HEALTHTECH S3
strategy solutions support

5110 Maryland Way, Suite 200, Brentwood, TN
615.309.6053
www.healthtechs3.com

2745 North Dallas Pkwy, Suite 100, Dallas, TX
800.228.0647
www.gaffeythealthcare.com

GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Improving Swing Bed Documentation with LEAN

July 12, 2019

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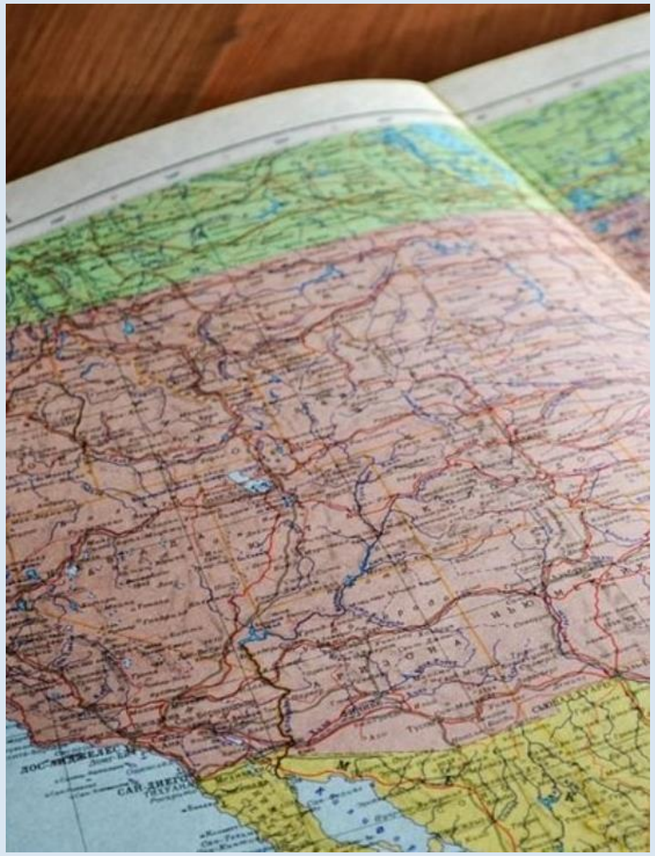
Nationwide Client Base



Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and critical access hospitals
- Example managed hospital client includes 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 client includes two-hospital NFP system 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

PRESENTER

Carolyn St.Charles
Regional 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 as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

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

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

carolyn.stcharles@healthtechs3.com
360-584-9868

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INSTRUCTIONS FOR TODAY'S WEBINAR

- 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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3rd Quarter 2019 Webinars

ALL WEBINARS ARE RECORDED

Understanding the ROI on Advanced Wellness Visits and Advanced Care Planning: Preparing the Right Person for the Job
Host: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3
July 11, 2019 at 12:00 pm CT
https://bit.ly/2Xs2YUN

Using the Concepts of Lean to Improve Swing Bed Documentation
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer, HealthTechS3
July 12, 2019 at 12:00 pm CT
https://bit.ly/2Ju7JmU

Community Health Needs Assessment – The Implementation Plan
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer and Julie Haynes – Strategic Planning Consultant, HealthTechS3
August 2, 2019 at 12:00 pm CT
https://bit.ly/2xzek9U

Improve your CCM Program Revenue: Incorporate Technology and Resources for Additional Reimbursement
Host: Faith M Jones, MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3
August 15, 2019 at 12:00 pm CT
https://bit.ly/2S08gAC

Swing Bed 101
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Regional Clinical Officer, HealthTechS3
September 6, 2019 at 12:00 pm CT
https://bit.ly/2xHt8Dj

Trends Facing Rural Healthcare Boards
Host: Michael Lieb – Regional Vice President & Director, Practice Management, HealthTechS3
September 13, 2019 at 12:00 pm CT
https://bit.ly/2YJVSaA

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Regulatory Resources

- State Operations Manual - Appendix W *(Rev. 183, 10-12-18)*
- State Operations Manual - Appendix PP *(Rev. 173, 11-22-17)*
- Medicare Claims Processing Manual, Chapter 4 (*Rev. 4308, 05-16-19)*
- Medicare Claims Processing Manual, Chapter 6 (*Rev. 4247, 03-01-19)*
- Medicare Benefit Policy Manual Chapter 8 *(Rev. 242, 03-16-18)*

REGULATORY CHANGES

1. Resident Choice of Physician - **Clarification**
2. Timelines for Reporting Abuse - **New**
3. PASARR – **Clarification**
4. Plan of Care – **Additional language** and **Clarification**
5. Provide Culturally-Competent and Trauma Informed Care – **New**
6. Reconciliation of Pre-Discharge Medications with Post-Discharge Medications – **New**
7. Dental Care – **Clarification** of Timelines
8. Transfer & Discharge – Information at Discharge and Ombudsman Notification ++++ many others - **New**

History of Lean

1. W. Edwards Deming – Improve design and product quality
2. Taiichi Ohno – Toyota Production Systems
3. Jim Womack – Lean & LEI (Lean Enterprise Institute)
4. Bowen & Spear – Decoding the DNA of the Toyota Production System
5. C. Jimmerson & D. Sobek – Lean for Healthcare

Lean

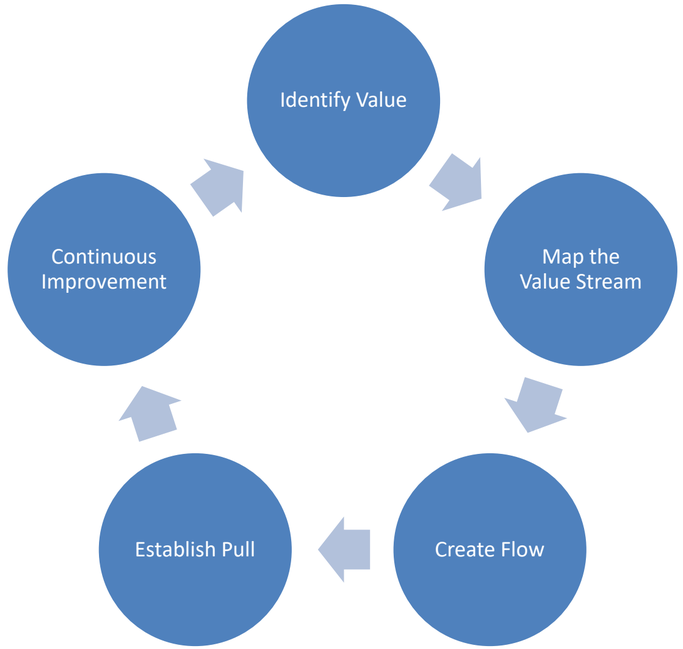
Define Value
Value is what the customer is willing to pay for --- finds valuable

Map the Value Stream
Identify all the activities that contribute to customer values. Activities that do not add value to the end customer are waste
WASTE
- Non-Value added but necessary
- Non-Value added and unnecessary

Create Flow
After removing waste, ensure that the flow of the remaining steps run smoothly without interruptions or delays. Strategies include breaking down steps, reconfiguring steps, leveling out workload, creating cross-functional departments, and training employees to be multi-skilled.

Establish Pull
Needed materials and information are available (just-in-time) for a smooth flow of work.

Continuous Improvement



Define Value

There are both internal and external customers – and there may be a different value proposition for each

Who is the END CUSTOMER?

External

- Payor
  - Cost-Effective
  - Patient meets skilled criteria

- Resident
  - Choice of SNF
  - Satisfied with care
  - Meet goals for Swing Bed stay
  - No surprise bills – understand financial obligations

- Referring Hospital
  - Streamline – Efficient referral process
  - Satisfied Patient
  - Meet Care Goals

Internal -- Your Hospital and Care Team

- Patient Satisfaction
- Efficient processes
- Revenue stream

Map the Value Stream - Take out Waste
Pre-Admission

Payor **Meet Criteria** **Cost-Effective**	**Patient** **Choice** **Satisfied with Care** **Meet Care Goals** **Financial Disclosure**	**Referring Hospital** **Streamline & Efficient** **Satisfied Patient** **Meet Care Goals**	**Your Hospital** **Efficient** **Revenue Stream (Cost-Effective)** **Patient Satisfaction** **Meet Quality / Care Goals**
1. Referral to Case Management 2. Case Management review for Swing Bed medical necessity 3. Case Management review of qualifying inpatient stay 4. Case Management review of available days 5. Payor Authorization (if needed)	1. Discussion with patient about reason / value of swing bed by physician. 2. Discussion with patient regarding swing bed – patient choice prior to swing bed admission 3. Discussion with patient about financial obligations	1. Referral to Case Management 2. Case Management review for Swing Bed medical necessity 3. Case Management initial review with provider to ensure acceptance 4. Case Management requests rehab review 5. Case Management requests nursing review 6. Case Management requests business office review 7. Case Management final review of all input from various disciplines 8. Case Management notifies referring hospital of decision to accept/not accept patient 9. Case Management notifies appropriate individuals of acceptance	1. Referral to Case Management 2. Case Management review for Swing Bed medical necessity 3. Case Management initial review with provider to ensure acceptance 4. Case Management requests rehab review 5. Case Management requests nursing review 6. Case Management requests business office review 7. Case Management final review of all input from various disciplines 8. Case Management final discussion with provider 9. Case Management notifies appropriate individuals of acceptance

Map the Value Stream - Take out Waste
Pre-Admission

Payor **Meet Criteria** **Cost-Effective**	**Patient** **Choice** **Satisfied with Care** **Meet Care Goals** **Financial Disclosure**	**Referring Hospital** **Streamline & Efficient** **Satisfied Patient** **Meet Care Goals**	**Your Hospital** **Efficient** **Revenue Stream (Cost-Effective)** **Patient Satisfaction** **Meet Quality / Care Goals**
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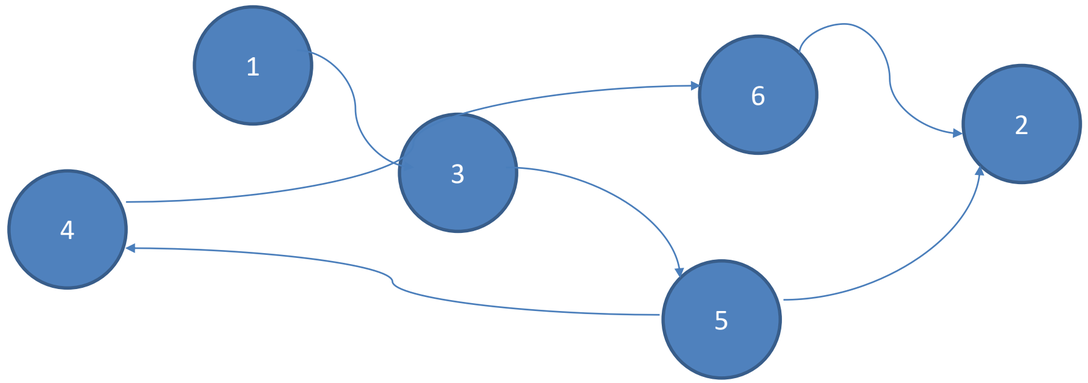
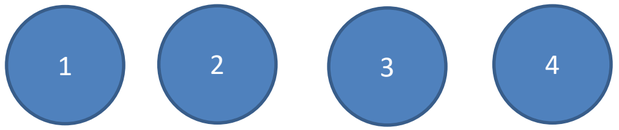
Create Flow





Create Flow – No Delays
Pre-Admission

Payor Meet Criteria Cost-Effective	Patient Choice Satisfied with Care Meet Care Goals Financial Disclosure	Referring Hospital Streamline & Efficient Satisfied Patient Meet Care Goals	Your Hospital Efficient Revenue Stream (Cost-Effective) Patient Satisfaction Meet Quality / Care Goals
1. Referral to Case Management 2. Case Management review for Swing Bed medical necessity 3. Case Management review of qualifying inpatient stay 4. Case Management review of available days 5. Payor Authorization (if needed) Cross-train Shift Supervisors to determine eligibility	1. Discussion with patient about reason / value of swing bed by physician 2. Discussion with patient regarding swing bed – patient choice prior to swing bed admission 3. Discussion with patient about financial obligations Cross-train Shift Supervisors to provide patient with necessary information	1. Referral to Case Management – Shift Supervisors 2. Case Management / Shift Supervisor review for Swing Bed medical necessity 3. Multi-Disciplinary Case Review – ideally with physician 4. Review with physician for acceptance of patient - if still needed 5. Case Management / Shift Supervisor notifies referring hospital of decision to accept/not accept patient 6. Case Management / Shift Supervisor notifies appropriate individuals of acceptance	1. Referral to Case Management – Shift Supervisors 2. Case Management / Shift Supervisor review for Swing Bed medical necessity 3. Case Management / Shift Supervisor initial review with provider to ensure acceptance 4. Multi-Disciplinary Case Review – ideally with physician 5. Review with physician for acceptance of patient – if still needed 6. Case Management / Shift Supervisor notifies appropriate individuals of acceptance

Establish Pull – Smooth Work Flow
Pre-Admission

Payor **Meet SNF Criteria** **Cost-Effective**	**Patient** **Choice** **Satisfied with Care** **Meet Care Goals** **Financial Disclosure**	**Referring Hospital** **Efficient** **Satisfied Patient** **Meet Care Goals**	**Your Hospital** **Efficient** **Revenue Stream (Cost-Effective)** **Patient Satisfaction** **Meet Quality / Care Goals**
1. Pre-approved criteria for types of patients Hospital will accept	1. Patient Information that includes financial obligations and other admission info that is Easy to Read / Understand	1. Pre-approved criteria for types of patients Hospital will accept 2. Follow-Up ALL transferred patients	1. Pre-approved criteria for types of patients Hospital will accept 2. Identification of patients at time of inpatient admission

Continuous Improvement

1. Patient Satisfaction

2. Number / % external referrals

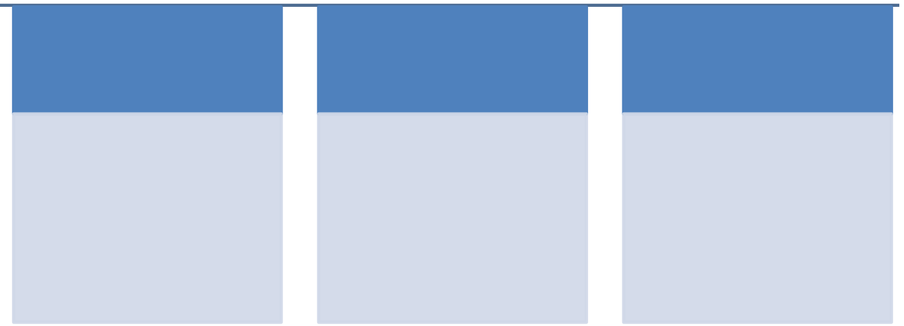
3. Time from referral to acceptance (referring hospitals)

4. Percent of patients identified as swing bed candidates at time of inpatient admission

5. Quality measures
   - Functional improvement
   - Met patient care goals as defined by patient

6. Process Measures
   - Patient Information provided
   - Documentation requirements met
     - Multi-disciplinary assessment within policy timeline
     - Multi-disciplinary plan of care within policy timeline

Admission: Process Steps



1. Provider: Order for Swing Bed

2. Provider: Orders for Swing Bed stay (medications, etc.)

3. Provider: Documentation by provider that patient meets criteria for swing bed and care cannot be provided in another setting

4. New medical record number / new chart

5. Patient required information provided verbally and in writing

6. Multi-Disciplinary assessment(s)

VALUE STREAM

1. Activities that add value

2. Activities that do not add value for the end customer = WASTE
   - Non-Value added but necessary
   - Non-Value added and unnecessary

Take out all steps that do not add Value
Eliminate Waste

Admission: Providers

1. Template certification for Swing Bed
   - Reason for swing bed admission (not medical diagnosis)
   - Care cannot be provided in another setting (lower level of care)

2. Develop pre-printed Swing Bed order set

3. Duplicate orders currently in place for inpatient stay **CAUTION!**

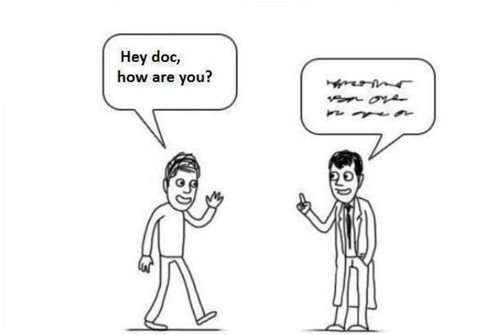
Admission: Patient Required Information

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

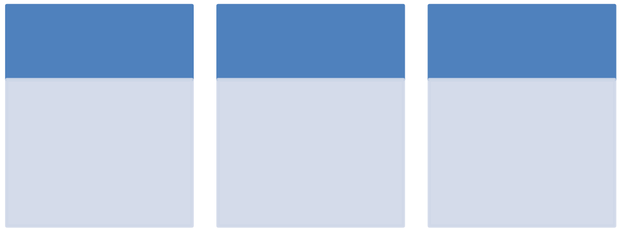
A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits.



- ❑ Description of Swing Bed
- ❑ Resident Rights and Responsibilities
- ❑ A description of Hospital's policies regarding advance directives
- ❑ Resident Choice of physicians
- ❑ Information on how to contact providers (ALL)
- ❑ Financial Obligations
- ❑ Transfer and Discharge policies
- ❑ 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

Admission: Patient Information

1. STANDARDIZED Patient Admission Packet that is:
   - Complete and includes all requirements
     - Who is responsible for ensuring packet is complete?
     - Who “makes up” packets
     - Who “updates” packets



2. Clearly defined responsibility for WHO delivers packet and discusses with patient
   - Just Case Management?
   - All nurses?
   - Some nurses?
   - How do you ensure a reliable process?

3. Documentation that patient received information verbally and in writing

Admission: COMPREHENSIVE ASSESSMENT

C-0388 §485.645(d)(6): Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter.

§483.20(b): Comprehensive assessments—

(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:

CAHs are exempt from completing a MDS

C-0388 §485.645(d)(6): The CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Also, note that CAHs are not required to complete the PASARR.

However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient**.**

Admission: Comprehensive Assessment

- ❑ Identification and demographic information
- ❑ Customary routines
- • Activities - Nursing - ??
- ❑ Cognitive patterns
- • Physician - Nursing - ??
- ❑ Communication
- ❑ Vision
- ❑ Mood and behavior patterns
- ❑ Psychosocial well-being –**Traumatic events (October 2018 CAH)**
- ❑ Physical functioning and structural problems
- ❑ Continence
- ❑ Disease diagnoses and health conditions
- ❑ Dental
- • Dietician - Nursing – Physician - ??
- ❑ Nutritional status
- • Dietician - Nursing - ??
- ❑ Skin condition
- ❑ Activity pursuit
- ❑ Medications
- ❑ Special treatments and procedures
- ❑ Discharge potential
- ❑ Review of PASARR (if one has been done)

Is there redundancy? Are multiple disciplines asking the same questions?
Are there templates for assessment that reduce redundancy?

Admission: TIMELINE

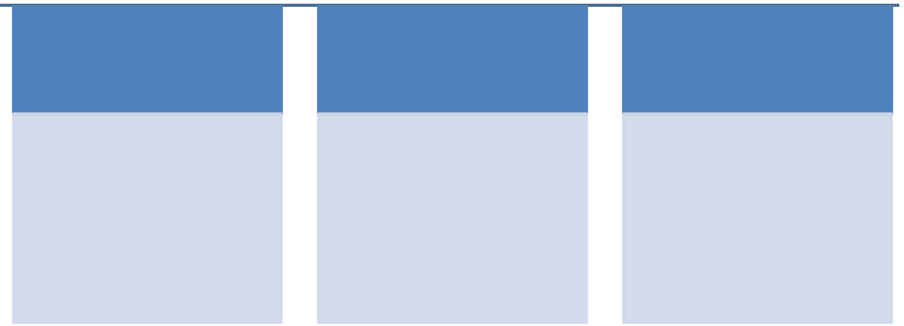
The new CoPs eliminate the requirement for specific timelines for Swing Beds in a CAH (7 day and 14 day timelines are not applicable).

However, timelines must be congruent with your Length of Stay. <u>For example</u>:

- ❑ Nursing within 24 hours
- ❑ Rehab within 48 hours
- ❑ Dietary within 48 hours
- ❑ Activities within 48 hours
- ❑ Social Services / Discharge Planning within 48 hours
- ❑ Pharmacy, if appropriate, within 48 hours

Have you defined timelines?

Continued Stay: Process Steps



1. Multi-Disciplinary Meetings
2. Multi-Disciplinary Plan of Care
3. Documentation to Plan of Care

VALUE STREAM

1. Activities that add value

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   - Non-Value added but necessary
   - Non-Value added and unnecessary

Take out all steps that do not add Value
Eliminate Waste

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Continued Stay: Regulatory Requirement Plan of Care

§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).

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

(ii) 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.

Continued Stay: Regulatory Requirement Plan of Care

C-0388 §485.645(d)(6):

(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.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

(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

Continued Stay: Plan of Care

VALUE STREAM

1. Activities that add value

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- Non-Value added and unnecessary

Take out all steps that do not add Value
Eliminate Waste

1. Assessment timelines for each discipline
   - Assessments completed prior to development of plan of care
   - Must be appropriate for length of stay
   - Is this PUSH or PULL?

2. Timeline for development of multi-disciplinary plan of care
   - Must be appropriate for length of stay
   - Is this PUSH or PULL?

3. WHO is involved in development of plan of care?

4. When are conferences scheduled to develop plan of care?

5. Is it just a paper process ----??? Is there value --- ??? Does the team (nursing too) actually look at the plan and follow-it? Do you really need a nursing care plan too???

6. How is the patient involved?

Continued Stay: Plan of Care
TRAUMA INFORMED CARE

Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.
http://traumainformedcareproject.org/index.php

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 while you are in the (Hospital) - (Nursing Home)?

DON'T PROBE – IF THEY SAY NO – IT'S NO
Trauma-Informed Care is a process, not a destination

Continued Stay: Plan of Care Documentation

Reason for Swing Bed Admission (not medical diagnosis)

Go Slow to Go Fast

Expected Length of Stay (projected)

Patient's potential and preference for future discharge (including setting)

Patient's goals for admission and expected outcome for Swing Bed Stay (in patient's own words)

Any traumatic events that would influence care?

Goal: Anticipated physical status at discharge
Services to be provided to meet physical status discharge goal

Goal: Anticipated mental status at discharge
Services to be provided to meet mental status discharge goal

Goal: Anticipated psychosocial status at discharge
Services to be provided to meet psychosocial status discharge goal

Any specialized services or specialized rehabilitative services provided as a result of PASARR recommendations
IF not following PASARR recommendations - WHY

Continued Stay: Plan of Care Documentation

Assessment / Need	Measurable Objective	Timeframe	Interventions	Update
Infection right knee	Complete course of IV antibiotic	14 days	1. Antibiotic as ordered by physician 2. Daily dressing changes	7/20/19: Tolerating antibiotic well. Wound healing (see nursing documentation)
Fall Risk	Evaluation by PT	2 days	1. PT to see 2 times daily 2. Up only with walker	7/20/19: Pt. continues to be unsteady when out of bed. Will provide walker.
Weight Loss	Increase weight to 130 pounds	1 week	1. Nutritional supplements 3 times per day 2. Weight 2 times per week 3. Document nutritional intake	7/20/19: Pt. continues to lose weight. Will change to different supplement per patient request.
Potential for deterioration in mental status without stimulation	Activities provided by CNA per activities plan	Three times per day	See activities plan	7/20/19: Patient participating in activities.

Continued Stay: Plan of Care

Needs identified as a result of the comprehensive assessment – including traumatic events

Look back at WHY patient was admitted to Swing Bed

Measurable objectives and timeframes

Meet medical, nursing, and mental and psychosocial needs

If you have a multi-disciplinary plan of care – DO YOU REALLY NEED A SEPARATE NURSING CARE PLAN?

Are recommendations getting lost – and not included in the plan of care (dietary for example)

Make sure you document participation – INCLUDING

- Nurse caring for patient
- CNA caring for patient
- PATIENT (agreement)

TRANSFER AND DISCHARGE

- ❑ Physician order for discharge
- ❑ Discharge plan with involvement of resident
- ❑ Discharge Documentation
  - Recapitulation of resident's stay
  - Final summary of resident status (elements in comprehensive assessment)
  - Where resident will reside
  - Arrangement for follow-up care
  - Post-discharge medical and non-medical services
- ❑ Notice of Discharge provided to Resident (as soon as discharge is known)
- ❑ Notice of Medicare Non-Coverage (Medicare), if applicable
- ❑ Notice sent to Ombudsman
- ❑ Information provided to the receiving provider
  - Contact information of the practitioner responsible for the care of the resident
  - Resident representative information including contact information
  - Advance Directive information
  - All special instructions or precautions for ongoing care, as appropriate
  - Comprehensive care plan goals
  - 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

Transfer and Discharge

1. Are all regulatory requirements being met?
2. Who is responsible for documenting each element?
3. Who is responsible for providing information to patient?
4. Who is responsible for providing information to the next provider of care?
5. Is the system Push or Pull?

Lean

Define Value
Value is what the customer is willing to pay for --- finds valuable

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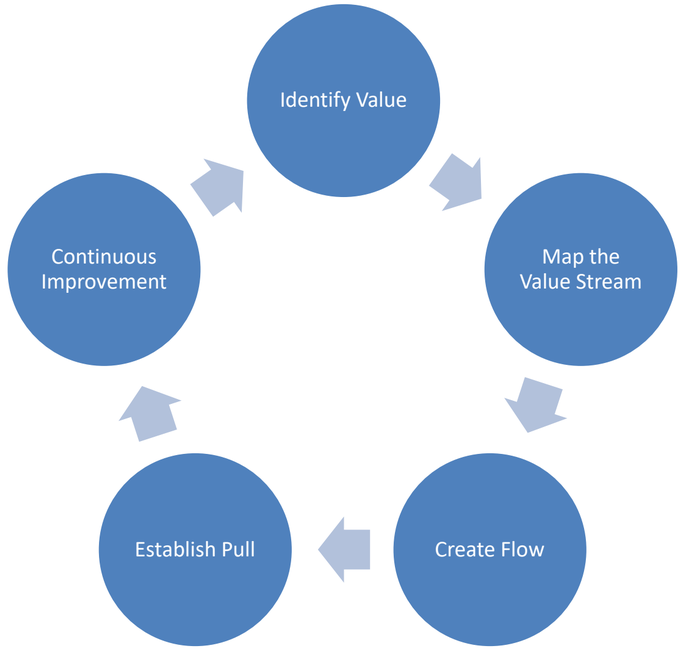
- Non-Value added and unnecessary

Create Flow
After removing waste, ensure that the flow of the remaining steps run smoothly without interruptions or delays. Strategies include breaking down steps, reconfiguring steps, leveling out workload, creating cross-functional departments, and training employees to be multi-skilled.

Establish Pull
Needed materials and information are available (just-in-time) for a smooth flow of work.

Continuous Improvement



jojo: Slowly, Gradually, Steadily

"There's no genius in our company. We do what we believe is right, trying every day to improve ***every bit and piece*****.** But when 70 years of very small improvements accumulate, they become a revolution."

Katsuaki Watanabe, CEO, Toyota Motor Company

Lessons from Toyota's Long Drive

by: Thomas A. Stewart and Anand P. Raman

July–August 2007 issue of Harvard Business Review

A3 Problem Solving

View with a microscope

Tool for “drilling” down into variation in the process

Documentation of problem solving activity

Tells the story visually

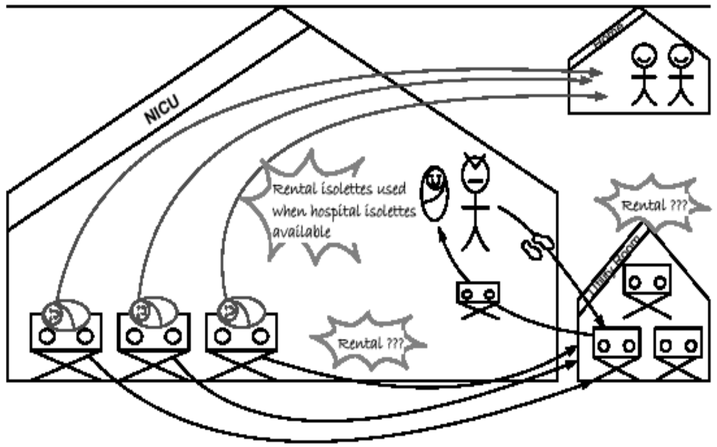
A3 Problem Solving

ISSUE The amount of money being spent in the NICU on rental equipment exceeded the demand for rental equipment.

BACKGROUND

The NICU has 10 isolettes and the capacity of 12 newborns. The normal census is eight newborns. When the census exceeds ten newborns NICU rents isolettes.
In six months $63,000 was spent on rental isolettes.

CURRENT CONDITION

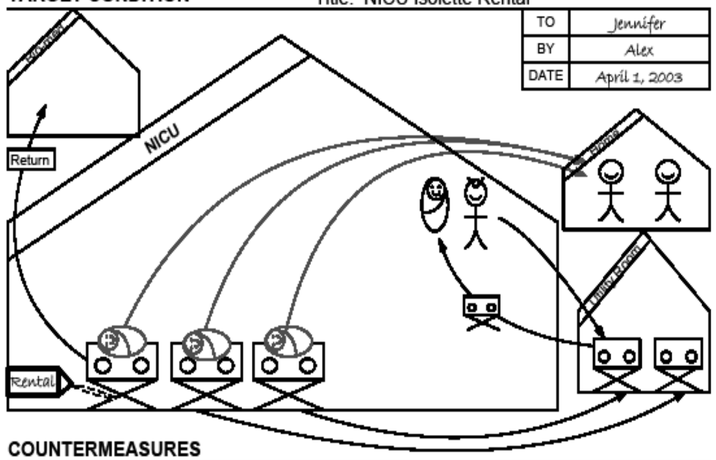


PROBLEM ANALYSIS

1. Rental isolettes are being used when hospital isolettes are available
   - why? Rental isolettes are stored in the utility room after use
     - why? All isolettes are the same model and look the same
       - why? Rental isolettes aren't clearly marked as rentals
2. Rental isolettes aren't returned to Biomed after use
   - why? RN's can't easily recognize rental vs. hospital owned isolettes
     - why? No clear identification as rental
   - why? No defined process for returning isolettes

TARGET CONDITION Title: NICU Isolette Rental

TO	Jennifer
BY	Alex
DATE	April 1, 2003



COUNTERMEASURES

1. Attach bright orange tags to rental isolettes when checked out of the bio-med department
2. Print directions for returning the isolettes on the orange tag
3. Half of the orange tag is retained in the bio-med department to track the rental equipment

IMPLEMENTATION

What	Who	When	Outcome
Create rental return instructions	Bio-med /RN	4/5/06	Instructions ready to print on tag
Create orange tags to be attached to rentals	Bio-med /RN	4/10/06	Tags ready for use
Orient bio-med/NICU staff on new process	Bio-med /NICU	4/15/06	New process implemented

COST / BENEFIT

Cost	$$$
Biomed and RN staff time	4 hours
Tag materials	$60
Benefit	**$$$**
Reduced rental fees ($63,000 - $27,800)	$35,200

TEST

Use tags for six weeks. Monitor weekly for possible revisions.

FOLLOW UP

October 22, 2003: Two tag revisions made in six weeks. In the six months after implementation, $27,800 spent on rental isolettes.

HEALTHTECH S³
strategy solutions support

Lean: Simple Formula

Liberate the ***people who do the work*** to use a proven method to look at what they do with "new eyes" to identify elements of the work that permit:

- Errors and delay in care/service
- Waste of resources
- Frustration in the workplace

THANK YOU

I hope this information has been helpful

Please contact me if you would like to schedule a review of your Swing Bed Program or have questions about the presentation

Stay Tune for a New
Swing Bed Collaborative Opportunity
Coming Soon!

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

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