Sullivan County Department of Public Health

Title: Plan of Treatment- 485 **Number**: AG-66 **Page Number:** 1 of 2	Original Approval: 1 2 / 9 9 Reviewed/ revised: 2/05, 5/05, 9/08, 3/16, 5/22, 3/24

Statement/ Purpose:
Establish a plan or care individualized to each patient in collaboration with the primary care provider (PCP) and each discipline.

Authority:
Title 10 Part 763.6, 763.7(a) (3)

Application:
SCDPH RN, PT, OT, ST

Terminology:
n/a

Responsible Party:
Director of Patient Services

Cross-Reference:
Admission Policy

Procedure:

1. A Plan of Treatment shall be developed within 10 days of admission to the agency and approved by the patient or representative based on the comprehensive interdisciplinary patient assessment. The plan shall designate a professional person employed by the agency to be responsible for coordinating care which includes but is not limited to: [763.6(b)]
   • Coordinate all services provided directly or by contract to patient by the agency [763.6(b)(1)]
   • Cooperate with other health, social and community organizations providing or coordinating care [763.6(b)(2)]
   • Consult with practitioner, local social services representative and discharge planner if applicable [763.6(b)(3)]
   • Maintain current clinical records, conduct case reviews and complete required patient-specific records and reports as appropriate [763.6(b)(4)]
   a. The Plan of Care shall include: [763.6(c)]

- all pertinent diagnoses
- mental, psychosocial, and cognitive status
- types of services and equipment required
- frequency and duration of visits
- prognosis

- rehabilitation potential
- functional limitations
- activities permitted
- nutritional requirements
- medications and treatments
- any safety measures to protect against injury
- a description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address underlying risk factors
- referrals and any other appropriate items
- patient and caregiver education and training to facilitate timely discharge
- patient specific interventions and education; measurable outcomes and goals identified by the agency and the patient
- information related to any advanced directives
- any additional items the agency or PCP may choose to include

2. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency and duration of such services [763.6(d)].
3. The Plan of Care shall be reviewed as frequently as required by changing patient conditions but at least every 60 days[763.6(e), 763.7(a)(3)(iii)].
   - Each review shall be documented in the clinical record [763.6(e)(1)].
   - Professional personnel shall promptly alert the patient's authorized practitioner to any significant changes in the patient's condition that indicate a need to alter the plan of care [763.6(e)(2)].
   - Any changes in the plan of care shall be added as an interim order and forwarded to the authorized practitioner for review and signature.
4. The completed Plan of care will be forwarded to the authorized practitioner for review and signature. The agency must ensure the Plan of Care has been returned signed within in 12 months after the establishment of care or prior to billing, whichever is sooner.

MISSED VISIT FREQUENCY:

- If frequency is not met as outlined in the plan of care, the clinician must notify the authorized practitioner as soon as possible. The missed visit frequency should be documented as a case communication note in the electronic medical record.
- The clinician will generate an interim order as an addendum to the plan of care for the missed visit frequency.