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.

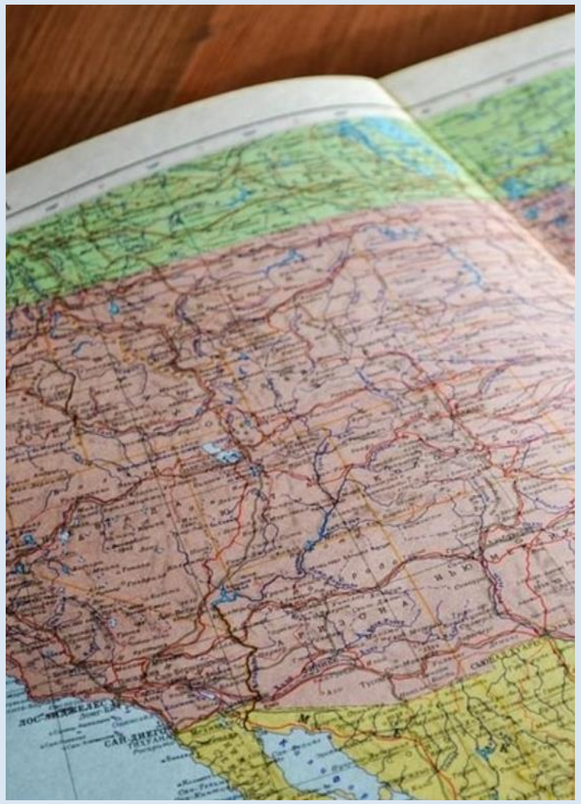
Your Swing Bed Program – It Takes A Village
June 5, 2020

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

HEALTHTECH S³
strategy solutions support

Nationwide Client Base

GAFFEY HEALTHCARE
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 Clients: Two-hospital NFP systems in southeast GA with numerous associated physician practices

Preferred vendor to:

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

HEALTHTECH S3
strategy solutions support

GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Areas of Expertise

Strategy - Solutions - Support

Governance & Strategy

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

Finance

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

Recruitment

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

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

Interim Executive & Department Leadership

Staffing Community Hospitals since 1971

HealthTechS3

Design.Build.Optimize → High Performance Teams

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

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

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

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

Mentoring/Support Team

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

HealthTechS3

Design.Build.Optimize → High Performance Teams

Operations

Neil Todhunter
President

Mike Lieb
VP - Interim Placement

Derek Morkel
CEO

Clinical

Carolyn St. Charles
Chief Clinical Officer

Faith Jones
Director of Care Coordination and Lean Consulting

John Coldsmith
Clinical Consultant

Financial/RCM

John Freeman
AVP Finance

Kevin Stringer
AVP Finance

Joy Smith
Senior Patient Financial Consultant

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

HEALTHTECH S3
strategy solutions support

ALL WEBINARS ARE RECORDED 2020 QUARTER 2 WEBINARS

The Swing Bed Patient-Driven Payment Model (PDPM) and Understanding the Importance of MDS v1.17

Date : April 14, 2020 **Time :** 12pm CST
Presenter : Reta A. Underwood, RAC-CT, C-NM, QCP, CPC
Host : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/3ao5Xjn

Appendix A and Appendix W Revised by CMS: A Road Trip Through the New Standards and Interpretive Guidelines

Date : April 17, 2020 **Time :** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/2UERPLT

Survey Savvy: How to Manage a Regulatory Survey

Date : May 1, 2020 **Time :** 12:00 pm CST
Presenter : John Coldsmith, *DNP, MSN, RN, NEA-BC - Clinical Consultant, HealthTechS3*
Host : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/3apGsxV

30-Day Hospital Turnaround & Margin Improvement - Strategies for Successful Operations

Date : May 22, 2020 **Time :** 12:00 pm CST
Presenters : Derek Morkel, *CEO, Gaffey Healthcare and* Neil Todhunter, *President, HealthTechS3*
https://bit.ly/2RsVOuf

Building the Bridge Between Annual Wellness and Care Coordination

Date : May 28, 2020 **Time :** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/2UnU9YK

Your Swing Bed Program – It Takes A Village

Date : June 11, 2020 **Time :** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/2WJKNrX

What an Interim Leader Can Bring To Your Hospital and Why You Might Need One - Now

Date : June 12, 2020 **Time :** 12pm CST
Presenter : Michael Lieb, *FACHE, Vice President – Interim Services, HealthTechS3*
https://bit.ly/3dxyGnD

Connecting the Dots between Transitional Care Management and HCAHPS

Date : June 25, 2020 **Time :** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/33VN8BB

HEALTHTECH S3
strategy solutions support

HEALTHTECH S3
strategy solutions support

Presenter

GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Carolyn St.Charles

Chief Clinical Officer

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

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

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

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

Instructions & Disclaimer

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

HEALTHTECH S3
strategy solutions support

www.healthtechs3.com

HealthTechS3 hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive. HealthTechS3 and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof. HealthTechS3 does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel. HealthTechS3 recommends that hospitals, clinics, their respective personnel, and all other third party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.

HEALTHTECH S3
strategy solutions support

learning Objectives

Upon completion of the webinar, the participant will be able to:

1. Identify principles for strengthening your hospital's Swing Bed Program
2. Describe at least two outcome measures for Swing Bed
3. Describe the importance of defining roles and responsibilities

Agenda

Principle #1: Define Your Village

Principle #2: Educate About the Value of Swing Bed

Principle #3: Collect and Share Outcome Data

Principle #4: Stay Up-to-Date on Swing Bed Regulatory Requirements

Principle #5: Understand Swing Bed Admission Criteria

Principle #6: Maintain Compliance with Pre-Admission to Post-Discharge Requirements

Principle #7: Clearly Define Job Responsibilities

Principle #8: Set a Goal – Celebrate Success

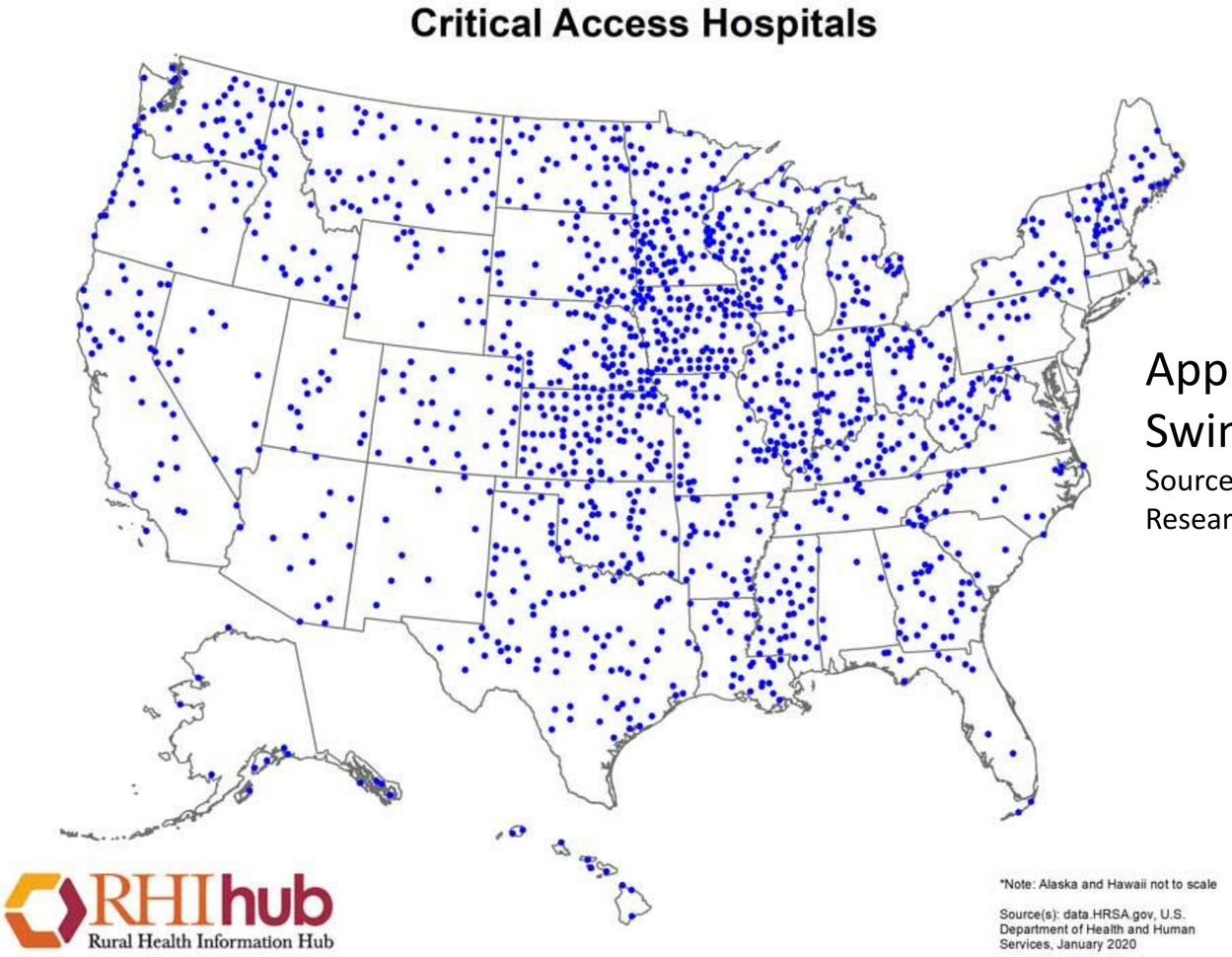
Principle #1
Who is in Your Village
It's Not Just Clinical!

Imaging
IT
RN
CNA
Social Work
EVS
PATIENT
Case Management
Admitting
OT
HUC
LPN
RT
ADMIN
HR
Provider
Speech
Dietary
Dietician
Marketing
LAB
HIM
PT
Facilities
Business Office

Principle #2
Educate About the Value of Swing Bed

- to your hospital
to your patients
- to your community

1,355 CAHs Critical Access Hospitals
January 1, 2020



Approximately 88% offer Swing Bed

Source: University of Minnesota Rural Health Research Center

Rural Hospitals

According to the United States Census Bureau, about 60 million people, or one in five Americans, live in rural America. In general, rural areas are sparsely populated, have low housing density, and are far from urban centers. While urban areas make up only 3 percent of the entire land area of the country, they are home to more than 80 percent of the population. Conversely, 97 percent of the country's land mass is rural but is home to just 19.3 percent of the total population.

According to data from HRSA.gov, as of January 2020 the United States had:

- 1,355 Critical Access Hospitals
- 4,478 Rural Health Clinics
- 3,896 Federally Qualified Health Centers located outside of Urbanized Areas
- 1,095 short term hospitals located outside of Urbanized Areas

A February 2020 report from the Chartis Center for Rural Health suggests 2019 was the worst year for rural hospital closures in a decade, with 19 rural hospitals shuttering.

Today, 453 of the 1,844 rural hospitals still operating in the U.S.—approximately one in four—show signs of being vulnerable to closure in the near future.

Swing Bed Value Proposition

	Swing Bed	Skilled Nursing Facility
Reimbursement	Cost-Based Per-Diem (Medicare) (2) Average of 12.5% of 2016 CAH inpatient revenue (Illinois)	Patient-Driven Payment Model (PDPM)
Providers	On-Site (usually) Same provider (if internal)	On-Call New Provider
Nursing Ratios	1:4 to 1:5 Nurse to Patient Ratios with more RN coverage	Minimum Nurse to Patient Ratios
Diagnostic Capability	On-Site (usually)	Requires transfer or ER visit
ALOS	(2) 10 Days (1) 13 Days (3) 9 – 14 Days	(2) 26 days
Readmission Rate	(2) < 5%	(2) 24.4%
Discharge to Independent Living	(1) 76.9%	

(1)Allevant data from over 60 Critical Access Hospitals in 18 States, 110,000 Swing Bed Days
(2) Rural Health Care White Paper Series: Illinois Critical Access Hospitals: *Exploring the Financial Impacts of the Swing Bed Program. Published February 2019*
(3) University of Minnesota Rural Health Research Center: *Critical Access Hospital Swing-bed Quality Measures: Findings from Key Informant Interviews*

Principle #3
Collect and Share Swing Bed Outcome Data

Swing Bed Value Proposition

	Swing Bed	Skilled Nursing Facility
Providers	On-Site (usually) Same provider (if internal)	On-Call New Provider
Nursing Ratios	1:4 to 1:5 Nurse to Patient Ratios with more RN coverage	Minimum Nurse to Patient Ratios
Diagnostic Capability	On-Site (usually)	Requires transfer or ER visit
ALOS	(2) 10 Days (1) 13 Days (3) 9 – 14 Days	(2) 26 days
Readmission Rate	(2) < 5%	(2) 24.4%
Discharge to Independent Living	(1) 76.9%	

(1)Allevant data from over 60 Critical Access Hospitals in 18 States, 110,000 Swing Bed Days
(2) Rural Health Care White Paper Series: Illinois Critical Access Hospitals: *Exploring the Financial Impacts of the Swing Bed Program. Published February 2019*
(3) University of Minnesota Rural Health Research Center: *Critical Access Hospital Swing-bed Quality Measures: Findings from Key Informant Interviews*

Critical Access Hospital
Swing Bed Quality Measures

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

MEASURES

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

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

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

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

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

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

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

Functional Status

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

Critical Access Hospital Swing Bed Potential Data Sources

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

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

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

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

Principle #4
Stay Up-to-Date on Swing Bed Regulations

Regulatory Resources

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

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

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

1135 Waiver

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

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

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

Regulatory Changes
October 2018, November 2019 and February 2020

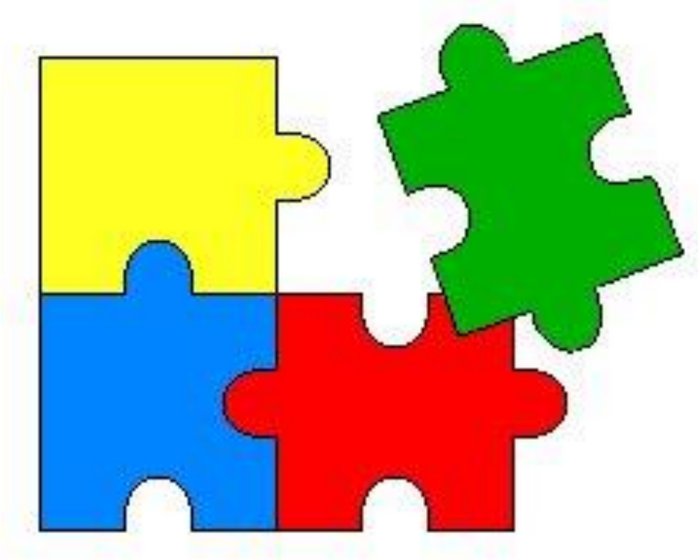
1. Resident Choice of Physician / How to Contact Physician – **New and Clarification – October 2018**
2. Timelines for Reporting Abuse – **New - October 2018**
3. PASARR – **Clarification - October 2018**
4. Plan of Care – **Additional language and Clarification - October 2018**
5. Provide Culturally-Competent and Trauma Informed Care – **New - October 2018**

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

6. Reconciliation of Pre-Discharge Medications with Post-Discharge Medications – **New – October 2018**
7. Dental Care – **Clarification of Timelines – October 2018**
8. Transfer & Discharge – Information to be provided at discharge to patient and PAC providers. Ombudsman Notification – **New – October 2018**
9. Activities by qualified professional – **Deleted – November 2019 / February 2020**
10. Right to Work - **Deleted – November 2019 / February 2020**
11. Full-time Social Work if more than 120 beds – **Deleted - November 2019 / February 2020**

Principle #5
Understand Swing Bed Admission Criteria

- expand types of patients you accept
- don't discharge too early



Swing Bed Criteria

Private Insurance – Their Rules
Medicaid – Different by State – Their Rules

1. The patient has Medicare Part A and has benefit days available
2. Medicare age or disability/disease eligibility requirements must be met
3. There must be a three-day qualifying stay (observation doesn't count)
4. A hospital-related medical condition treated during your qualifying 3-day inpatient hospital stay, even if it wasn't the reason you were admitted to the hospital.
5. A condition that started while you were getting care in the SNF for a hospital-related medical condition (for example, if you develop an infection that requires IV antibiotics while you're getting SNF care
6. Patient must be admitted to Swing Bed within thirty days of discharge from acute care
7. The patient's condition meets criteria to necessitate inpatient skilled nursing services

There is no limit on the Length of Stay for Medicare patients ---- as long as skilled criteria continues to be met.

However, coinsurance is required after day 20 and full cost beyond day 100 for Medicare

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

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

Definition Skilled

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 all of the following four factors are 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 (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
(Rev. 261; Issued: 10-04-19)

Definition Skilled

30.2.2 - Principles for Determining Whether a Service is Skilled
(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.B, SNF-214.1.B

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.

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

Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet

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

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

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

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

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

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

Swing Bed Patients

Orthopedic

Complex Medical

Cardiac

Respiratory – Basic and Complex

Neurological

Wound

Complex Surgical

Wound

SKILLED NURSING IS UNDER UTILIZED

- Management and evaluation of plan of care
- Observation and Assessment of Patient's Condition
- Teaching and Training
- Direct Skilled Nursing Services

Principle #6
Maintain Compliance with Regulatory Requirements
Pre-Admission to Post-Discharge

Pre-Admission Screening

1. Identify who is responsible for coordinating pre-admission screening
2. Identify who is responsible for coordinating screening if primary person is not available
3. Ensure standardized screening for all referrals – develop a screening template
4. Establish criteria to guide decision making developed by consensus of team members
5. If there is a lack of consensus identify who makes the final decision.
6. For patients with straight-forward needs, consider allowing case manager and physician to make decision
7. Review the process periodically to ensure the process is efficient

Patient Notices / Disclosures at Admission

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

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

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

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

C-1608 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
§485.645(d) SNF Services.

- ❑ Description of Swing Bed
- ❑ Resident Rights and Responsibilities
- ❑ Description of Hospital's policies regarding advance directives
- ❑ Choice of physicians
- ❑ Information on how to contact providers (ALL)
- ❑ Financial Obligations
- ❑ Transfer and Discharge policies
- ❑ Notice of privacy practices
- ❑ How to file grievance or complaint
- ❑ Hospital responsibility for preventing patient abuse
- ❑ Information for reporting Abuse and Neglect
- ❑ Contact information for Hospital and State Agencies including State Ombudsman

Comprehensive Assessment

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

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

Comprehensive Assessment

§483.20(b) The assessment must include at least the following:

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

Establish timelines for assessment

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

- ❖ Don’t forget customary routine
- ❖ Don’t forget Dietitian assessment - Nursing risk screen is not sufficient
- ❖ Don’t forget psycho-social / trauma
- ❖ Don’t forget dental status
- ❖ Don’t forget PASARR (if applicable)

Reassessment After Significant Change

§483.20(b)
…….significant change in the resident's physical or mental condition.

(For purposes of this section, a “significant change” means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

Plan of Care

§483.21(b) Comprehensive care plans.

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

(i) The **services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25, or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

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

(2**) In consultation with the resident and the resident's representative(s)—**
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Plan of Care

7-days not applicable to swing Bed
Timelines must be congruent with your Length of Stay

IDT meeting should be within 48 – 72 hours of admission to develop comprehensive plan of care

(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.

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

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

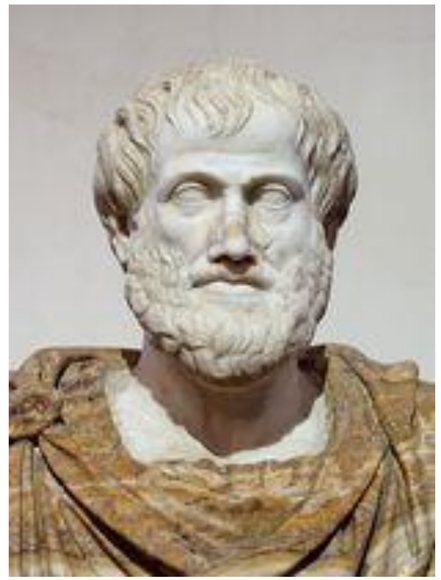
Individual Discipline Assessments and Patient Goals are the Parts The Care Plan is the Whole and is MORE than the individual assessments

Rehab usually writes really good goals – but not always integrated with other disciplines

Nursing goals too often “canned” or “templated” – but they are good at identifying safety risks

Other Disciplines – Maybe

It’s OK to have goals developed by individual disciplines – but they must be:
1 – Developed with input from the patient and agreed to by the patient
2 - Discussed and agreed to by the IDT
3 - Include discharge goals
4 – Written with measurable objectives and time frames



“The whole is greater than the sum of its parts.”
— Aristotle

Make sure you identify risks to patient (fall / infection, etc.)

IDT is where it all comes together

Example
Plan of Care & IDT Notes

DC Goal from Patient: Home with family

Long Term Goals (to be met prior to discharge)
Note: Individual disciplines may also have a plan of care
Example Goal 1: Patient will be able to dress independently within 2 weeks (prior to discharge)
Example Goal 2: Patient will receive 14 days of antibiotic therapy.
Example Goal 3: Patient will improve nutritional status as evidenced by an increase in BMI within 2 weeks (prior to discharge)
Example Goal 4: Patient will give insulin independently including understanding order and administration within 2 weeks (prior to discharge)
Patient in concurrence with long and short-term goal: (Please identify who discussed with patient and when as well as any modifications the patient requested.

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

Goal ____ Intervention ____

Discipline: Nursing

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

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

Goal needs to be modified (YES/NO).

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

Goal Met (Date):

Example
Plan of Care

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN			
Long Term Goal	**Short Term Goals**	**Interventions**	**Discipline Responsible**
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy
		Nursing will que patient to dress each morning Saturday - Sunday	Nursing
	Patient will be independently put on shoes within 7 days (April 3)	OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy
		Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing
	Patient will undress independently within 7 days and put on pajamas (April 3)	OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy
		Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing

Example
Plan of Care & IDT Notes

EXAMPLE: MULTI-DISCIPLINARY CARE PLAN and IDT Note							
Long Term Goal	Short Term Goals	Interventions	Discipline Responsible	Date	Date	Date	Date
Goal 1: Patient will be able to dress independently within 2 weeks (April 10)	Patient will be able to put on shirt and pants independently within 5 days (April 1)	1. OT will que patient to dress each morning with increasing independence Monday – Friday	Occupational Therapy	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modified	☐ Met ☐ Not Met ☐ Modify	☐ Met ☐ Not Met ☐ Modified
		1. Nursing will que patient to dress each morning Saturday - Sunday	Nursing				
	Patient will be independently put on shoes within 7 days (April 3)	1. OT will que patient to put on shoes each morning Monday – Friday	Occupational Therapy				
		1. Nursing will que patient to put on shoes each morning Saturday – Sunday	Nursing				
	Patient will undress independently within 7 days and put on pajamas (April 3)	1. OT will que patient to undress and put on pajamas each evening Monday - Friday	Occupational Therapy				
		1. Nursing will que patient to undress and put on pajamas each evening Saturday – Sunday	Nursing				

Transfer and Discharge

§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.

Transfer and Discharge

§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

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

Notice of Discharge

§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii)Include in the notice the items described in paragraph (c)(5) of this section.

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

Discharge Planning - February 2020
Selection of PAC Provider

A-0804 (Rev.) §482.43(a)(8)
(8) The hospital must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data that includes, but not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use on measures.** The hospital must ensure that the post-acute care data on quality measures and data on resource measures is relevant and applicable to the patient's goals and treatment preferences.

C-1425 (Rev.)
(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.

Sources of Post Acute Care Quality Measures

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

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

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

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

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

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

Principle #7
Clearly Define Responsibilities

Include Swing Bed Responsibilities in Job Descriptions
Measure Competency

Job Descriptions and Competency

Include responsibilities related to Swing Bed in EACH disciplines job description

If Rehab or Dietary are a contract service – include responsibilities related to Swing Bed in contract including timeliness

Provide education about Swing Bed, including value to hospital, at least annually to ALL staff regardless of position.

Develop competencies for all clinical staff. A Swing Bed patient does not have the same needs as a patient in an acute bed. *Note: TJC requires "population specific" competencies. Swing Bed is a type of "population".*

Responsibilities

Responsibility	Primary or Required	Back-Up or Other	Responsibility	Primary or Required	Back-Up or Other
Maintain knowledge of current regulations and share with team			Discharge Summary		
Schedule periodic external or internal mock surveys			Discharge: Plan of Care		
Pre-Admission Screening and Insurance Verification			Discharge: Choice of PAC provider		
Admission Decision			Discharge: Medication Reconciliation		
Patient Notices at Admission			Discharge: Information to Next Provider of Care		
Comprehensive Assessment			Discharge: Notices to Patient		
IDT Coordinator – Schedule Mtgs / Notes			Discharge: Notice to Ombudsman		
IDT Attendees			Staff Job Descriptions, Education, Competency		
Interdisciplinary Plan of Care			Outcome Data (Collection, Analysis, Reporting)		
Communication with Patient About Plan of Care			Brand Marketing – Brochures, etc.		
			Daily outreach to referral hospitals		

Responsibilities - Example

Responsibility	Primary or Required	Back-Up or Others	Responsibility	Primary or Required	Back-Up or Other
Maintain knowledge of current regulations and share with team	Swing Bed Coordinator	SB Clinical Team	Discharge Summary	Provider	
Schedule periodic external or internal mock surveys	Swing Bed Coordinator	Quality Director	Discharge: Plan of Care	Patient IDT	
Pre-Admission Screening and Insurance Verification	Case Mang.	Nsg. Supv.	Discharge: Choice of PAC provider	Case Mang.	Nsg. Supv.
Admission Decision	Provider Case Mang.	Provider Nsg. Supv.	Discharge: Medication Reconciliation	Nsg.	
Patient Notices at Admission	Case Mang.	Nsg. Supv.	Discharge: Information to Next Provider of Care	Case Mang.	Nsg. Supv.
Comprehensive Assessment	Assign by element of assessment		Discharge: Notices to Patient	Case Mang.	Nsg. Supv.
IDT Coordinator – Schedule Mtgs / Notes	Swing Bed Coordinator		Discharge: Notice to Ombudsman	Case Mang.	Nsg. Supv.
IDT Attendees	Patient, Provider, RN, CNA, Dietary	Rehab Pharmacy	Staff Job Descriptions, Education, Competency	IDT HR	
Interdisciplinary Plan of Care	Patient IDT		Outcome Data (Collection, Analysis, Reporting)	IDT Quality	
Communication with Patient About Plan of Care	Case Mang	Provider	Brand Marketing – Brochures, etc.	Marketing	
			Daily outreach to referral hospitals	Swing Bed Coordinator	Case Mang.

Principle #8

SET A GOAL

COMMUNICATE THE GOAL
DEVELOP A PLAN
CELEBRATE SUCCESS

Imaging

Provider

IT

RN

Social Work

EVS

Case Management

PATIENT

Admitting

OT

HUC

LPN

CNA

RT

ADMIN

HR

Speech

Dietary
Dietician

Marketing

HIM

LAB

PT

Facilities

Business Office

HEALTHTECH S3
strategy solutions support

ALL WEBINARS ARE RECORDED 2020 QUARTER 2 WEBINARS

The Swing Bed Patient-Driven Payment Model (PDPM) and Understanding the Importance of MDS v1.17

Date : April 14, 2020 **Time :** 12pm CST
Presenter : Reta A. Underwood, RAC-CT, C-NM, QCP, CPC
Host : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/3ao5Xjn

Appendix A and Appendix W Revised by CMS: A Road Trip Through the New Standards and Interpretive Guidelines

Date : April 17, 2020 **Time :** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/2UERPLT

Survey Savvy: How to Manage a Regulatory Survey

Date : May 1, 2020 **Time :** 12:00 pm CST
Presenter : John Coldsmith, *DNP, MSN, RN, NEA-BC - Clinical Consultant, HealthTechS3*
Host : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/3apGsxV

30-Day Hospital Turnaround & Margin Improvement - Strategies for Successful Operations

Date : May 22, 2020 **Time :** 12:00 pm CST
Presenters : Derek Morkel, *CEO, Gaffey Healthcare and* Neil Todhunter, *President, HealthTechS3*
https://bit.ly/2RsVOuf

Building the Bridge Between Annual Wellness and Care Coordination

Date : May 28, 2020 **Time :** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/2UnU9YK

Your Swing Bed Program – It Takes A Village

Date : June 11, 2020 **Time :** 12pm CST
Presenter : Carolyn St.Charles, *RN, BSN, MBA, Chief Clinical Officer*
https://bit.ly/2WJKNrX

What an Interim Leader Can Bring To Your Hospital and Why You Might Need One - Now

Date : June 12, 2020 **Time :** 12pm CST
Presenter : Michael Lieb, *FACHE, Vice President – Interim Services, HealthTechS3*
https://bit.ly/3dxyGnD

Connecting the Dots between Transitional Care Management and HCAHPS

Date : June 25, 2020 **Time :** 12pm CST
Presenter : Faith M Jones, *MSN, RN, NEA-BC – Director of Care Coordination and Lean Consulting, HealthTechS3*
https://bit.ly/33VN8BB

HEALTHTECH S3
strategy solutions support

QUESTIONS

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

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