Health Policy PA.6001: Medical Records Maintenance
F. Centers for Medicare and Medicaid Services (CMS) Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 8, Revised 06/09/2011
G. Title 42, Code of Federal Regulations (C.F.R.), 460.98(b)(4) and (c), §§460.104 - 460.106

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.2002	Care Planning	PACE
Revised	10/01/2014	PA.2002	Care Planning	PACE
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Revised	04/01/2017	PA.2002	Care Planning	PACE
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Revised	02/01/2022	PA.2002	Care Planning	PACE
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Revised	03/01/2024	PA.2002	Care Planning	PACE
Revised	01/01/2025	PA.2002	Care Planning	PACE

IX. GLOSSARY

Term	Definition
Interdisciplinary Team (IDT)	A team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within their scope of practice as defined by State laws with regards to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within their scope of practice as defined by State laws with regards to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's – level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or their representative; and 11. Driver or their representative.
Medical Records	Written documentary evidence of treatments rendered to plan Members.
Participant	An individual enrolled in the CalOptima Health PACE program.
Plan of Care	As defined in Title 42, section 460.106 of the Code of Federal Regulations, a comprehensive care plan developed by the interdisciplinary team for each Participant to identify the care needed to meet the medical, physical, emotional, and social needs of the Participant, as identified in the initial comprehensive assessment.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.