HealthTech

Patient Centered Multi-Disciplinary Plan of Care

Carolyn St.Charles
Chief Clinical Officer, HealthTech

| 2023

Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a Master's degree in Business Administration from the Foster School of Business at the University of Washington and a Bachelor's degree in nursing from Northern Arizona University.

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
carolyn.stcharles@health-tech.us
Office: 360.584.9868
Cell: 206-605-3748

Disclaimer

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive.

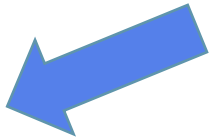
HealthTech and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof.

HealthTech does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel.

HealthTech recommends that hospitals, clinics, their respective personnel, and all other third-party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters

Schedule

1. Swing Bed Admission and Discharge	Jan 18
2. Patient-Centered Multi-Disciplinary Plan of Care	Feb 1
3. Beyond Basics	Feb 15
4. Navigating Appendix PP and Intermediate Swing	March 1
5. Working as a Team	March 15
6. Frequently Asked Questions	March 29



HealthTech

Barriers

Barriers to developing an effective Multi-Disciplinary Plan of Care

1 – The IDT regulations were written for LTC and Skilled Nursing (they do apply to Swing Bed). In LTC and Skilled Nursing the MDS guides the process but it not required for CAH Swing Beds.

2 – Nursing staff (in particular) are not used to – or educated about how to write goals that are measurable and time-limited.

3 – Although we frequently have "*informal*" conversations about patients – we usually don't have formal meetings with the intent of developing a comprehensive plan of care that includes all disciplines. Even we do bedside rounding – we don't use that to develop a multi-disciplinary plan of care.

4 – Documentation templates are not set up for multi-disciplinary documentation. ***It's Tough!*** LTC and Skilled Nursing can use the MDS process which makes it easier.

5 – It takes time! Especially with a short length of stay ------- organizing the team – holding the meetings – documenting – ALL must be done in a relatively short period of time.

6 –Scheduling meetings at a time that everyone on the team can attend.

HealthTech

Developing the Multi-Disciplinary Plan of Care

The Care Planning process starts with the comprehensive assessment

C-1620 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20) §485.645(d)(5) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter),

except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b),

or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. Discharge potential
17. Review of PASSAR – if one has been done

Source: State Operations Manual Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)

The Care Plan must be person-centered

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a **comprehensive person-centered care plan for each resident**, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

The Care Plan must include services to attain or maintain highest practicable.....

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i)The services that are to be furnished to attain or maintain the resident's **highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25, or §483.40; and

The Care Plan must include services not provided due to the patient’s exercise of rights

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's **exercise of rights** under §483.10, including the right to refuse treatment under §483.10(c)(6).

The Care Plan must include recommendations from the PASARR

C-1620 §483.21(b) Comprehensive care plans

(1) The facility must develop and implement a **comprehensive person-centered care plan for each resident**, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) **Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations**. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record

PASARR is a screening tool to identify residents with serious mental illness (SMI), mental retardation (MR), or a related condition (RC). Federal regulations do not require that a PASARR is completed for Swing Bed Patients.

Some states require completion of a PASARR for all SNF and Swing bed patients

http://www.pasrrassist.org

The Care Plan must take into account cultural preferences & history of trauma

C-1620 §483.21(b)

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—

(i) Meet professional standards of quality

(i) Be provided by qualified persons in accordance with each resident's written plan of care

(iii) **Be culturally-competent and trauma-informed**

The Care Plan must take into account cultural preferences & history of trauma

Appendix PP/F656 and P/F699 (Revised 2022): Care Planning Cultural Preferences and Trauma

- Does the care plan describe interventions that reflect the resident's cultural preferences, values and practices?

- For residents with a history of trauma, does the care plan describe **corresponding interventions for care that are in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident?**

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 208;10-21-22)

The Care Plan must take into account cultural preferences & history of trauma

The goal is not therapy but rather to eliminate or mitigate triggers that could cause re-traumatizing of the resident

The Care Plan must include the patient’s goals for admission, desired outcomes, and discharge preferences

C-1620 §483.21(b) Comprehensive care plans

(i)In consultation with the resident and the resident's representative(s)—The **resident's goals for admission and desired outcomes.**

(A) The **resident's preference and potential for future discharge**. 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, for this purpose.

(B) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section

The Care Plan must be developed by an Interdisciplinary Team

C-1620 §483.21(b

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.
7-DAYS IS TOO LONG FOR Swing Bed

(ii) **Prepared by an interdisciplinary team**, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

The Care Plan must be developed by an Interdisciplinary Team - Physician

The regulations require a physician to attend. However, a nurse practitioner or physician assistant who are involved in the patient's care could be designated to attend by the physician.

The Care Plan must be developed by an Interdisciplinary Team - Dietician

The regulations require a “representative from dietary” which may be the dietary manager.

However ---- if at all possible, the dietician should attend.

If the dietician cannot attend – the dietary manager or representative must be able to speak to nutrition goals.

The Care Plan must be developed by an Interdisciplinary Team - Rehab

For most Swing Bed patients, *but not all,* Rehab is usually one of the services provided.

This may be PT and/or OT and/or Speech.

If some of the therapy is provided by a PTA or a COTA --- the licensed PT or OT should attend the IDT meetings. The PTA or COTA could also attend as appropriate.

The Care Plan must be developed by an Interdisciplinary Team – Other Disciplines

Case Manager / Discharge Planner
These individuals are almost always included! They are a critical part of the team.

Pharmacy
If there is a complicated medication regimen or the patient is receiving antibiotics or is receiving psychotropic drugs ---- include the pharmacist.

Cardiopulmonary
For patients who are on oxygen or have a respiratory-related diagnosis – include cardiopulmonary.

Nursing Manager
If at all possible include the nursing manager – they can support nursing staff and provide education as needed.

Business Office / Finance
Some organizations include a representative from finance to assist with financial questions.

The Care Plan must be developed by an Interdisciplinary Team – Patient

To the extent practicable, the participation of the resident and the resident's representative(s).

Ideally, the patient and/or representative attends the care conference. If this is not practical you may designate someone to review the plan with the patient and/or representative after the meeting.

HOWEVER – the patient's concurrence with the plan MUST be documented in the medical record.

If the patient does not concur, the team needs to reconvene and modify the plan of care.

Important: Some surveyors will cite the organization if the patient or representative is not given a copy of the plan of care!

The Care Plan must include measurable objectives and timeframes

C-1620 §483.21(b) Comprehensive care plans.

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes **measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessmen**t.

Reminder --- Baseline Plan of Care within 48 hours of admission

F655 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) **Baseline Care Plans**

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 of the resident that meet professional standards of quality care. The baseline care plan must—

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—

(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable

Reminder --- Baseline Plan of Care within 48 hours of admission

F655 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) **Baseline Care Plans**

INTENT §483.21(a) Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to

- promote continuity of care and communication among nursing home staff,
- increase resident safety,
- safeguard against adverse events that are most likely to occur right after admission;
- ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 208;10-21-22

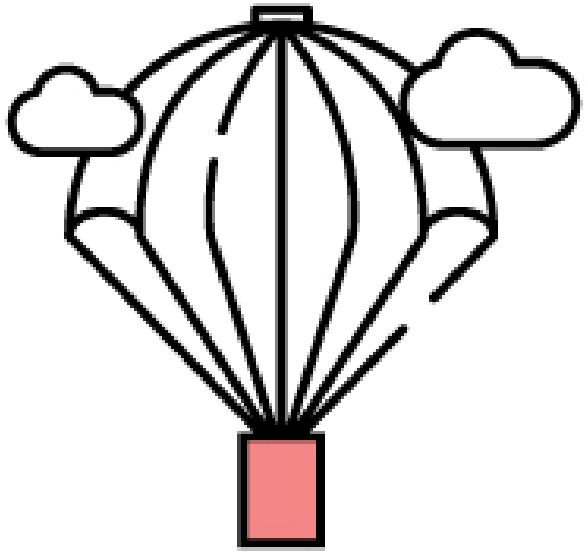
HealthTech

IDT Meetings

Effective IDT Meetings

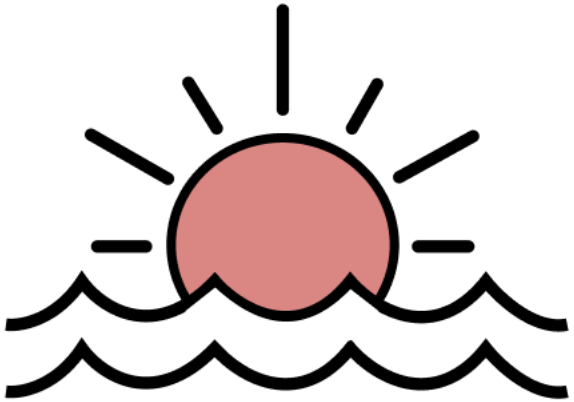
Have a team discussion **BEFORE** the conference with the patient.

This allows ideas to be shared freely and a draft plan developed for discussion with the patient.



Effective IDT Meetings

Start on time

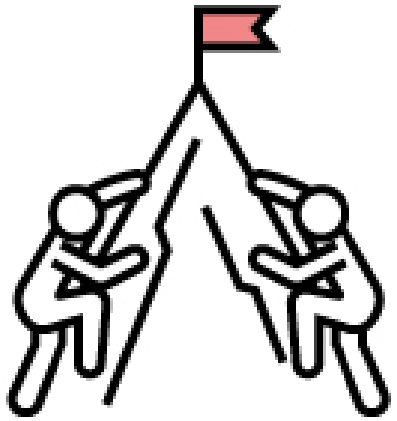


Effective IDT Meetings

Have an agenda

Effective IDT Meetings

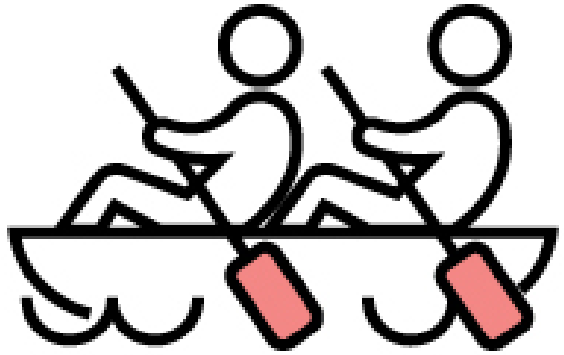
Everyone prepared



Effective IDT Meetings

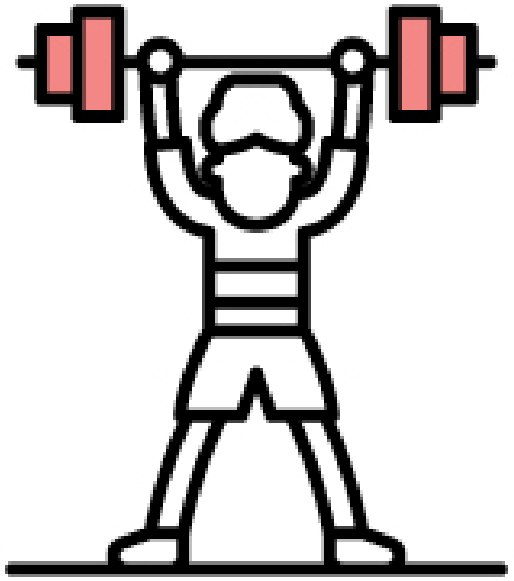
Everyone understands their role

Team members must understand the roles and contributions of each discipline on the team.



Effective IDT Meetings

Designated Facilator

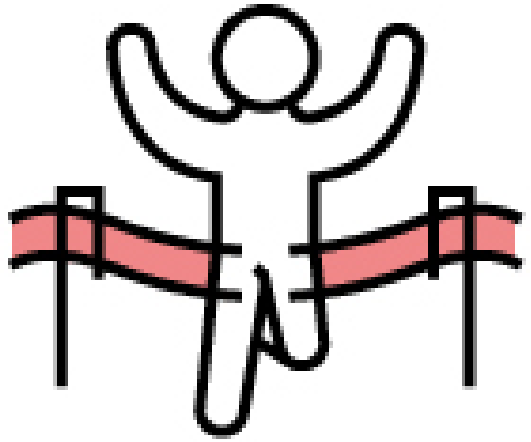


The Whole is Greater than the Sum of the Parts

Each discipline documenting separately **is not** a multi-disciplinary plan of care.

The intent of the IDT meeting is to share ideas and plans.

Team members **must integrate** their assessments and recommendations for intervention, which creates a comprehensive care plan.



Respectful Communication

Do not refer to “*the patient*” . Address the patient directly by name.

If others are attending (family, caregivers, etc.) ensure you still involve the patient.

Don’t use medical jargon – use terms the patient can understand.

Take time to listen to the patient and what they have to say!

Remember -----
Patient Goals – Not Team Goals

WHY HAS THE PATIENT BEEN ADMITTED?
WHY ARE THEY IN SWING BED?

Review / Discuss

- Patient's goals for admission and desired outcomes
- Patient's preferences for discharge
- Each discipline's assessment (Focus on those areas specific to why the patient has been admitted to Swing Bed)

Develop Goals

- Long Term Goals (measurable objectives and timeframes
- Short Term / Intermediate Goals (measurable objectives and timeframes)
- Document patient's concurrence with goals

Sample IDT Meeting Agenda

Discharge Plan

- Any update on discharge plans?
- Has anything changed?
- Does the discharge plan or timeline need to be modified?

Long Term Goals

- Review Long Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Can the patient sustain the goals if they are discharged today, or do they need additional time in the hospital to ensure there is a safe discharge?

Short Term Goals

- Review Short Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Are there any other goals that need to be added?
- If there are rehabilitation goals, how is nursing supporting the goals?

Nutrition and Hydration

- Has the patient experienced a weight loss or gain since the last meeting, and how much has the weight changed?
- If more than 5% has the dietician assessed the patient and what are the recommendations?
- Is there documentation in the medical record regarding nutrition and hydration?

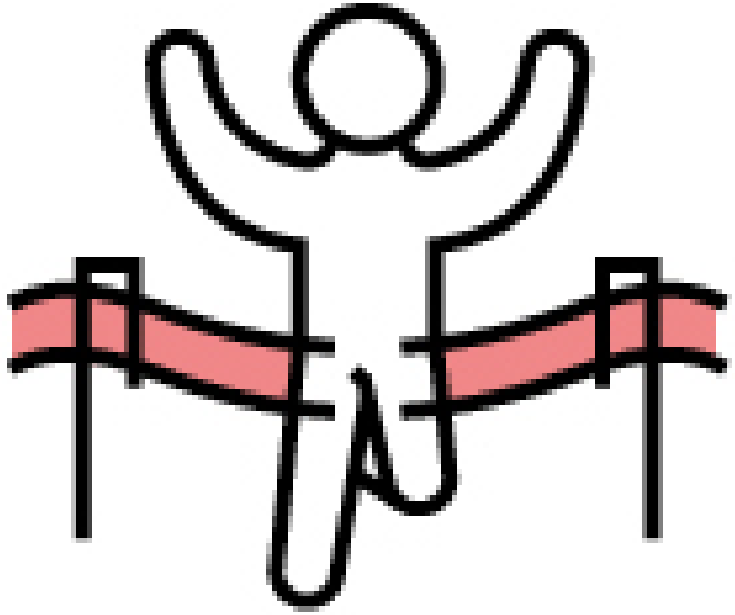
Patient Input

- Does the patient agrees with the goals and plan?
- Ask the patient to discuss any issues or provide feedback for the team

HealthTech

Examples of Measurable Goals & IDT Plan

Remember – The Whole is Greater than the Sum of the Parts



Example Measurable Goals

Discharge Goal: Mr. Jones's goal is to be discharged home, with home health if needed. He will be living with his wife.

Long Term Goal (to be achieved before discharge):
Mr. Jones will be able to dress and undress independently before discharge.

Responsible Discipline(s): Occupational Therapy and Nursing

Short Term Goals

1) Mr. Jones will be able to put on his shirt and pants independently within five days of admission.
2) Mr. Jones will be able to put on his shoes independently within seven days of admission.

Example Measurable Goals

Discharge Goal: Ms. Love's goal is to be discharged to the Assisted Living where she resided before the hospital admission.

Long Term Goal (*To be achieved before discharge):*
Ms. Love will check blood sugars and administer insulin independently before discharge.

Responsible Discipline(s): Nursing and Pharmacy

Short Term Goals

1) Ms. Love will demonstrate appropriate techniques and times for checking blood sugar within two days of admission.
2) Ms. Love will identify the correct dose of insulin based on blood sugar within three days of admission.
3) Ms. Love will demonstrate drawing up insulin and administering insulin using sterile technique within four days of admission.
4) Ms. Love will identify signs and symptoms of hypoglycemia and hyperglycemia and what actions to take within five days of admission

Example IDT Plan #1

Date **Patient Name** **MR Number**

Date of Admission **Reason for Admission** **Expected Date of Discharge**

Attendees by Name (Required for those in **BOLD**)

- ☐ **Provider**
- ☐ **RN caring for patient**
- ☐ **CNA caring for patient**
- ☐ **Representative from Dietary**
- ☐ **Patient or Patient Representative**
- ☐ Swing Bed Coordinator / Case Manager
- ☐ Rehabilitation
- ☐ Pharmacist

Significant History:

Patient's Discharge Goal (Patient's own words)

Long Term Goal(s) (What needs to occur for patient to be discharged in measurable terms)

Interventions	**Responsible Discipline**	☐ **Met** ☐ **Not Met** ☐ **Progressing** ☐ **Modifications Needed to Goal/Interventions**

Notes:

Example IDT Plan #2

Date **Patient Name** **MR Number**

Date of Admission **Reason for Admission** **Expected Date of Discharge**

Attendees by Name (Required for those in **BOLD**)

- ☐ **Provider**
- ☐ **RN caring for patient**
- ☐ **CNA caring for patient**
- ☐ **Representative from Dietary**
- ☐ **Patient or Patient Representative**
- ☐ Swing Bed Coordinator / Case Manager
- ☐ Rehabilitation
- ☐ Pharmacist

Patient's Discharge Goal *(Stated in patient's own words)*

Long Term Goal *(What needs to occur for patient to be discharged in measurable terms)*

Discharge Planning

Nutrition and Hydration Weight at Admission: Weight/Gain or Loss (If more than five (5) pounds requires a specific nutritional plan)

Date	**Current Weight**	**Loss / Gain**	**Goal**	**Interventions By Discipline**

LONG TERM GOAL	**Short-Term Goals**	**Interventions by Discipline**	**Progress**

IDT Meeting Dte

- ☐ Met
- ☐ Not Met
- ☐ Progressing

Notes:

HealthTech

Example IDT Plan #3

Patient Discharge Goal: Home with family
Long Term Goals (to be met prior to discharge)

Example Goal 1: Patient will be able to dress independently within 2 weeks and prior to discharge

Example Goal 2: Patient will receive 14 days of antibiotic therapy

Example Goal 3: Patient will improve nutritional status as evidenced by an increase in BMI to 20 within 2 weeks and prior to discharge

Example Goal 4: Patient will give insulin independently including accurately checking blood sugar, understanding dose based on blood sugar, when to administer, how to administer within 2 weeks and prior to discharge

Example IDT Plan #4

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN and IDT Note

Long Term Goal	Short Term Goals	Interventions	Discipline Responsible	Date	Date	Date
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	1. OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modify
		2. Nursing will que patient to dress each morning Saturday - Sunday	Nursing			
	Patient will be independently put on shoes within 7 days (April 3)	1. OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy			
		2. Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing			
	Patient will undress independently within 7 days and put on pajamas (April 3)	1. OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy			
		2. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing			

Example IDT Plan #5 (page 1)

Meeting Date:

Attendees:

- ❑ Patient
- ❑ Patient Rep.
- ❑ RN
- ❑ CNA
- ❑ PT
- ❑ OT
- ❑ ST
- ❑ Dietary
- ❑ Activities
- ❑ Social Service
- ❑ Provider

Patient Desired Discharge Place:

Expected Date of Discharge

Discharge Goals (To be met prior to discharge)

Example IDT Plan #5 (page 2)

Nursing

Goals (Must be Measurable and Time Oriented)

Goal 1:
Interventions
Progressing / No Change / Decline

Goal 2:
Interventions
Progressing / No Change / Decline

Goal 3:
Interventions
Progressing / No Change / Decline

Example IDT Plan #5 (page 3)

Dietary

Admit Weight Last Weight Weight Gain Weight Loss
Diet Order Supplement Order
Adequate Intake Inadequate Intake

Goals (Must be Measurable and Time Oriented)

Goal 1:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 2:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 3:
Interventions (include who is responsible)
Progressing / No Change / Decline

Example IDT Plan #5 (page 4)

Activities

Independent Activities: Activity Cart Reading TV/Music Family / Friends
Assisted Activities: Cards Crafts

Goals (Must be Measurable and Time Oriented)

Goal 1:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 2:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 3:
Interventions (include who is responsible)
Progressing / No Change / Decline

Example IDT Plan #5 (page 5)

Physical Therapy

Goals (Must be Measurable and Time Oriented)

Goal 1:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 2:
Interventions (include who is responsible)
Progressing / No Change / Decline

Goal 3:
Interventions (include who is responsible)
Progressing / No Change / Decline

Example IDT Plan #5 (page 6)

Discharge Planning

Psycho-social Concerns, Family Concerns, Status

Discharge Plan

Post Plan of Care in Patient's Room

Include both Long Term Goal and Short Term Goals for day or week.

If you don't post in the patient's room (*which you should*) – give patient a copy of goals.

Let me know if you have questions.....

Carolyn St.Charles, MBA, BSN, RN
Chief Clinical Officer
Carolyn.stcharles@health-tech.us
360.584.9868