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MDS Alert

MDS As Care Planning: Are You Ready for Baseline Care Plans?

Make sure you understand this Phase 2 requirement to avoid being cited F655.

Make sure you're prepared for the implementation of Phase 2 requirements before Nov. 28, 2017. Learn about what mistakes an MDS coordinator or nurse assessment coordinator might make, along with tricky situations you might encounter with the newly required baseline care plan. Know how to document that your team members are providing the best care possible, and make sure your facility avoids F-tag 655.

Brush up on the requirements

The baseline care plan is part of a push by CMS to make sure residents receive the best care possible. The baseline care plan is designed to be an instructional tool to guide staff with information on how to provide effective care until the comprehensive care plan is developed, says **Marilyn Mines, Rn, BC, RaC-Ct**, Senior Manager at **Marcum LLP** in Deerfield, Illinois.

"The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary," CMS says, in the current Appendix PP.

CMS requires a baseline care plan to include, at the minimum:

- Initial goals based on admission orders
- Physician orders
- Dietary orders
- Therapy services
- Social services
- PASARR recommendation, if applicable

It's designed as an initial, flexible plan. "The baseline care plan must reflect the resident's stated goals and objectives, and include interventions that address his or her current needs," CMS says. "It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable." But staff must recognize that the baseline care plan is cursory, and make adjustments and interventions as the resident needs and as the care plan evolves.

What should a baseline care plan look like?

If you're a member of a trade organization, such as the American Association for Nurse Assessment Coordination or their sister organization, the American Association of Directors of Nursing Services, you may be able to glean a baseline care plan template from their resources or a fellow member.

Consultants have great advice and tools for their clients, as well. Developing a baseline care plan template within your facility, or collaborating with someone who can help you make sure you're accurately portraying the needs and goals of your unique population, may be daunting but could be the best approach. A template that is too generic may not capture information essential to providing the best care to residents entering your facility, says **Linda Elizaitis**, president and CEO of **CMSCompliance Group** in Melville, New York.

"The baseline care plan should help to safeguard against potential adverse events that could occur soon after admission by providing sufficient information so that there is continuity of care across shifts and disciplines," she says. "The

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baseline care plan provides the framework for what we need to do to care for the resident's immediate needs whether it is addressing a potential fall risk or ensuring we have the necessary medications available to prevent negative outcomes for someone who has just entered the facility."

What could go wrong?

One of the biggest challenges about the baseline care plan is the required timeframe a plan must be developed within 48 hours of a resident's admission.

The point of completing the baseline care plan within 48 hours of admission is to ensure that MDS coordinators or nurse assessment coordinators are assessing the resident and developing a plan of care in a timely manner a plan that addresses a host of resident needs, including safety concerns, Elizaitis says.

"This could be problematic, given a resident who arrives late Friday evening to a facility," Elizaitis points out. "CMS has noted that while the updated RoPs do not state specific requirements on how to create the baseline care plan, it does clearly state that facilities are expected to create a process that ensures that new admissions have a Baseline Care Plan completed within 48 hours."

But there's some murkiness on how that 48-hour timeframe applies to all aspects of the baseline care plan. CMS notes that the plan or a summary thereof must be shared with the resident and the resident's representative, but it's still unclear whether this must happen within 48 hours as well. Regardless, sharing the plan with the resident and representative is a change in and of itself, and could cause snags in the MDS process for the whole team.

Take the new requirements as an opportunity to really involve your team members across disciplines. With the time crunch, you should be inspired to make the baseline care plan as interdisciplinary as possible. This may mean that staff needs more training and education, especially those who work the evening/night or weekend shifts and may not have had to be as involved in the care planning process before these changes. Look at the MDS by breaking it down into smaller pieces that can be handled more quickly: For example, ftaff nurses can start the clinical pieces based on physician orders as the resident is admitted.

Make sure you and your colleagues are focusing on the resident as your write the baseline care plan. "There should be a section that includes information on the resident's background and preferences that need to be considered," Elizaitis says. "The new RoPs emphasize resident choice and autonomy, and failing to take the time to find out what is important from the resident and/or representative wastes a good opportunity to truly learn about the resident and his/her needs."

Once you and team members write the plan, don't forget to provide a written summary in plain language not medical terminology to the resident and representative before the comprehensive care plan is developed, Elizaitis says.

"This includes providing them with updates to the baseline care plan until the comprehensive care plan is developed," she points out. Crucially, remember that you need to document your sharing of the baseline care plan in the resident's medical record.

These are big changes in workflow and process, so don't be afraid to think out of the box when you're figuring out how to make sure you are dotting your i's and crossing your t's. "Providing a summary of the care plan to a resident/resident representative has not been a routine practice and will require system revisions and assigning staff responsibility for entering required documentation into the record," Elizaitis says.

Don't forget that the plan is designed to be cursory. "Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change," CMS says. "In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable."

F-Tags are a risk

Beyond wanting to provide the best care possible for your new residents, as well as documenting your and your team's

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efforts, you want to make sure your baseline care plans are up to snuff so you can avoid F-tags.

"A facility stands being cited at F655 if baseline care plan issues are identified," Elizaitis says. "Even if a low-level deficiency is cited, it will have points associated with it that can affect your star rating, especially if multiple deficiencies are cited."

Plus, CMS gives these instructions to surveyors to make sure a facility's care plans comply:

"If the facility completes a comprehensive care plan instead of the baseline care plan, review the requirements of the comprehensive care plan at §483.21(b). If the care plan does not meet the requirements of §483.21(b), cite at the appropriate corresponding tag(s):

- F656 Develop Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons."

But don't let the fear of F-Tags be your sole motivation to get your baseline care planning down pat as soon as possible. There are larger ramifications to watch out for.

"Not only is lack of appropriate and timely care planning harmful to the resident, but going forward, when the SNF Valued-Based Purchasing Program 30-Day, all-cause, unplanned hospital readmission is effective for fiscal year 2019, poorly performing SNFs will be penalized," Elizaitis says.

Real money is very much at stake. "Starting in October 2018, CMS will withhold 2 percent of SNF Medicare payments to use for funding an incentive pool, and then a little more than half of that will be distributed back to SNFs after they have been ranked lowest to highest. SNFs providing higher-quality services will be rewarded more, and the lower performers will be penalized by receiving less payment," she says.

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