HEALTHTECH S3
strategy solutions support

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GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Swing Into Winter: Understanding Swing Bed
February 12, 2021

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

FIFTY YEARS OF
Building Leaders | Transforming Hospitals | Improving Care

Presenter

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. Carolyn has been employed by HealthTechS3 for more than 20 years and is currently the Chief Clinical Officer.

In her role as Chief Clinical Officer, Carolyn conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, 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 in working with rural hospitals to both develop and strengthen Swing Bed programs.

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Nationwide Client Base

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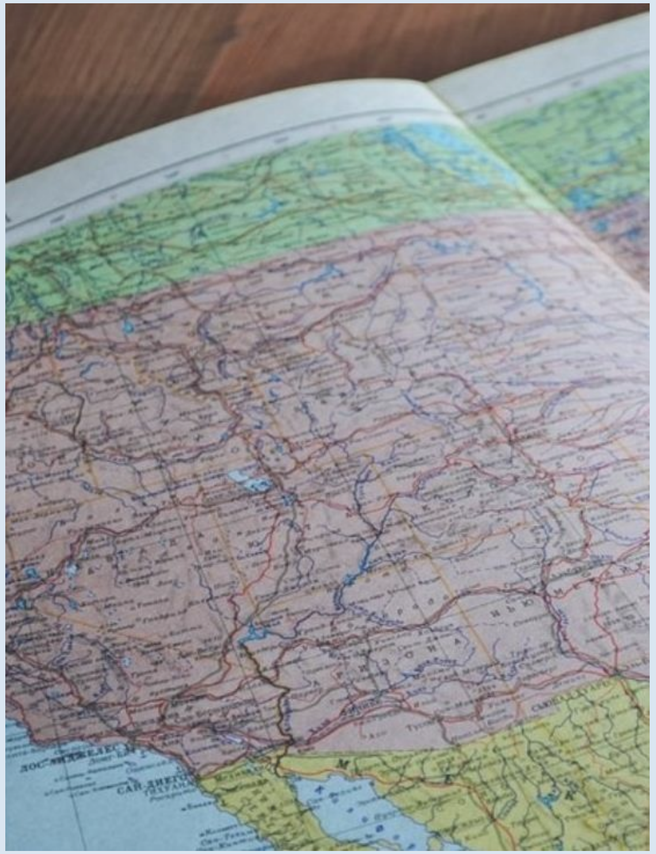

Currently provides hospital management, consulting services and technology to:

- 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 Client: 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

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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

- **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 HealthTechS3 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

Executive

Derek Morkel
CEO

Neil Todhunter
President

Jennifer LeMieux
COO

Recruiting

Mike Lieb
VP - Interim Placement

Peter Goodspeed
VP – Executive Search

Kevin Hardy
Dir. - Executive & Interim Recruiting Svcs.

Consultants

Carolyn St. Charles
Chief Clinical Officer

Joy Smith
Sr. Patient Financial Consultant

Jeff Hollingsworth
Exec. Dir., Supply Chain & Group Purchasing

John Freeman
AVP - Finance

Faith Jones
Dir. - Care Coordination & Lean Consulting

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

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2021 QUARTER 1 WEBINARS

QAPI Tools: Tips & Tricks:
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : January 15, 2020 **Time :** 12pm CST
https://bit.ly/3ohziCQ

How Are the Changes in the Physician Fee Schedule Affecting Your Care Coordination and Visit Billing?
Host: Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Presenter : Julie Seaman, CCS, CCS-P, Coding & CDI Director, eCatalyst Healthcare Solutions
Date : January 21, 2020 **Time :** 12pm CST
https://bit.ly/3b7JDxG

Swing into Winter: Understanding Swing Bed ← **We are Here**
Presenter : Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer
Date : February 12, 2020 **Time :** 12pm CST
https://bit.ly/3b5SnEv

Happy Anniversary to the Annual Wellness Visit!
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : February 18, 2020 **Time :** 12pm CST
https://bit.ly/3hHXD2g

ALL WEBINARS ARE RECORDED

A Day in The Life of a Minority Hospital Executive
Host: : Kevin Hardy, Director Executive & Interim Recruiting, HealthTechS3
Presenter : Andre Storey, FACHE VP & COO, Memorial Hermann Cypress
Date : February 26, 2020 **Time :** 12pm CST
https://bit.ly/2LjeTie

What's Wrong with this Picture? Identifying Safety Risks in Your Hospital
Host: Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer, HealthTechS3
Presenter: Ernie Allen, ARM, CSP, CPHRM, CHFM
Date : March 12, 2020 **Time :** 12pm CST
https://bit.ly/2JJ5Pmt

Managing Behavioral Health Patients in your Primary Care Practice with Collaborative Care Management
Presenter : Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
Date : March 18, 2020 **Time :** 12pm CST
https://bit.ly/3pKbBnd

The Impact of the Pandemic on Hospitals' Senior Leadership Roles and Responsibilities
Host: Peter Goodspeed, VP Executive Search, HealthTechS3
Presenter : Kevin Hardy, Director Executive & Interim Recruiting, HealthTechS3
Date : March 26, 2020 **Time :** 12pm CST
https://bit.ly/358mRBL

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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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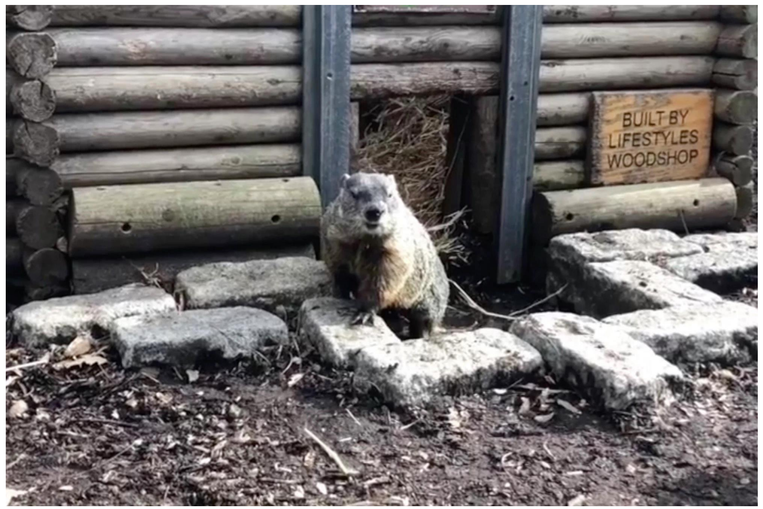
But Before We Get Started……

Groundhog Day 2021
Punxsutawney Phil predicts 6 more weeks of winter

Groundhog Day 2021
Staten Island Chuck predicts early spring

According to a 2012 study, Chuck is a more accurate meteorologist, making correct predictions 80 percent of the time, compared to Phil's pitiful 39 percent success rate

Source: SI Chuck is red hot By Dan Macleod February 3, 2012



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What We'll Cover

1. Regulatory Requirements
2. Auditing Your Swing Bed
3. Barriers to Growth
4. Engaging the Organization

REGULATORY REQUIREMENTS

Keeping Up With Changes

1. Check periodically by searching for:
   - Appendix W SOM (Critical Access Hospitals)

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

3. Sign up for alerts / notifications from CMS

4. Hospital Associations / Rural Health Organizations will usually post notices when there are updates

5. HealthTechS3 Webinars on Swing Bed (Usually one per quarter)

Regulatory Changes

October 2018, November 2019, February 2020

1. Resident Choice of Physician / How to Contact Physicians / Providers
   New and Clarification - October 2018
2. Timelines for Reporting Abuse
   New - October 2018
3. Incorporate Pre-Admission Screening and Resident Review (PASARR) in the Plan of Care or document rationale for not including findings
   Clarification - October 2018
4. Plan of Care
   Additional language and Clarification - October 2018
5. Provide Culturally-Competent and Trauma Informed Care
   New - October 2018
6. Medication Reconciliation at Discharge
   New - October 2018
7. Transfer & Discharge – Information at Discharge provided to next post-acute care provider
   New - October 2018
8. Notification of ombudsman at discharge
   New - October 2018
9. Choice of post-acute care provider and provision of resource and quality data
   New - November 2019 and February 2020
10. Routine & 24-hour dental care
    Hospital policy for loss or damage of dentures is facility's responsibility
    New - February 2020

Interpretative Guidelines have not been published for Appendix W February 2020 revisions

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Regulatory Changes Cont.

October 2018, November 2019, February 2020

11. Activities by qualified professional
    - **Deleted - November 2019**

12. Right to Work
    - **Deleted - November 2019**

13. Full-time Social Work only if more than 120 beds
    - **Deleted - November 2019**

Interpretative Guidelines have not been published for the Appendix W February 2020 revisions

REGULATORY REQUIREMENTS
With a focus on the
New - or - Challenging

Information Provided at Admission to Patient

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
- ❑ Patient Rights and Responsibilities
- ❑ A description of hospital policies regarding advance directives
- ❑ Resident Choice of physicians
- ❑ Information on how to contact providers (ALL)
- ❑ Financial Obligations
- ❑ Transfer and discharge
- ❑ 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

Helpful Hints

At a minimum patient rights must be provided VERBALLY

Make sure your Swing Bed Packet is Complete

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Patient Rights and Responsibilities

C-1608 §485.645(d) SNF Services.

The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) Resident Rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter).

Helpful Hint

Make sure you aren't using Long Term Care Rights

FINANCIAL OBLIGATIONS

C-1608 §483.10(g)(17)

§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 §483.10(g)(17)(i)(A) and (B) of this section.

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.

Helpful Hint

Make sure you are providing both Medicare and Medicaid information –

and update Medicare co-pay every year

Comprehensive Assessment

C-1620 §483.20(b)

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. (**CAHs don't have to use RAI)** The assessment must include at least the following:

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. **Psychosocial well-being – HISTORY of traumatic events** (October 2018)
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. (Discharge potential
17. **Review of PASSAR – if one has been done**

Helpful Hint

Make sure all elements are assessed including History of Trauma and PASSAR

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?

Helpful Hint

Include as part of Nursing or Social Work or Discharge Planning Assessment

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.

•

PASARR 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 PASARR is completed for Swing Bed Patients.

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

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

http://www.pasrrassist.org

Helpful Hints

Check at time of admission if patient has a PASARR

Include review at first multi-disciplinary care team meeting – and document

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).

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

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

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.

Helpful Hints

Pay close attention to MEASURABLE and TIME FRAMES

Always include the patient – and document input

Post in Patient's Room

Review at EVERY IDT meeting

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

Helpful Hints

7-Days is TOO LONG – must be appropriate to your LOS

Ensure required members of IDT team are included

Example Plan of Care & IDT Notes

Patient Discharge Goal: 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 and 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 to ____within 2 weeks and prior to discharge

Example Goal 4: Patient will give insulin independently including accurately checking blood sugar, understanding dose based on blood sugar, when to administer, how to administer within 2 weeks and prior to discharge

Patient is in concurrence with long and short-term goal:

Identify who discussed with patient and when as well as any modifications the patient requested.

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				

Reassessment After Significant Change

A "**significant change**" may include, but is not limited to, any of the following, or may be determined by a MD/DO's decision if uncertainty exists.

- **Deterioration in two of more activities of daily living (ADLs),** or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent. For example, pronounced deterioration in function and communication following a stroke.
- **Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself,** such as spoon, toothbrush, or comb. Temporary loss of ability, such as during an acute illness, is not included.
- **Deterioration in behavior or mood,** to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident's psychosocial status are not likely to improve without staff intervention.
- **Deterioration in a resident's health status**, where this change places the resident's life in danger (e.g., stroke, heart disease, metastatic cancer); where the change is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or change that is associated with an initial diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time (e.g., Alzheimer's disease or diabetes); or the onset of significant, unplanned weight loss (5% in the last 30 days, 10% in the last 180 days).

Helpful Hint

Frequently Missed ---- Discuss as part of IDT Meetings

Choice of Post-Acute Provider

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.

Helpful Hints

Patient must also be given choice of Swing Bed – even if they are your patient

Identify "geographic area" for which you will provide information

Update whenever CMS updates information (put date on info)

Make sure you include quality and resource information – not just name of provider

Must explain choices to patient – not just give them web site info for CMS

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.

Helpful Hints

Review your policy

Have a weekend and holiday plan

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.

Helpful Hints

Review your policy

Have a weekend and holiday plan

Notice Before Discharge - Content

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;
(vi) 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 established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) 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

There is NOT a CMS form

Helpful Hints

Review your policy

Have a weekend and holiday plan

DISCHARGE NOTIFICATION

Date: _____ Name: _____

Admission Date: _____ Medicare #: _____

Dear

Your discharge from the Swing Bed Program at _____ is expected to occur _____ (when). You will be discharged to _____(where - location) because _____ (reason).

If you disagree with your discharge plan, you have the right to appeal this action with the State of _____Division of Health (State contact). To do so, contact:

Division of Quality Assurance
Address and Phone

or the long-term care ombudsman: (Ombudsman contact).

Board on Aging and Long Term Care
Address and Phone

Sincerely,
Name and Title

_____ _____ _____

Patient Signature Date Time

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

Helpful Hints

Review your policy

Have a weekend and holiday plan

Notice of Medicare Non-Coverage

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711
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 Non-Coverage (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 Skilled Nursing Facilities **includes beneficiaries receiving Part A and B services in Swing Beds.**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf

Helpful Hints

Review your policy

Have a weekend and holiday plan

ABUSE RECOGNITION AND 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.

Helpful Hints

Review your policy

Make sure policy has been updated to include new timelines and reporting structure

Educate ALL staff --- this is NOT external abuse

REVIEW POLICIES AND PROCEDURES

Swing Bed Polices & Procedures

Admission

1. Admission criteria and process for determining if patient meets admission criteria
2. Choice of providers and provision of contact information for providers
3. Admission disclosures / information to patient including providing information verbally
4. Physician Certification (and Recertification)
5. Admission Orders

Assessment

6. All required assessment elements including a) what discipline assesses each element; b) time frames for assessments to be completed; c) assessment of trauma; d) review of PASARR
7. Nutritional Assessment by Dietitian (usually separate policy)
8. Reassessment with change of condition

Care Planning

9. Interdisciplinary Team Planning including participation of required disciplines (CNA, RN, Provider)
10. Patient Involvement in development of plan of care
11. Frequency of care plan review and updates

Transfer and Discharge

12. Choice of post-acute provider
13. Discharge Assessment and Discharge Plan of Care
14. Patient Notification of Discharge
15. Ombudsman Notification
16. Liability Notices and Appeal to QIO Process
17. Information provided to next post-acute provider

Please note, some policies may have a combination of elements. Not every bullet needs to be a separate policy.

Swing Bed Policies & Procedures cont.

Other

18. Abuse, Neglect, and Exploitation
19. Advance Directives (Hospital policy can apply to Swing Bed)
20. Dental Services
21. Financial Obligations
22. Grievances and Complaints
23. HIPAA Privacy (Hospital policy can apply to Swing Bed)
24. Medication Management
25. Patient Rights and responsibilities
26. Personal Property (May be included in patient rights)
27. Photographs (Hospital policy can apply to Swing Bed)
28. Privacy Practices (Hospital policy can apply to Swing Bed)
29. Provider choice and providers contact information
30. Quality Improvement (QAPI) Hospital policy can apply to Swing Bed)
31. Restraints (Hospital policy can apply to Swing Bed – Note: Swing Bed Patient Rights include freedom from restraints.)
32. Social Services
33. Staffing
34. Transportation for Outside Medical and Dental Care
35. Visitation (May be included in patient rights)

Please note, some policies may have a combination of elements.
Not every bullet needs to be a separate policy.

CONDUCT REGULAR SWING BED AUDITS

1. Pre-Admission

2. Admission

3. Continued Stay

4. Transfer & Discharge

5. Outcome Measures

High Risk Areas / Common Problems

1. Admission - Patient Disclosures
    - Admission packet includes all required patient information - and provided to every Swing Bed patient
    - Choice of providers
    - Provider contact information
    - Financial obligations include annual Medicare co-pay

2. Admission Assessment
    - Assessment(s) completed within the time frame specified in policy
    - Assessment includes ALL required elements including history of trauma and review of Pre-Admission Screening and Resident Review (PASARR)

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 or when there is a significant change

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

Audit Do's and Don'ts

1. Audits work best if done with a IDT team and/or staff caring for patient

2. Start with a comprehensive audit of several charts – then drill down to areas of concern

3. Implement corrective actions (look for root cause)

4. Re-Audit

Audit Tool Included at End of Presentation

PROGRAM GROWTH

Barriers to Growth

1. Lack of staff and provider knowledge regarding Swing Bed criteria. Unaware of types of patients that can be admitted including criteria NOT ASSOCIATED with Rehab (education, training, management of plan of care, etc.
2. Lack of staff and provider knowledge about length of stay and improvement standard
3. Lack of staff and provider knowledge about Swing Bed benefits to patient and hospital
4. Lack of agreed criteria for types of patients that can be accepted for Swing Bed care
5. Lack of reliable system and timeliness for responding to referrals
   - Process for accepting referrals
   - Physician availability
   - Other team members availability
6. Competition in the market
7. Lack of marketing to patients – community – providers – other hospitals
8. Lack of administrative support
9. Lack of criteria to measure Swing Bed outcomes and processes
10. Lack of feedback to staff and providers who care for Swing Bed patients
11. Lack of feedback to referral sources who care for Swing Bed patients

Turn Barriers Into Opportunities

1. **Educate** staff and provider knowledge regarding Swing Bed criteria . **Develop** policy for types of patients that can be admitted including education, training, management of plan of care, etc.

2. **Educate** staff and providers about length of stay and improvement standard

3. **Educate s**taff and provider about Swing Bed benefits to patient and hospital

4. **Develop** criteria for types of patients that can be accepted for Swing Bed care with concurrence of Administration, Nursing Leaders, Providers

5. **Develop** systems and processes for responding to referrals with a targeted response time

6. **Review / Understand / Track** competition in the market

7. **Develop** marketing materials for patients (including those being transferred) – community – providers – other hospitals

8. **Active / Visible** administrative support

9. **Develop** criteria to measure Swing Bed outcomes and processes

10. **Share** feedback about program outcomes with staff and providers who care for Swing Bed patients

11. **Share** feedback about program outcomes with referral sources

ENGAGE THE ORGANIZATION

Engage the Organization

1. Think of Swing Bed as a strategic service line ---- not just a few beds on Med-Surg.

2. Create organizational goals, include review and approval by governing board. MAY be part of strategic plan.
   - Admissions
   - Length of Stay
   - Quality Outcomes

2. Track and report on goals to governing board, senior leaders, medical staff, staff thru-out the organization

3. If you aren't meeting your Swing Bed goals? --- Why Not?
   - Engage those most directly responsible for Swing Bed Care in identifying problems and creating solutions
   - Listen to what the team has to say!
   - Provide administrative support to remove barriers and help with solutions

4. Tell Stories – Celebrate Success

THANK YOU

Carolyn St.Charles
Chief Clinical Officer

I hope this information has been helpful!

Please contact me if you would like to schedule
a virtual or on-site Swing Bed Review

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AUDIT CRITERIA

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.** **2. The patient requires skilled services on a daily basis** **3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF** **4. 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: Assessment & Continued Stay

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: Assessment and Continued Stay

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** **•CNA with responsibility for patient** **•Member of food and nutrition staff** **•To the extent practicable, the participation of the resident and the resident's representative(s)**
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: Developed by interdisciplinary team : Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident
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: Assessment and Continued Stay

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?
Pain 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?

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** **D. 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.**

Swing Bed Audit: Discharge and Transfer

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

Swing Bed Audit: Outcome Measures

Hospital Compare
MBQIP
HCAHPS
Average Length of Stay
Discharge Disposition
Readmissions
Staffing Ratios
Harm Events
Hospital target for time from referral (external) to acceptance or denial
Assessment by each discipline completed per policy (timeliness and content)
Multi-Disciplinary Plan completed per policy (timeliness and content)
Swing Bed Patient Satisfaction (Specific to Swing Bed)
Staff Satisfaction
Provider Satisfaction
External Referral Sources Satisfaction

SWING BED CRITERIA

SKILLED CRITERIA

30 - Skilled Nursing Facility Level of Care - General (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132, SNF-214

Care in a SNF is covered if <u>all of the following four factors are met</u>:

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 (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

2. The patient requires these skilled services on a daily basis (see §30.6); and

3. 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.)

4. 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.

Source: 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

MEDICARE 3-DAY QUALIFYING STAY

The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals.

In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.

Time spent in observation status or in the emergency room prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay, as a person who appears at a hospital's emergency room seeking examination or treatment or is placed on observation has not been admitted to the hospital as an inpatient; instead, the person receives outpatient services.

Source: 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

Source: https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care

Medicare Qualifying Condition

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.

Source: 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

Source: https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care

SKILLED CRITERIA - MEDICARE

30.2.2 - Principles for Determining Whether a Service is Skilled

- If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;
  - e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

- The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service.

- **While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.**

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.

MEDICARE BENEFITS POLICY MANUAL

The Medicare Benefit Policy Manual Chapter 8 has <u>MANY</u> examples of the types of patients that qualify for Swing Bed (SNF) care.

Medicare Benefit Policy Manual Chapter 8 – 20.1
Rev. 261; Issued: 10-04-19)

Medicare Daily Skilled Care

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a *7* days a week basis.

- **Skilled Restorative Nursing – Skilled Nursing**
  - A skilled restorative nursing program to positively *affect* the patient's functional well-being, the expectation is that the program be rendered at least 7 days a week.
- **Skilled Rehabilitative Therapy**
  - A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and receive those services on at least *5* days a week. (If therapy services are provided less than *5* days a week, the "daily" requirement would not be met.)
- **Maintenance therapy**
  - Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.

Source: Medicare Benefit Policy Manual Chapter 8 – 20.1

PHYSICAL THERAPY

30.4.1 – Skilled Physical Therapy
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Skilled physical therapy services must meet all of the following conditions:

The services must be directly and specifically related to an active written treatment plan that is based upon an initial evaluation performed by a qualified physical therapist after admission to the SNF and prior to the start of physical therapy services in the SNF that is approved by the physician after any needed consultation with the qualified physical therapist. In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon readmission to the SNF, prior to the start of physical therapy services in the SNF;

The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program. NOTE: See Section E. Maintenance Therapy for more guidance regarding when skilled therapy services are necessary for the performance of a safe and effective maintenance program

The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and,

The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Teaching or Training

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:

- Teaching self-administration of injectable medications or a complex range of medications;
- Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
- Teaching self-administration of medical gases to a patient;
- Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
- Teaching patients how to care for a recent colostomy or ileostomy;
- Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
- Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
- Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
- Teaching patients the proper care of any specialized dressings or skin treatments.

SKILLED NURSING

30.3 - Direct Skilled Nursing Services to Patients (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.2, SNF-214.2

Some examples of direct skilled nursing services are:

- Intravenous or intramuscular injections and intravenous feeding;
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
- Naso-pharyngeal and tracheotomy aspiration;
- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception);
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception);
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception);
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

WHAT IS NOT SKILLED CARE?

30.5 - Nonskilled Supportive or Personal Care Services (Rev. 1, 10-01-03) A3-3132.4, SNF-214.4

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

- Administration of routine oral medications, eye drops, and ointments (the fact that patients cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);
- General maintenance care of colostomy and ileostomy;
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying and cleaning containers and clamping the tubing);
- Changes of dressings for uninfected post-operative or chronic conditions;
- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
- Routine care of the incontinent patient, including use of diapers and protective sheets;
- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or requires adjustment of traction);
- Routine care in connection with braces and similar devices;
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);
- Assistance in dressing, eating, and going to the toilet;
- Periodic turning and positioning in bed; and
- General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)