DISCLOSURE OF COMMERCIAL INTERESTS

I have no commercial interests.

THE PERSON IN PERSON-CENTERED CARE PLANNING

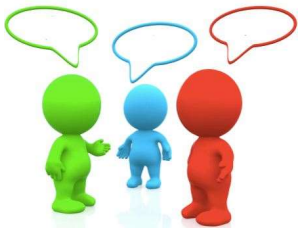
2

OBJECTIVES

- Describe the new and improved interdisciplinary team and care planning process based on new requirements of participation from CMS.
- Identify one way to use the Eden Alternative Domains of Well-Being™ as a framework for creating an individualized care plan.
- Practice writing their own care plan based on the Domains of Well-Being.

3

WHOSE CARE PLAN IS IT ANYWAY?



4

PERSON-CENTERED CARE MEANS …

- Focus on the resident as the center of control, and
- Supports each resident in making his or her own choices.
- Makes an effort to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and having an understanding of the resident's life before coming to reside in the nursing home.

5

6 THE REGULATIONS

PERSON-CENTERED CARE PLANNING

- IDT and Resident to assess, develop, and implement care plans
- Care Plans should be **STRENGTH** based
- Care plan goals must be achievable and the facility must provide those resources necessary for an individual resident to be successful in reaching those goals.

7

48-HOUR BASELINE CARE PLAN F655

- Initial set of instructions to facilitate smooth transition of care and to provide effective, person-centered care starting at admission

8

48-HOUR BASELINE CARE PLAN

- Minimum of 6 key elements:
  - Initial goals based on admission orders (**Resident's Stated Goals and Objectives)**
  - All physician orders, including medications and administration schedule
  - Dietary orders
  - Therapy services
  - Social services
  - PASARR recommendations, if PASARR completed
- Could be replaced by the comprehensive care plan if done within 48 hours of admission

9

YOUR CASE STUDY

- You have temporarily lost the use of both of your hands and range of motion in your neck more than 20 degrees. It is the new syndrome caused by tweeting, texting, facebooking, and relying on your thumbs to function. Your family is on a cruise to Alaska, so you are coming to stay with us short-term at Green Acres.

10

TABLE EXERCISE – YOUR BASELINE CARE PLAN

1. Using the previous slide, quickly outline your own baseline care plan as required by the regulations
2. What is missing? What is it important to you that I know about you before providing care?
3. Have a table discussion about what's missing and how the community could collect that information

11

DEVELOPING 48HR BASELINE CARE PLAN

- How will you make sure the resident & their representative will receive the following summary:
  - The initial goals **as stated by the resident**
  - A summary of the resident's medications and dietary instructions
  - Any services and treatments to be administered by the facility and personnel acting on behalf of the facility
- Format and location your discretion - the medical record must contain evidence that the summary was given to the resident / representative
- The guidance at F655 states, "The facility must provide the resident and the representative, if applicable, with a **written summary** of the baseline care plan

12

COMPREHENSIVE CARE PLANS F656

- Develop and implement a comprehensive, person-centered care plan for each resident, consistent with the resident rights
- Include measurable objectives and timeframes to meet resident's needs (medical, nursing, mental and psychosocial) as identified in the comprehensive assessment
- Describe at a high level services to be provided as well as resident's goals and preferences

13

COMPREHENSIVE CARE PLAN

- Include summary of resident's strengths, goals, desired outcomes, life history, personal and cultural preferences, PASARR findings and specialized services needed

14

COMPREHENSIVE CARE PLAN

- Include discharge planning elements and discharge plans as appropriate
  - Preference for future discharge, desire to return to community
  - Referrals to local contact agencies or other entities as well as updates in response to information from those entities
- Services that would otherwise have been provided that resident exercised right to refuse
- Must be developed within 7 days after completion of comprehensive resident assessment

15

COMPREHENSIVE CARE PLAN

- Participate in developing the plan, be informed of the care to be provided, and participate in decision-making, in language he or she can understand
  - Identify individuals and roles to participate, request meetings, request revisions to plan
  - Participate in establishing goals and expected outcomes of care, including duration, frequency, type, and amount

16

COMPREHENSIVE CARE PLAN

- Rooted in resident's rights
  - Be informed of care options, risks, benefits, alternatives
  - Refuse or discontinue treatment
  - Self-administer meds if IDT determines clinically appropriate
  - Be informed in advance of changes to the plan
  - Receive the services in the plan
  - Review and sign off on significant changes

17

COMPREHENSIVE CARE PLAN

- Center must inform residents of these rights and facilitate their participation; assess strengths and goals; incorporate personal and cultural preferences
- No right to receive medically unnecessary or inappropriate services

18

GUIDANCE FOR COMPREHENSIVE CARE PLANS

- Person-centered
- Describe the resident's medical, nursing, physical, mental and **psychosocial needs and preferences** and how the facility will assist in meeting these needs and preferences.
- Residents set goals (SMART)
- Person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward his/her goal(s).

19

GUIDANCE FOR COMPREHENSIVE CARE PLANS

- MDS and CAAs as starting point …
- Risks
- Preferences
- NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the clinical assessment process is more fluid and should be ongoing. The lack of ongoing clinical assessment and identification of changes in condition, to meet the resident's needs between required RAI assessments should be addressed at …

20

INFORMED CHOICE

- In situations where a resident's choice to decline care or treatment (e.g., due to preferences, maintain **autonomy**, etc.) poses a risk to the resident's health or safety, the comprehensive care plan must identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempts to find alternative means to address the identified risk/need should be documented in the care plan.

21

FROM CMS REGION V

- Care Plans must be individualized
- "Canned" or "rote" care plans = WIDESPREAD citations for care plans (That is an "F"!)

22

COMPREHENSIVE CARE PLAN F657

- Prepared and reviewed by IDT that now must include, in addition to attending physician and RN with responsibility for that resident, nurse aide and member of food and nutrition services (new)
  - Include resident and their representative(s) to the extent practicable; document an explanation if not practicable
- Review after each assessment and revised based on changing goals, preferences and needs of the resident and in response to current interventions
- Advanced notice of care conference

23

CARE PLAN MEETS PROFESSIONAL STANDARDS F658

- No requirement for the surveyor to cite a reference or source for the standard of practice that has not been followed related to care and services provided within professional scopes of practice,
- However, in cases where the facility provides a reference supporting a particular standard of practice for which the surveyor has concerns, the surveyor must provide evidence that the standard of practice the facility is using is not up-to-date, widely accepted, or supported by recent clinical literature.

24

COMPREHENSIVE CARE PLANS – SERVICES PROVIDED BY QUALIFIED PERSONS F659

- The facility must ensure that services provided or arranged are delivered by individuals who have the skills, experience and knowledge to do a particular task or activity. This includes proper licensure or certification, if required

25

TABLE EXERCISE – WRITE YOUR COMPREHENSIVE CARE PLAN

- What is important to you in the areas of ADLs, safety, mobility, activities, etc? Be sure to include all of your medications.
- How does this care plan compare to what you usually see?

26

EDEN ALTERNATIVE ® DOMAINS OF WELL-BEING

- **IDENTITY**—being well-known; having personhood; individuality; having a history
- **GROWTH**—development; enrichment; expanding; evolving
- **AUTONOMY**—liberty; self-determination; choice; freedom
- **SECURITY**—freedom from doubt, anxiety, or fear; safety; privacy; dignity; respect
- **CONNECTEDNESS**—belonging; engaged; involved; connected to time, place, and nature
- **MEANING**—significance; heart; hope; value; purpose; sacredness
- **JOY**—happiness; pleasure; delight; contentment; enjoyment

27

IDENTITY

Having a history
individuality
well-known
personhood

CONNECTEDNESS

Belonging
Engaged
Involved

SECURITY

Safety Privacy
Dignity Respect
Freedom from Anxiety

Autonomy

Choice
Freedom
Self-governance
Self-determination

MEANING

Hope
Value
Purpose
Significance

MEANING: PURPOSE

Becoming engaged, staying involved in a purpose, in purposeful activities is a key to living out our lives as happy, fulfilled individuals.

GROWTH

Development
Evolving
Enrichment

JOY

Happiness
Pleasure
Delight
Contentment

MR. MCNALLY

Laying the Foundation for Person Centered Care

36

HOW TO PROCEED

- Distribute the clues, facedown, to all the members of the hive as they would deal a deck of cards. Everyone should have several clues.
- The clues contain fragments of information about Mr. Thomas McNally, who lives at the nursing home. Some of the information is clinical in nature and some of it is personal. All the information is necessary to solve the mystery.
- After all the clues are distributed work together to piece together the story about Mr. McNally. Share what you know in order to solve the mystery.

37

WHAT IS CAUSING MR. MCNALLY'S DECLINE?

- Take 15 minutes to map out the story.

1. What was he like when he came in?
2. What happened to him?
3. How are facility routines contributing to the decline in Mr. McNally's condition?

38

DEBRIEF: WHAT DO YOU KNOW ABOUT MR. MCNALLY THAT COULD HAVE HELPED HIM IMPROVE AND THRIVE?

4. What clues do you have about Mr. McNally's strengths, needs and interests?
5. How can these strengths and interests be used as starting points to an individualized approach that reverses the decline?
6. If you were Mr. McNally, what would you need?

39

7. What changes in the facility routine would need to happen so that Mr. McNally's personal routine could be restored?
8. How could you handle this differently from the moment he arrived at your home?
9. What additional information is needed?
10. Who else would need to be involved in the discussion?

40

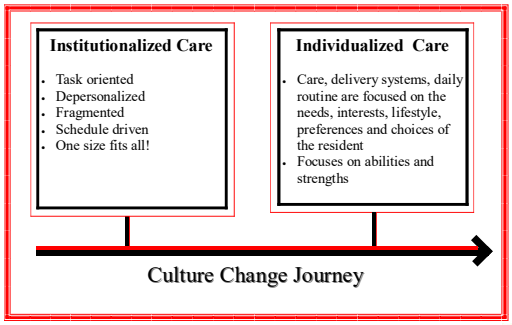
IATROGENESIS – LOSS OF LOCOMOTION

- "We caused it"

41

THE JOURNEY TO INDIVIDUALIZED CARE

42



43

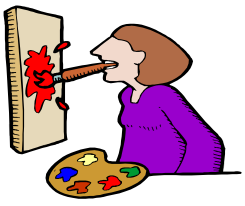
MUTUAL GOAL: PROVIDERS & ROP

- Highest practicable physical, mental, and psychosocial well-being"
  - the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process.
  - Determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental and/or psychosocial needs of the individual

44

PRACTICABLE

- It's everyone's job!



45

46 CARE PLANNING

RAI Manual

WELL-DEVELOPED CARE PLANS

- Looks at each resident as a whole human being with unique characteristics and strengths;
- Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS);
- Gives the IDT a common understanding of the resident;

47

WELL-DEVELOPED CARE PLANS

- Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers);
- Provides additional clarity of potential issues and/or conditions by looking at possible causes and risks (CAA process);
- Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow- up;

48

WELL-DEVELOPED CARE PLANS

- Looks at each resident as a whole human being with unique characteristics and strengths;
- Reflects the resident's/resident representative's input, goals, and desired outcomes;

49

WELL-DEVELOPED CARE PLANS

- Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning);
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the individualized care plan as appropriate and necessary.

50

51

CARE PLANNING PROCESS

RAI Manual plus

CARE PLANNING – IDT TOGETHER

1. Measurable goals
2. Care plan goal statements should include the subject (first or third person), the verb, the modifiers, the time frame, and the goal(s).
3. Separate care plan for each CAA not required.

52

CARE PLANNING – IDT TOGETHER

4. Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

53

INFORMATION GATHERING

- The MDS and CAAs
- Medical and physical risk assessments
- "All About Me" or similar questionnaires
- Discussions with front-line staff
- **RESIDENT!**

54

CAAS AND CARE PLANNING

- Triggered does not mean care plan
- Analysis of Triggered:
  - Warrant investigations or not
  - Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
  - Can help to minimize the onset or progression of impairments and disabilities; and
  - Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

55

IMPORTANT!!!

- Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately.
- For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments

56

CAAS AND CARE PLANNING

- IDT Decision Making: Identification of issues and resident's unique characteristics, goals, preferences, strengths, and needs.
- After IDT decides on focus statement, goals and approaches, one person volunteers to put fingers to keyboard to enter the problem.

57

MR MC NALLY'S 48 HR BASELINE CP

- What needed to be included?
- What are his strengths? (Hint: Go back to Slide 25, Questions 4 -6)
- What would be traditional care plan "focuses" or "problems" or "needs"?

58

48 HOUR BASELINE CARE PLAN

- What else is key to success?
- What didn't CMS list?
  - Customary Routine
  - Preferences
  - Who Am I?

59

WHAT WOULD BE IDEAL?

- What does the ideal care planning experience look like?
  - Who is involved?
  - Where is it happening?
  - How is the room arranged?
  - What is being discussed?
  - Who is doing the talking and what are they talking about?

60

WHAT WOULD BE IDEAL?

- What would the ideal care plan format be like?
  - What information does it contain?
  - How is it formatted?
  - How is it created and by whom?
  - How is it updated and by whom?

61

EDEN ALTERNATIVE ® DOMAINS OF WELL-BEING

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- **MEANING**—significance; heart; hope; value; purpose; sacredness
- **JOY**—happiness; pleasure; delight; contentment; enjoyment

62

HOW DID LACK OF THESE MANIFEST IN MR. MCNALLY?

- **IDENTITY**—being well-known; having personhood; individuality; having a history
- **GROWTH**—development; enrichment; expanding; evolving
- **AUTONOMY**—liberty; self-determination; choice; freedom
- **SECURITY**—freedom from doubt, anxiety, or fear; safety; privacy; dignity; respect
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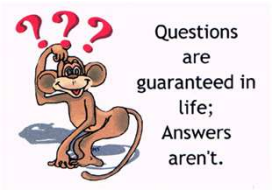
63

SUMMARY

- What insights does this provide for how they can expand their care-planning activities to make sure that they have the information they need to individualize their care?
- Facility routines meant to provide care for residents can inadvertently harm them. Individualizing care around an individual's routines, instead of the facility's routines, can reverse this harm and help individuals thrive.

64



65

RESOURCES

- www.cms.gov. Appendix P and PP
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html
- www.ahca.org
- Power, Allen. Dementia Beyond Drugs. 2017. Health Press.
- 2017 RAI Manual

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