Care Plan Documentation Requirements

Each care plan requires documentation of the following in the patient's chart:

- [ ] 1. Detailed review of medical history and current therapies
- [ ] 2. Substitute decision maker (name & contact info) if appropriate
- [ ] 3. Documentation of eligible condition(s) for planning fee (e.g. diagnoses, frailty score, results, life expectancy)
- [ ] 4. Date & time of face-to-face planning visit
- [ ] 5. Clinical plan for patient's care
- [ ] 6. Current health status using validated assessment tools when appropriate
- [ ] 7. Patient's values, beliefs and personal health goals
- [ ] 8. Expected outcomes as a result of the plan and advanced care planning when appropriate
- [ ] 9. Other care providers' roles and involvement in patient's care
- [ ] 10. Time frame for re-evaluation of the plan
- [ ] 11. Confirmation the plan has been created and shared with the patient and other allied care providers when appropriate