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Ask Carolyn – Your Swing Bed Questions Answered

July 24, 2020

Presenter: Carolyn St.Charles, RN, BSN, MBA
Chief Clinical Officer, HealthTechS3

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Nationwide Client Base

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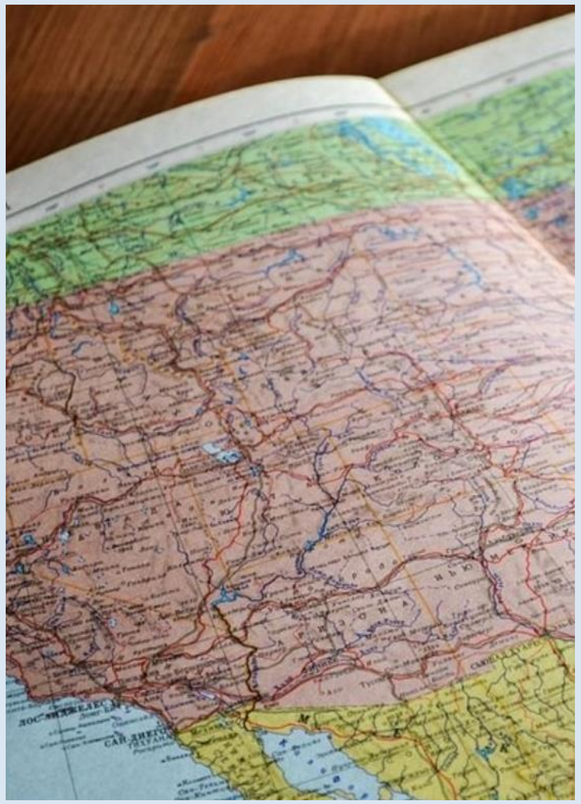

Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and Critical Access hospitals

  Example Managed Hospital Client: Barrett Hospital and Healthcare in Dillon, MT, Ranked as a Top 100 Critical Access Hospital for 8 years in a row

  Example Technology and AR Services Clients: Two-hospital NFP systems in southeast GA with numerous associated physician practices

Preferred vendor to:

- California Critical Access Hospital Network
- Western Healthcare Alliance Partner with Illinois Critical Access Hospital Network
- Vizient Group Purchasing Organization

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Areas of Expertise

Strategy - Solutions - Support

Governance & Strategy

- Executive management & leadership development
- Community health needs assessment
- Lean culture

Finance

- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

Recruitment

- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

Interim Executive & Department Leadership

Staffing Community Hospitals since 1971

HealthTechS3

Design.Build.Optimize → High Performance Teams

- **The Right Person** – Our experience and understanding of your hospital is the key to placing the right Executive or Department Leader
- **Immediate Response** – Interim needs are typically immediate. Our bench strength allows us to find the right executive quickly to provide a seamless transition
- **Experience** – Over 49 years of supporting executives & teams in hospitals and healthcare companies of all sizes
- **Support Services** – Our business is managing hospitals more efficiently. We provide comprehensive support services to all our Interim Executives and Department Leaders

- **Our Depth:**
We support all positions including CEO, CFO, CNO, CIO, Clinic Administration and Department Leaders

- **Interim Executive Placement Services:**
"Blue Mountain Hospital District has benefited from the interim executive placement services HealthTech S3 provides. Our current CFO started as an interim placement for BMHD, prior to joining our organization in a permanent capacity. The success with this placement has motivated us to consult Health Tech with two subsequent interim executive needs." **Derek Daly, CEO BMHD**

Retained | **Contingency** | **Interim** | **Contract**

Mentoring/Support Team

Every Interim Executive and Department Leader is backed by a support team and mentor who help ensure that the team gets the right results

HealthTechS3

Design.Build.Optimize → High Performance Teams

Operations

Neil Todhunter
President

Mike Lieb
VP - Interim Placement

Derek Morkel
CEO

Clinical

Carolyn St. Charles
Chief Clinical Officer

Faith Jones
Director of Care Coordination and Lean Consulting

John Coldsmith
Clinical Consultant

Financial/RCM

John Freeman
AVP Finance

Kevin Stringer
AVP Finance

Joy Smith
Senior Patient Financial Consultant

Retained | **Contingency** | **Interim** | **Contract**

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2020 QUARTER 3 WEBINARS

Community Health Needs Assessments: More Than a Regulation – A Tool to Assist in Delivering Care
Date : July 14, 2020 **Time :** 12pm CST
Presenter : Julie Haynes, Strategic Planning Consultant
Presenter : Faith M Jones, MSN, RN, NEA-BC Director of Care Coordination and Lean Consulting
https://bit.ly/2ZqPgzr

Ask Carolyn – Your Swing Bed Questions Answered
Date : July 24, 2020 **Time :** 12pm CST
Speaker : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
https://bit.ly/2Zw55os

More Than a Plan: Keeping Your Physical Environment of Care Safe for Patients, Staff and Visitors
Date : August 7, 2020 **Time :** 12pm CST
Host : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Speaker : Dr. Frank Mineo, FACHE, CEM, CHSP, CHEP
https://bit.ly/3eRC5ho

Effective Communication in Healthcare
Date : August 14, 2020 **Time :** 12pm CST
Host : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Speaker : John A. Coldsmith, DNP, MSN, RN, NEA-BC
https://bit.ly/2AiNkAq

Bringing Care Coordination to Specialty Practices: Principle Care Management
Date : August 27, 2020 **Time :** 12pm CST
Speaker : Kevin Franke, BSN, Principal Consultant, Care Partner, LLC
Facilitator : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
https://bit.ly/3dQiaya

The Role of a Rural Hospital's Board in a Time of Crisis: How the Hospital Board and CEO Ensure an Organization's Success During COVID-19
Date : September 4, 2020 **Time :** 12pm CST
Speaker : Peter Goodspeed, Vice President of Executive Search
https://bit.ly/38fXyOI

Rural Healthcare Challenges in Times of Change
Date : September 11, 2020 **Time :** 12pm CST
Host : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Presenters : Rhonda Mason, Cobre Valley Regional Medical Center; Margie Molitor, *Hot Springs County Memorial Hospital*; Deborah Morris, *Blue Mountain Hospital*; Terry Odom, *Powell Valley Healthcare*
https://bit.ly/38gZWEI

Innovating Care Models for Opioid Use Disorder Patients
Date : September 24, 2020 **Time :** 12pm CST
Presenter : Rebecca Morgan, CEO, Spark Creative
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting
https://bit.ly/2ZyjQaC

The Hospital's Role in Getting the Right Interim Leader – What Does it Need to Know?
Date : September 25, 2020 **Time :** 12pm CST
Speaker : Mike Lieb, FACHE – Vice President
https://bit.ly/2BvqXZ7

An Introduction to Our Cloud-Based Optimum Financial Statement Toolkit (OFST)
Date : September 30, 2020 **Time :** 12pm CST
Presenter : John Freeman, Associate Vice President
Presenter : Kevin Stringer, Associate Vice President
https://bit.ly/2YPQG7G

ALL WEBINARS ARE RECORDED

Presenter

Carolyn St.Charles

Chief Clinical Officer

Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position with HealthTechS3 for more than fifteen years.

In her role as Chief Clinical Officer, she conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, and Rural Health Clinics. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.

Carolyn has extensive experience in working with rural hospitals to both develop and strengthen SwingBed programs.

carolyn.stcharles@healthtechs3.com

360-584-9868

Instructions & Disclaimer

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all of your questions – but if we don't get to them during the webinar we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

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Agenda

1. Swing Bed Survey – THANK YOU!
2. Regulatory Requirements
3. COVID-19 and Waivers
4. Admission Criteria
5. Admission Processes and Notices
6. Multi-Disciplinary Plan of Care and Documentation
7. Discharge Processes and Notices
8. Other Questions
9. Best Practices

Lots of Questions

Some Answers









The waivers can be a little confusing – please check the exact wording in the waivers and how they would apply to your specific situation.

Some regulations are not always clear and we don't have interpretative guidelines for new regulations issued in February
I am not CMS!

Contrary to popular belief – I don't know the answer to every question!

I WILL NOT go over every slide. Some slides are reference information for your use.

SWING BED SURVEY

Thank you to everyone who completed the Swing Bed Survey

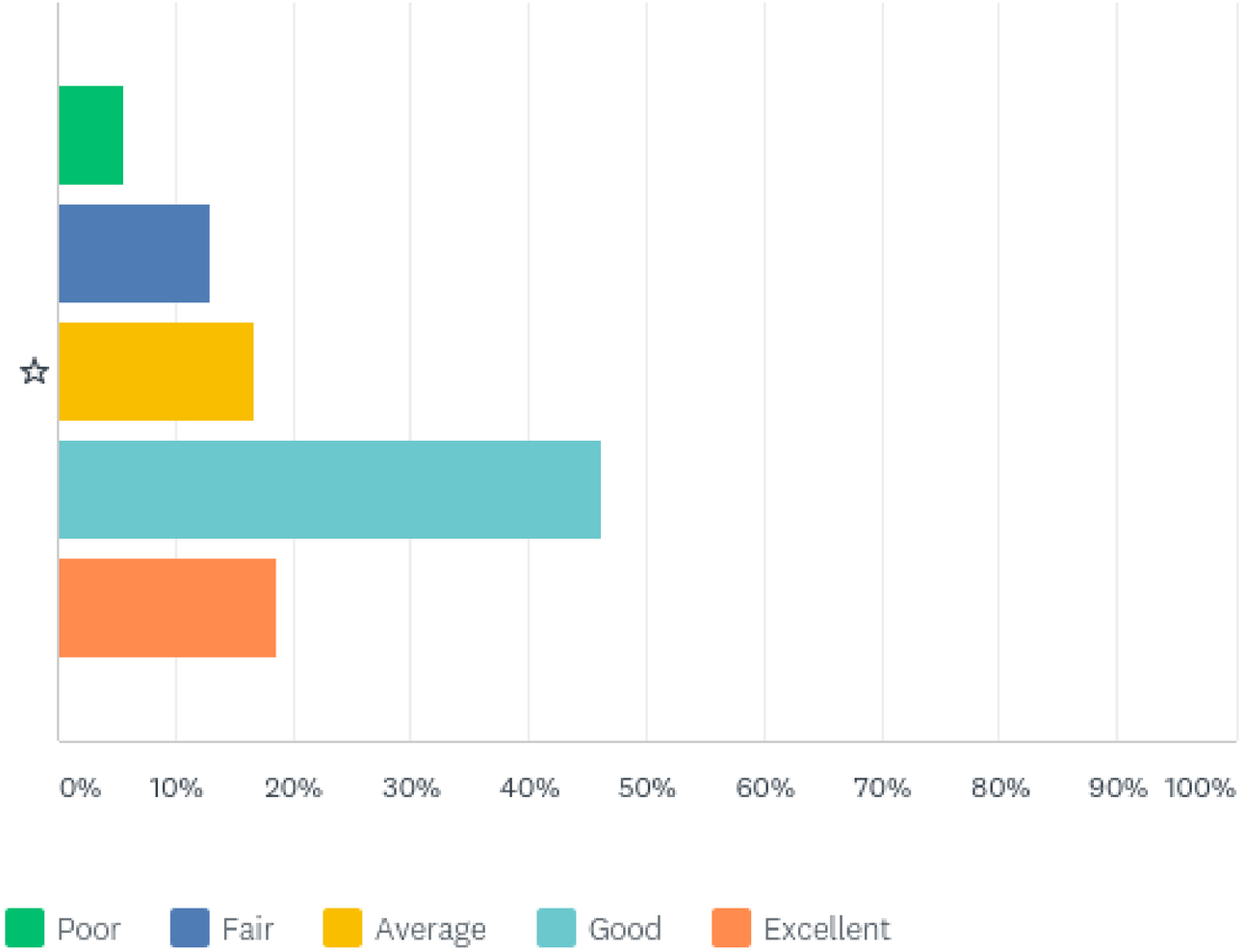
There were a total of 55 responses

Results of survey are included thru out the webinar slides

Survey slides not discussed during are included at the end of the presentation

Q3: How would you rate your Swing Bed Program?

Weighted Average 3.59



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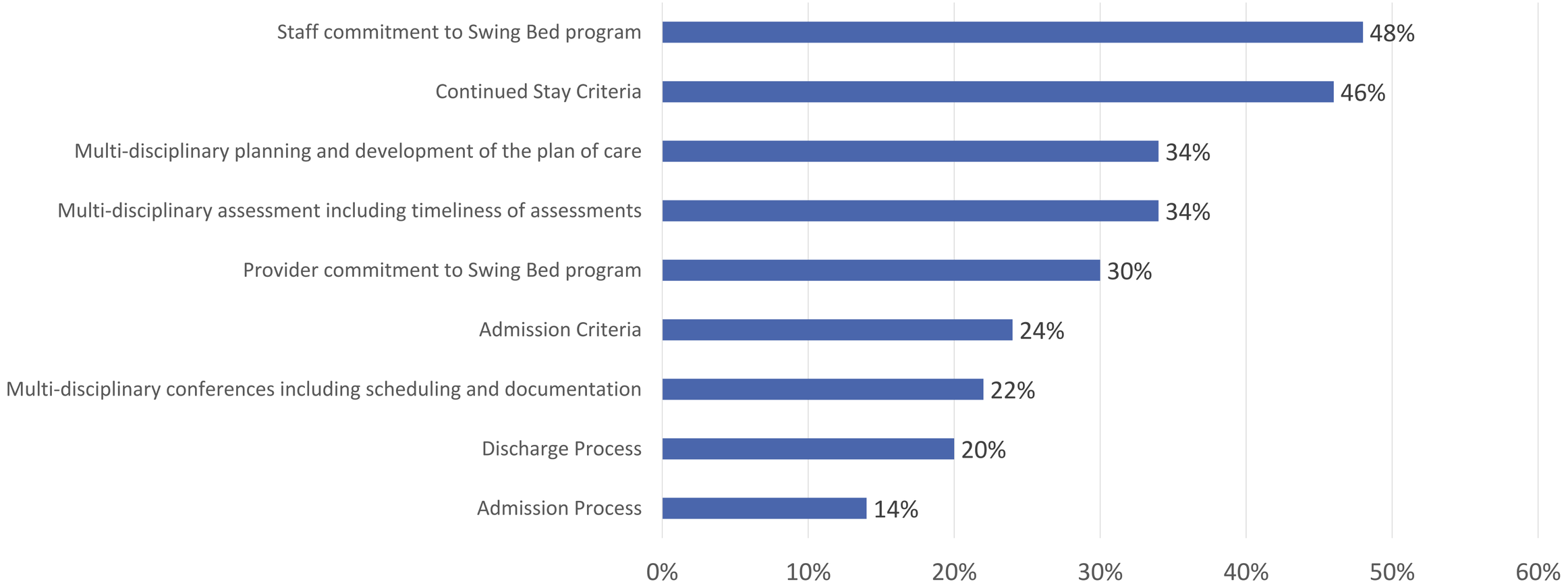
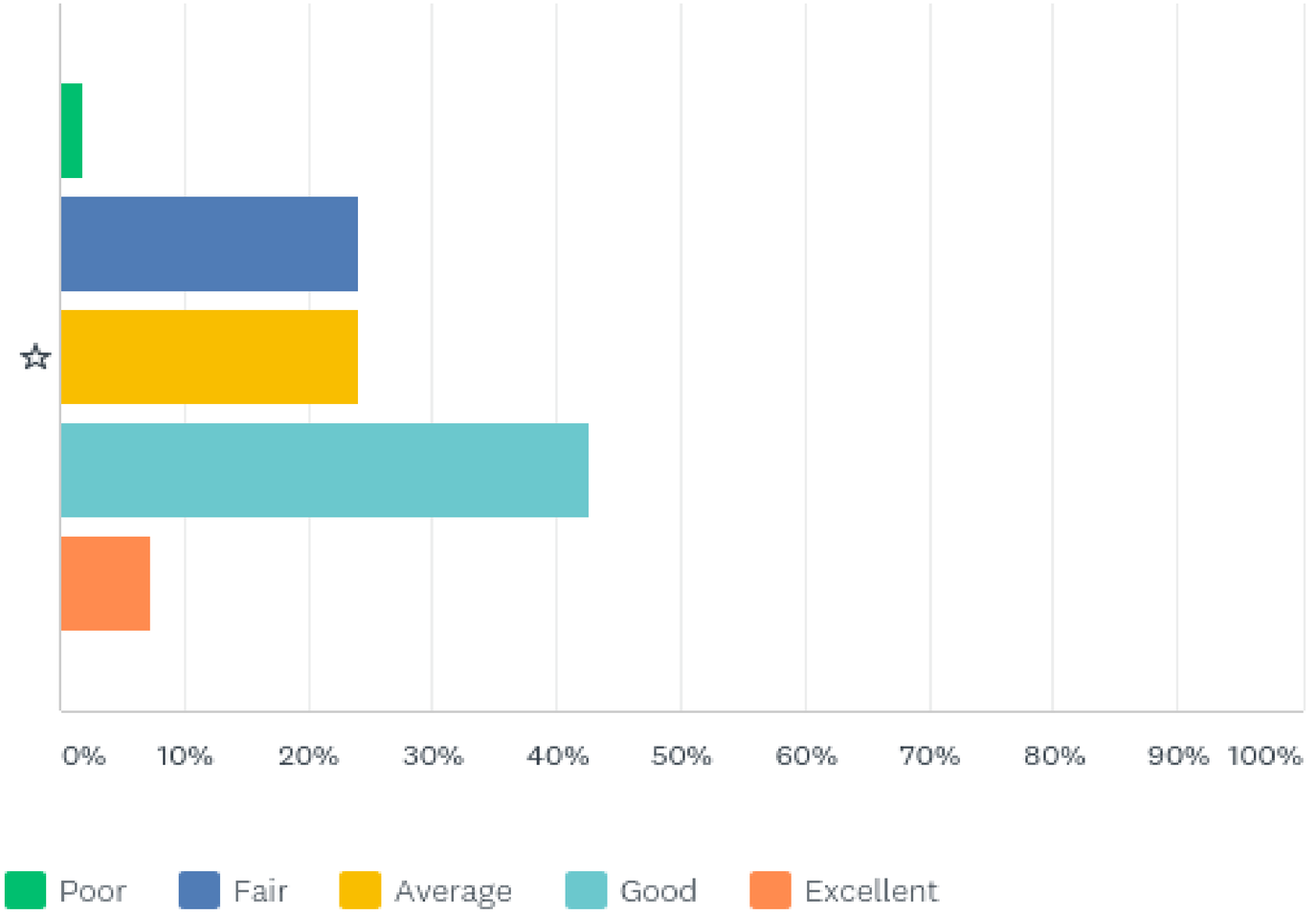
Q30: Please choose the process you find most challenging related to Swing Bed.(select all that apply)



REGULATORY REQUIREMENTS

Q7: How would you rate the Swing Bed team knowledge of the Conditions of Participation (regulations) for Swing Bed?

Weighted Average 3.30



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Regulatory Resources

Appendix W (CAH) (Rev. 200, 02-21-20)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

Appendix A (Hospital) (Rev. 200, 02-21-20)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_a_hospitals.pdf

Note: Appendix W and Appendix A revision do not include interpretative guidelines for new standards.

1135 Waiver

Appendix PP (Long Term Care) (Rev. 173, 11-22-17)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Medicare Benefits Manual Chapter 8 (Rev. 261; Issued: 10-04-19)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

Omnibus Burden Reduction Final Rule CMS (11/29/2019)
https://www.cms.gov/newsroom/fact-sheets/omnibus-burden-reduction-conditions-participation-final-rule-cms-3346-f

COVID-19 and WAIVERS

Covid-19 and Waivers

Q: Any idea how long the 3 midnight stay Medicare waiver will last?

A: No --- but the waivers are only valid as long as the COVID-19 Public Health Emergency exists

Q: Does CMS have any waivers that are being used at this time?

A: There are multiple waivers in place
6/25/2020: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Covid-19 and Waivers

Q: Do the CMS blanket waivers (no need for 3 day stay and being able to restart SNF benefits when days are exhausted) apply to swing bed.
Q: Does waiving (pursuant to section 1812(f) of the Act) the requirement for a 3-day prior hospitalization for coverage of a SNF stay apply to swing-bed services furnished by CAHs and rural (non-CAH) swing-bed hospitals?

A: Yes

CMS: COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing
Under the section 1812(f) waiver, CAHs and rural (non-CAH) swing-bed hospitals may furnish extended care services to a SNF-level patient even if the patient has not had a 3-day prior hospitalization in that or any other facility.
file:///C:/Users/carol/OneDrive/Documents/COVID%2019/COVID_FFS-Inclusive_FAQs-updated_7.15.2020_0.pdf

Covid-19 and Waivers

Q: Processes and implications of applying CMS waiver for swing beds in a non—CAH. Particularly, financial impact of DRG inpatient with COVID Modifier vs. Swing bed per diem rate.

A: All PPS SWP providers will be paid under PDPM and not affect the DRG payment of the hospital stay payment

The waiver process would be followed and SNF medical necessity and skilled service requirements are expected in the swing bed patient medical record. The waiver is to utilize swing bed but requirements are the same with waiver.

The MDS waiver is for submission and transmission timeframes but still require the swing bed to utilize the RAI Process on each swing bed. The waiver does not eliminate the RAI process or the need to do the MDS assessments.

Covid-19 and Waivers

Q: What are facilities requiring for swing bed patient's in relation to COVID on new admissions?

A: Generally - Placing the patient in isolation until a Negative Covid test is the most common.

Q: In light of the ongoing COVID-19 pandemic, I wondered if there are any specific recommendations related to managing the Swing Bed patient rights and responsibilities and other admission paperwork?

Is Swing Bed paperwork still being done with staff going into COVID positive rooms?

Is it being done via phone to avoid bringing paperwork into the room?

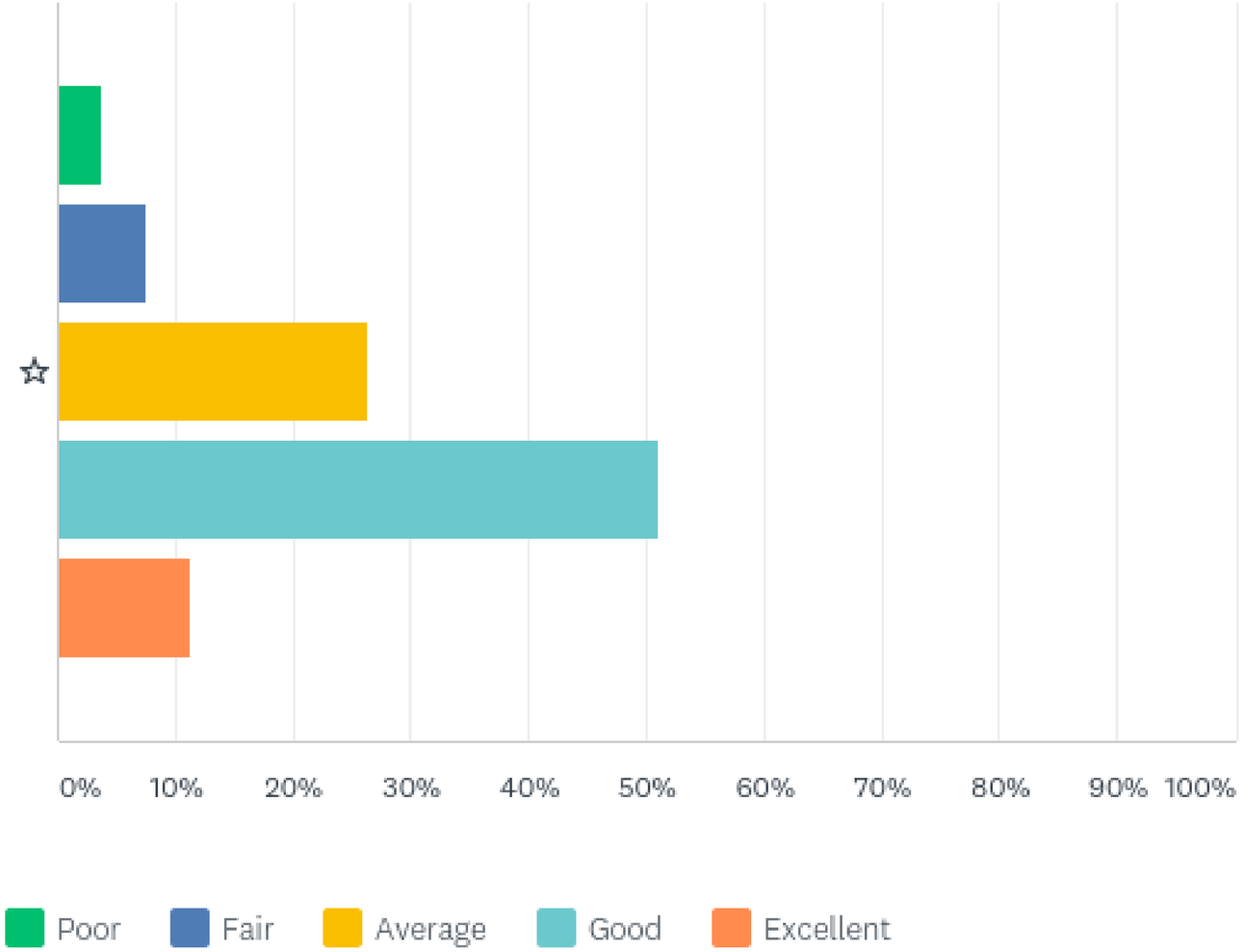
A: You are still required to provide the information both in writing and verbally.

Any ideas? – Use the question / chat box

ADMISSION CRITERIA

Q4: How would you rate the Swing Bed admission process?

Weighted average 3.58



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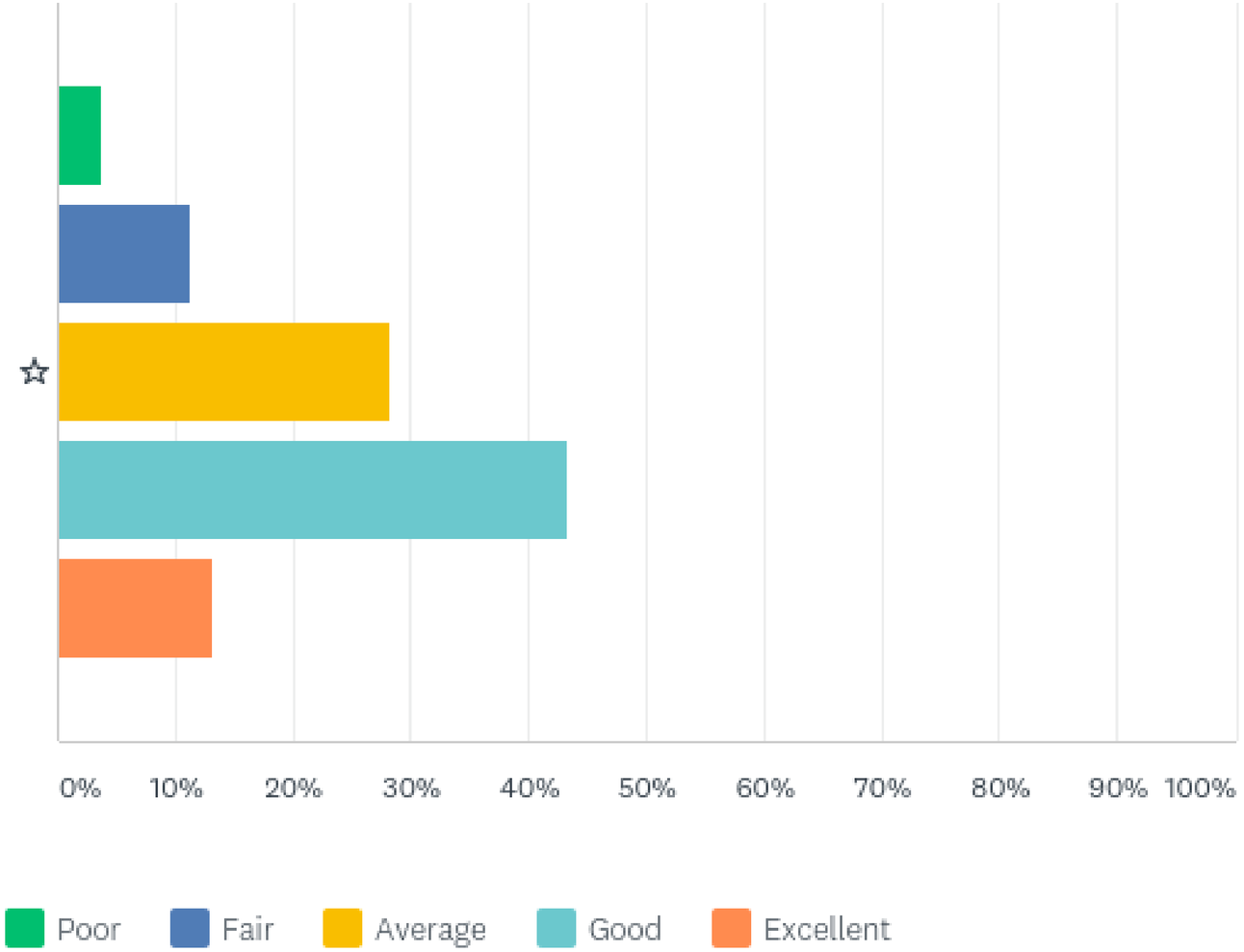
Q5: How knowledgeable is the Swing Bed team about admission and ongoing stay criteria (e.g. what types of patients can be admitted to Swing Bed and how long they can stay)?

Weighted Average 3.51



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3-Day Qualifying Stay

Q: We would like more information on how best to determine if a patient needs another 3 night stay within a 30 day window. How do you determine same benefit period?
For instance, patient had 3 night stay for hip replacement, stayed in Swing bed for week, went home 1 day, fell at home (he wouldn't stay longer in Swing bed), diagnosed with back injury and needs swing bed again. To us, the fall resulted from weakness from hip replacement so he doesn't need another 3 night stay. Medicare said it was a separate incident not stemming from first so it was a new benefit period. But this all occurred within those 30 days.

A: You could try to appeal (?)

Medicare Benefit Policy Manual Chapter 8 - Three-Day Prior Hospitalization
To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.

Swing Bed Discharge to SNF or Long Term Care

Q: Can swing bed be used when patients will be discharged to long term care? Our acute length of stay has been creeping up, which we attribute partly to an increased use of Observation status that has lessened our shorter acute stays, as well as some other delayed discharges. Our philosophy regarding swing bed is that the goal should be for the patient to return home. I am aware of hospitals that will use swing bed as a "bridge" if a nursing home isn't able to accept a patient or there are other delays in discharge. We'd appreciate your thoughts on that.

A: Patients can be discharged to long term care. However if they still have a skilled need – that may be a problem unless the patient requests to be discharged to LTC.

Q: If we admit someone to SWB for skilled rehab and skilled nursing and the patient is making slow progress and it is felt that the patient would benefit from a more long term skilled rehab stay can a patient do a lateral discharge to a SNF? Or can we only do that if the patient is not making progress and now is determined to need "custodial" cares.

A: My understanding is that lateral transfers are not allowed – unless requested by the patient.

Appendix W C-1600 §485.645

- *There is no length of stay restriction for any CAH swing-bed patient.*
- *There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.*
- *While there is no length of stay limit for patients in swing-bed status, the intended use for swing beds is for a transitional time period to allow the patient to fully recover to return home or while awaiting placement into a nursing facility.*
- *The CAH should document in the patient's medical record efforts made for nursing facility placement.*

CAH 96-Hour Rule and Swing Bed

Q: CAHs utilizing swing bed to meet the 96 hour rule – is this a problem

A: Yes. IF the patient still meets acute care - they are not appropriate for Swing Bed. PEPPER report (although only distributed annually by CMS) – looks at 3-day admissions to Swing or SNF.

Q: If a patient does not have PT/OT but is still acute after 96 hours what do we do?

A: PT/OT is not the only reason for a Swing admission -- Patient must meet skilled criteria to be admitted to Swing Bed

C-1026 §485.635(b)

……Furthermore, for each Medicare beneficiary, the CAH is required in accordance with Medicare payment law and regulations to have the practitioner who admits the beneficiary as an inpatient certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. However, while it may be true that CAHs generally are not expected to handle patients requiring complex, specialized inpatient services, such as those services provided by trauma centers, or cardiac surgery centers, CAHs should be able to handle a range of patient needs requiring inpatient admission. CMS does not believe it is in the best interest of patients for them to routinely be transferred to a more distant hospital if instead their care can be provided locally without compromising quality or the length of stay requirements (78 FR 50749). Accordingly, acute inpatient services must be furnished to patients who present to the CAH for treatment so long as the CAH has an available inpatient bed and the treatment required to appropriately care for the patient is within the scope of services offered by the CAH.

End of Life

Q: Can you use swing bed for end of life care? And what would skilled need be?

We understand that end of life care can be provided if the patient has a skilled nursing need, but we often feel we can find reasons for a skilled need and just as easily dispute those needs (i.e. pain management and the need for IV/IM medications to alleviate pain).

A: Skilled care need is required for admission to Swing Bed. Palliative care is not a skilled need. If you think there is a skilled need – very detailed documentation is essential.

See Skilled Criteria next slide

Skilled Criteria

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 261; Issued: 10-04-19)

30 - Skilled Nursing Facility Level of Care – General
Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care.

Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet

No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.

There are situations in which the patient's potential for improvement would be a reasonable criterion to consider, such as when the goal of treatment is to restore function. We note that this would always be the goal of treatment in the inpatient rehabilitation facility (IRF) setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered.

However, Medicare has long recognized that there may be situations in the SNF, home health, and outpatient therapy settings where, even though no improvement is expected, skilled nursing and/or therapy services to prevent or slow a decline in condition are necessary because of the particular patient's special medical complications or the complexity of the needed services.

The manual revisions clarify that a beneficiary's lack of restoration potential cannot, in itself, serve as the basis for denying coverage in this context, without regard to an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question. Conversely, such coverage would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of *nonskilled* personnel.

Medicare has never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition. Thus, such coverage depends not on the beneficiary's restoration potential, but on *whether skilled care is required*, along with the underlying reasonableness and necessity of the services themselves. The manual revisions serve to reflect and articulate this basic principle more clearly. Therefore, denial notices for claims involving maintenance care in the SNF, HH, and OPT settings should contain an accurate summary of the reason for the determination, which should always be based on whether the beneficiary has a *need for skilled care* rather than on a lack of improvement.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/jimmo_fact_sheet2_022014_final.pdf

Management of Plan of Care

Q: Skilled care for management of a care plan and observation / assessment – how can this be applied in the swing bed environment?

A: Medicare Benefits Manual Chapter 8 has great examples

Medicare Benefit Policy Manual Chapter 8 Management and Evaluation of a Patient Care Plan
The development, management, and evaluation of a patient care plan, based on the physician's orders and supporting documentation, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety.

However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment.

The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.

The patient's clinical record may not always specifically identify "skilled planning and management activities" as such.
Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management, as illustrated in the following Examples

Example 1 – Medicare Benefits Manual Chapter 8

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until such time as skilled care is no longer required in coordinating the patient's treatment regimen, even though the individual services involved are supportive in nature and do not require skilled nursing personnel. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the stabilization of the patient's medical condition and safety.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

Example 2 – Medicare Benefits Manual Chapter 8

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

Documentation of Skilled Need

Q: Does the qualifying skilled need whether it be Rehab or Nursing have to be documented by the provider or can it be included in the interdisciplinary admission eval/assessments?

A: Provider documentation AND Interdisciplinary Assessment

Medicare Benefit Policy Manual Chapter 8
40 - Physician Certification and Recertification of Extended Care Services
Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished. The SNF must obtain and retain the required certification and recertification statements. The A/B MAC (A) may request them to assist in determining medical necessity when necessary.

The SNF will determine how to obtain the required certification and recertification statements. There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met. Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services for purposes of the program. There must be a separate signed statement indicating that the patient will require on a daily basis SNF covered care.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

ADMISSION PROCESSES

Admission Processes

Q: Do most EMR systems require a discharge and readmission when patient goes from Swing SNF to an ICF waitlist bed?

A: Sorry – not sure about this one. YES if from acute to swing. May depend on how it is being billed???

Q: Is there a way the swing bed admissions could be streamlined better between facilities?
Q: Is there a way that we can streamline the process between insurance, physicians, and admits: especially when it comes to direct swing bed patients from other facilities?

A:

- Develop criteria for types of admissions you will accept at your facility in collaboration with providers
- Use the criteria to develop a checklist and use when you are reviewing patients for admissions. Identify any issues of concern for provider review
- Provide checklist to providers as part of their review and decision making process
- Identify WHO are the critical individuals that must agree to admission --- whole team / case manager and provider / other?
- Set a timeline for responding to admission requests – and monitor – including reasons for not meeting timeline

Any ideas? – Use the question / chat box

Nurse Practitioners and Physician Assistants H&P

Q: What is the regulation for Arizona when a NP who is the hospitalist completing the Admission and H&P. The CMS CoPs state it has to be a provider. Looking at how do other organizations handle the ruling.

Q: When using FNP for H&P or discharge summary, do we still need an attestation from physicians that they have been involved in the assessment and plan of care and agree with the FNP?

A: I'm not sure about Arizona specifically.
C-0998: NP can complete the H&P
C-0986: All inpatient records must be signed by a physician

Nurse Practitioners and Physician Assistants

C-0984 §485.631(b)(1)(iii)
In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH'S patient records, provides medical orders, and provides medical care services to the patients of the CAH;
Survey Procedures §485.631(b)(1)(iii)

- *How does the CAH ensure that an MD/DO periodically reviews CAH patient records in conjunction with staff mid-level practitioners and provides medical care to CAH patients?*
- *What evidence demonstrates that there is a periodic review of patient records by the CAH MD/DO(s)?*

C-0993 §485.631(c)(1)(ii) *Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.*
Survey Procedures §485.631(c)(1)(ii)
How does the CAH ensure that mid-level practitioners at the CAH participate with an MD/DO in the review of their patients' health records?

C-0998 §485.631(c)(3)
Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.
Interpretive Guidelines §485.631(c)(3)
The CAH regulations do permit licensed mid-level practitioners, as allowed by the State, to admit patients to a CAH.
However, CMS regulations do require that Medicare and Medicaid patients be under the care of an MD/DO if admitted by a mid-level practitioner and the patient has any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.
Evidence of being under the care of an MD/DO must be in the patient's medical record.
If a CAH allows a mid-level practitioner to admit and care for patients, as allowed by State law, the governing body (or responsible individual) and medical staff would have to establish policies and bylaws to ensure patient safety.
As applicable, the patient's medical record must demonstrate MD/DO responsibility/care.

Nurse Practitioners and Physician Assistants

C-0986 §485.631(b)(1) [*The doctor of medicine or osteopathy-]*
(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, or physician assistants. (v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

Interpretive Guidelines §485.631(b)(1)(iv) & (v)
All inpatient records for patients whose treatment is/was managed by a nonphysician practitioner in the CAH, i.e., nurse practitioners, clinical nurse specialists, or physician assistants, must be reviewed periodically by a CAH MD/DO who must sign the records after the review has been completed. The MD/DO review is expected to cover all applicable inpatient records open at the time of the review, as well as all applicable inpatient records closed since the last review. In the case of inpatients whose care is/was managed by an MD/DO, as evidenced by an admission order, progress notes, and/or medical orders, etc., but who also receive services from a non-physician practitioner, a subsequent MD/DO review of the inpatient record is not required. In States where State law requires a collaborating physician to review medical records, co-sign medical records, or both for outpatients whose care is managed by a nonphysician practitioner, i.e., a nurse practitioner, a clinical nurse specialist, a certified nurse midwife, or a physician assistant, a CAH MD/DO must review and sign a sample of outpatient records. The outpatient medical record sample reviewed must be representative of all non-physician practitioners providing care to patients of the CAH. The CAH determines by policy the size of the sample reviewed and signed; however, CMS recommends, but does not require, a sample size of 25% of the records of all outpatient encounters managed by a non-physician practitioner since the prior MD/DO review. If State law requires MD/DO review or signature of a larger percentage of the outpatient records, the CAH must comply with State law. In States where no physician record review or physician co-signature is required for patients managed by a non-physician practitioner, an MD/DO is not required to review or sign outpatient records of such patients. Neither the regulation nor the preamble to the final rule adopting this regulation (79 Fed. Reg. 27105, May 12, 2014) specify a particular timeframe to satisfy the requirement for “periodic” review, but the CAH must specify a maximum interval between inpatient record reviews in its policies and procedures. The CAH is expected to take into account the volume and types of services it offers in developing its policy. For example, a CAH that has only four certified beds and one MD/DO on staff and which does not always have an inpatient in house would likely establish a different requirement for inpatient record review than a CAH with 25 certified beds, multiple MDs/DOs on staff and a high inpatient occupancy rate. Further, there is no regulatory requirement for the review of records to be performed on site and in person. Thus, if the CAH has electronic medical records that can be accessed and digitally signed remotely by the MD or DO, this method of review is acceptable. Therefore, CAHs with and without the capability for electronic record review and signature might also develop different policies for the maximum interval between reviews

Patient Required Notices - Admission

Q: Can the verbiage be changed so that it is more user friendly for patients?
I get many questions and we have all run into the patient that believes they can stay for 20 days no matter what?

A: I don't know that you can change verbiage….. But consider……

- Explain that 20 days is only the point that co-pay becomes effective
- Emphasize that (just like an acute stay) length of stay is based on the need for skilled care
- Provide some examples of average length of stay in Swing Bed for similar conditions / diagnosis
- Ensure providers and interdisciplinary team reinforce length of stay
- Provide care goals based on expected length of stay

Q: Review of Medicare notices to be given.
Q: What financial forms are required for Swing Bed patients? Are there different Conditions of Registration forms for Swing Bed patients?
Q: What are the exact forms required to be completed for a swing bed admission

A: In addition to hospital required forms……. See next page

Required Notices at Admission

Information provided both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act.

Such notification must be made prior to or upon admission and during the resident's stay.

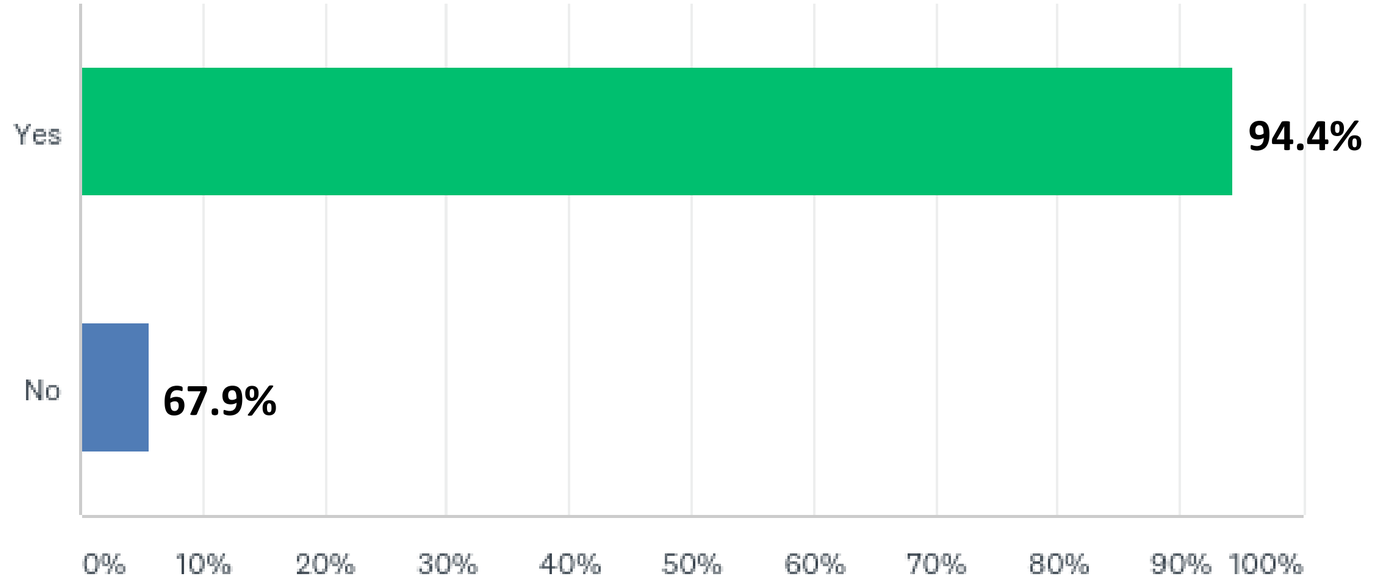
Receipt of such information, and any amendments to it, must be acknowledged in writing

A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits.

C-1608 §485.645(d) SNF Services.

- ❑ Description of Swing Bed - Recommended
- ❑ Resident Rights and Responsibilities
- ❑ Advance Directives
- ❑ Choice of physicians
- ❑ Information on how to contact providers
- ❑ Financial Obligations
- ❑ Transfer and Discharge Rights
- ❑ Visitation
- ❑ Notice of privacy practices
- ❑ How to file grievance or complaint
- ❑ Hospital responsibility for preventing patient abuse
- ❑ Information for reporting Abuse and Neglect
- ❑ Contact information for Hospital and State Agencies including State Ombudsman

Q11: Are Swing Bed patients provided with their Rights and Responsibilities specific to Swing Bed?



Notice of Resident Rights and Responsibilities

C-1608 §485.645(d) SNF Services.

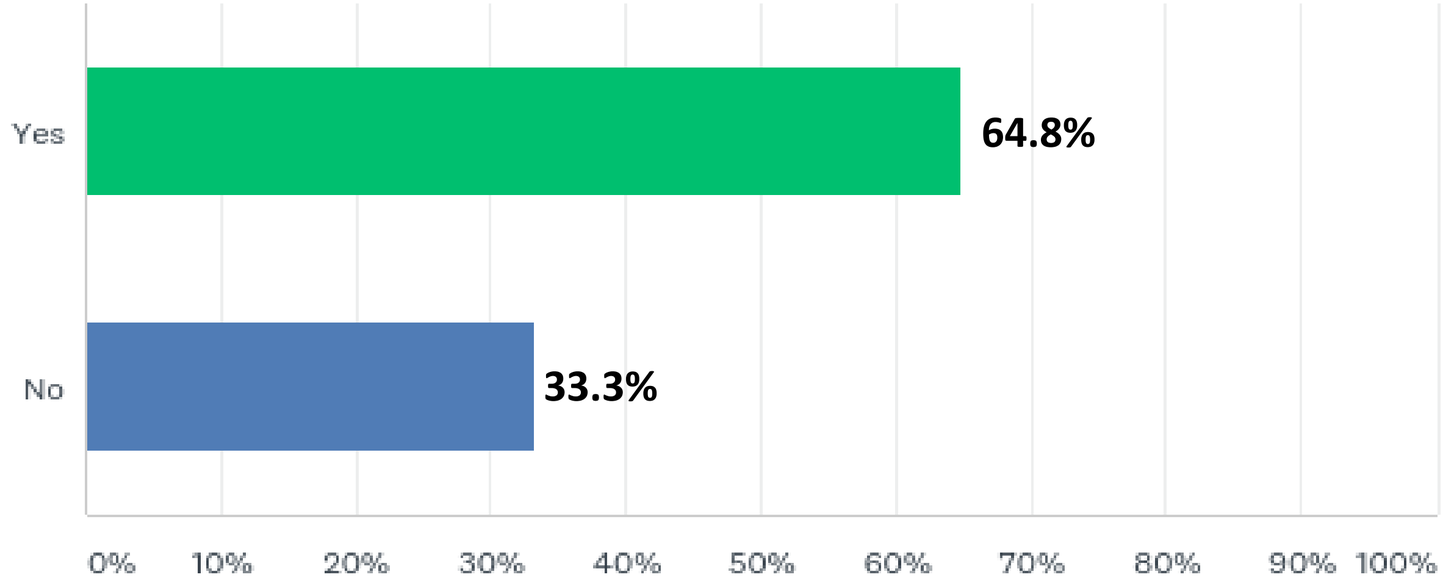
Information provided both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act.

Such notification must be made prior to or upon admission and during the resident's stay.

Receipt of such information, and any amendments to it, must be acknowledged in writing

A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits.

Q8: Do you provide Swing Bed patients with a choice of providers?



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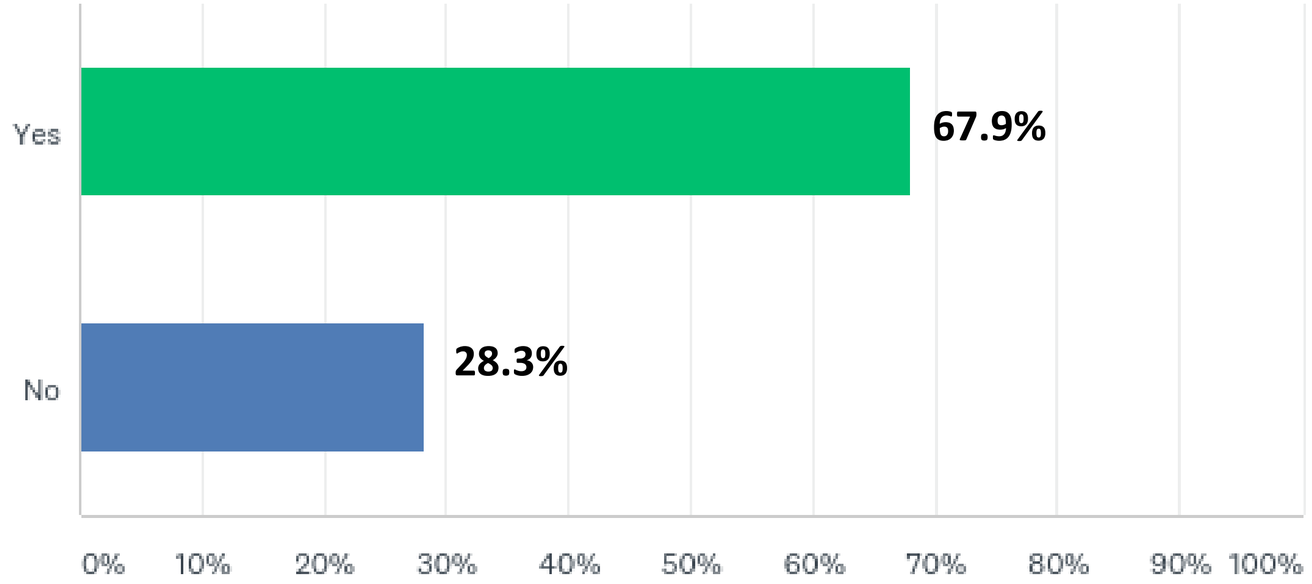
Choice of Physician

C-1608 §483.10(d)

Choice of attending physician. The resident has the right to choose his or her attending physician.

(1) The physician must be licensed to practice, and
(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.
4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.
(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

Q9: Do you provide patients with information on how to contact their providers, including consulting physicians?

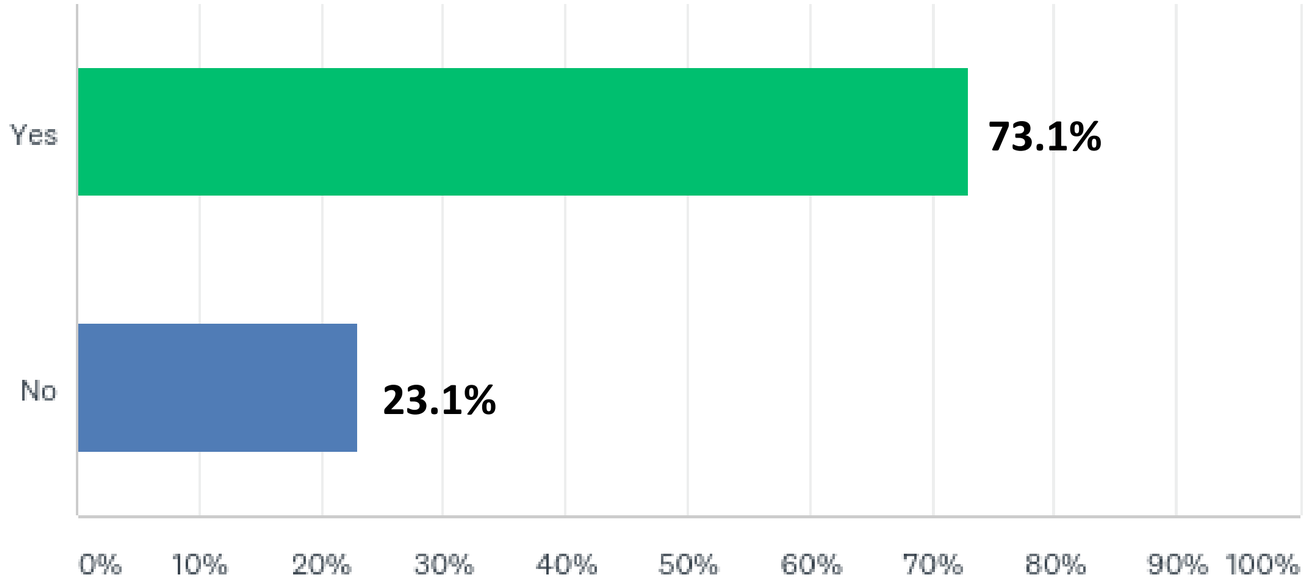


Provider Contact Information

C-1608 §483.10(d)

(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

Q10: Are patients provided with information about expected financial obligations? (Not generic hospital costs but those costs associated with the Swing Bed stay.



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Disclosure of Financial Obligations

C-1608 §483.10(g)(17)

The facility must— (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—

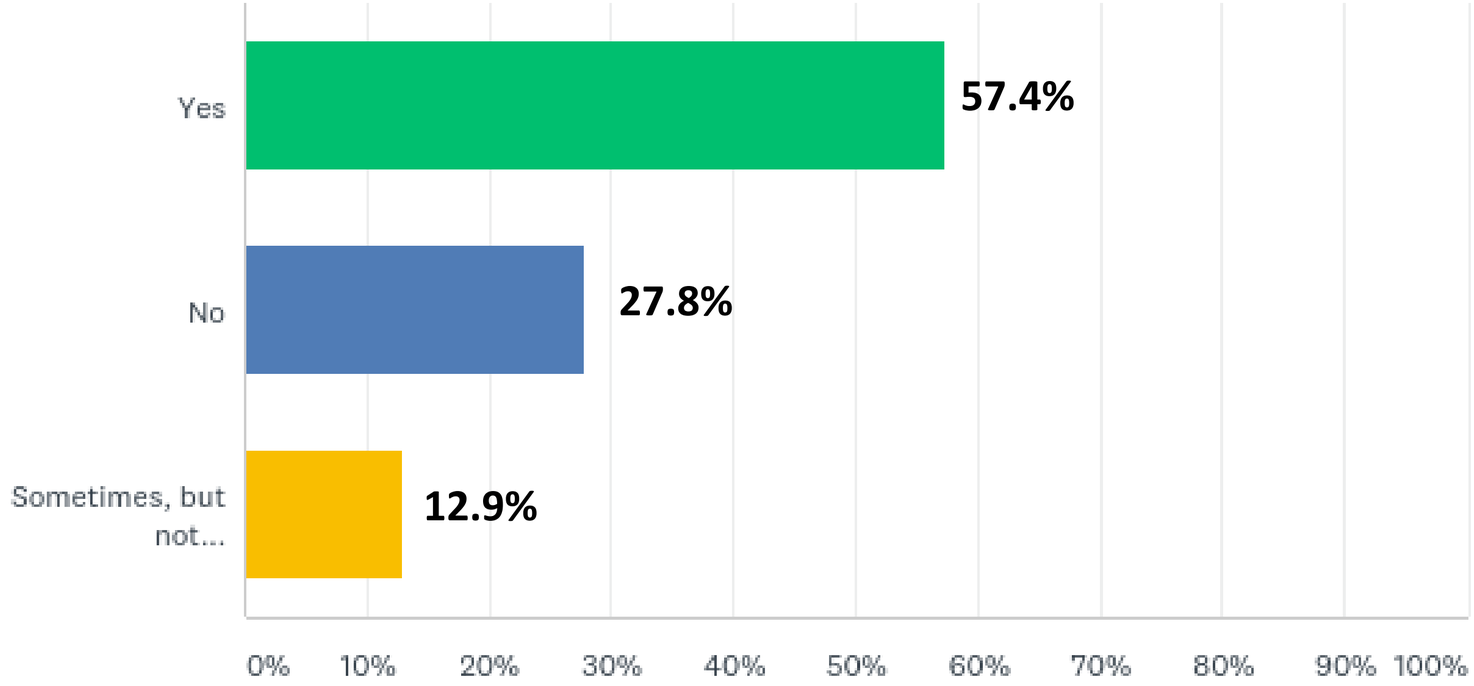
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in

C-1608 §483.10(g)(18)

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

Q12: Are Swing Bed patients assessed for trauma at the time of admission? (Culturally Competent / Trauma Informed Care)



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Culturally-Competent and Trauma Informed Care

C-1620 §483.21(b) Comprehensive care plans

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) (Be culturally-competent and trauma-informed.

Example

1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?
2. Have you experienced the loss of a close friend, relative, or a pet that you loved recently?
3. Have you had any past trauma in your life that we should know about so we can better care for you?
4. If you have experienced some kind of trauma is there something that helps you feel better?
5. Is there anything we can do to help during your stay with us?

DON'T PROBE – IF THEY SAY NO – IT'S NO

Comprehensive Assessment

C-1620 §483.20(b) Comprehensive assessments—
CAHs are not required to use RAI

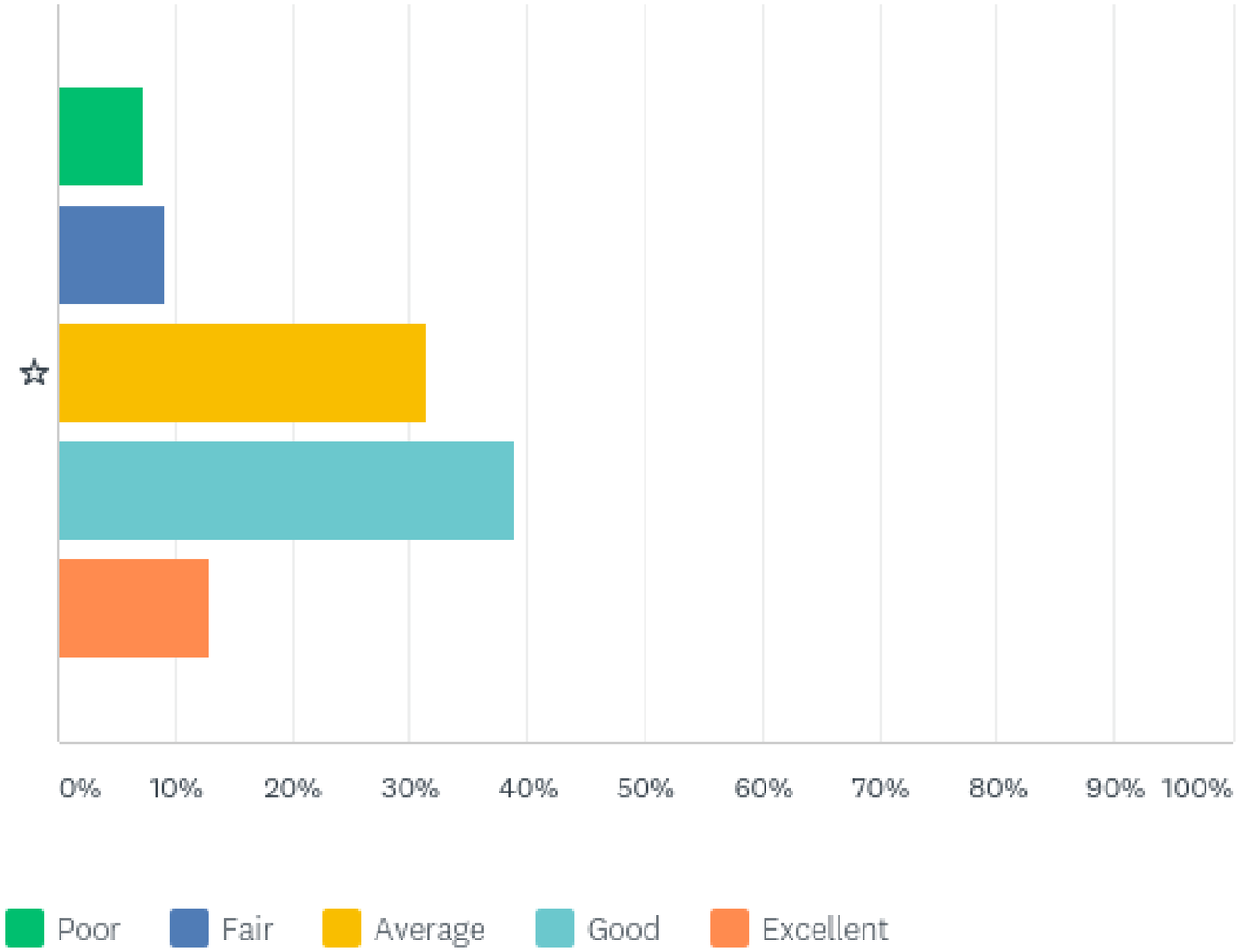
(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

- ❑ *Identification and demographic information*
- ❑ *Customary routine*
- ❑ *Cognitive patterns*
- ❑ *Communication*
- ❑ *Vision*
- ❑ *Mood and behavior patterns*
- ❑ *Psychosocial well-being –traumatic events*
- ❑ *Physical functioning and structural problems*
- ❑ *Continence*
- ❑ *Disease diagnoses and health conditions*
- ❑ *Dental status*
- ❑ *Nutritional status*
- ❑ *Skin condition*
- ❑ *Activity pursuit*
- ❑ *Medications*
- ❑ *Special treatments and procedures*
- ❑ *Discharge potential*
- ❑ *PASSAR – if applicable*

MULTI-DISCIPLINARY PLAN OF CARE DOCUMENTATION

Q6: How would you rate the Multi-Disciplinary Planning process?

Weighted Average 3.41



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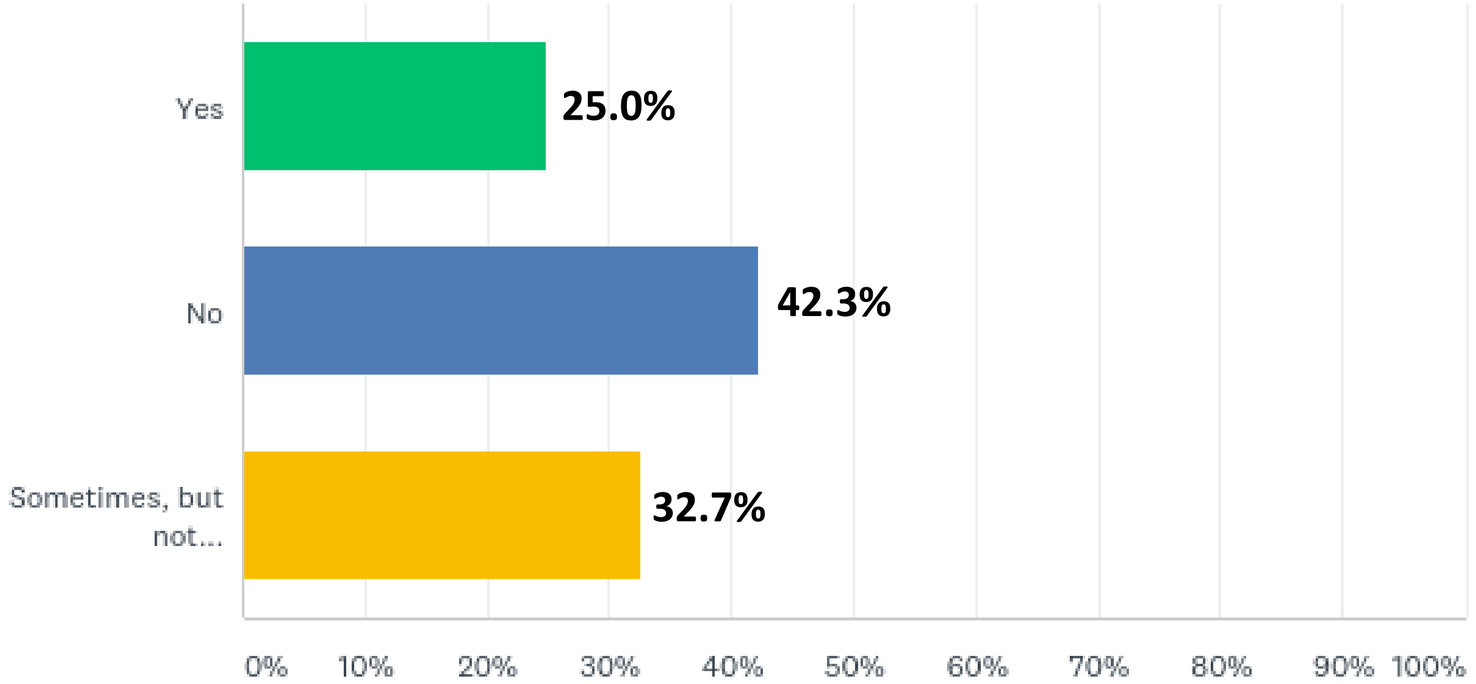
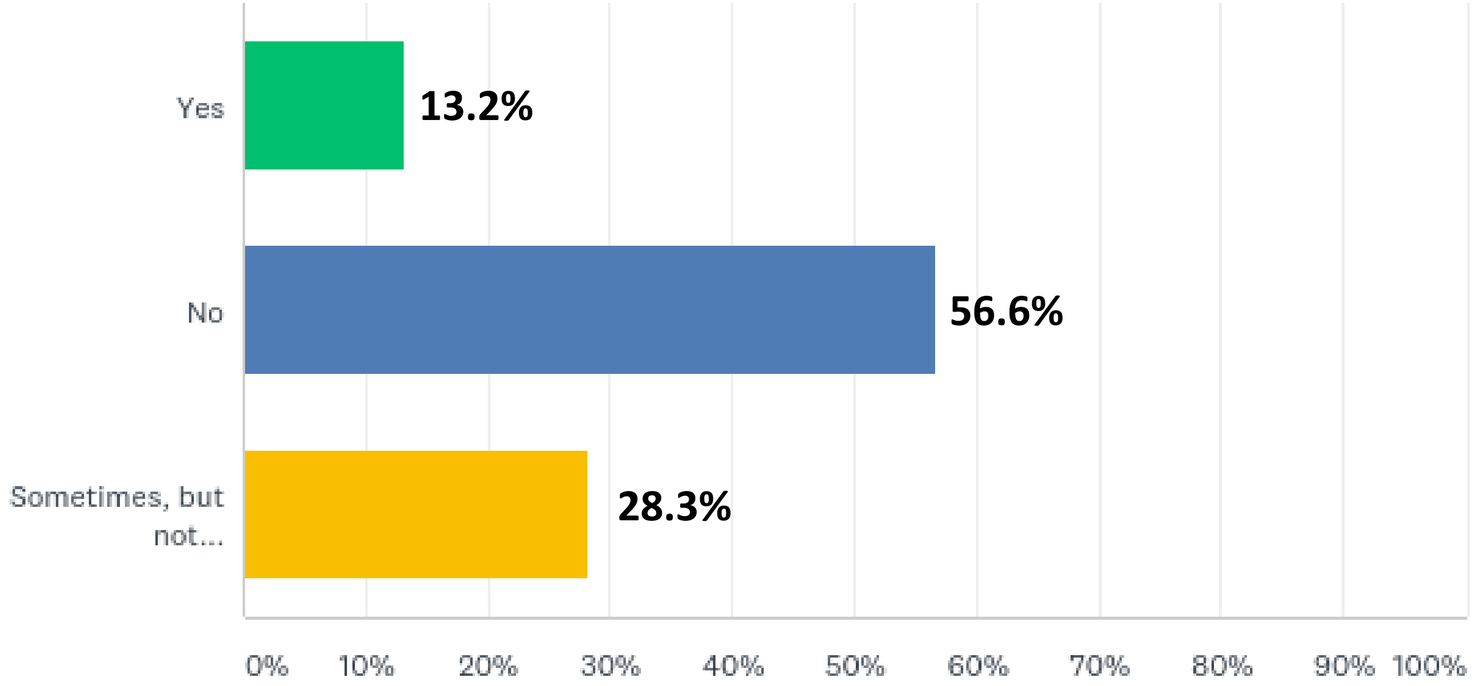
Q18: Is a Certified Nursing Assistant (CNA) involved in developing the Swing Bed patient's plan of care?



Q20: Does the CNA caring for the patient attend the Swing Bed multi-disciplinary conference(s)?

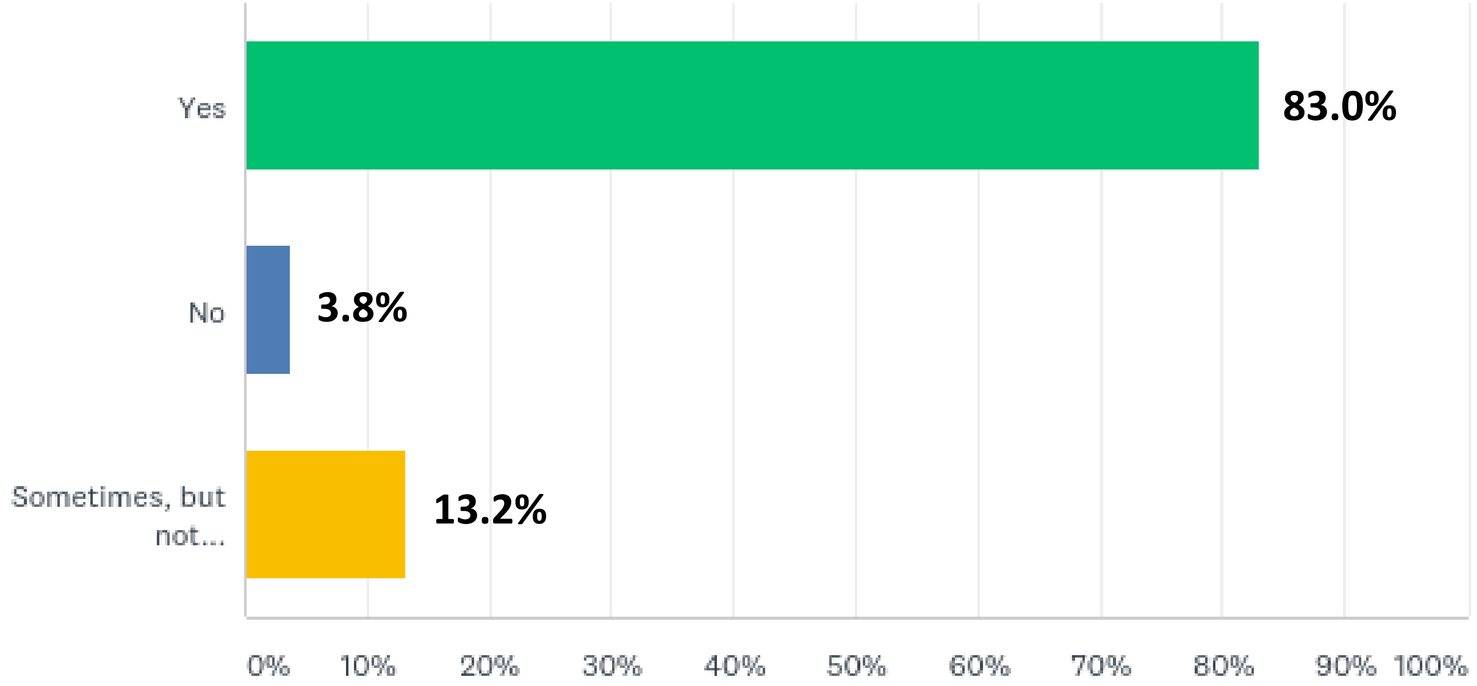


CNA Participation

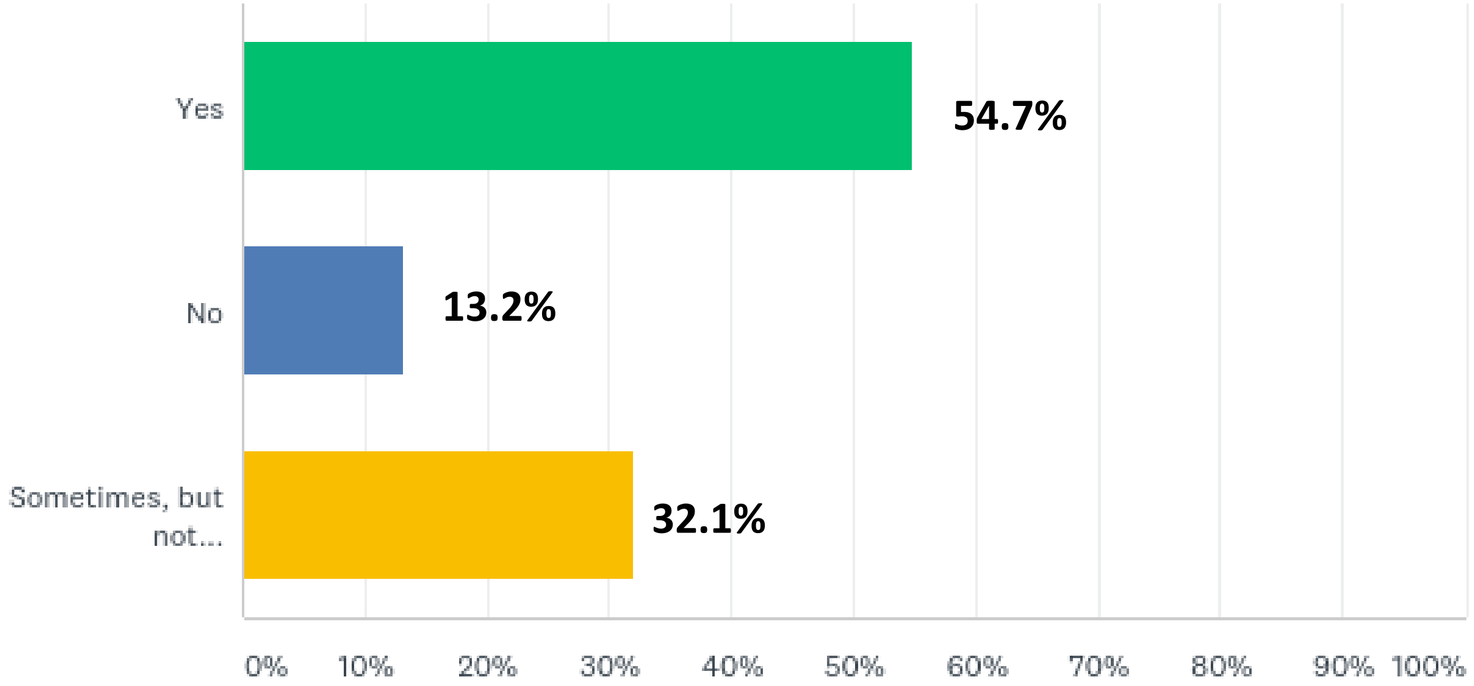
C-1620 §483.21(b) Comprehensive care plans

2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment. ***Time Frame NOT APPLICABLE TO CAH***
(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.

Q19: Is the RN assigned to the Swing Bed patient involved in developing the patient's plan of care?



Q21: Does the RN caring for the Swing Bed patient attend the multi-disciplinary conference(s)?



RN Participation

C-1620 §483.21(b) Comprehensive care plans

2) A comprehensive care plan must be—
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(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.

Food and Nutrition Staff Participation

C-1620 §483.21(b) Comprehensive care plans

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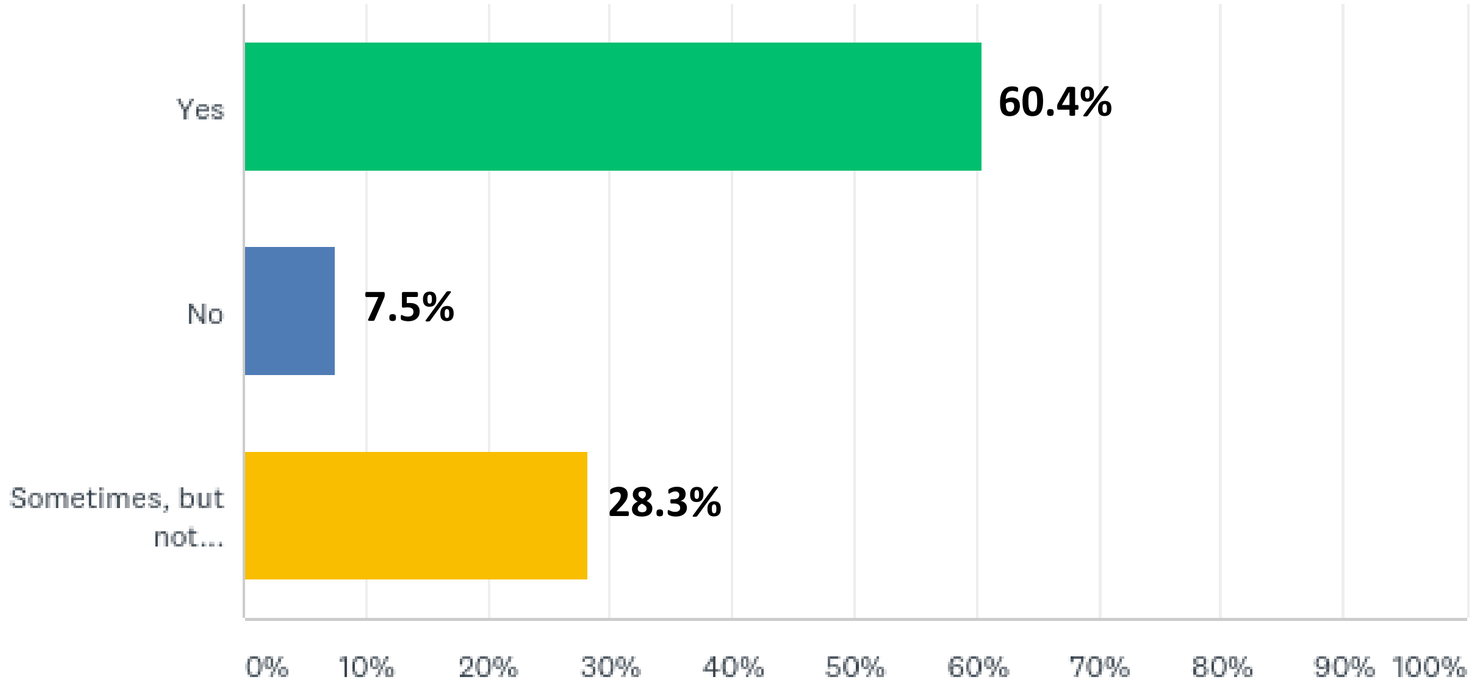
(i) Developed within 7 days after completion of the comprehensive assessment. ***Time Frame NOT APPLICABLE TO CAH***
(ii) Prepared by an interdisciplinary team, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide 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.

Q22: Are providers expected to attend the Swing Bed multi-disciplinary conference(s)?

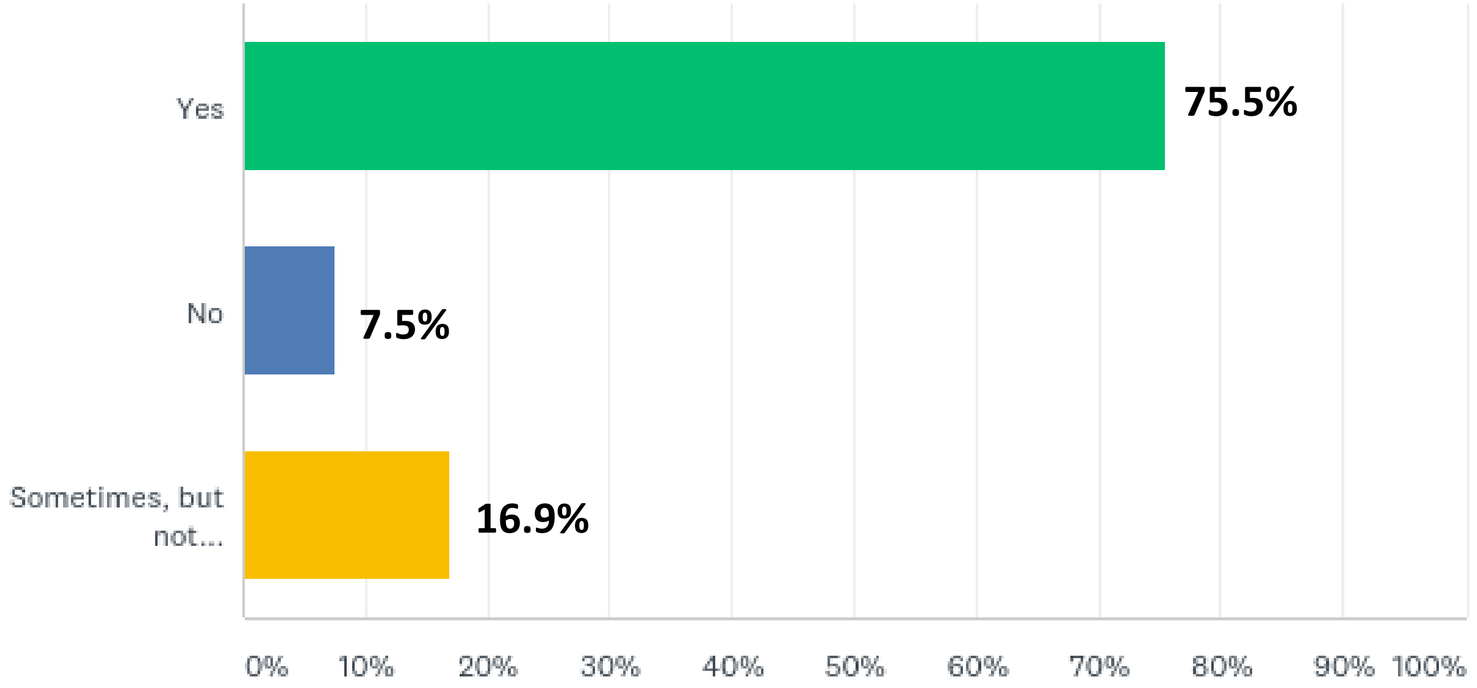


Provider Participation

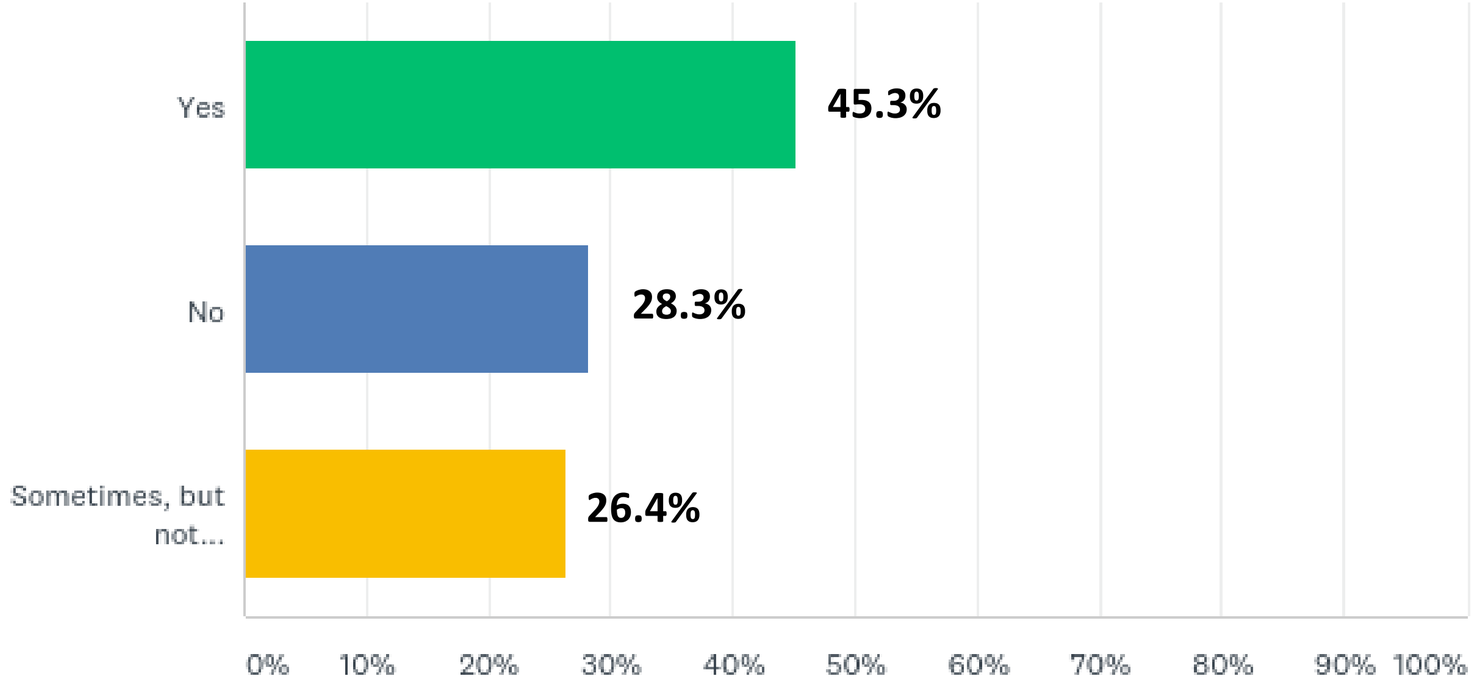
C-1620 §483.21(b) Comprehensive care plans

2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment. ***Time Frame NOT APPLICABLE TO CAH***
(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.

Q23: Is the Swing Bed patient, or patient's representative, involved in developing the plan of care?



Q24: Does the Swing Bed patient, or patient's representative, attend multi-disciplinary conference(s)?



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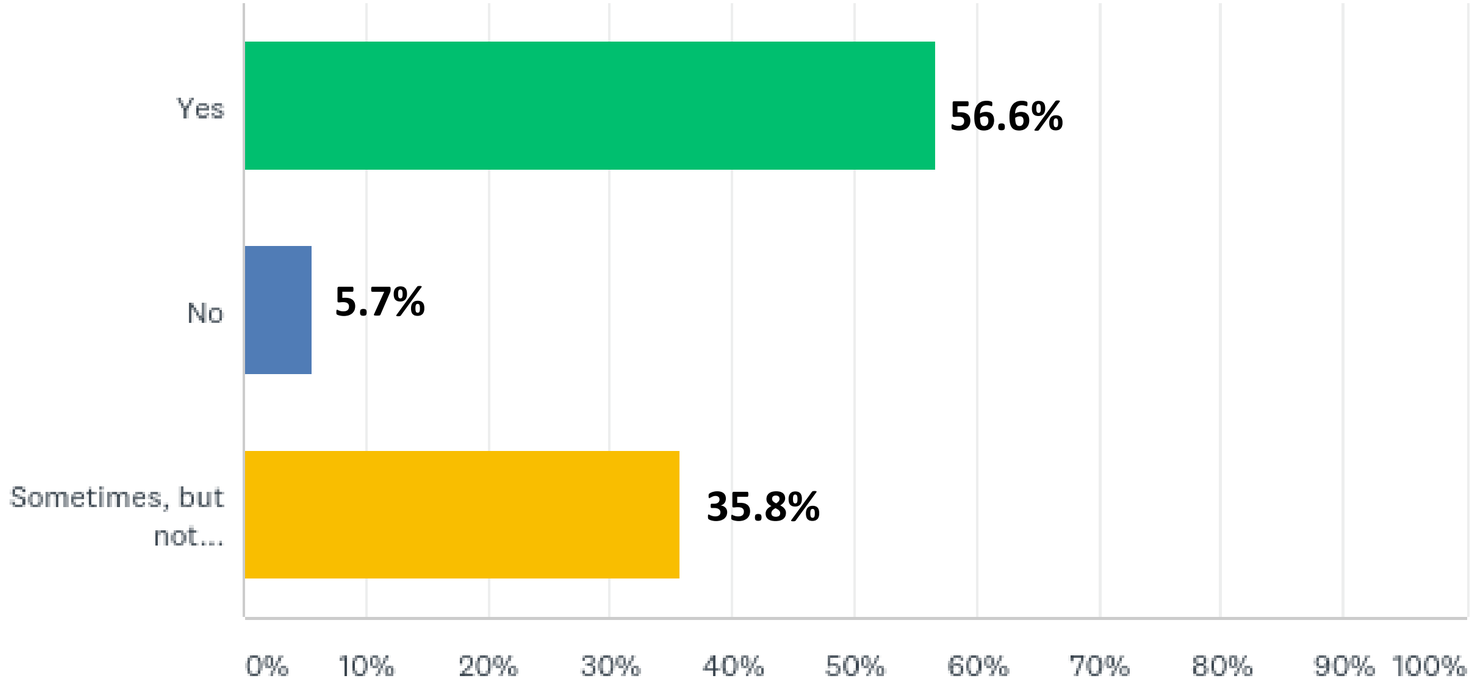
Patient Participation

C-1620 §483.21(b) Comprehensive care plans

2) A comprehensive care plan must be—
(i) Developed within 7 days after completion of the comprehensive assessment. ***Time Frame NOT APPLICABLE TO CAH***
(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.

Q25: Does the Swing Bed multi-disciplinary plan of care include measurable objectives and timelines?



Multi-Disciplinary Plan of Care

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
(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).

(1)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.

(2) 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.

Example Plan of Care & IDT Notes

DC Goal from Patient: Home with family

Long Term Goals (to be met prior to discharge)
Note: Individual disciplines may also have a plan of care
Example Goal 1: Patient will be able to dress independently within 2 weeks (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 within 2 weeks (prior to discharge)
Example Goal 4: Patient will give insulin independently including understanding order and administration within 2 weeks (prior to discharge)
Patient in concurrence with long and short-term goal: (Please identify who discussed with patient and when as well as any modifications the patient requested.

Summary of Patient's Progress to Meet Goals at each IDT Mtg.

Goal ____ Intervention ____

Discipline: Nursing

Patient in concurrence with goal: (Please identify who discussed with patient any modifications the patient requested.

Patient is on -track and meeting goals (YES / NO). If no, why.

Goal needs to be modified (YES/NO).

If goals or interventions need to be modified – identify revisions needed to plan of care

Goal Met (Date):

Example Plan of Care

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN			
Long Term Goal	**Short Term Goals**	**Interventions**	**Discipline Responsible**
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)	OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy
		Nursing will que patient to dress each morning Saturday - Sunday	Nursing
	Patient will be independently put on shoes within 7 days (April 3)	OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy
		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)	OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy
		Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing

Example Plan of Care & IDT Notes

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN and IDT Note							
Long Term Goal	Short Term Goals	Interventions	Discipline Responsible	Date	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 ☐ Modified	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modified
		1. 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				
		1. 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				
		1. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing				

Frequency of Documentation

Q: What are your documentation requirement minimums in relation to skilled patients for nursing, providers, pharmacy review, etc. –
Q: What is the requirement for documentation related to skilled needs? Does it have to be daily, weekly, etc.? And who should document this?

A: There are no specified frequencies in the CoPs for documentation including providers. Documentation should be based on patient's needs. If PT sees patient daily – they should document daily, etc.

Documentation requirements in the CoPs are related to the following ----

- C-1620: Initial assessment (See slide on admission assessment). Timeline depends on hospital policy.
- C-1620: Reassessment if there is a change of condition
- C-1620: Development of multi-disciplinary plan of care, including discharge goals. Timeline depends on hospital policy.
- Assessment of patient's progress in meeting multi-disciplinary plan of care goals, including discharge goals
- C-1626: Nutrition and Hydration
- Activities (for PPS Swing Bed only)

Communication

Q: How are you keeping good communication between your Interdisciplinary team members to ensure the patient's plan of care is well know and the discharge plan is being worked on consistently throughout the stay? For example: what adaptive equipment has the family purchased, what is still outstanding, care specifics communicated from therapy to the nursing staff. - What type of report tool are other facilities using to help with communication.

A: I'm not sure about report tools – but many facilities have daily walking rounds in addition to a weekly multi-disciplinary care conference.

Any ideas? – Use the question / chat box

DISCHARGE PROCESSES

Patient Required Notices - Discharge

Q: Discharge Summary....483.21(c)(2) -- does this information need to be in provider documentation or can it be throughout interdisciplinary notes such as provider notes, pharmacy, social services, case management etc.

Q: What are best practices of informing patients of the non-coverage letters

Q: What are the exact forms required to be completed for a swing bed discharge

Q: Discharge rights and responsibilities r/t CoP

NEW IM and DND
(just in case you aren't using the new version)

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

April 6, 2020
Hospitals are strongly encouraged to begin using the new Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) **as soon as possible, but no later than May 1, 2020.**

Patient Required Notices - Discharge

200 - Expedited Review Process for Hospital Inpatients in Original Medicare

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to a QIO for an expedited review when a hospital, with physician concurrence, determines that inpatient care is no longer necessary. …… Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the ***Important Message from Medicare (IM)*** *a statutorily required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.*

200.1 Hospitals Affected by these Instructions.

The term hospital is defined in the regulation as any facility providing care at the inpatient hospital level, whether that care is short term or long term, acute or non acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care or providing a broader spectrum of services. This definition includes critical access hospitals. This means all hospitals paid under the Inpatient Acute Prospective Payment System (IPPS), sole community hospitals/regional referrals centers or any other type of hospital receiving special consideration under IPPS (for example, Medicare dependent hospitals, Indian Health Service hospitals); hospitals not under IPPS, including, but not limited to: hospitals paid under State or United States territory waiver programs, hospitals paid under certain demonstration projects cited in regulation (§489.34), rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children's hospitals, and cancer hospitals. ***Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious nonmedical health care institutions are also excluded.***

Hospital Inpatients who are Medicare Beneficiaries.

These instructions apply to beneficiaries in original Medicare who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as those in observation stays or in the emergency department, do not receive these notices, unless they subsequently require inpatient care. ***Medicare beneficiaries in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.***

Source: Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Table of Contents

Patient Required Notices - Discharge

260.2

The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a ***Notice of Medicare NonCoverage (NOMNC****) before their services end: For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.*

- *Home Health Agencies (HHAs)*
- *Comprehensive Outpatient Rehabilitation Services (CORFs)*
- *Hospice*
- *Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy).*

A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B.

A NOMNC must be delivered by the SNF when both Part B therapies are ending.

Skilled Nursing Facilities includes beneficiaries receiving Part A and B services in Swing Beds

Source: Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Table of Contents

Notice of Discharge

C-1610 §483.15(c)(3) Notice before transfer

Before a facility transfers or discharges a resident, the facility must—
(i) 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.***

The facility must ***send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman****.*
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii)Include in the notice the items described in paragraph (c)(5) of this section.

C-1610 §483.15(c)(5) ***Contents of the notice.***
The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

Discharge Summary

§483.21(c)(2) *Discharge summary*

When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(i) ***A recapitulation of the resident's stay*** *that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.*

(ii) A ***final summary of the resident's status*** *to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.*

(iii) ***Reconciliation of all pre-discharge medications*** *with the resident's post-discharge medications (both prescribed and over-the-counter).*

(iv) ***A post-discharge plan of care that*** *is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.*

Communication to Next Provider of Care

C-1610 §483.15(c)(2) *Documentation*

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

*(iii) Information provided to the **receiving provider** must include a **minimum** of the following:*
(A) Contact information of the practitioner responsible for the care of the resident
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate
(E) Comprehensive care plan goals
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care

(c)(1)(i)(A) through (F)
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility…….; or
(F) The facility ceases to operate

Physician Discharge Documentation

C-1610 §483.15(c)(2) *Documentation.*

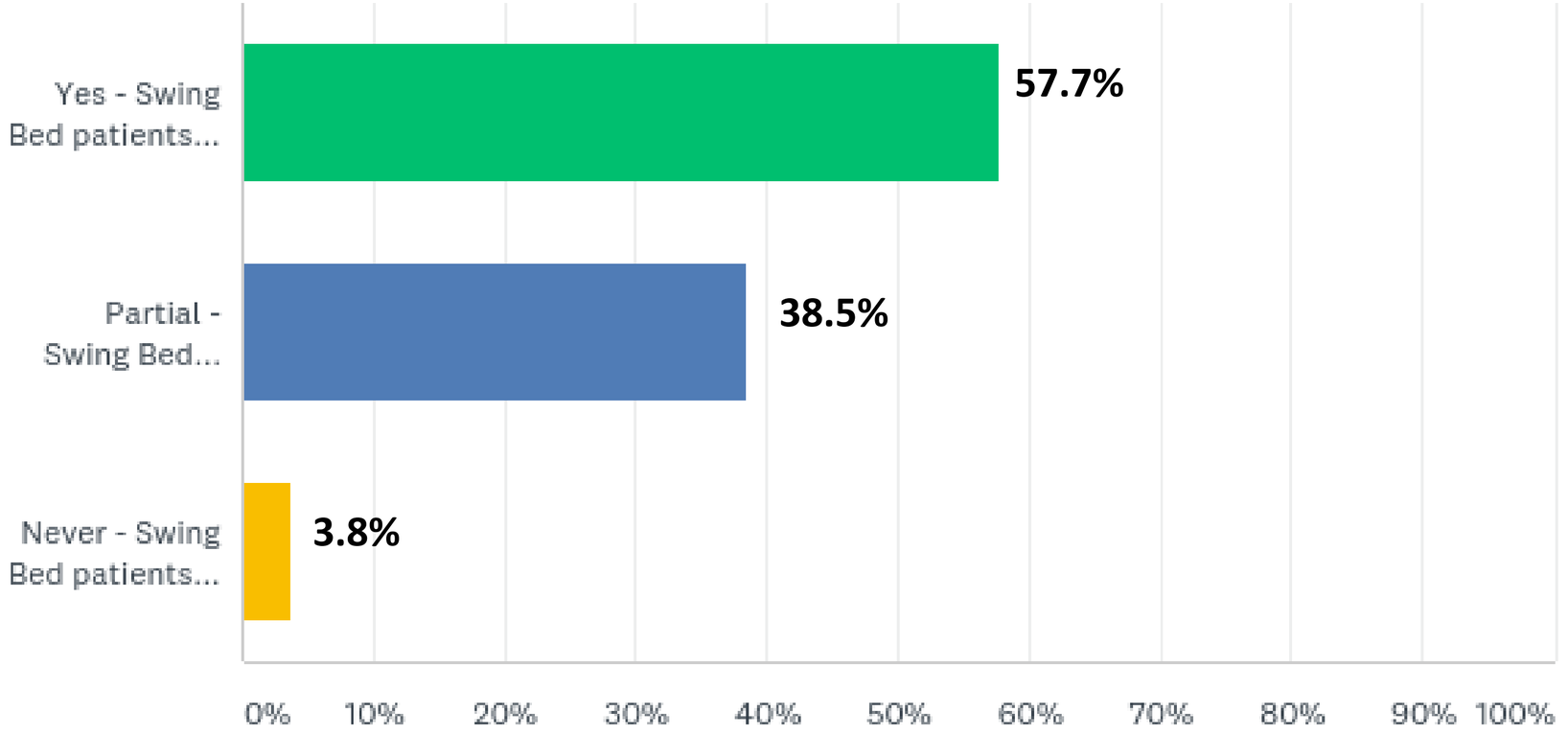
(c)(2)(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

*(A) The **resident's physician** when transfer or discharge is necessary under paragraph (A) or (B) of this section;*
***(A)** The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility*
***(B)** The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;*

*(B) A **physician** when transfer or discharge is necessary under paragraph (C) or (D) of this section*
***(C)** The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;*
***(D)** The health of individuals in the facility would otherwise be endangered;*

Q27: Are Swing Bed patients given a choice of post-acute providers (Swing Bed, SNF, Home Health, IRF) including information about quality and resource utilization? This includes when a patient is discharged from acute and admitted to Swing Bed in the same hospital.



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Discharge - Selection of PAC Provider

A-0804 §482.43(a)(8)

(8) The hospital must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data that includes, but not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use on measures.** The hospital must ensure that the post-acute care data on quality measures and data on resource measures is relevant and applicable to the patient's goals and treatment preferences.

C-1425

(8) The CAH must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measure**s. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Sources of Post Acute Care Quality Measures

Nursing Home Compare
https://www.medicare.gov/nursinghomecompare/search.html

Hospital Compare
https://www.medicare.gov/hospitalcompare/search.html

Inpatient Rehab
https://www.medicare.gov/inpatientrehabilitationfacilitycompare

Home Health Compare (SNF)
https://www.medicare.gov/homehealthcompare/search.html

Long Term Care Hospital
https://www.medicare.gov/longtermcarehospitalcompare

Name	Overall Rating	Health Inspections	Staffing	Quality Measures	Distance
Puget Sound Healthcare Center	****				
Regency Olympia Rehabilitation and Nursing Center	*****				
Providence Mother Joseph Care	*****				

Critical Access Hospital
Swing Bed Quality Measures

There is currently no publicly available data for Swing Beds in a Critical Access Hospital. Swing-beds for Critical Access Hospitals have not been included in national efforts to address comparability of post-acute quality measures (e.g., IMPACT Act and NQF). Study by University of Minnesota Rural Health Research Center to develop Swing Bed Quality Measures Voluntary quarterly reporting by 131 CAHs in 14 states for 12 months. (April 2018 – April 2019)

MEASURES

Discharge Disposition for swing-bed patients who resided in the community prior to swing bed stay

- To home
- Transferred to a NH/LTC facility
- Transferred to a higher level of care

Discharge Disposition for swing-bed patients who resided in a nursing home prior to swing bed stay

- Discharged to nursing home
- Transferred to nursing home
- Transferred to a higher level of care

Swing Bed patients who had one of the following for the same or related condition as the swing bed stay – or a new condition different from the swing bed stay

- Unplanned hospital inpatient stay
- Another Swing Bed stay
- Emergency Department Visit
- Observation Stay
- Nursing Home Stay

Source: Policy Brief October 2019, *Quality Measures For Critical Access Hospital Swing-Bed Patients*

Functional Status

- Risk-adjusted change in self-care score between swing bed admission and discharge
- Risk-adjusted change in mobility score between admission and discharge

Critical Access Hospital Swing Bed Potential Data Sources

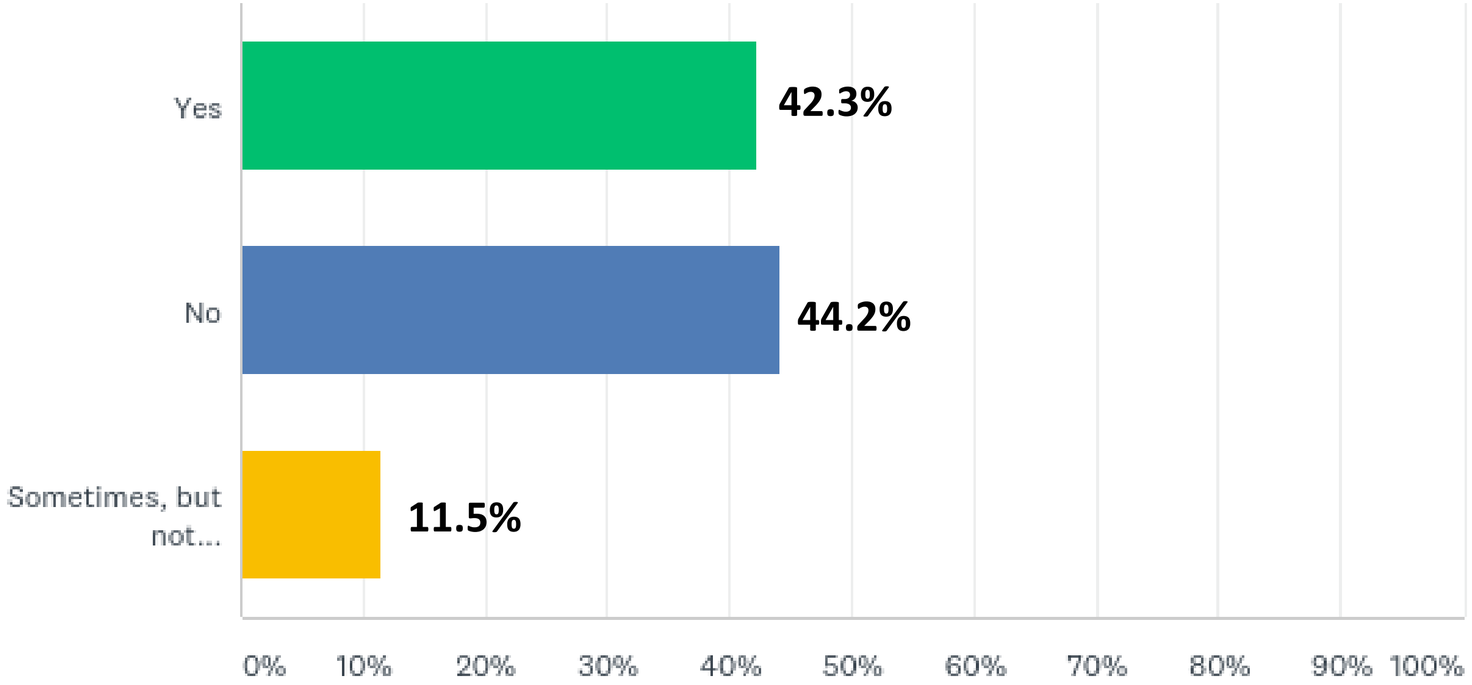
1. External Data (if available)
   - Hospital Compare
   - MBQIP data
   - HCAHPS data
   - Other Data bases

2. Internal Data – If you're not collecting data now specific to Swing Bed ---- you should be
   - Average Length of Stay
   - Discharge Disposition (Home, SNF, Home with Home Health etc)
   - Readmissions
   - Patient Satisfaction
   - Culture of Safety
     - Team Huddles
     - Harm Events
     - Nurse Staffing Ratios

CRITICAL: PPS hospitals **MAY** be excluding CAH Swing Bed when they provide patients with a choice of PAC choices based on the lack of quality and resource use data.

- Call and talk to them – find out if they are still including you
- Provide ANY data you may have that they can share with patients

Q26: Is the Ombudsman notified when a Swing Bed patient is discharged?



Ombudsman Notification

C-1610 §483.15(c)

(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—
(i) 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. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

OTHER QUESTIONS

Continued Stay

Q: How to deal with insurance requirements limiting length of stay

A: Unfortunately, you have to play by their rules.

- Document – Document – Document
- Use the provider if needed
- Negotiate contract terms at renewal

Rural Health Network

Q: Are all CAH's required to be part of a formalized rural health network? I'm referring to all of the specifications under C-0802.

A: No – unless specified in State Plan per CMS

Critical Access Hospital is a designation given to eligible rural hospitals by CMS. Congress created the CAH designation through the Balanced Budget Act of 1997 (Public Law 105-33) in response to a string of rural hospital closures during the 1980s and early 1990s. Since its creation, Congress has amended the CAH designation and related program requirements several times through additional legislation. Also authorized in the Balanced Budget Act of 1997, Congress created the Medicare Rural Hospital Flexibility Program to support new and existing CAHs. Rural health networks work to address the gaps, disparities, and barriers in rural areas using collaboration and shared problem solving, and are a long-term solution for rural communities to sustain their health care organizations and support the wellness of their communities. Rural health networks are born out of the needs of their communities.

Under the statute, Sec. 1820(d), https://www.ssa.gov/OP_Home/ssact/title18/1820.htm, (d) the Rural Health Network with respect to a State, consists of— (A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and (B) at least 1 hospital that furnishes acute care services. (2) Agreements.— (A) In general.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

Not all CAHs must be members of a Rural Health Network but you may want to check if this is a requirement in your State.

Thank you for reaching back out,

Anita Moore, MS, RN
Critical Access Hospital Team
Division of Continuing and Acute Care Providers
Quality, Safety & Oversight Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Appendix A

Q: Also, and I think you alluded to it during the webinar, would CAH's be wise to be aware of and could they look towards meeting some of the items in Appendix A? I'm thinking that there are some who would love to go with the allowed lessening of requirements for full H&P's.

A: I wouldn't recommend using Appendix A since you are held accountable for Appendix W standards – unless they are more "strict". I think my comment in a previous webinar may have been in relationship to QAPI which is effective March 2021, but is not yet included in Appendix W.

Activities

Q: Activity requirements for swing bed: updated regs in Dec./Jan. Thought had to do with not requiring us to have a certified activities director but now unable to locate the reg.

Answer

Appendix W deleted references to activities
Appendix A requirements have not changed

CMS / Critical Access Hospitals: *We expect that for those patients who receive swing-bed services for an extended period of time, their nursing care plan – as required by §482.23(b)(4) for hospitals and §485.635(d)(4) for CAHs – is based on assessing the patient's nursing care needs - and will support care that holistically meets the needs of the patient, taking into consideration physiological and psychosocial factors.*

Appendix W: Activities by qualified professional – DELETED

Appendix A: A-1568 Patient activities (§483.24(c)) – No Change

Activities

Q: What kind of documentation is needed for an activity program?

A: For Swing Beds in a PPS Hospital

1. Comprehensive assessment
2. Plan of Care with specific types and frequency of activities
3. Documentation of activities as defined in the Plan of Care

Appendix A: A-1568 Patient activities (§483.24(c))

(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

Oral Care / Dental Education Nursing Assistants

Q: Is there a requirement for a oral care or dental Inservice for nursing assistants annually? (there used to be but can't find it now)

A: There is nothing in Appendix W or Appendix A related education for oral care / dental care. Appendix PP refers to specific training requirements such as communication, abuse, etc. – but not oral or dental care.

BEST PRACTICES

Hopefully ---- some best practices have been covered during the webinar. Other thoughts to consider:

1. Administrative Support
2. Clearly identify goals for Swing Bed Program --- what is your goal for admissions / length of stay
3. Communicate VALUE of Swing Beds to the organization including important source of revenue – on an ongoing basis – not just one-time
4. Treat Swing Bed as a specialty service with distinct competencies – not just an extension of Med-Surg
5. Provider support and buy-in
6. Swing Bed Champion ----- but remember ***It takes a team!***
7. Collect and publish outcome data so benefits of Swing Bed are communicated both internally and externally
8. Strive to "get better" – what's working? – what's not? – how do we improve?

MORE QUESTIONS
THOUGHTS
COMMENTS
IDEAS FOR BEST PRACTICE

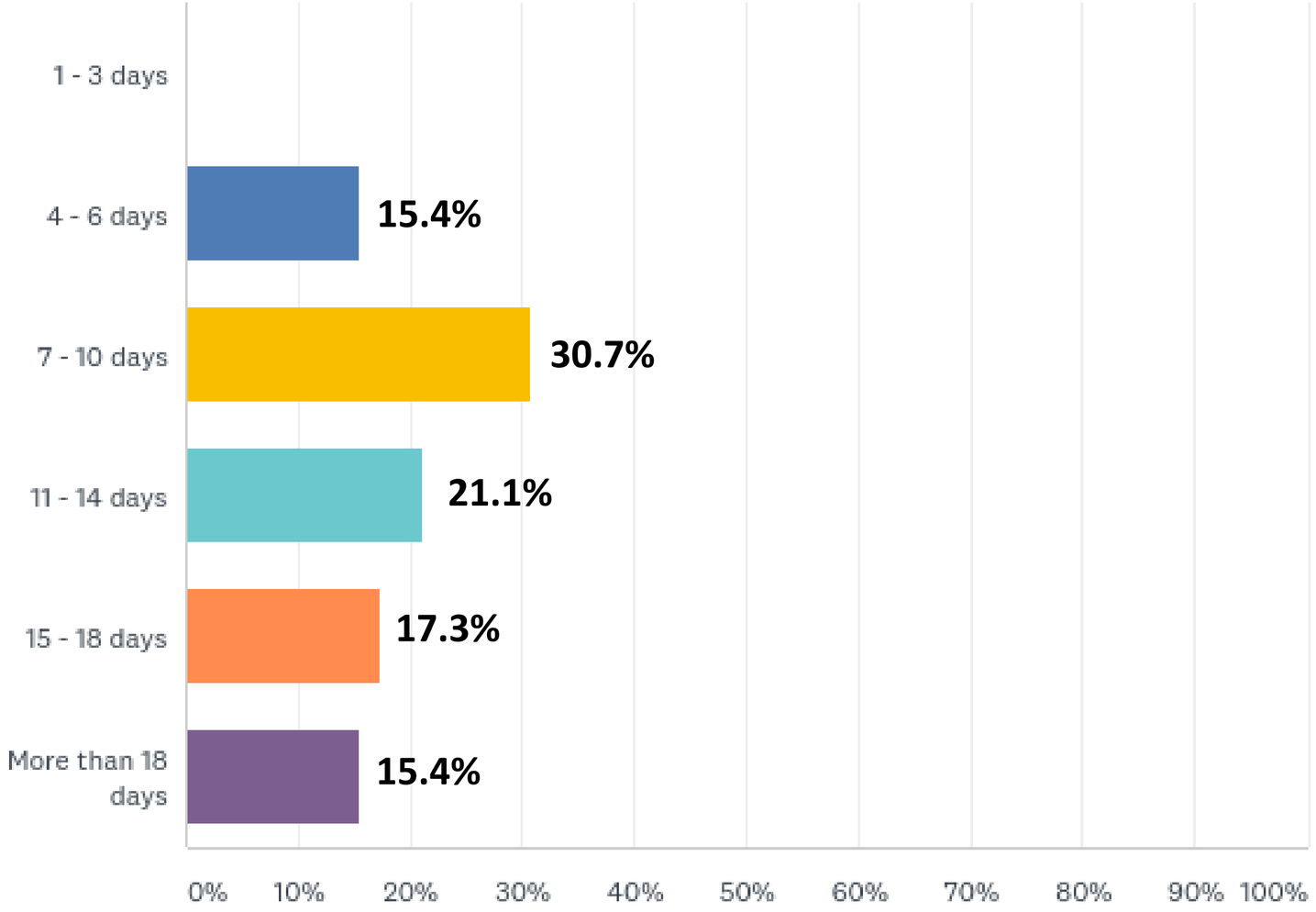
Thank You for Your Time and Attention
I had fun – I hope you did too!

If you are interested in a Swing Bed Review,
please contact me.

Carolyn St.Charles
carolyn.stcharles@healthtechS3.com
Office: 360-584-9868
Cell: 206-605-3748

ADDITIONAL SWING BED SURVEY QUESTIONS NOT COVERED IN PRESENTATION

Q13: For the last 12 months, what was the average length of stay (ALOS) in Swing Bed?



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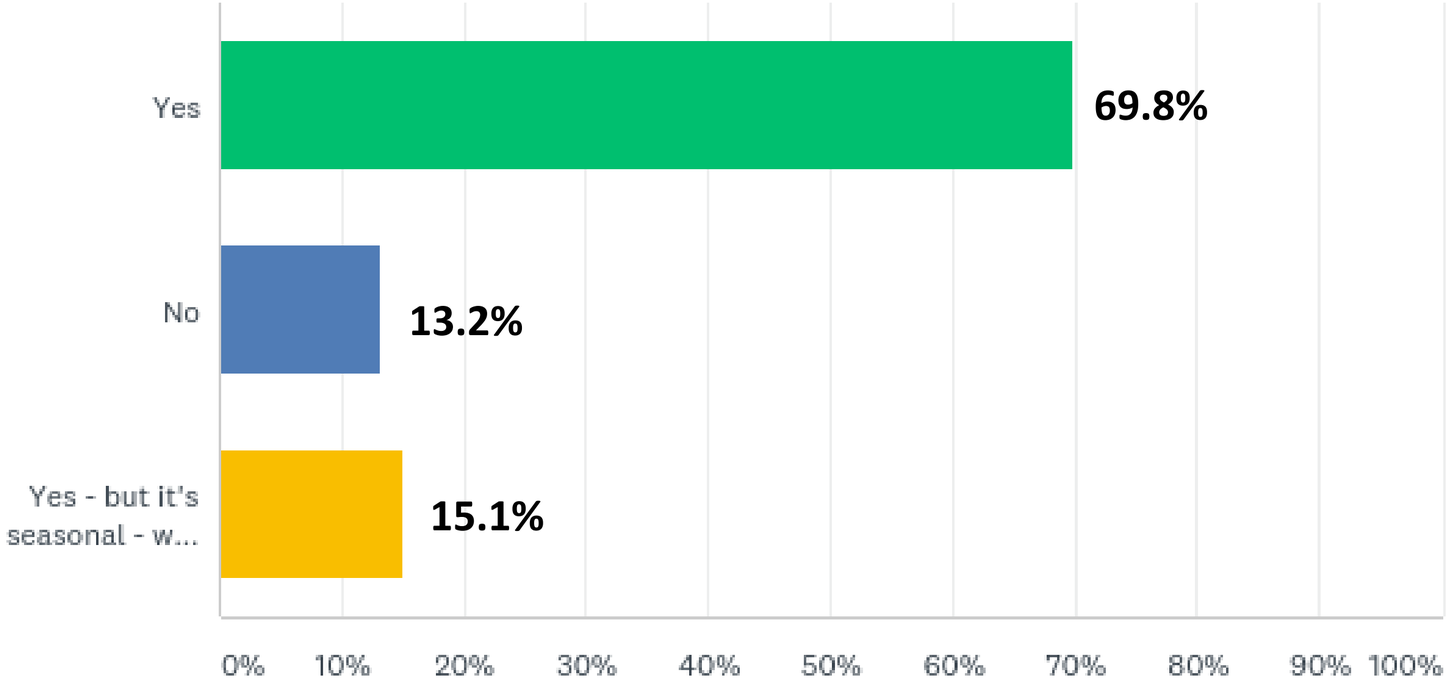
Q14: What is the primary reason for admission to Swing Bed?

ANSWER CHOICES	RESPONSES	
Rehab - PT, OT, Speech	77.36%	41
Wound care with IV antibiotics	3.77%	2
Teaching/education (e.g. medication management, tracheotomy/surgical incision/stoma care, etc.)	1.89%	1
Medical conditions (e.g. CHF, pneumonia, stroke, etc.)	13.21%	7
TOTAL		53

Q15: Would you like to increase your Swing Bed volume?



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Q16: What are the primary reasons preventing you from increasing Swing Bed volume? Please check all that apply.

ANSWER CHOICES	RESPONSES	
NA - We don't want to increase Swing Bed volume.	11.76%	6
Competition in our service area including SNF or other Swing Bed programs	13.73%	7
Lack of referrals from PPS Hospitals	19.61%	10
Lack of support by providers / physicians	5.88%	3
Lack of Speech Therapy	5.88%	3
Lack of marketing	7.84%	4
Lack of commitment by nursing, physical therapy, other disciplines	11.76%	6
TOTAL		51

Q17: What is the primary source of admissions to Swing Bed?