Comprehensive Person-Centered Care Planning

(§483.21)

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Comprehensive Person-centered Care Planning

(§483.21) Summary

NEW SECTION

The revised care planning requirements highlights the importance of—

- Safe transitions across care setting
- Safely reduce hospital readmissions and unnecessary hospitalizations
Comprehensive Person-centered Care Planning (§483.21)

Previous Items

✓ Comprehensive care plans was within the Resident Assessment regulatory set at §483.20
✓ Did not include “Person-centered” the title
✓ With the exception of the Resident Assessment requirements, all previous subsections of §483.20 were re-designated to this new regulatory section

Key Requirements

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide -
- Effective and person-centered care for the resident that meets professional standards of quality care
- Must be developed within 48 hours of a resident’s admission
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

- Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
  - Initial goals based on admission orders
  - Physician orders
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendation, if applicable

A *summary* of the baseline care plan is to be provided to the resident and their representatives that includes;

- The initial goals of the resident
- A summary of the resident’s medications and dietary instructions
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

And;

- Any services and treatments to be administered by the facility and personnel acting on behalf of the facility

- Any updated information based on the details of the comprehensive care plan, as necessary

The facility may develop a comprehensive care plan in place of the baseline care plan (due within 48 hours of admission) if it meets the following requirements—
Comprehensive Person-centered Care Planning (§483.21)
Key Requirements

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights that—

- Meet their medical, nursing, mental and psychosocial needs (identified in their comprehensive assessment)
- Must include measurable objectives and timetables for goal accomplishment

...and must describe—

- The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.....and....
- Any services that would otherwise be required under the quality of life and/or behavioral health services regulation but are not provided due to the resident’s exercise of rights
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

- Any specialized services or rehabilitative services resulting from the PASARR recommendations
  - If a facility disagrees with the findings of the PASARR, you must indicate its rationale in the resident’s medical record

After consultation with the resident and the resident’s representative, the comprehensive care plan must describe;

- The resident’s goals for admission and desired outcomes
- The resident’s preference and potential for future discharge
- Discharge plans (as appropriate)
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

Facilities must document –

- Whether the resident’s desire to return to the community was assessed; and

- Any referrals to local contact agencies and/or other appropriate entities

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

A comprehensive care plan must be developed—

- Within 7 days after completion of the comprehensive assessment

- After each assessment (includes both the comprehensive and quarterly reviews), the care plan must be reviewed and revised by the interdisciplinary team

...and
Comprehensive Person-centered Care Planning (§483.21) Key Requirements

- Prepared by an interdisciplinary team, that minimally includes:
  - Attending physician
  - Registered nurse with responsibility for the resident
  - Nurse aide with responsibility for the resident
  - Member of food and nutrition services staff
  - Social worker (*not required in final rule, but, good practice when included*)
  - Other appropriate staff or professionals in disciplines as determined by the resident’s needs or as requested by the resident

Comprehensive Person-centered Care Planning (§483.21) Key Requirements

CMS does not require that any of the members of the IDT participate in person!

- Facilities have the flexibility to determine how to hold IDT meetings whether in person of by conference call

Nor did they specify the type of communication the IDT must use!
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

IDT members may use electronic communication as well as informal discussions to participate in IDT meetings.

• The facility may determine that participation by the CNA or any other member may be best met through email participation or written notes.

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

• Need to include the participation of the resident and the resident’s representative(s) in the care planning process

• An explanation must be included in the resident’s record if their participation has been determined to not be practicable for the development of the resident’s care plan.
Comprehensive Person-centered Care Planning (§483.21) Key Requirements

An example of when it may not be practical for a resident to participate in the development of their care plan may be in the case of a resident whose ability to make decisions about care and treatment is impaired, or a resident who has been formally declared incompetent by a court.

CMS expects that to the extent practicable, these residents would be kept informed and consulted on personal preferences regarding their care.

Comprehensive Person-centered Care Planning (§483.21) Key Requirements

The services provided or arranged by the facility must—
- Meet professional standards of quality
- Be provided by qualified persons
- Be culturally-competent and trauma-informed
Comprehensive Person-centered Care Planning (§483.21)  
Key Requirements

Culturally-competent and trauma-informed care are approaches that help to minimize triggers and re-traumatization.

- Care that addresses the unique needs of Holocaust survivors and survivors of war, disasters, and other profound trauma are an important aspect of person-centered care for these individuals.  
    
    (more direction to be provided with the release of the interpretative guidelines 😊)

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Comprehensive Person-centered Care Planning (§483.21)  
Key Requirements

Discharge Planning

- The facility must develop and implement an effective discharge planning process, focusing on—
  - The residents discharge goals
  - Preparing them to be active partners and effectively transition them to post-discharge care
  - The reduction of factors leading to preventable readmissions
  - Ensuring their discharge rights are honored
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

The facility’s discharge planning process must—

✓ Ensure that the resident’s discharge needs are identified and result in the development of a discharge plan for the resident
✓ Include regular re-evaluation to identify changes which require modification of the discharge plan
✓ Involve the interdisciplinary team in the ongoing process of developing the discharge plan

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

✓ Consider caregiver/support person availability and capability to perform required care as part of the identification of discharge needs
✓ Involve the resident and resident representative in the development and inform them of the final plan
✓ Address the resident’s goals of care and treatment preferences
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

✓ Document that a resident has been asked about their interest in receiving information regarding returning to the community—

  o Section Q of the MDS provides for this

  o If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

  o Must update the resident’s comprehensive care plan and discharge plan in response to information received from referrals

  o If discharge to the community is determined to not be feasible, you must document...

  who made the determination and why ????
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

Oh my goodness….will this ever end?

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

For residents who are being transferred to another SNF or will be discharged to a HHA, IRF, or LTCH, you’ll need to assist them in selecting a PAC provider by using data that includes, but is not limited to:

- SNF, HHA, IRF, or LTCH standardized patient assessment data
- Data on quality measures
- Data on resource use (to the extent the data is available)
Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

You will need to ensure that the post-acute care data is relevant and applicable to the resident’s goals of care and treatment preferences.

- The data presented is not intended to recommend facilities, but rather presented in order to assist residents/families in making informed decisions regarding the selection of a post-acute care provider.
- Data must be based on the individual goals and preferences of the resident.
- Facilities will need to demonstrate compliance with this requirement by showing evidence that the relevant data was presented.

Comprehensive Person-centered Care Planning (§483.21)

Key Requirements

Your documentation of the resident’s discharge needs and subsequent discharge plan must be complete and timely. The resident’s record must reflect that—

- You discussed the results of the evaluation with the resident or resident’s representative, and
- All relevant resident information was incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.
Comprehensive Person-centered Care Planning (§483.21)  
**Key Requirements**  
When the discharge of a resident is anticipated, a discharge summary must be documented and provided to the resident that minimally includes—  
• A recapitulation of their stay  
  o Diagnoses  
  o Course of illness/treatment or therapy  
  o Pertinent lab, radiology, and consultation results  

Comprehensive Person-centered Care Planning (§483.21)  
**Key Requirements**  
With the consent of the resident or resident’s representative, a final summary of the resident’s status (Resident Assessment) be available for release to authorized persons and agencies.
Comprehensive Person-centered Care Planning (§483.21) Key Requirements

Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter)
  - CMS clarified this to be medications a resident was prescribed prior to being discharged from the facility to those they are prescribed when leaving the facility (not pre-hospitalization meds).

Comprehensive Person-centered Care Planning (§483.21) Key Requirements

A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident’s representative(s), must indicate –
  - Where the individual plans to reside
  - Any arrangements that have been made for the resident’s follow up care
  - Any post-discharge medical and non-medical services
Comprehensive Person-centered Care Planning (§483.21) Implementation Deadline

**Comprehensive Person-centered Care Plans**
- Phase 1: November 28, 2016

**Except for** –
- Baseline Care Plan  
  - Phase 2: November 28, 2017
- Trauma Informed Care  
  - Phase 3: November 28, 2019

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Comprehensive Person-centered Care Planning (§483.21)

**QUESTIONS?**
Comprehensive Person-centered Care Planning (§483.21)

Work Group Probes

How will you demonstrate the baseline care plan was developed within 48 hours of a resident’s admission?

Do you currently have a process for providing a summary of the baseline care plan is to the resident/representatives in a manner that they can access and understand? Electronic charting?

Will you have to develop or revise a policy/procedure related to method of care planning participation?

How will demonstrate participation in care planning to reflect inclusion of the CNA and food/nutrition services staff?

Comprehensive Person-centered Care Planning (§483.21)

Work Group Probes

Will you have to develop or revise informational material for resident/representative for rights related to participation in the care planning process, determining who will represent them?

What about the “services that would otherwise be required under the quality of life and/or behavioral health services regulation but are not provided due to the resident’s exercise of rights”? Might need to add this to your policy/procedure on care planning? - including the part if you disagree with the findings of the PASARR.
Comprehensive Person-centered Care Planning (§483.21) Work Group Probes

Documenting whether the resident’s desire to return to the community was assessed; and any referrals to local contact agencies and/or other appropriate entities - ??? Policy revision

Will you have to develop or revision forms for baseline CP for copy to resident, discharge summary/instructions for resident that also reflects participation by resident/representative?

Section Q of the MDS – does your process already include this data into the care planning?

Comprehensive Person-centered Care Planning (§483.21) Work Group Probes

If the resident indicates an interest in returning to the community, do you already document any referrals to local contact agencies or other appropriate entities made for this purpose, or is this a policy development?

If discharge to the community is determined to not be feasible, the facility must document who made the determination and why, Policy revision?
Comprehensive Person-centered Care Planning (§483.21)
**Work Group Probes**

How will you assist residents and their resident representatives in selecting a PAC provider by using data? and, who/where will this be documented to demonstrate compliance with this requirement by showing evidence that the relevant data was presented?

How will you incorporate obtaining the consent of the resident or resident’s representative, a final report of the resident’s status (Resident Assessment) so that it is available for release to the next PAC provider or even the resident’s physician?

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Comprehensive Person-centered Care Planning (§483.21)
**Resources**

“Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements”
https://oig.hhs.gov/oei/reports/oie-02-09-00201.asp

SAMSHA’s Concept of Trauma and Guidance for a Trauma-Informed Approach.
http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf
Comprehensive Person-centered Care Planning (§483.21)

Resources

The Council on Social Work Education, NASW’s standards and indicators for cultural competence.

OIG (OEI-02-09-00201) https://oig.hhs.gov/oei/reports/oei-02-09-00201.asp

National Physician Orders for Life-Sustaining Treatment Paradigm (POLST)

Take a break.
You deserve it!