PointClickCare®

Requirements of Participation, Frequently Asked Questions

August/September 2017

Updated November 2017

Contents

TIMING

1. **What release will the updates (dashboards and assessments) be in?**

   3.7.14 in the middle of November time frame. Version numbers can be found at the bottom of every page on PointClickCare. The assessment will be pushed out in a patch after the 3.7.14 upload.

2. **Will PointClickCare be adding more features for Phase 3?**

   Yes, but there has been no determination as to what those may be as of yet. PointClickCare now has a product manager who looks just at all regulatory changes to drive product changes as necessary and she is spearheading an internal effort to assess what changes need to come next.

WEBINAR HANDOUTS

3. **Will we get copies of the documents you mentioned in the webinar?**

   Yes - in addition to the resources at the back of the deck to help, we will also be sending a Word doc of a facility assessment template with the PointClickCare reports listed, a compiled FAQ from all sessions, and a link to the recording of an in-depth seminar our product team did on the changes to psychotropic drugs and F329. These will be sent to you after the completion of all the webinars, so in the week of September 11th.

DASHBOARD VIEWS

4. **Will the new dashboard panel reports export to Excel?**

   Not with the initial release. This feedback has been provided to the teams working on these features.

5. **Will the dashboards also list diagnosis/indication for use?**

   Currently, this is not in the proposed solution. It has been provided back to the product group.

6. **Will there be a charge for the additional dashboard views?**

   No.

7. **Can homes manually add medications to either of the dashboards?**

   This is not functionality that will be available. We would ask that you enter a case for drugs not populating the dashboards as expected. We are populating based on the classification assigned and therefore, you should not have to manually update the listing.

8. **Does the home need to be using eMAR to see these dashboards?**

   The home must be using the Orders Management Module but is not required to use eMAR.

9. **Will the BCP Dashboard be pushed to homes?**

   No, homes will need to create the Resident Baseline Care Plan view in setup and assign to internal roles as appropriate.

ASSESSMENTS/UDAs

10. **Will all homes receive the new assessment?**

    Yes.

11. **For the baseline care plan, what will the system UDA provide that we cannot build already today? Will there be special features?**

    No new features are being added. We are using the existing toolset for these UDAs.

12. **Will these new assessments appear under construction?**

    Yes. Users with the right security access can edit the assessment to add triggers and move it online.

13. **Will the assessment have triggers to the CP library?**

    Triggers need to be built from the specific library of the home – most homes have customized their libraries and therefore we cannot push triggers. Homes will be required to edit the system UDA and add triggers to their customized library.

14. **Will PASRR information pull into the UDA?**

    Most PASRR are completed on paper and therefore will NOT pull into the UDA.

15. **Will you be able to make changes to the system assessments that will be added?**

    Yes. You will be able to copy these forward and edit them to add content or to change the format to use the care planning tool which will streamline documentation and aid in completion of the care plan in a timely manner.

16. **My understanding is that facilities can chose to do a full comprehensive care plan vs the basic CP if it's done within 48 hrs. Will PointClickCare offer any additional assistance/tools if a facility does the comprehensive assessment?**

    Homes may elect to do a comprehensive care plan within 48hrs as part of the rule. Below are the requirements stipulated in Appendix PP related to Baseline and Comprehensive Care Plan Compliance. The Baseline care plan can be based on ANY assessment that achieves the stated goals and intent of the rule but the Comprehensive Care Plan MUST be based on the MDS/CAA's.

    *** NEW***

    §483.21(a)(1) 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.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.

(ii) A summary of the resident's medications and dietary instructions.

(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

Baseline Care Plan Summary

The facility must provide the resident and the representative, if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include:

o *Initial goals for the resident;*

o *A list of current medications and dietary instructions, and*

o *Services and treatments to be administered by the facility and personnel acting on*

behalf of the facility; The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. The facility may choose to provide a copy of the baseline care plan itself as the summary, as long as it meets all of the requirements of the summary.

Given that the baseline care plan is developed before the comprehensive assessment, it is possible that the goals and interventions may change. 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.

§483.21(b) Comprehensive Care Plans §483.21(b)(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 time*frames* 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

(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*).

(iii) 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.

(iv)In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) 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.

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

When developing the comprehensive care plan, facility staff must, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

If a Care Area Assessment (CAA) is triggered, the facility must further assess the resident to determine whether the resident is at risk of developing, or currently has a weakness or need associated with that CAA, and how the risk, weakness or need affects the resident. Documentation regarding these assessments and the facility's rationale for deciding whether or not to proceed with care planning for each area triggered must be recorded in the medical record.

There may be times when a resident risk, weakness or need is identified within the context of the MDS assessment, but may not cause a CAA to trigger. The facility is responsible for addressing these areas and must document the assessment of these risks, weaknesses or needs in the medical record and determine whether or not to develop a care plan and interventions to address the area. If the decision to proceed to care planning is made, the interdisciplinary team (IDT), in conjunction with the resident and/or resident's representative, if applicable, must develop and implement the comprehensive care plan and describe how the facility will address the resident's goals, preferences, strengths, weaknesses, and needs.

Please refer to your State RAI coordinator or Survey Office for further clarification or information.

17. With the requirement that BCP be in a language that resident can understand, will there be opportunity for language conversions?

The regulation requires that to where the extent possible, the resident should be involved in the care planning process (§483.10(b)(7)(iii). Homes can edit the language on the care plan to be understandable to the resident/representative during this process. Further changes to the care planning process and outputs are being evaluated by PointClickCare. Additional changes will be announced through the regular release notification process.

18. Will the BCP dashboard also have a portion of a care plan that is of readable font?

This will be something we consider for future releases. Further changes to the care planning process and outputs are being evaluated by PointClickCare. Additional changes will be announced through the regular release notification process.

DISCHARGE PROCESS

19. Will there be a resident-friendly discharge list available? Will it be a principal discharge document with all services, medications, time of day and last dose given in common language?

There will be no changes to current functionality to produce client facing discharge materials. This is something we will explore as a larger development effort for the future.

20. Are we required to send a letter to the Ombudsman on discharges and transfers for all residents?

Clarification memo can be found here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-27.pdf

The clarification memo states that all discharges EXCEPT Resident-Initiated transfers or discharges, require notification to the ombudsman. Appendix PP, Effective November 29, 2017 states:

"Notice of Transfer or Discharge and Ombudsman Notification For facility-initiated transfer or discharge of a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. ***While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state.***" Pg. 164. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf,

F623 will address requirements for discharges and transfers and the regulations are found at §483.15(c)(3) Notice Before Transfer, §483.15(c)(4) Timing of the notice, §483.15(c)(5) Contents of the notice, §483.15(c)(6) Changes to the notice and §483.15(c)(8) Notice in advance of facility closure.

If you are unsure as to the requirements from your state Ombudsman or whether there is a specific format or form for your state, please reach out to the state Ombudsman office for clarification. Some clients have let us know that their state only requires notification with High-Risk transfers.

http://ltcombudsman.org/uploads/files/library/regulations-regarding-transfer-discharge-faqs.pdf

http://www.health.state.mn.us/divs/fpc/profinfo/061917callfile4.pdf

Sample Notices:

https://www.dhs.wisconsin.gov/dqa/memos/10-032-discharge-notice.pdf

http://ltcombudsman.org/uploads/files/issues/fl-sample-notice.pdf

21. **If a resident is transferred to the hospital, for any reason, the Ombudsman needs notified? i.e.: resident has chest pain and facility doesn't have EKG.**

    Refer to notes above.

FACILITY ASSESSMENT

22. **We completed the facility assessment already. Should we complete the evaluation close to the due date?**

    The requirement is to have it completed BY the due date and to revise it if there are any additional changes that would require modification or at least annually. If there are not any significant changes to your resources, staffing or business operations, you should be fine.

23. **Are you considering making the facility assessment a dashboard or single exportable report? Or part of Analytics?**

    Once more clear guidance is provided by CMS, we will look at alternatives to a Word Doc and how we can bring materials together to assist with this requirement.

OTHER

24. **When will the new survey entrance form be available in PointClickCare?**

    We are looking at the requirement currently.

25. **The BCP - will this require a specific care plan library?**

    It does not require a specific care plan library.

26. **Is requirement for antimicrobial stewardship or antibiotic stewardship?**

    The requirement is for antibiotic stewardship (F881) §483.80(a)(3). Antibiotics are a subset of antimicrobials.

27. **CMS just released guidance for surveys and use of a matrix that gathers information about every SNF resident. Do you foresee PointClickCare having a report that will meet this requirement?**

    We have this document in the development queue but cannot guarantee that it will be available for November 28th. We will update homes of its availability through normal release notices.