G572

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§484.60(a) Standard: Plan of care.

(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician *or allowed practitioner* refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician *or allowed practitioner* is consulted to approve additions or modifications to the original plan.

Interpretive Guidelines §484.60(a)(1)

"Patient-specific measurable outcome" is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization.

Patient-specific goals must be individualized to the patient based on the patient's medical diagnosis, physician *or allowed practitioner* orders, comprehensive assessment and patient input. Progress/non-progress toward achieving the goals is evaluated through measurable outcomes. The HHA must include goals for the patient, as well as patient preferences and service schedules, as a part of the plan of care (See §484.60(a)(2) below).

"Periodically reviewed" means every 60 days or more frequently when indicated by changes in the patient's condition (see §484.60(c)(1)).

The patient's physician *or allowed practitioner* orders for treatments and services are the foundation of the plan of care. If the HHA misses a visit or a treatment or service as required by the plan of care*, the HHA should make every attempt to reschedule the missed visit. If the visit cannot be rescheduled, the responsible physician or allowed practitioner should be notified, and the HHA should document the potential clinical impact of missed treatments or services. The HHA should advise and educate the patient on the potential impacts of missed visits.*

If the patient or the patient's representative refuses care that could impact the patient's clinical wellbeing (such as dressing changes or essential medication) on more than one occasion, then the HHA must attempt to identify the reason for the refusal. If the HHA is unable to identify and address the reason for the refusal, then the HHA must communicate with the patient's responsible physician *or allowed practitioner* to discuss how to proceed with patient care.

The physician *or allowed practitioner* should not be approached to reduce the frequency of services based solely on the availability of HHA staff.

In instances where the HHA receives a general referral from a physician *or allowed practitioner* that requests HHA services but does not provide the actual plan of care components (i.e., treatments and observations) for the patient, the HHA will not be able to create a comprehensive plan of care to include goals and services until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician *or allowed practitioner*.