HEALTHTECH S3
strategy solutions support

5110 Maryland Way
Suite 200
Brentwood, TN 37027
615.309.6053
www.healthtechs3.com

2745 North Dallas Pkwy
Suite 100
Dallas, TX 75093
800.228.0647
www.gaffeythealthcare.com

GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Keeping Your Swing Bed Program Survey Ready

November 6, 2020

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

FORTY - EIGHT YEARS OF
Building Leaders | Transforming Hospitals | Improving Care

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Nationwide Client Base

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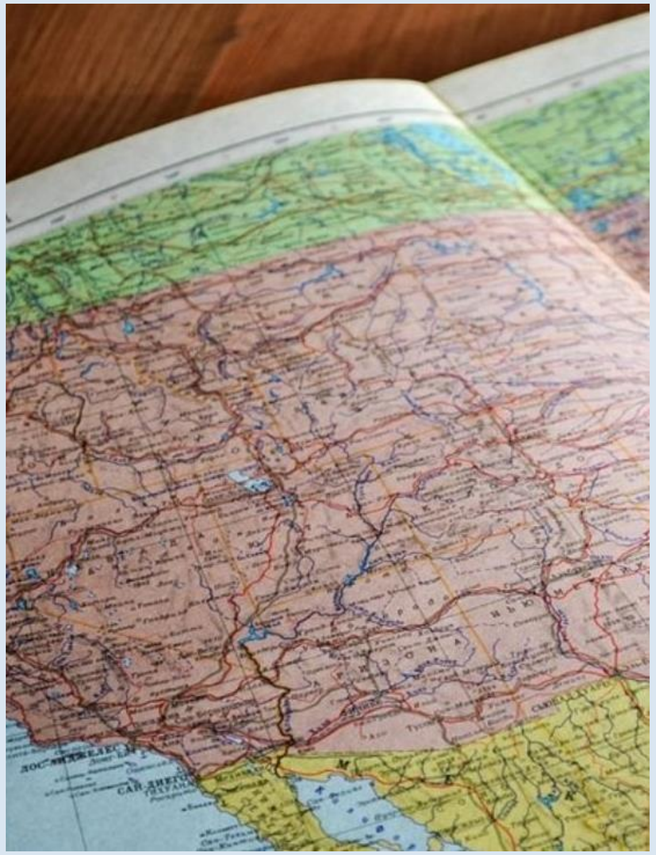
TECHNOLOGY. RESULTS.



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 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

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ALL WEBINARS ARE RECORDED

2020 QUARTER 4 WEBINARS

Medical Staff Credentialing and Privileging: The Basics and Beyond
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : October 9, 2020 **Time :** 12pm CST
https://bit.ly/36kIT5G

Care Coordination Staffing Strategies
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : October 29, 2020 **Time :** 12pm CST
https://bit.ly/3kSmK2S

Keeping Your Swing Bed Program Survey-Ready
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : November 6, 2020 **Time :** 12pm CST
https://bit.ly/2GjPHWz

The Role of a Rural Hospital's Board in a Time of Crisis: Part 2
Presenter : Peter Goodspeed, Vice President of Executive Search
Date : November 13, 2020 **Time :** 12pm CST
https://bit.ly/3l4Hogl

It's Not If, But When: Is Your Organization Prepared for the Next Emergency Event
Host: : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Presenter : Ernie Allen, **ARM, CSP, CPHRM, CHSP**
Date : November 17, 2020 **Time :** 12pm CST
https://bit.ly/3n13Ybo

The Critical Early Days of a New Hospital Executive - Interim or Permanent
Presenter : Mike Lieb, FACHE – Vice President
Date : December 4, 2020 **Time :** 12pm CST
https://bit.ly/3cIY4XG

Advance Care Planning: Are Your Patient's Wishes Being Communicated?
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : December 7, 2020 **Time :** 12pm CST
https://bit.ly/3ihndtB

National Patient Safety Goals – What's New for 2021
Presenter : John A. Coldsmith, DNP, MSN, RN, NEA-BC
Date : December 18, 2020 **Time :** 12pm CST
https://bit.ly/2GjPUJl

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Presenter

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TECHNOLOGY. RESULTS.

Carolyn St.Charles
Chief Clinical Officer
HealthTechS3

Carolyn began her career in healthcare 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 Chief Clinical Officer with HealthTechS3 for the last 20 years.

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

Carolyn has extensive experience working with rural hospitals to develop and strengthen swing bed programs.

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

Swing Bed

The Social Security Act (the Act) permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or SNF care.

As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements.

Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital.

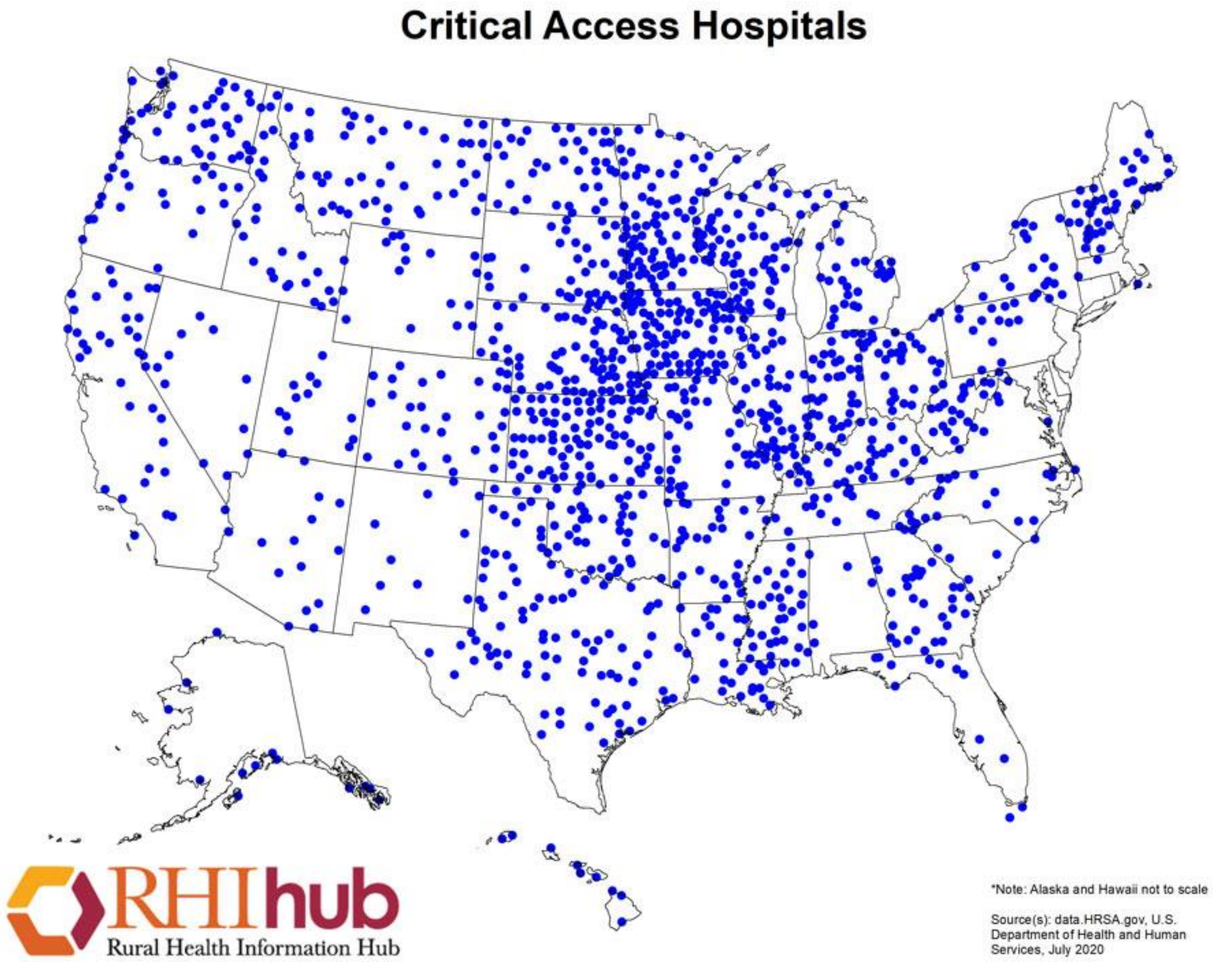
Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Critical Access Hospitals – July 2020

1,350 Critical Access Hospitals

Approximately 88% provide swing bed services

Source: University of Minnesota Rural Health Research Center



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

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

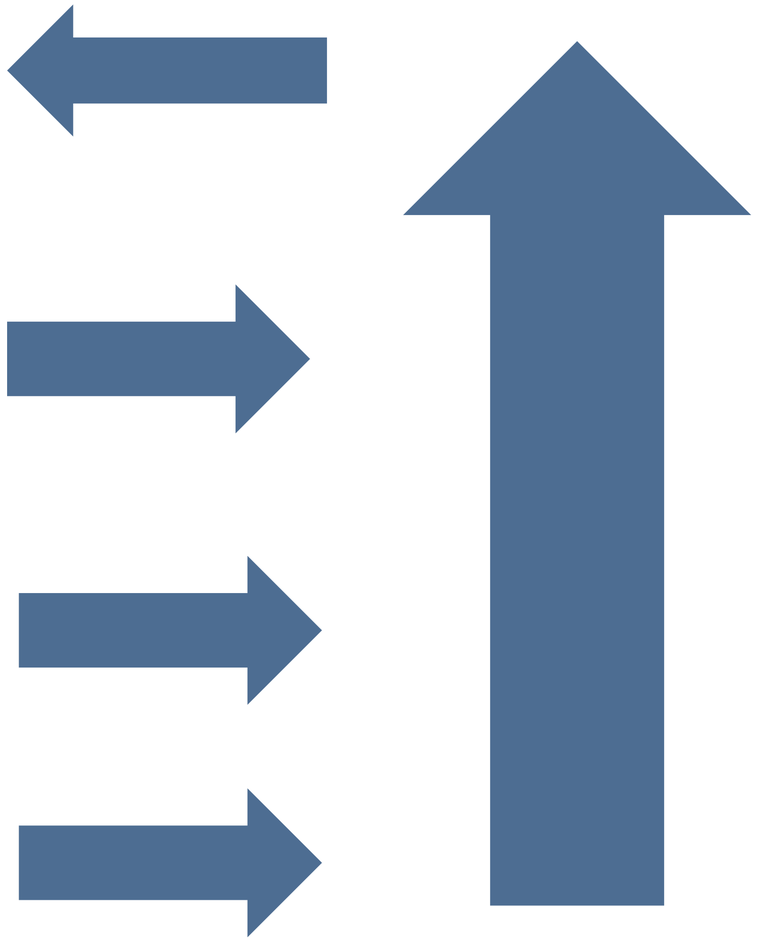
Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

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
file:///C:/Users/carol/OneDrive/Documents/Resources/2019-20736%20Federal%20Register.pdf

CMS Federal Register - Discharge Planning
https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences
file:///C:/Users/carol/OneDrive/Documents/Resources/2019-20732%20discharge%20planning%20rules.pdf

Regulatory Changes

November 2017	LTC Revisions State Operations Manual **Appendix PP**
October 2018	Swing Bed Revisions State Operations Manual **Appendix W**
November 2019	Swing Bed Revisions **Federal Register**
February 2020	Swing Bed Revisions State Operations Manual **Appendix W**



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Keeping Up With Changes

1. Check periodically by searching for:
   - Appendix W SOM
   - Appendix A SOM

2. Check CMS web site periodically
   - https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

3. Sign up for alerts / notifications from CMS

4. Hospital Associations will usually post notices when there are updates

OCTOBER 2018: CHOICE OF PERSONAL PHYSICIAN

C-1608 §483.10(d) Choice of attending physician. The resident has the right to choose his or her attending physician. 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.

(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.

(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.

Hospital: A-1511 §483.10(d)

October 2018: Reporting Abuse

C-1612 §483.12(b) The facility must develop and implement written policies and procedures that:
(1)Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,
(2)Establish policies and procedures to investigate any such allegations,

C-1612 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
(2) Have evidence that all alleged violations are thoroughly investigated.
(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Hospital: A-1566 §483.12(b)(1) §483.12(b)(2): §483.12(c):

OCTOBER 2018: CULTURALLY COMPETENT TRAUMA INFORMED CARE

C-1620 §483.21(b)
(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality. (ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) Be culturally-competent and trauma-informed.

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

Sample Assessment Questions - *MY QUESTIONS – NOT FROM CMS*
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?

OCTOBER 2018: PLAN OF CARE

C-1620 §483.21(b)
(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment.

(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.

Timelines must be congruent with your Length of Stay

For example:IDT meeting within 48 – 72 hours of admission to develop comprehensive plan of care

October 2018: 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).

(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)—

The resident's goals for admission and desired outcomes.

(A) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

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

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

OCTOBER 2018: PASARR

C-1620 §483.21(b) Comprehensive care plans.
(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(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.

PASRR is a screening tool to identify residents with serious mental illness (SMI), mental retardation (MR), or a related condition (RC)

Federal regulations do not require that a PASRR is completed for Swing Bed Patients.

However, new regulatory requirements require that you review and incorporate the PASRR in the plan of care if appropriate – if one has been done.

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

http://www.pasrrassist.org

October 2018: Notice to Ombudsman

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.**

Send Discharge Notice you provide to patient

Appendix PP §483.15(c)(3)-(6)

Guidance - Notice of Transfer or Discharge and Ombudsman Notification

Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state

OCTOBER 2018: TRANSFER AND DISCHARGE

C-1610 §483.15(c)(2)
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.

October 2018: Transfer & Discharge

C-1620 §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.

November 2019 Federal Register - February 2020 CoP

Discharge Planning

C-1400 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
A Critical Access Hospital (CAH) must have an **effective discharge planning process** that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from the CAH to postdischarge care, and reduce the factors leading to preventable CAH and hospital readmissions.

C-1404 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
The CAH's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.

C-1412 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(4) Upon the request of a patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient.

C-1406 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.

November 2019 Federal Register - February 2020 CoP

Discharge Planning

C-1408 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post- CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

C-1410 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

C-0417 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

C-1420 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(6) The CAH's discharge planning process must require regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes

C-1420 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(7) The CAH must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.

November 2019 Federal Register - February 2020 CoP

Discharge Planning

C-1425 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(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 measures**. 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.

Not included in Appendix W – but the information was included in CMS Publications

A-0815 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
The hospital must include the discharge planning a list of HHA's, SNF's, IRF's, or LTCH's that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.
(i) The list must only be presented to patients for whom home health care post hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.
(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.
(iii) The hospital must] document in the patient's medical record that the list was presented to the patient or to the patient's representative.....

A-0816 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of the post-discharge services and must, when possible, respect the patient's or the patient's representative goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patients.

A-0817 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of part 420, subpart C, of this chapter.

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

Swing Bed Audit

1. Pre-Admission
2. Admission
3. Continued Stay
4. Transfer & Discharge
5. Outcome Measures

But First…….New QAPI Regulations effective March 2021

Federal Register / Vol. 84, No. 189 / Monday, September 30, 2019

The regulations at §485.641 regarding Quality Assessment and Performance Improvement Programs (QAPI) in critical access hospitals (CAHs) must be implemented by March 30, 2021

SOM Appendix W has not been updated to incorporate the QAPI requirements as of September 2020

Quality Definitions

Quality Control – product oriented – focuses on defect identification
"An aggregate of activities (such as design analysis and inspection for defects) designed to ensure adequate quality especially in manufactured products" (Merriam-Webster)

Quality Assurance – process oriented – focuses on doing the right things the right way
*"The maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production" (kwäl*ə*dē* ə*'SHo͝orəns)*

"QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards." (CMS)

Performance Improvement – focuses on improvement of current processes and identification of new approaches
"PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI aims to improve processes involved in health care delivery and quality of life." (CMS)

Quality Assurance / Performance Improvement (QAPI) – coordination of QA and PI
QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. (CMS)

***The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted.* (CMS)**

CAH QAPI CoPs (Federal Register)

C-1300 (Rev. – Effective March 30, 2021)
§485.641 Quality assessment and performance improvement program.

The CAH must develop, implement, and maintain an
- Effective,
- Ongoing,
- CAH-wide,
- Data-driven,

quality assessment and performance improvement (QAPI) program.
The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.

§485.641 Quality assessment and performance improvement program.

(b) The QAPI program must:

(1) Be appropriate for the complexity of the CAH's organization and services provided.

(2) Be ongoing and comprehensive.

(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).

(4) Use objective measures to evaluate its organizational processes, functions and services.

(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmission.

§485.641 Quality assessment and performance improvement program.

(d) For each of the areas listed in paragraph (b) of this section, the CAH must
(b)(1) Be appropriate for the complexity of the CAH's organization and services provided.
(b)(2) Be ongoing and comprehensive.
(b)(3)Involve all departments of the CAH and services (including those services furnished under contract or arrangement).
(b)(4)Use objective measures to evaluate its organizational processes, functions and services.
(b)(5)Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmission.

(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.

(2) Use the measures to analyze and track its performance.

(3) Set priorities for performance improvement, considering either high volume, high-risk services, or problem prone areas.

§485.641 Quality assessment and performance improvement program.

(e) The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.

Swing Bed QAPI

1. Swing Bed is a key patient care service line
2. In setting priorities, Swing Bed can be considered either high-volume, high-risk, or problem-prone area
3. Audit can be used to identify areas for improvement - even though program may be working well
4. Audit can include (should include) outcome indicators

Quality Assurance / Performance Improvement (QAPI) – coordination of QA and PI
QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. (CMS)

The focus of a QAPI program is to proactively maximize quality improvement activities and programs, even in areas where no specific deficiencies are noted. (CMS)

Audits

The following pages have audit criteria from pre-admission to discharge.

Although you can certainly use the tool for retrospective chart review ----- BEST to use tracers and include members of the multi-disciplinary team.

Swing Bed Audit: Pre-Admission

Medicare: Benefit days available
Medicare Skilled Criteria *(All 4 must be met)* 1. 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; 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.
Medicare Skilled Criteria *(All 4 must be met)* 1. The patient requires skilled services on a daily basis
Medicare Skilled Criteria *(All 4 must be met)* 1. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
Medicare Skilled Criteria *(All 4 must be met)* 1. 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.
Medicare: 3-Day qualifying inpatient stay within the last 30 days Admission to Swing Bed for treatment of a condition for which the beneficiary was receiving inpatient hospital services or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. 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.
Other payors: Pre-authorization for Swing Bed stay
For patients in same facility moving from inpatient to swing bed: Quality and Resource information for post-acute providers in the geographic area provided in writing and discussed with patient. Includes information about hospital's Swing Bed program.
For patients in same facility moving from inpatient to swing bed: Patient choice of skilled nursing provider documented in the medical record
Admission reviewed by staff as specified in hospital policy
Needs of patient can be met in Swing Bed including need for specialized equipment and or staff (i.e. speech therapy, wound care, etc.)
Physician review and agreement to accept patient
Patient agrees to Swing Bed admission

Swing Bed Audit: Admission

Admitting: All hospital required admitting forms completed
Medical Records: New account number with new medical record separate from inpatient stay
Provider: Discharge order from inpatient *if in the same facility*
Provider: Admission order to Swing Bed
Provider: Document reason for admission to Swing Bed
Provider: Certification that patient requires skilled care on a daily basis
Provider: Documents expected Length of Stay
Provider: Documents expected discharge disposition
Provider: Orders for care in Swing Bed
Provider: History and Physical within time frame specified in bylaws
Patient Notices: Provided verbally and in writing prior to or upon admission
Patient Notices: Copies provided to patient
Patient Notices: Signed copies in medical record or attestation
Patient Notice: Swing Bed Overview and Description of Program
Patient Notice: Rights and Responsibilities
Patient Notice: Choice of Physicians
Patient Notice: Contact information for all providers involved in care
Patient Notice: Financial Obligations (specific to swing bed)
Patient Notice: Advance Directives
Patient Notice: Transfer and Discharge Rights
Patient Notice: Visitation
Patient Notice: How to file a grievance or complaint
Patient Notice: Hospital responsibility for preventing abuse
Patient Notice: Contact information for Hospital and State licensing agency including State Ombudsman

Swing Bed Audit: Admission Assessment & Reassessment

Assessment: Identification and demographic information
Assessment: Customary routine
Assessment: Cognitive patterns
Assessment: Communication
Assessment: Vision
Assessment: Mood and behavior patterns
Assessment: Psychosocial well-being and history of traumatic events
Assessment: Physical functioning and structural problems
Assessment: Continence
Assessment: Disease diagnoses and health conditions
Assessment: Dental status
Assessment: Nutritional status
Assessment: Skin condition
Assessment: Activity pursuit
Assessment: Medications
Assessment: Special treatments and procedures
Assessment: Discharge potential
Assessment: Review of PASSAR (if a PASSAR has been done prior to admission. Will have been done if patient LTC resident)
Reassessment: Comprehensive reassessment with any significant change of condition

Swing Bed Audit: Plan of Care

Plan of Care: Initial Plan of Care developed within 3 days of admission
Plan of Care: Interdisciplinary Plan of Care developed within 7 days of admission, or sooner as specified in policy
Plan of Care: Developed by interdisciplinary team that includes at a minimum: • Attending physician • Registered nurse with responsibility for the patient • Nurses aide with responsibility for the patient • Member of food and nutrition staff • To the extent practicable, the participation of the resident and the resident's representative(s) • Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident
Plan of Care: 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.
Plan of Care: Includes measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment
Plan of Care: Includes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required
Plan of Care: Includes any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment
Plan of Care: Includes 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
Plan of Care: Includes in consultation with the resident and the resident's representative(s), the resident's goals for admission and desired outcomes
Plan of Care: Includes 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
Plan of Care: Includes discharge plans
Plan of Care: Is the Plan of Care updated at least weekly with input from the interdisciplinary team and the patient

Swing Bed Audit: Other Documentation You May Want To Audit

Provider order for Rehab (if appropriate for patient)
Rehab provided at frequency specified in the therapy goals
Rehab (PT/OT/Speech) provided at least 5 days per week
Dietician assessment and recommendations implemented (For example, if dietician recommends weekly weights – check and see if they were done; if dietician recommends snack at bedtime – check and make sure snack was offered)
Patient assessed for hydration and documented by nursing staff
PPS Hospital Only: Activities assessment completed, activities plan developed, and activities offered and documented per the plan
Advance Directive • If patient has an advance directive, is a copy in the medical record? • If patient has an advance directive, is there a provider order for resuscitation that honors the advance directive? • If the patient does not have an advance directive, were they offered information about how to complete an advance directive?
Nutrition Risk: If the patient was determined to be at nutritional risk, were physician and dietician orders and recommendations implemented (i.e. daily weight, calorie count, percent meal consumption, etc.)
Fall Risk: If the patient is determined to be at fall risk, was the hospital policy followed (i.e. falling star on door, arm band, etc.)
Skin Breakdown Risk If the patient is determined to be at risk for skin break-down was the hospital policy followed (i.e. turning, special mattress, etc..)
Medication: Were medications given on time and as ordered?
Pain Medication: Was a pain scale completed before and after pain medication administration?
PRN Medication: Are there specific indications for PRN medications – including pain medication?
Oxygen: If patient is on oxygen is there a provider order and is the order being followed?

Use Tracers!

Swing Bed Audit: Discharge and Transfer

Provider Documentation Reason for transfer or discharge for any of the following reasons requires physician documentation in the medical record A. Transfer or discharge necessary for the resident's welfare and the resident's needs cannot be met in the facility B. 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 The health of individuals in the facility would otherwise be endangered
Provider Documentation When transfer or discharge is due to the resident's welfare and the resident's needs cannot be met in the facility, documentation includes • Facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)
Provider Documentation Discharge Summary that includes 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.
Patient Notification *For patients being discharged to a post-acute provider (SNF, LTC, Home Health, IRF)* Quality and Resource information for post-acute providers in the geographic area provided in writing, discussed with patient and documented in the medical record.
Patient Notification Patient provided with Notice of Medicare Non-Coverage

Swing Bed Audit: Discharge and Transfer

Patient Notification

Timing of Transfer or Discharge Patient Notice

Notice at least 30 days before the resident is transferred or discharged

OR

Notice of Transfer or Discharge must be made as soon as practicable before transfer or discharge when:

- The safety of individuals in the facility would be endangered
- The health of individuals in the facility would be endangered,
- The resident's health improves sufficiently to allow a more immediate transfer or discharge
- An immediate transfer or discharge is required by the resident's urgent medical needs
- A resident has not resided in the facility for 30 days

Patient Notification

Patient notified of transfer or discharge and the reasons for the move. Patient notice includes:

- The reason for transfer or discharge;
- The effective date of transfer or discharge
- The location to which the resident is transferred or discharged;
- 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
- The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
- For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities
- For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

Ombudsman

Copy of the patient notice of transfer or discharge sent to the State Ombudsman

Swing Bed Audit: Discharge and Transfer

Patient Preparation for Discharge Provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Orientation must be provided in a form and manner that the resident can understand. Documented in medical record.
Medication Reconciliation Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
Post-Discharge Plan of Care 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.
Additional information provided to next *post-acute care provider* Contact information of the practitioner responsible for the care of the resident
Additional information provided to next *post-acute care provider* Resident representative information including contact information
Additional information provided to next *post-acute care provider* Advance Directive information
Additional information provided to next *post-acute care provider* All special instructions or precautions for ongoing care, as appropriate
Additional information provided to next *post-acute care provider* Comprehensive care plan goals
Additional information provided to next *post-acute care provider* All other necessary information, including a copy of the resident's discharge summary

Swing Bed Audit: Outcome Measures

Hospital Compare
MBQIP
HCAHPS
Patient agrees to Swing Bed admission
Average length of stay
Discharge Disposition (Home, SNF, Home with Home Health etc.)
Readmissions
Swing Bed Patient Satisfaction
Culture of Safety: Team Huddles
Culture of Safety: Staffing Ratios
Culture of Safety: Harm Events

High Risk Areas / Common Problems

1. Admission - Patient Disclosures
    - Admission packet includes all required patient information and current
    - Information provided to patient as required by CoPs
    - Choice of providers
    - Financial obligations include annual Medicare co-pay

2. Admission Assessment
    - Assessment(s) completed within time frame specified in policy
    - Assessment includes ALL required elements including trauma

3. Plan of Care
    - Required disciplines participate in development of plan of care
    - Plan of care includes measurable objectives and timeframes
    - Plan of care includes participation of patient
    - Plan of care updated as needed

4. Discharge
    - Choice of post-acute providers
    - Discharge notice to patient
    - Discharge notice to ombudsman
    - Required information to next provider of care

Important Notes About Audits – Teams – Improvement

1. Prioritize Swing Bed improvement as a QAPI project. Discuss at Quality Committee and get commitment from committee. Consider as an organizational multi-disciplinary project.

2. Develop a team charter (if you decide to use Swing Bed as an as an organizational multi-disciplinary project

3. Consider a staff and provider survey – or interviews - to identify key areas that need improvement

4. Although you can certainly use the audit tool for retrospective chart review ----- **BEST to use tracers and involve members of multi-disciplinary team including nursing staff.** At a minimum - this should not be one person sitting in a room auditing charts

5. When you are auditing ----- beware of your sample sizes (minimum of 30)

6. For any metric - make sure you have a data plan that clearly describes:

- Clearly defined measure with numerator and denominator
- Benchmark and/or Target
- What you are going to measure
- Who is going to collect data
- Who is going to analyze data
- Where will data be reported

Important Notes About Audits – Teams – Improvement

7. Once you have identified improvement opportunities ---- don't tackle everything at once – focus on areas where there is the "biggest problem". Use your PDCA process. **Continue to monitor is not a corrective action!**

8. Don't forget "**just do it**" for simple solutions

9. Consider establishing goals for the Swing Bed Program ---- not just the component parts (i.e. audits)

- Admissions (volume)
- Time from request for Swing Bed to Acceptance or Denial (especially important for external referrals)
- Staff satisfaction with Swing Bed program
- Provider satisfaction with Swing Bed program
- Patient satisfaction with Swing Bed program

HEALTHTECH S3
strategy solutions support

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THANK YOU

I hope this information has been helpful!

Please contact me if you would like to discuss the information provided in the presentation, or would like to schedule a Swing Bed Review

Carolyn St.Charles
Chief Clinical Officer

HealthTechS3
5110 Maryland Way, Suite 200
Brentwood, TN 37027
Phone: 206-605-3748
www.healthtechs3.com
carolyn.stcharles@healthtech3.com