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GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

Making Your Swing Bed Program Survey Ready

Montana Flex Program Regional Conference

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

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

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Nationwide Client Base

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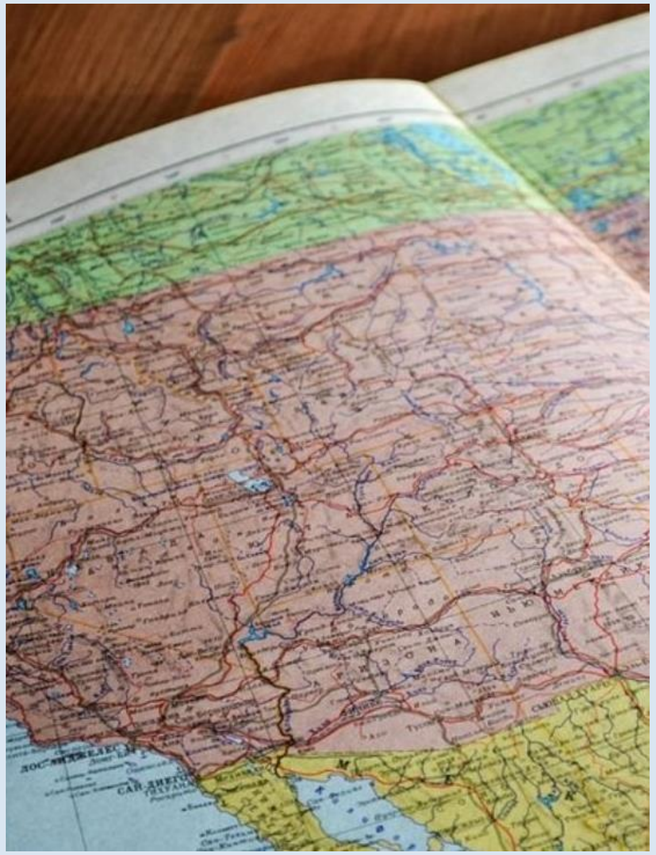

Currently provides hospital management, consulting services and technology to:

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

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

  Example technology and AR services client includes two-hospital NFP system in southeast GA with numerous associated physician practices

Preferred vendor to:

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

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Areas of Expertise

Strategy – Solutions - Support

Governance & Strategy

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

Finance

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

Recruitment

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

Clinical Care & Operations

- Continuous survey readiness
- Care coordination
- Swing bed consulting

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ALL WEBINARS ARE RECORDED

2020 QUARTER 4 WEBINARS

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

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

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

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

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

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

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

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

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Presenter

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Carolyn St.Charles
Chief Clinical Officer
HealthTechS3

Carolyn began her career in healthcare as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles, and has been in her current position as Chief Clinical Officer with HealthTechS3 for the last 20 years.

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

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

carolyn.stcharles@healthtechs3.com
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Disclaimer

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What We'll Cover - At Warp Speed

- Challenges and Opportunities
- Regulatory Requirements
- Pre-Admission
- Growth Opportunities
- Continued Stay
- Transfer and Discharge
- Abuse Recognition and Reporting
- Common Problems, Auditing, QAPI
- Swing Bed Policies and Procedures (Reference)
- **Your Questions and Discussion**

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Swing Bed

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

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

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

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

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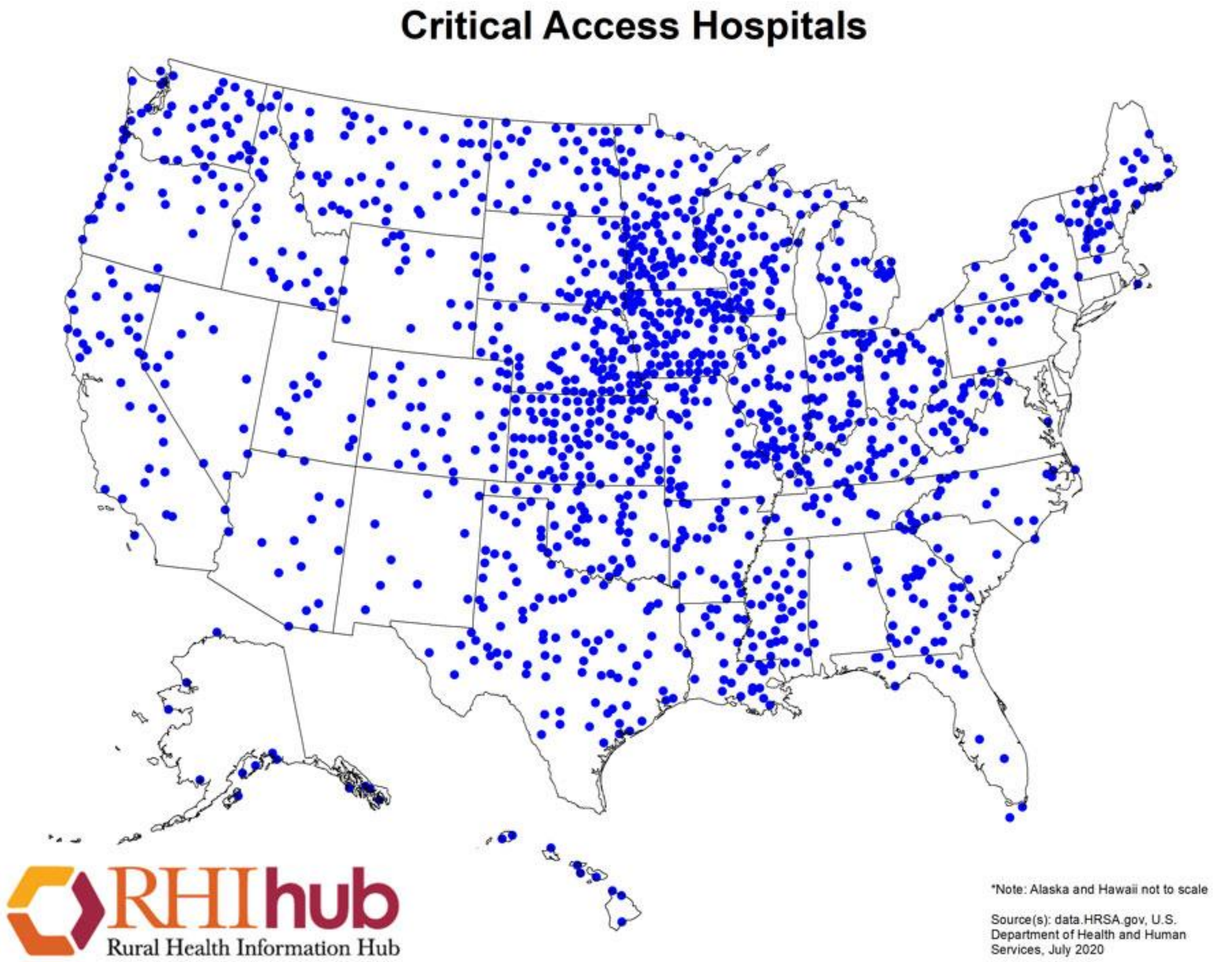
Critical Access Hospitals – July 2020

1,350 Critical Access Hospitals

Approximately 88% provide swing bed services

Source: University of Minnesota Rural Health Research Center



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CHALLENGES AND OPPORTUNITIES

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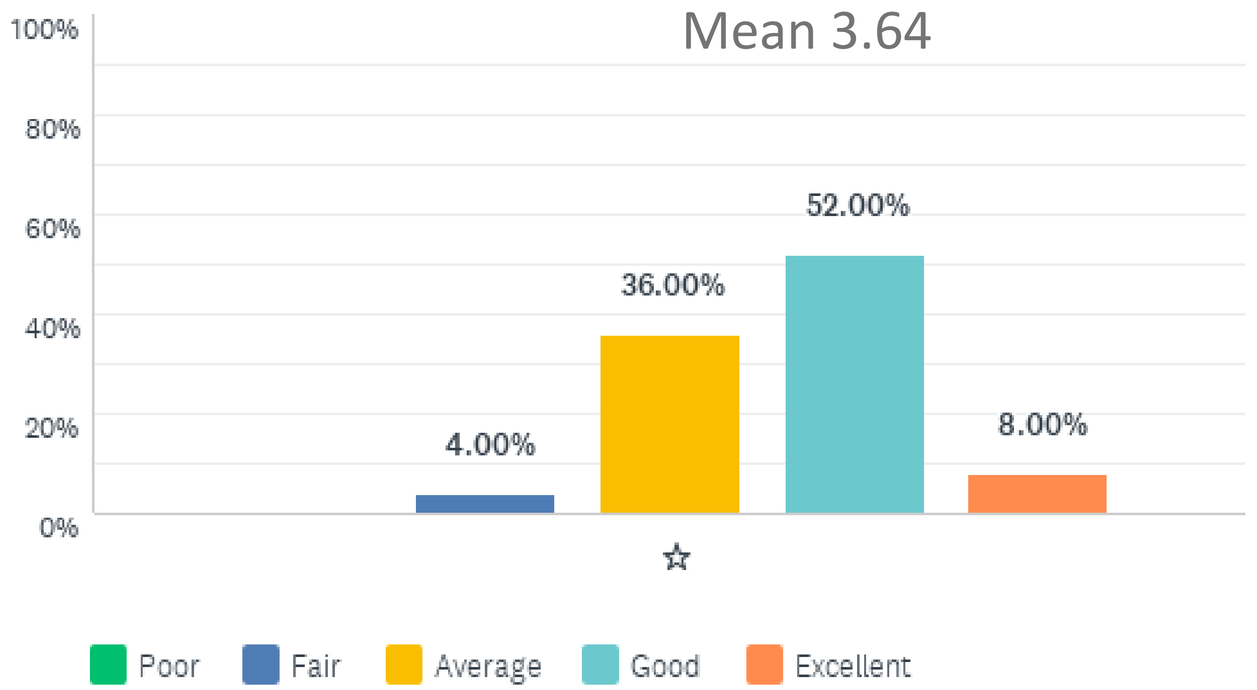
Q3 How would you rate your Swing Bed Program?



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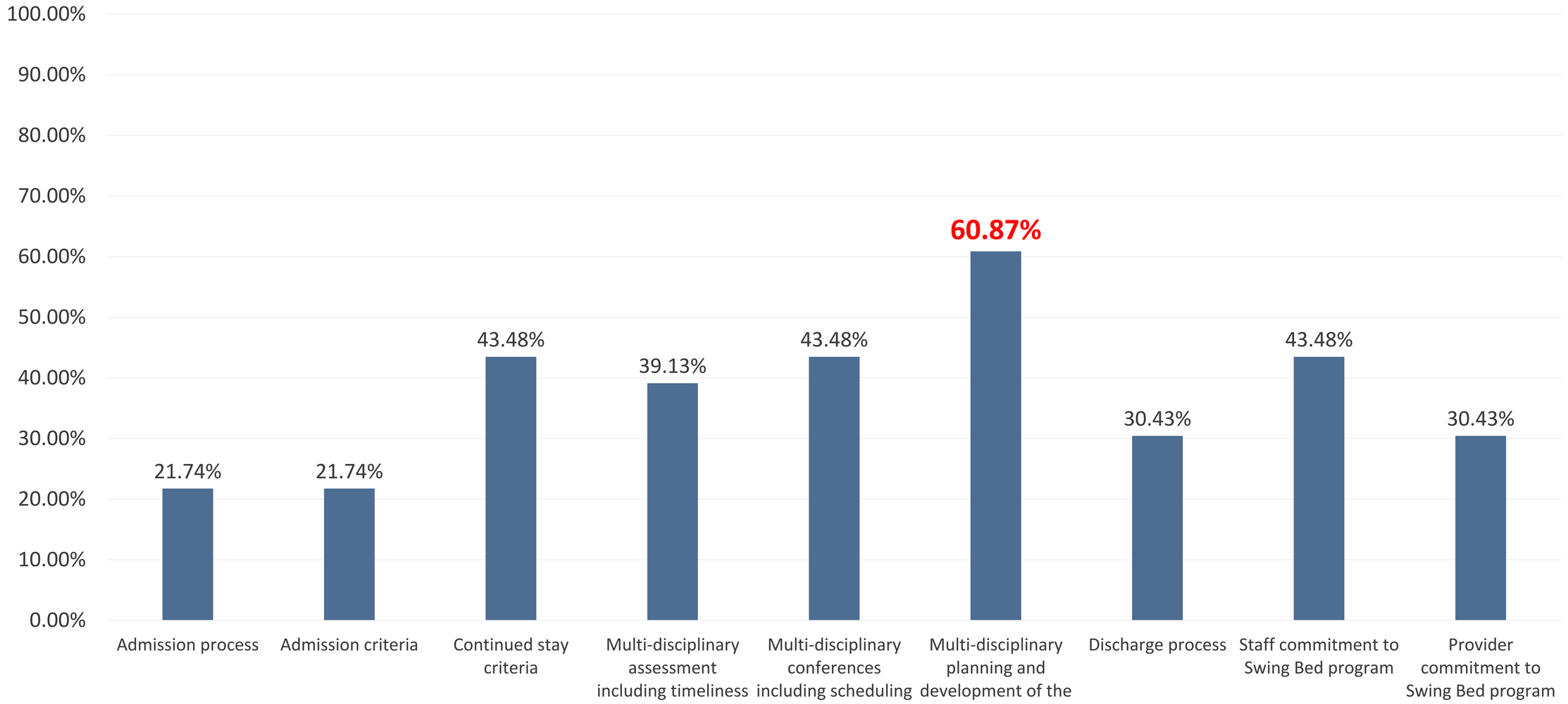
Q30 Please choose the process you find most challenging related to Swing Bed (select all that apply)



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REGULATORY REQUIREMENTS

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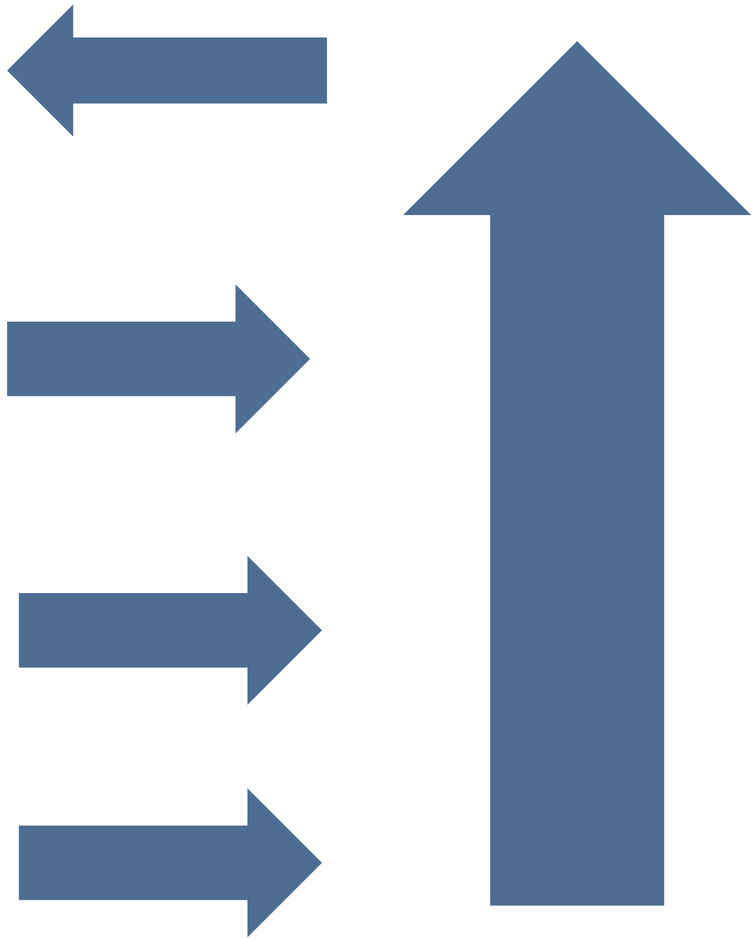
Regulatory Changes

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



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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 the 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

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Keeping Up With Changes

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

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

3. Sign up for alerts / notifications from CMS

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

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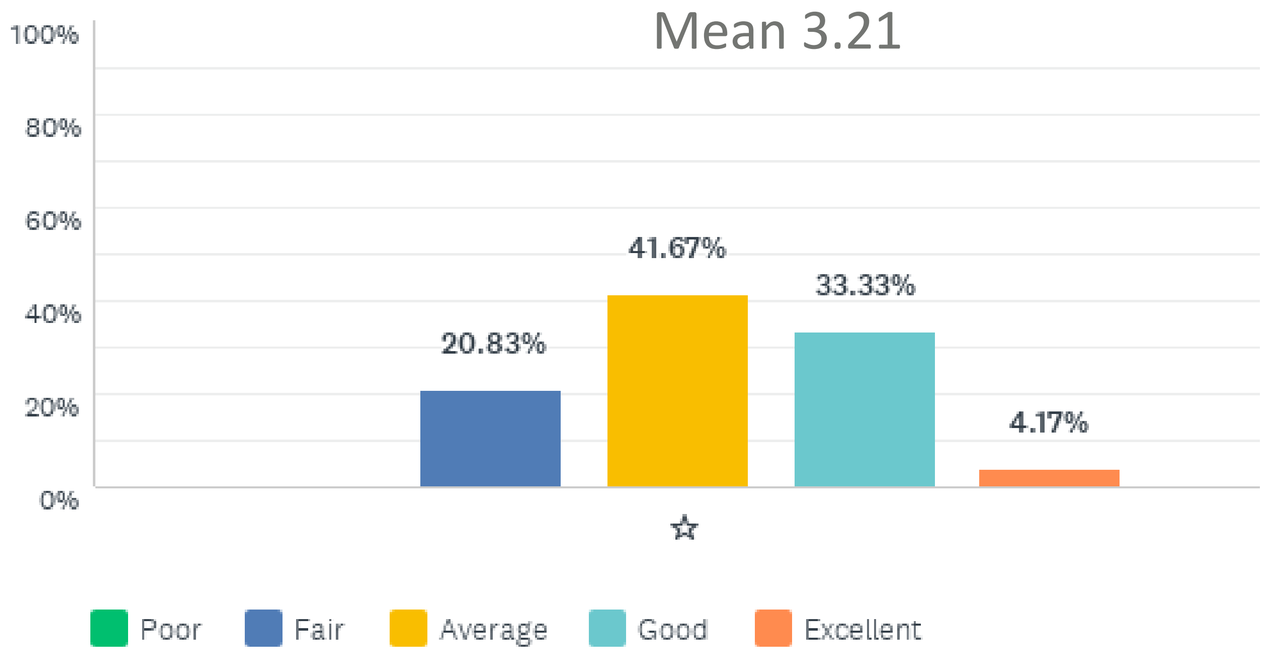
Q7 How would you rate the Swing Bed team knowledge of the Conditions of Participation (regulations) for Swing Bed?



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PRE-ADMISSION

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November 2019 Federal Register - February 2020 CoP

Discharge Planning

C-1425 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(8) The CAH must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data** that includes, but is not limited to, HHA, SNF, IRF, or LTCH data **on quality measures and data on resource use measures**. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

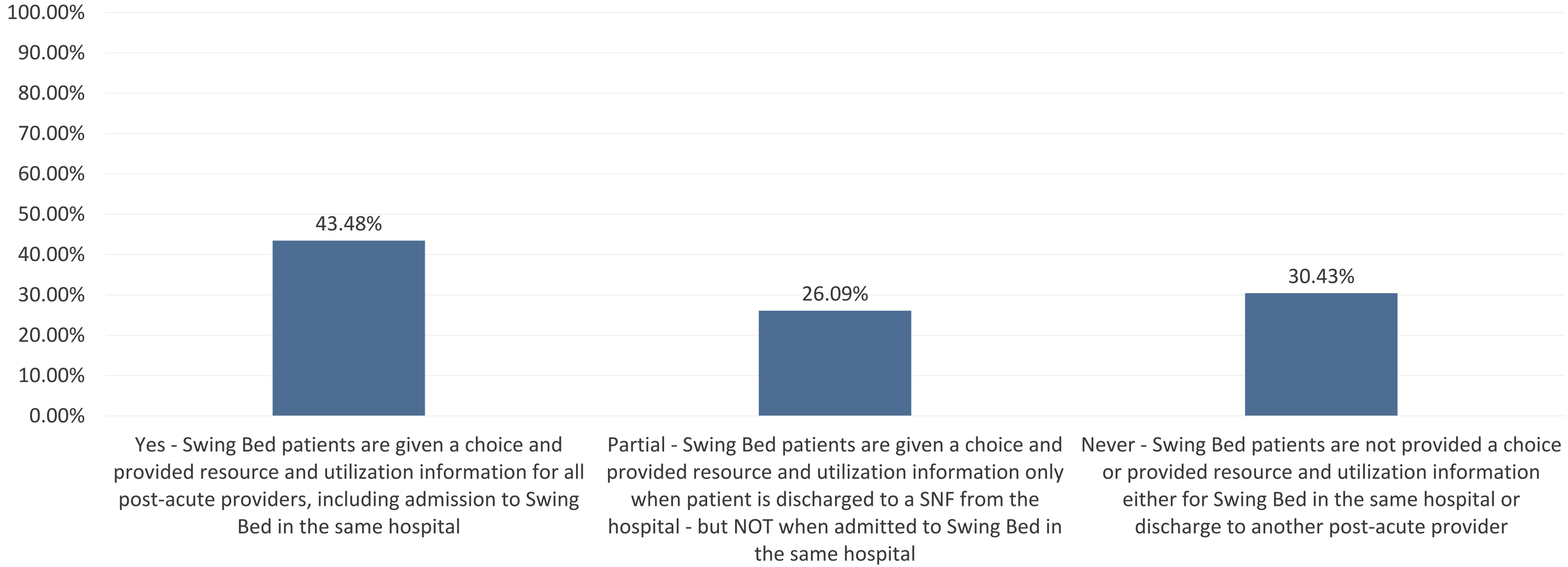
Not included in Appendix W – but the information was included in CMS Publications

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

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

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

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



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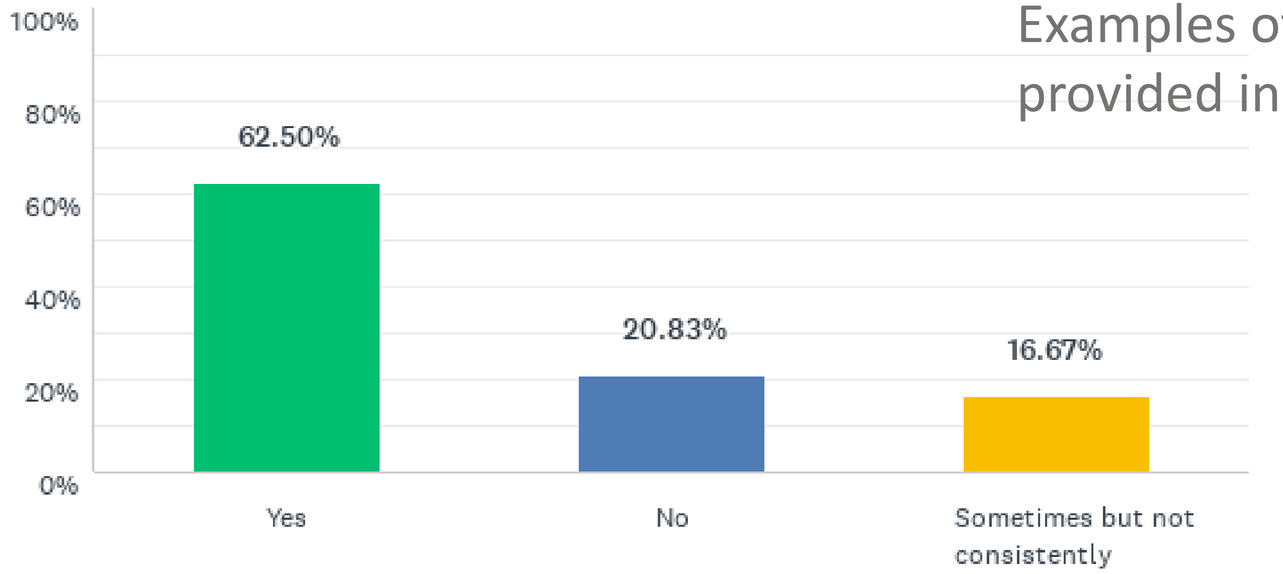
Q28 Are Swing Bed resource and utilization data collected internally?



Examples of data will be provided in discussion of QAPI

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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

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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

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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

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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.**

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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.

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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)

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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

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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.

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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.

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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.

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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.)

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GROWTH OPPORTUNITIES

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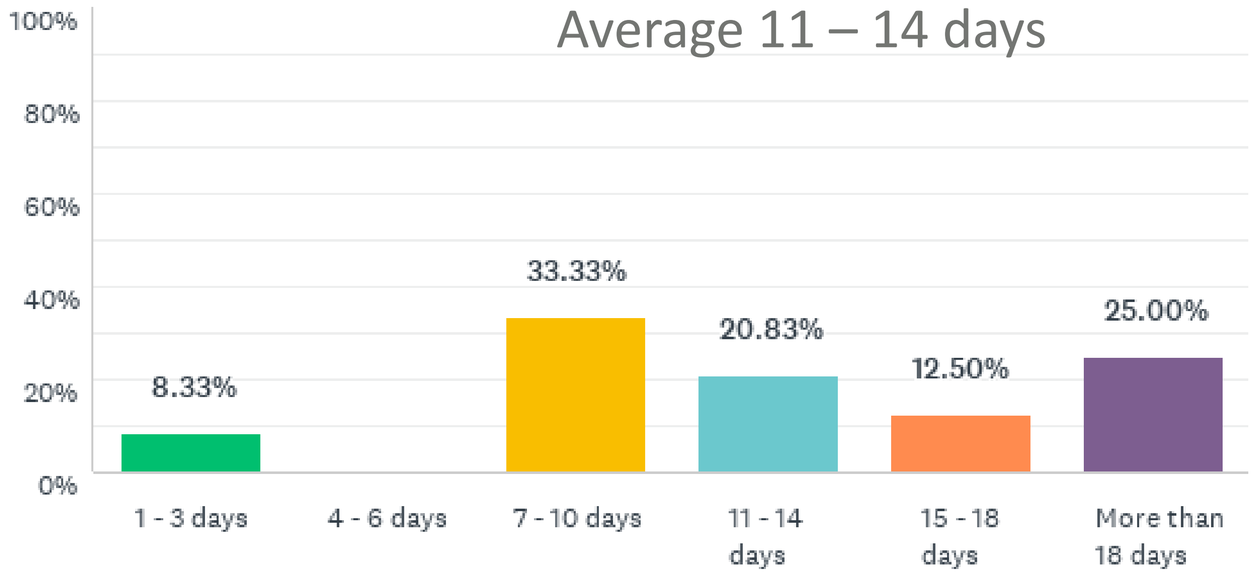
Q13 For the last 12 months, what was the average length of stay (ALOS) in Swing Bed?



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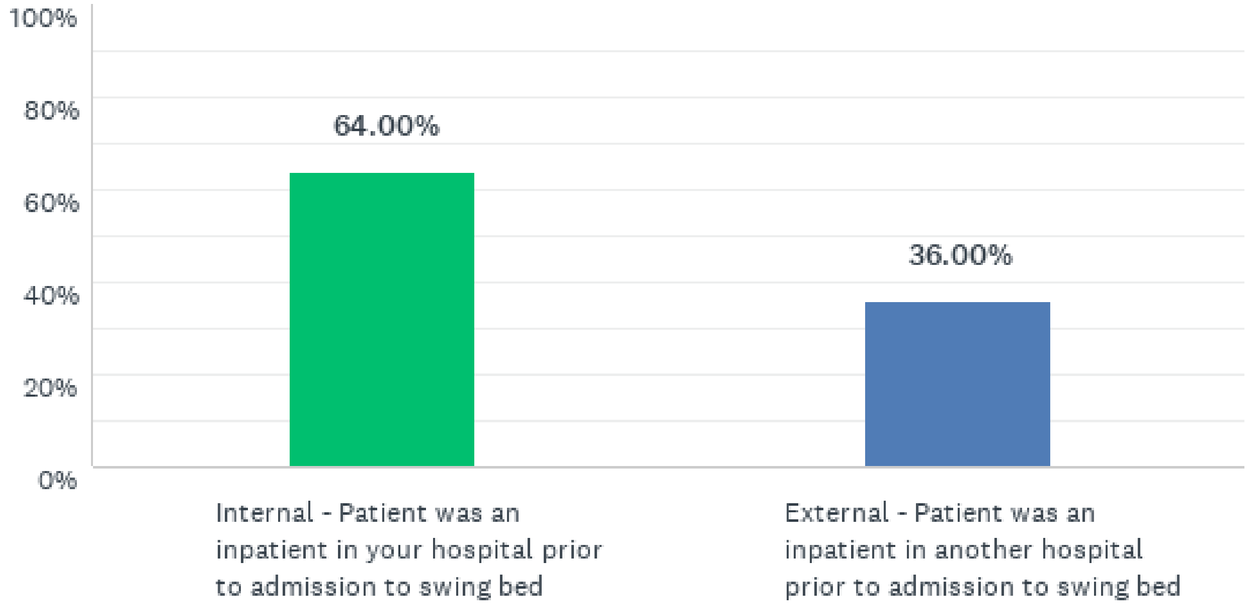
Q17 What is the primary source of admissions to Swing Bed?



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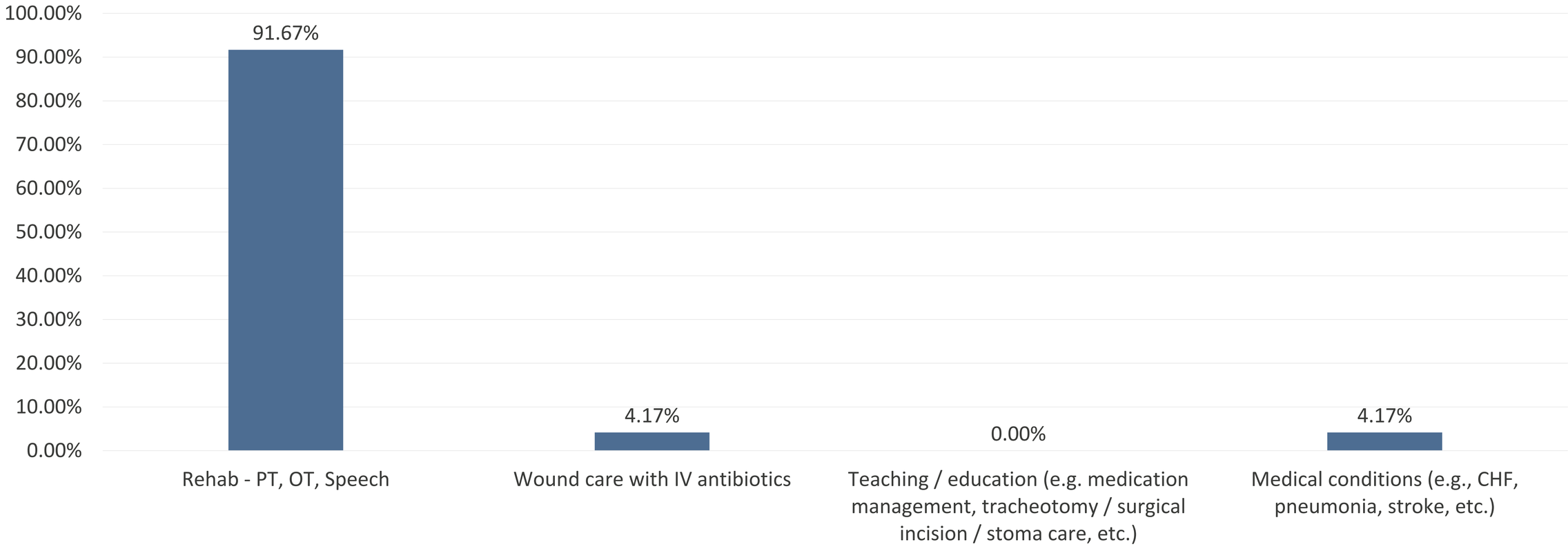
Q 14 What is the primary reason for admission to Swing Bed?



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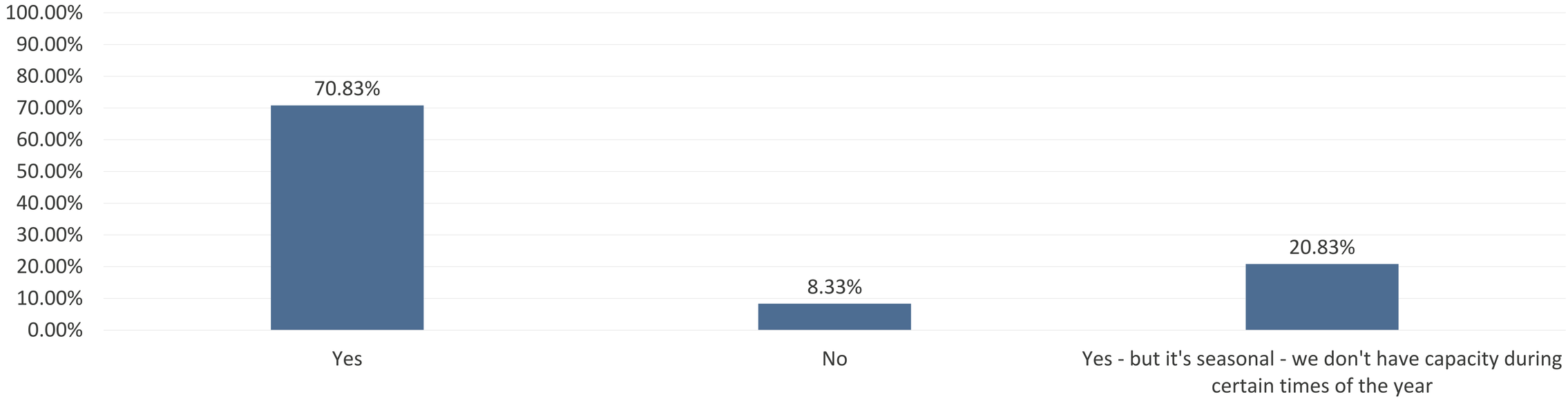
Q15 Would you like to increase your Swing Bed volume?



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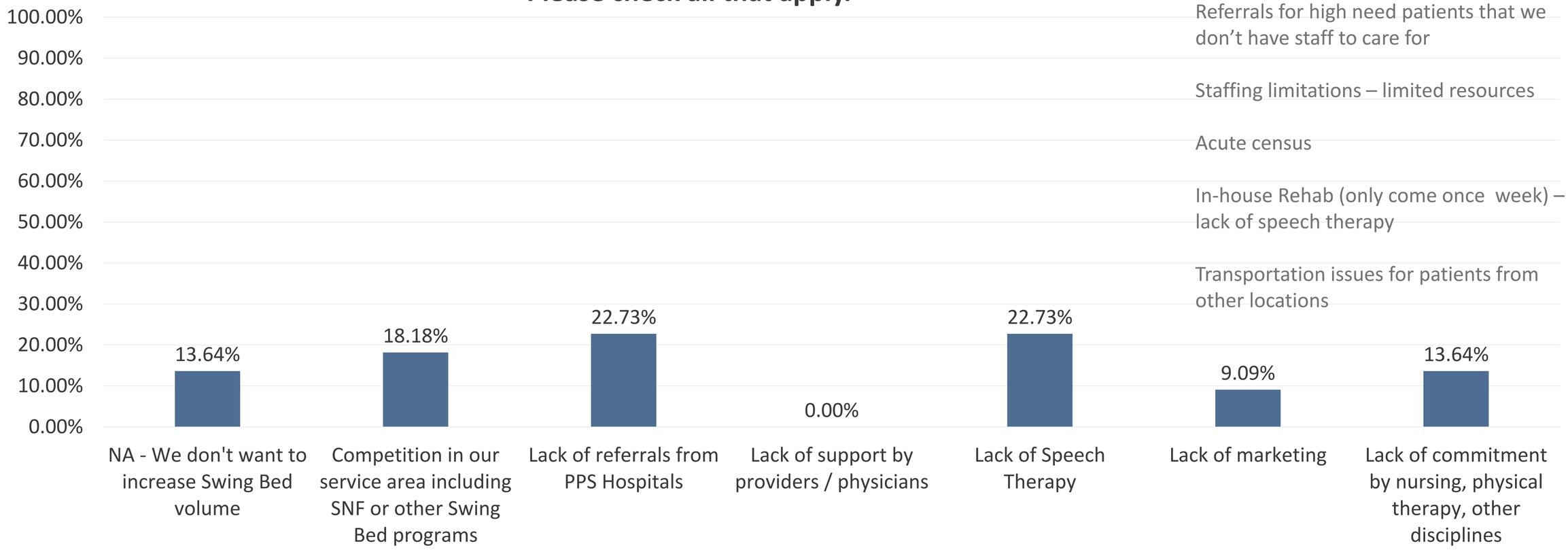
Q 16 What are the primary reasons preventing you from increasing Swing Bed volume? Please check all that apply.



Comments:

Referrals for high need patients that we don't have staff to care for

Staffing limitations – limited resources

Acute census

In-house Rehab (only come once week) – lack of speech therapy

Transportation issues for patients from other locations

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ADMISSION

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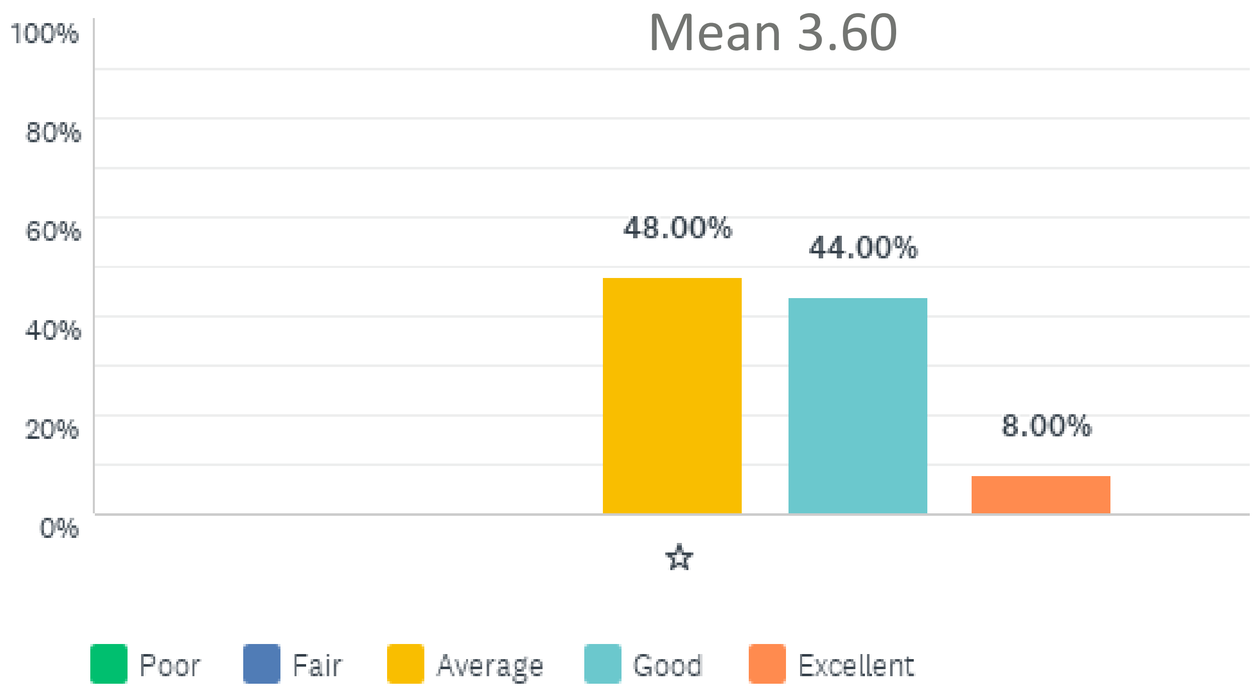
Q4 How would you rate the Swing Bed admission process?



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CERTIFICATION – SPECIFIC FORM NOT REQUIRED

Patient Name: _____ **Admission Date:** _____ **Health Insurance:** _____

Reason for Admission:	
Goals for Admission:	
Expected Length of Stay:	
Admission to swing bed is for the same condition(s) for which the Patient received inpatient hospital services	☐ **YES** ☐ **NO** (if no, please explain)
CERTIFICATION Required at time of admission	I certify that services are required to be given on a daily basis which, as a practical matter, can be only be provided in a swing bed or skilled nursing facility.

_____ Physician Signature

_____ Date and Time

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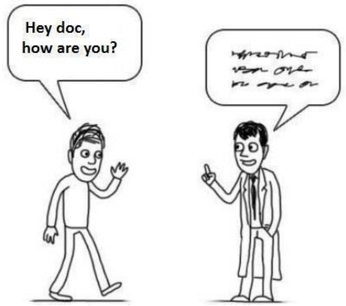
Information Provided at Admission to Patient

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 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

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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).

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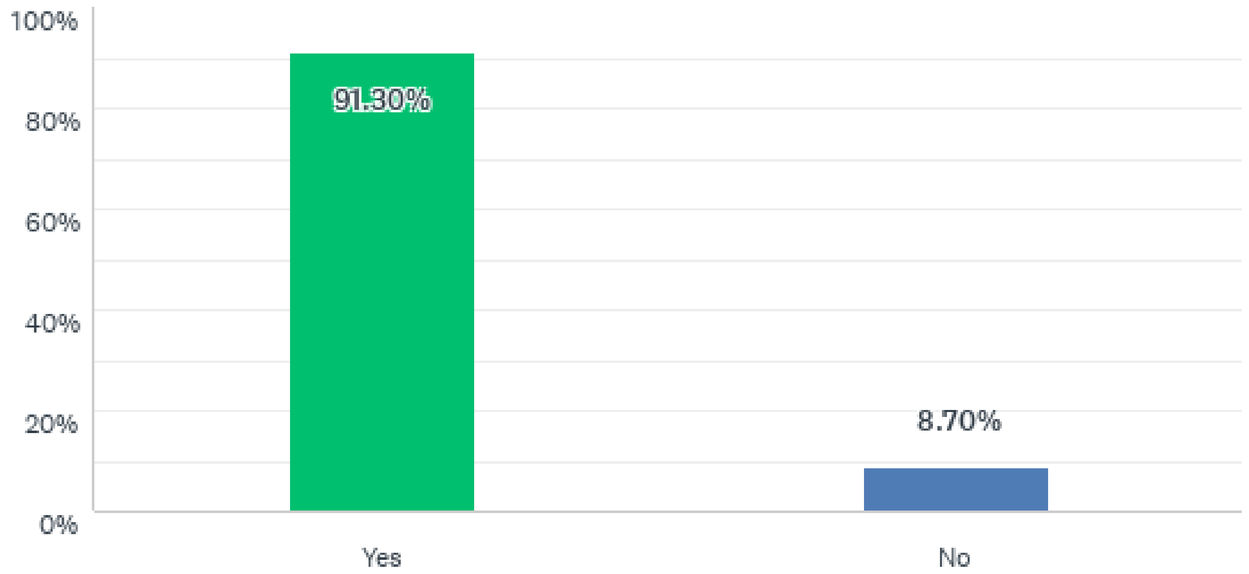
Q11 Are Swing Bed patients provided with their Rights and Responsibilities specific to Swing Bed?



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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.

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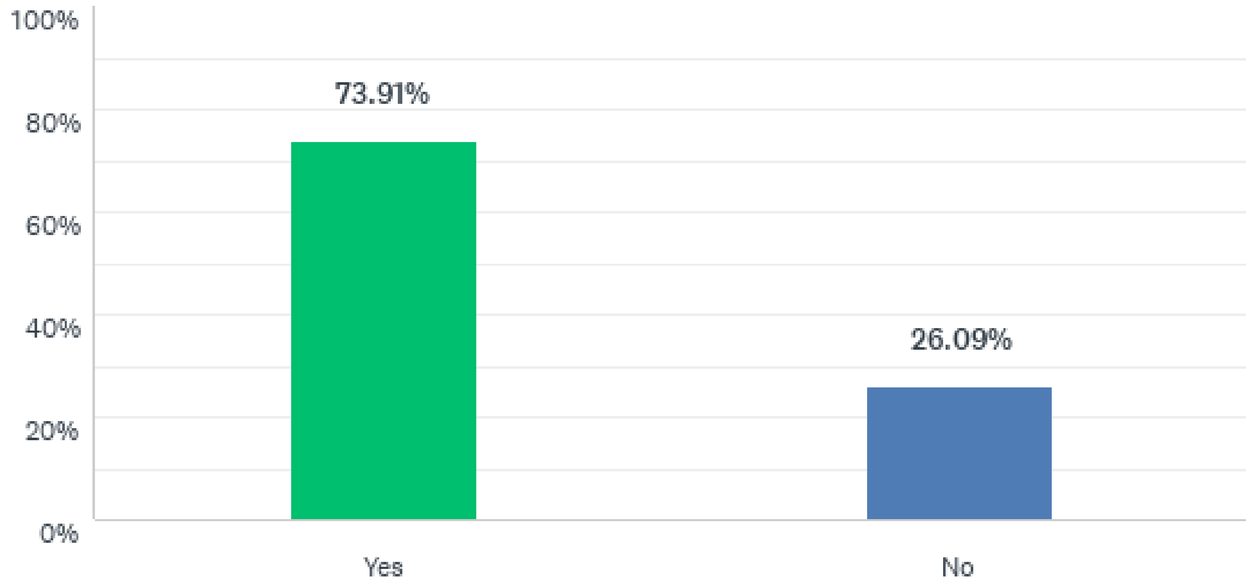
Q10 Are patients provided with information about expected financial obligations? (Not generic hospital costs but those costs associated with the Swing Bed stay.)



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October 2018: Choice of Personal Physician

C-1608 §483.10(d) Choice of attending physician. The resident has the right to choose his or her attending physician. The physician must be licensed to practice, and

(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

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

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

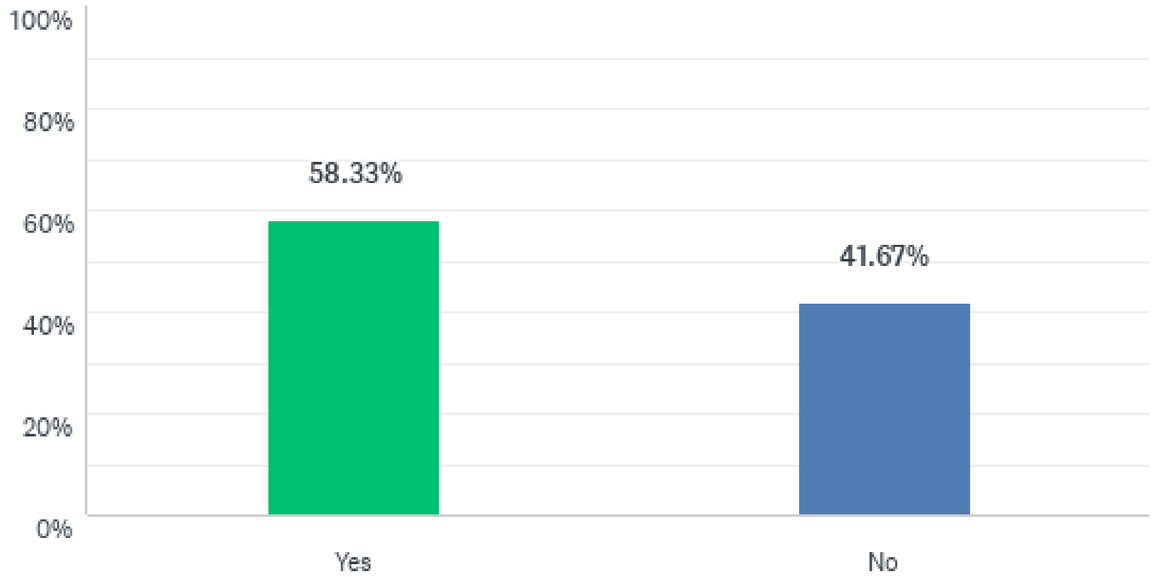
(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

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

Comments:
Not sure how to do this with hospitalist program

We only have our providers available – There isn't a choice

Not sure how to do this



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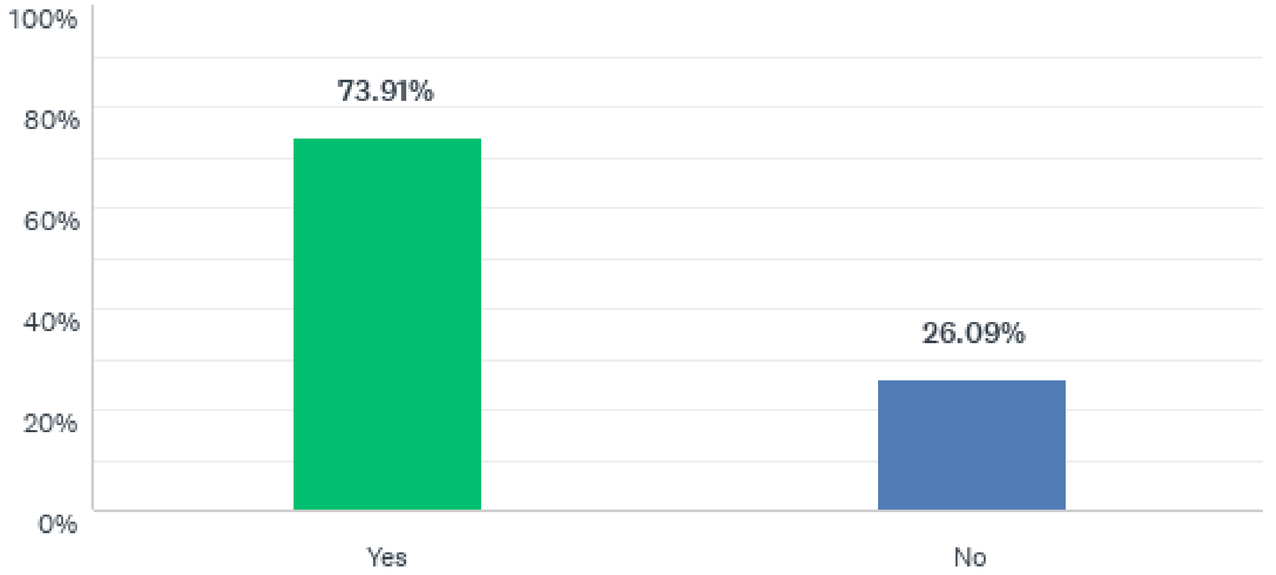
Q9 Do you provide patients with information on how to contact their providers, including consulting physicians?



Comments:
Verbal – but not in writing

If they have a question the nurse would contact the provider

There are only our providers

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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. 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**

…….except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter.

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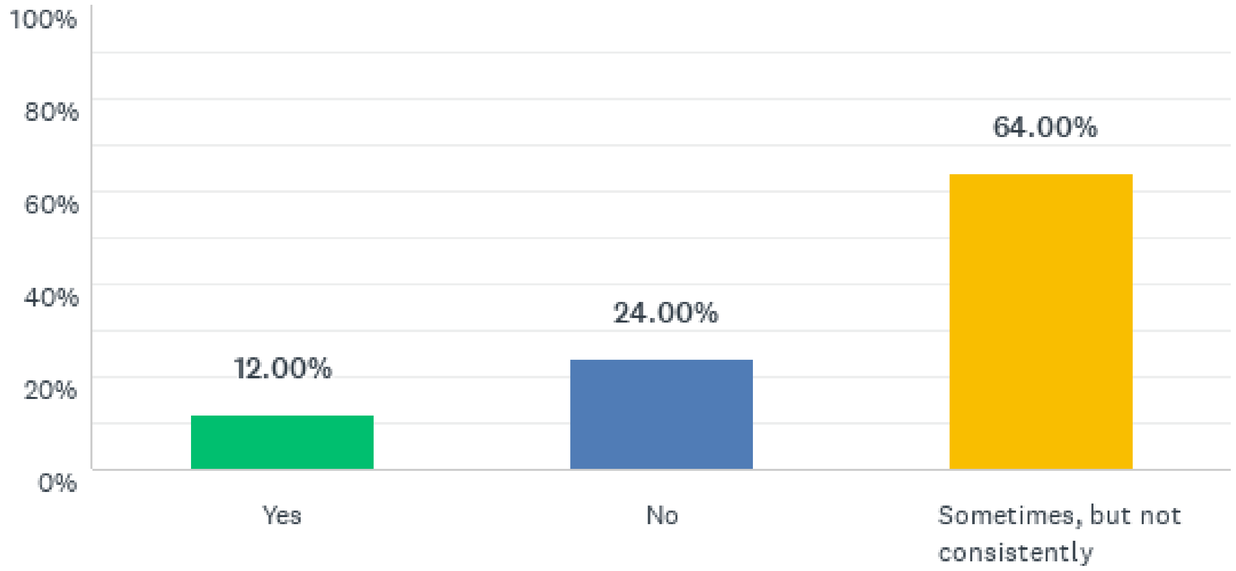
OCTOBER 2018: CULTURALLY COMPETENT TRAUMA INFORMED CARE

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

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

Sample Assessment Questions - *MY QUESTIONS – NOT FROM CMS*
1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?
2. Have you experienced the loss of a close friend, relative or a pet that you loved recently?
3. Have you had any past trauma in your life that we should know about so we can better care for you?
4. If you have experienced some kind of trauma is there something that helps you feel better?
5. Is there anything we can do to help while you are in the hospital?

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



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OCTOBER 2018: PASARR

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

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

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

CONTINUED STAY

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OCTOBER 2018: PLAN OF CARE

C-1620 §483.21(b) Comprehensive care plans

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

(i) The **services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being** as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

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

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

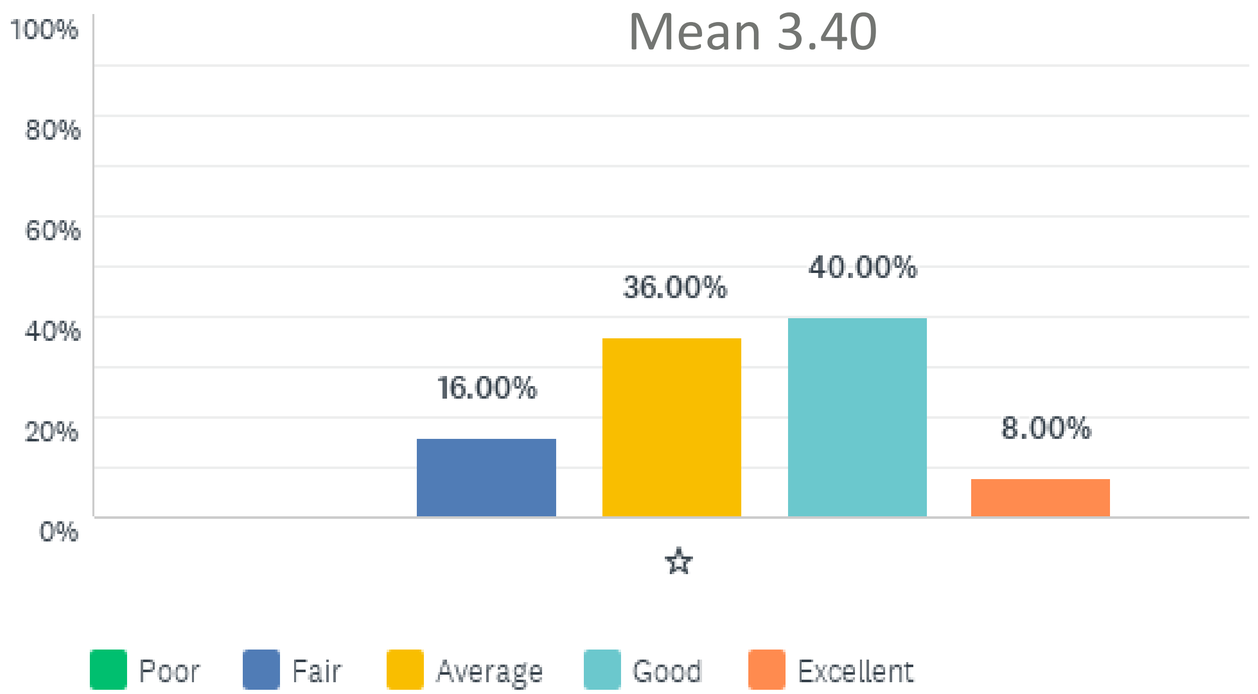
The resident's goals for admission and desired outcomes.

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

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

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

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



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OCTOBER 2018: PLAN OF CARE

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

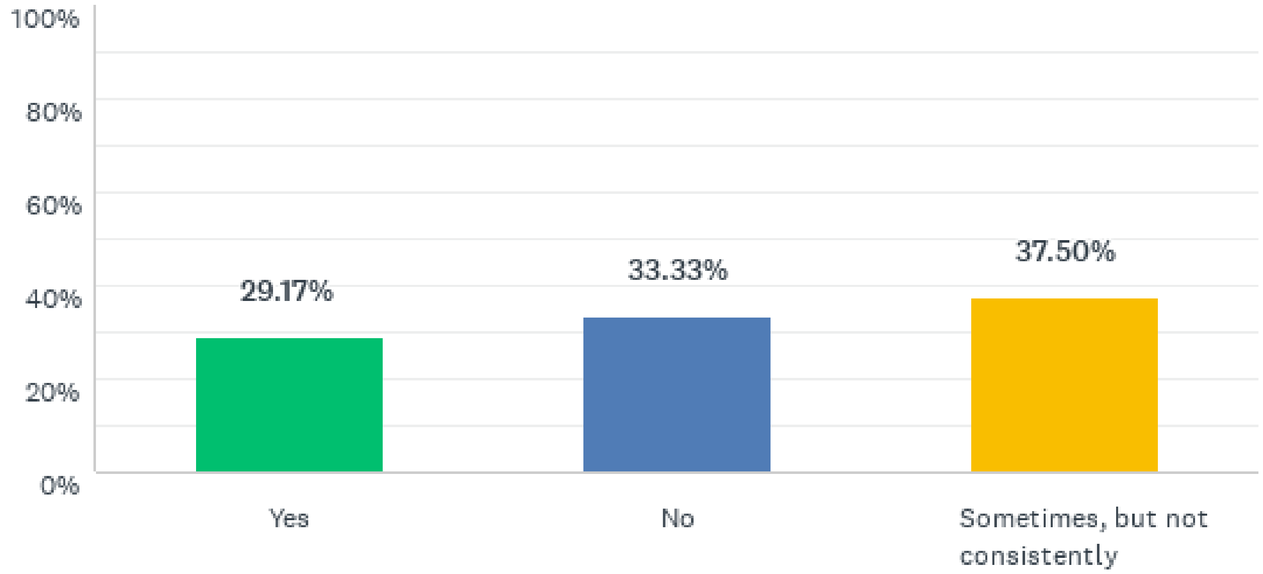
(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Timelines must be congruent with your Length of Stay

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

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



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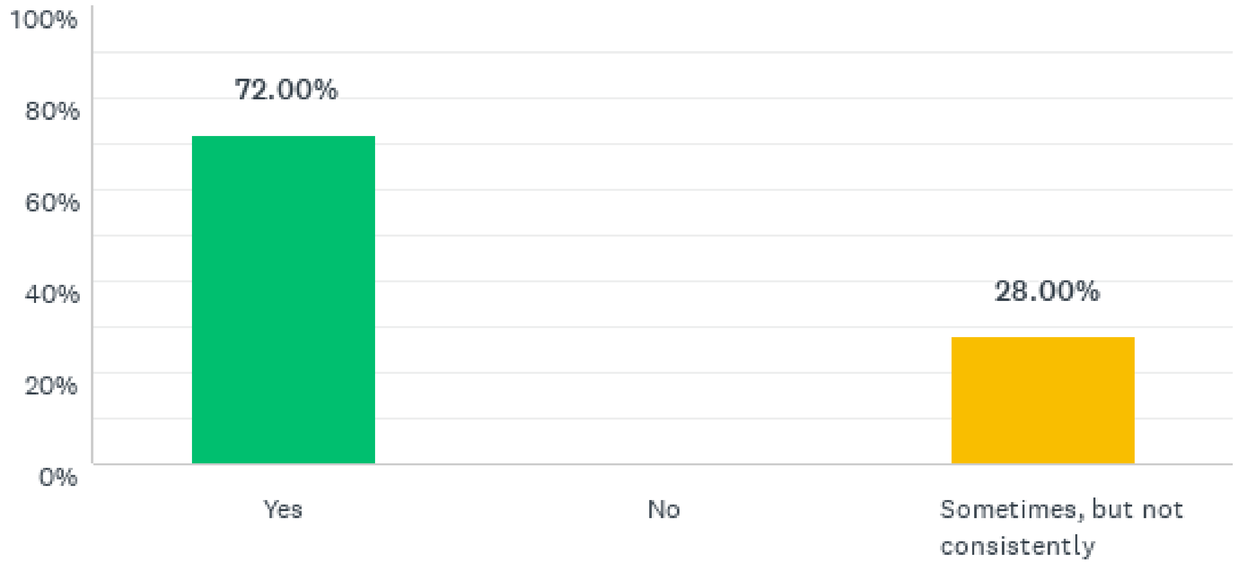
Q19 Is the RN assigned to the Swing Bed patient involved in developing the patient's plan of care?



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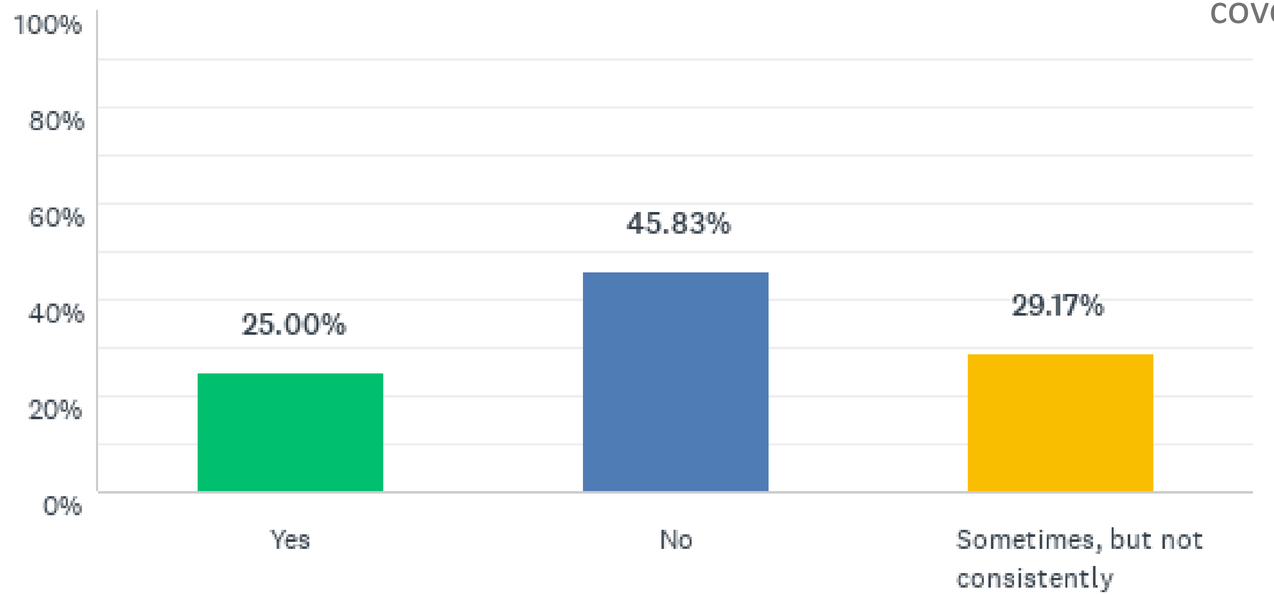
Q20 Does the CNA caring for the patient attend the Swing Bed multi-disciplinary conference(s)?



Comments:
Not able to provide floor coverage – limited staff

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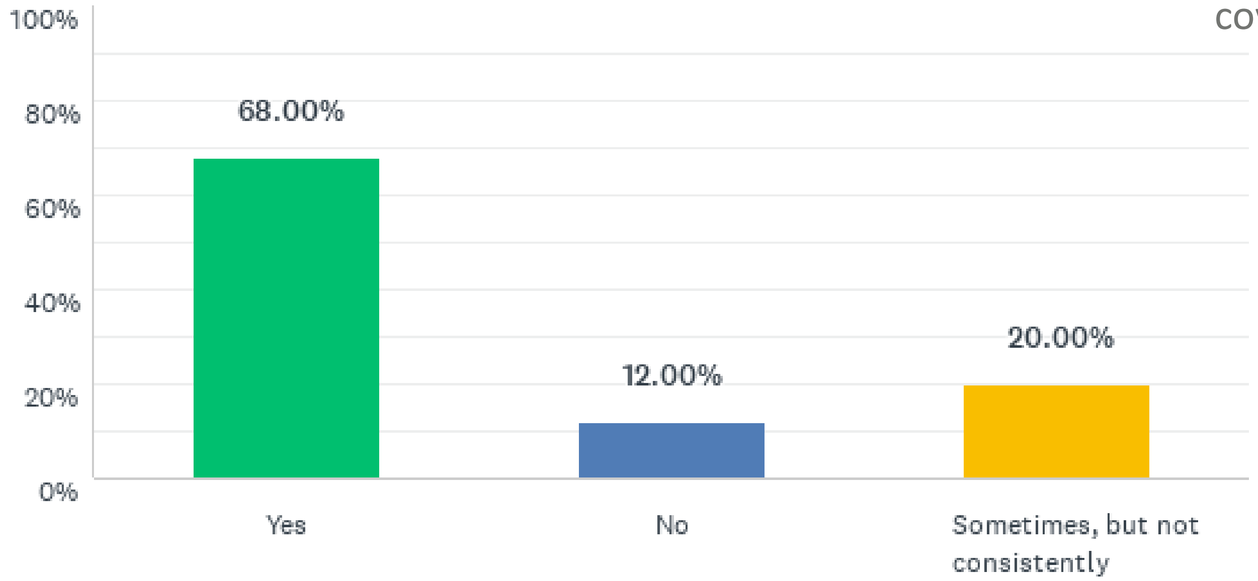
Q21 Does the RN caring for the Swing Bed patient attend the multi-disciplinary conference(s)?



Comments:
Not able to provide floor coverage – limited staff

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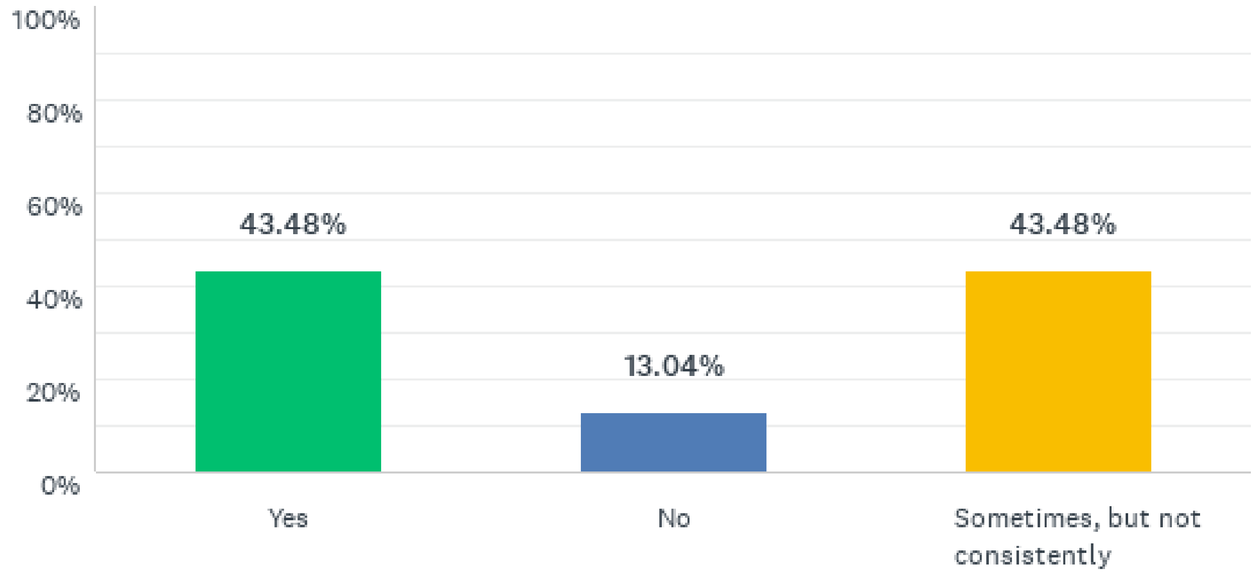
Q22 Are providers expected to attend the Swing Bed multi-disciplinary conference(s)?



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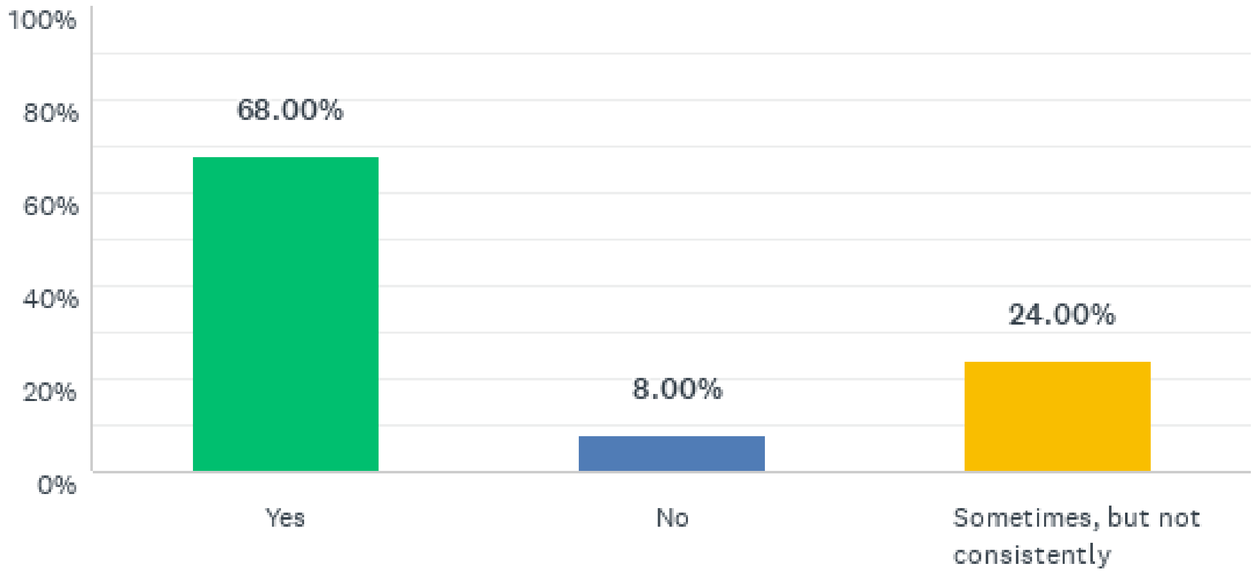
Q23 Is the Swing Bed patient, or patient's representative, involved in developing the plan of care?



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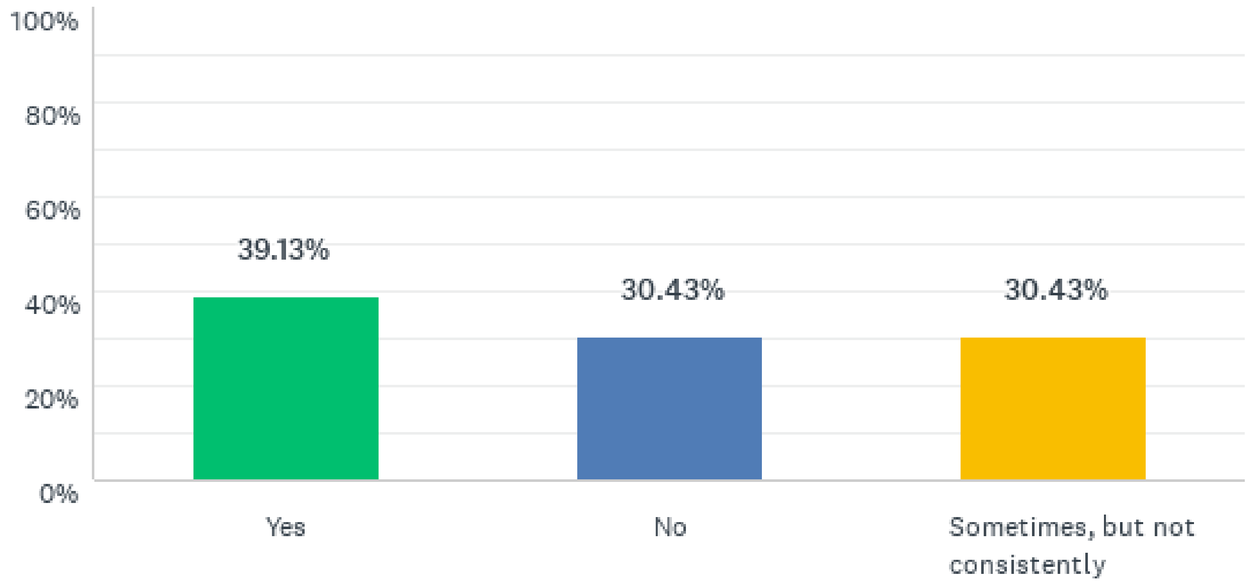
Q24 Does the Swing Bed patient, or patient's representative, attend multi-disciplinary conference(s)?



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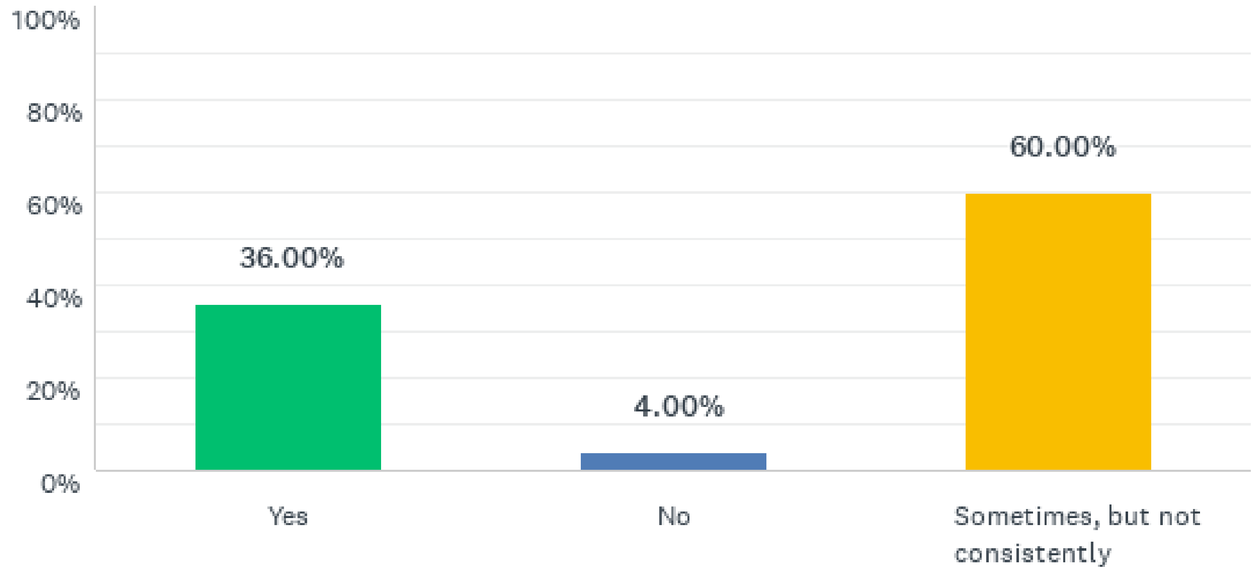
Q25 Does the Swing Bed multi-disciplinary plan of care include measurable objectives and timelines?



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Individual Discipline Assessments

are the Parts

The Care Plan is the Whole and is MORE than

the individual assessments

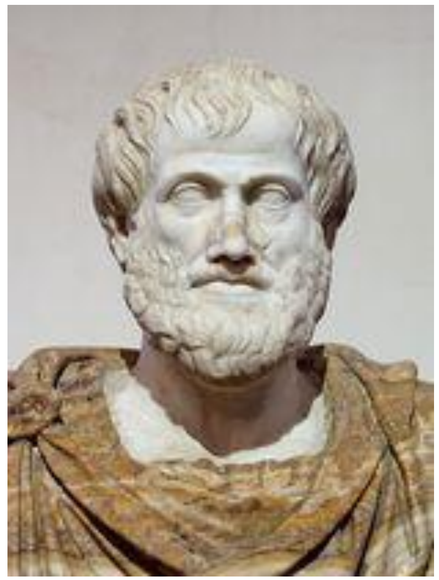
Rehab usually writes really good goals – but not always integrated with other disciplines

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

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.

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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				

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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).

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TRANSFER & DISCHARGE

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November 2019 Federal Register - February 2020 CoP

Discharge Planning

C-1425 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
(8) The CAH must assist patients, their families, or the patient's representative in **selecting a post-acute care provider by using and sharing data** that includes, but is not limited to, HHA, SNF, IRF, or LTCH data **on quality measures and data on resource use measures**. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

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

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

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

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

OCTOBER 2018: TRANSFER AND DISCHARGE

C-1610 §483.15(c)(2)
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:
(A)Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

October 2018: Transfer & Discharge

C-1620 §483.21(c)(2): Discharge summary. When the facility anticipates discharge a resident must have a **discharge summary** that includes, but is not limited to, the following:

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

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

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

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

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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;

There is NOT a CMS form

(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

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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

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October 2018: Notice to Ombudsman

C-1610 §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. **The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**

Send Discharge Notice you provide to patient

Appendix PP §483.15(c)(3)-(6)

Guidance - Notice of Transfer or Discharge and Ombudsman Notification

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

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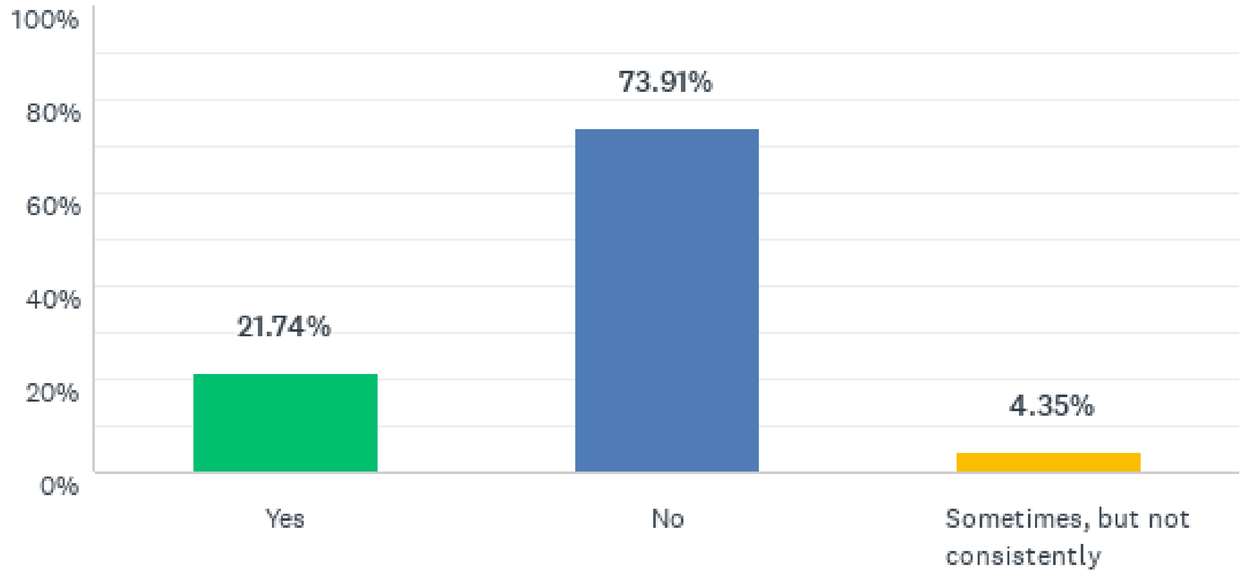
Q26 Is the Ombudsman notified when a Swing Bed patient is discharged?



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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

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ABUSE RECOGNITION AND REPORTING

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October 2018: Reporting Abuse

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

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

COMMON PROBLEMS
AUDITING
QAPI

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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

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Swing Bed Audit

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

AUDIT EXAMPLE PROVIDED

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Swing Bed QAPI

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

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

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

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Important Notes About Audits – Teams – Improvement

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

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

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

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

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

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

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

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Important Notes About Audits – Teams – Improvement

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

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

9. Consider establishing goals for the Swing Bed Program ---- not just the component parts (i.e. audits)
- Admissions (volume)
- Time from request for Swing Bed to Acceptance or Denial (especially important for external referrals)
- Staff satisfaction with Swing Bed program
- Provider satisfaction with Swing Bed program
- Patient satisfaction with Swing Bed program

10. SHARE IMPROVEMENTS WITH STAFF - PROVIDERS

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RESOURCE
SWING BED
POLICIES & PROCEDURES

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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.

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Swing Bed Policies & Procedures cont.

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.

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YOUR QUESTIONS

Discussion Questions

1 – What was your biggest “ah-ha” moment from the presentation or the Swing Bed audit?

2 – What have you been found to be the most successful strategy / process in developing the multi-disciplinary plan of care?

3 – What have you found to be the most successful strategy in growing your Swing Bed program?

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THANK YOU

GAFFEY HEALTHCARE
TECHNOLOGY. RESULTS.

I hope this information has been helpful!

Please contact me if you would like to discuss the information provided in the presentation.

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SWING BED SURVEY
25 RESPONDENTS

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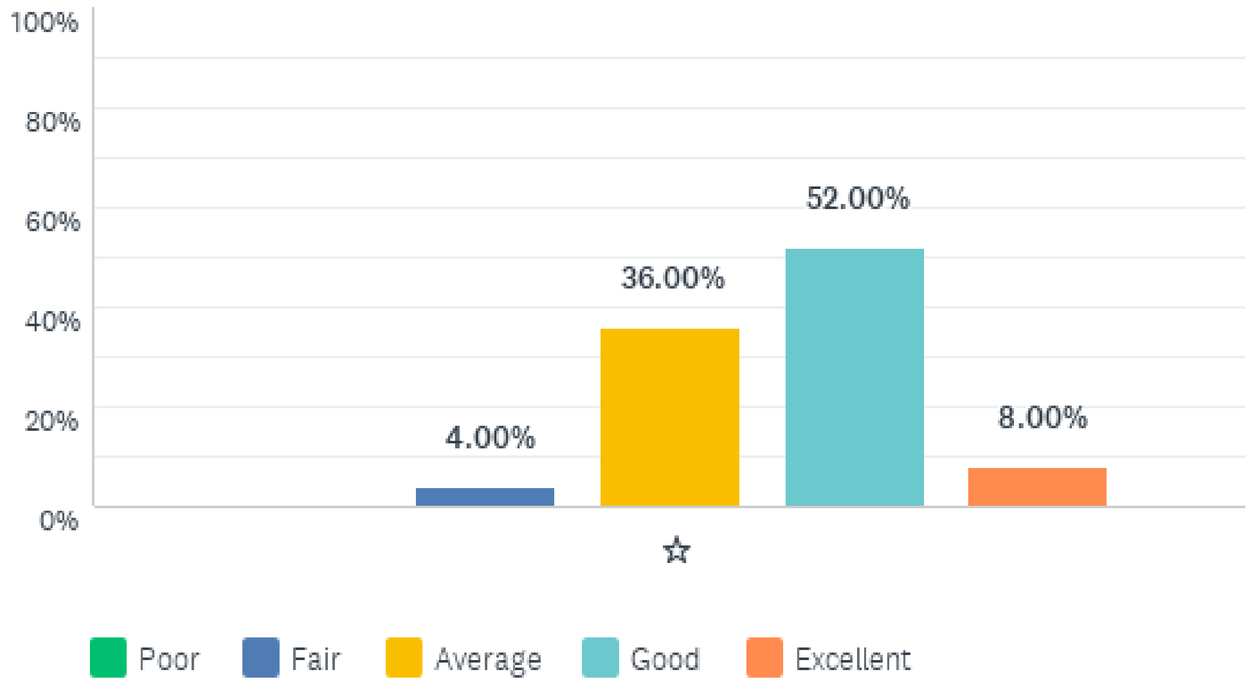
Q3 How would you rate your Swing Bed Program?



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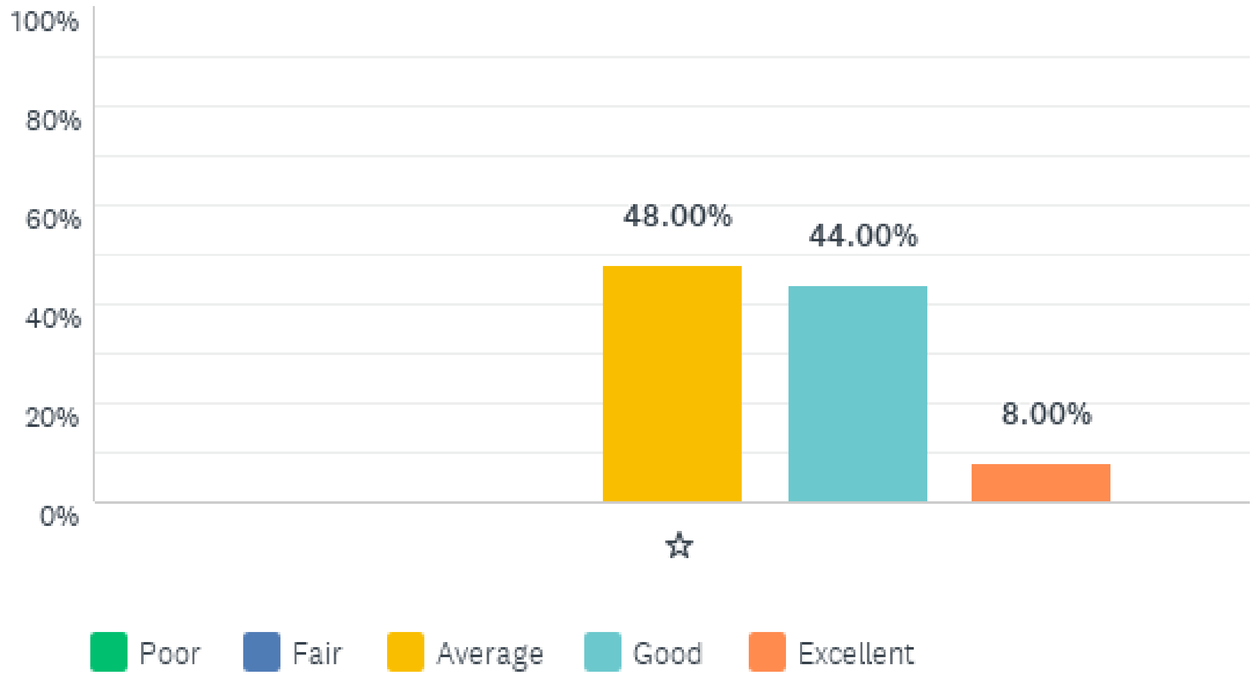
Q4 How would you rate the Swing Bed admission process?



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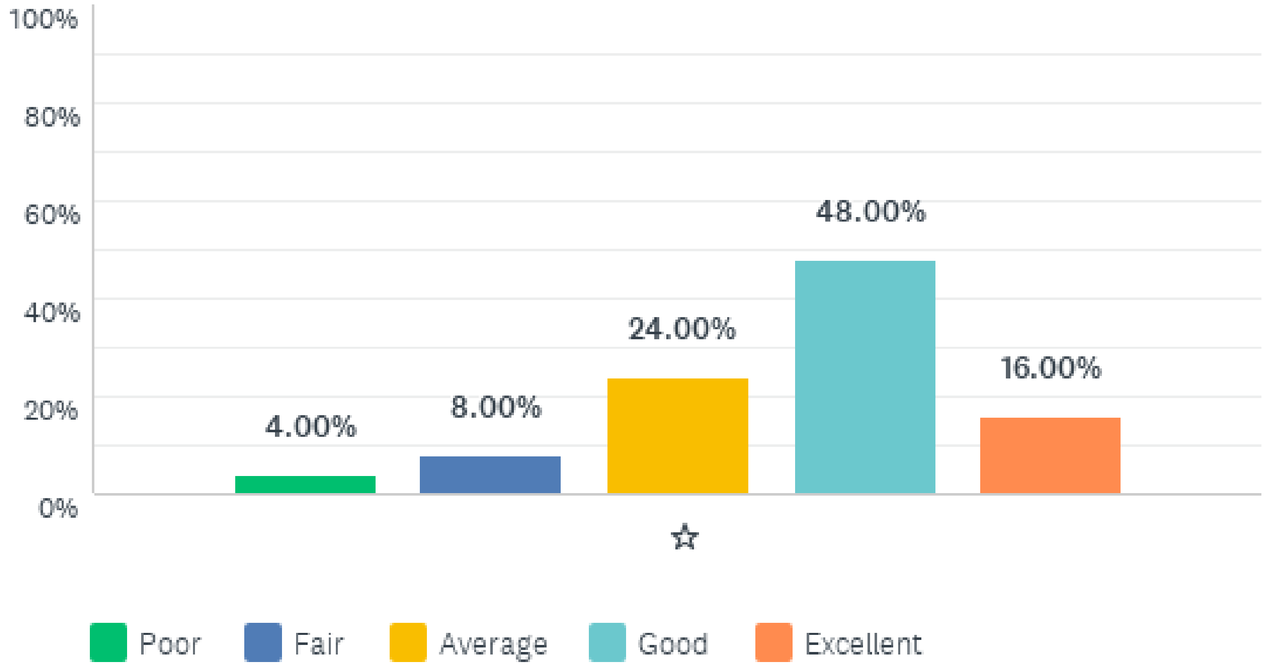
Q5 How knowledgeable is the Swing Bed team about admission and ongoing stay criteria (e.g. what types of patients can be admitted to Swing Bed and how long they can stay)?



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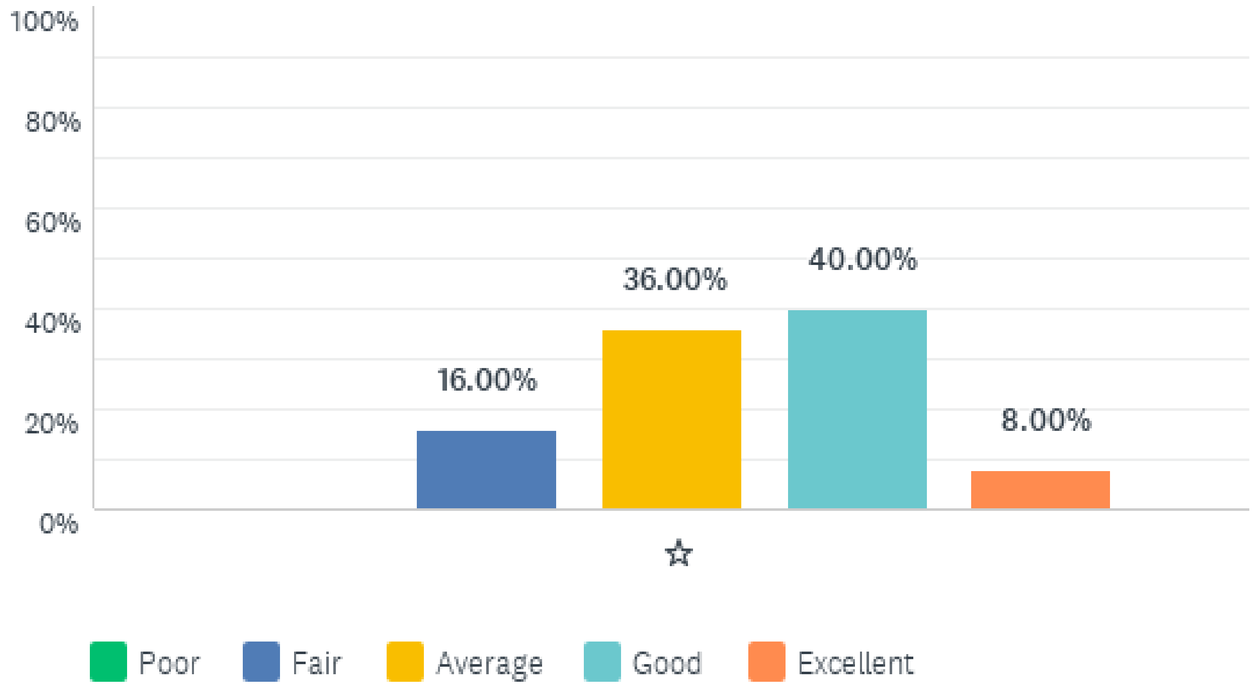
Q6 How would you rate the Swing Bed Multi-Disciplinary Planning process?



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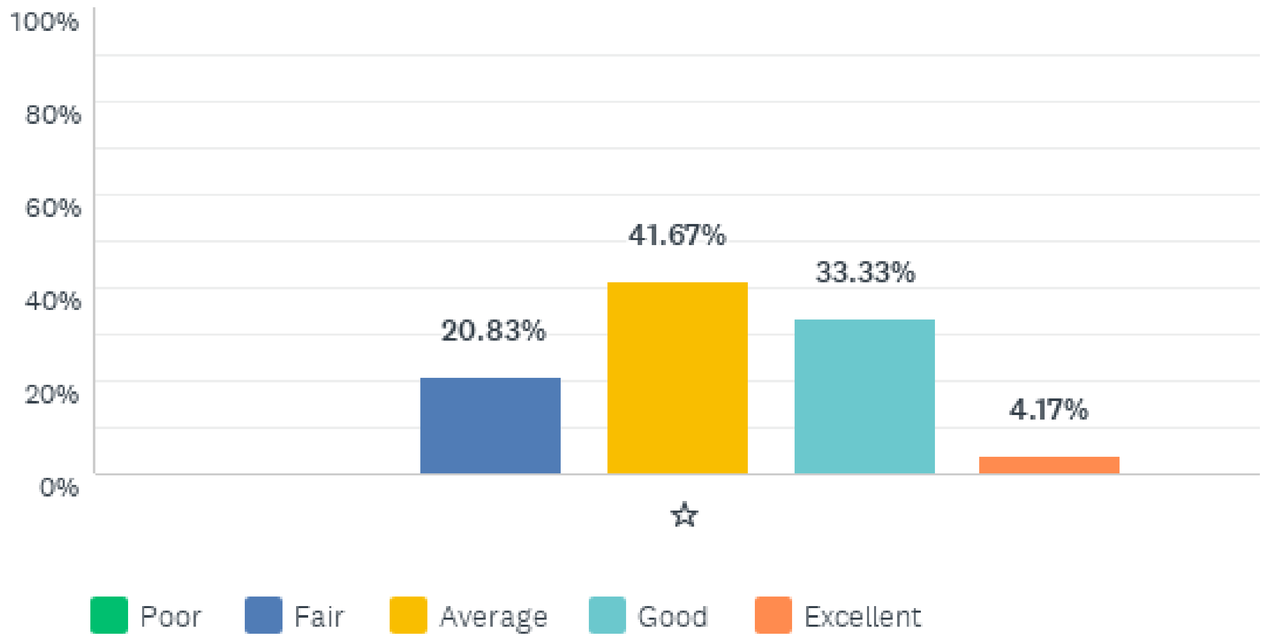
Q7 How would you rate the Swing Bed team knowledge of the Conditions of Participation (regulations) for Swing Bed?



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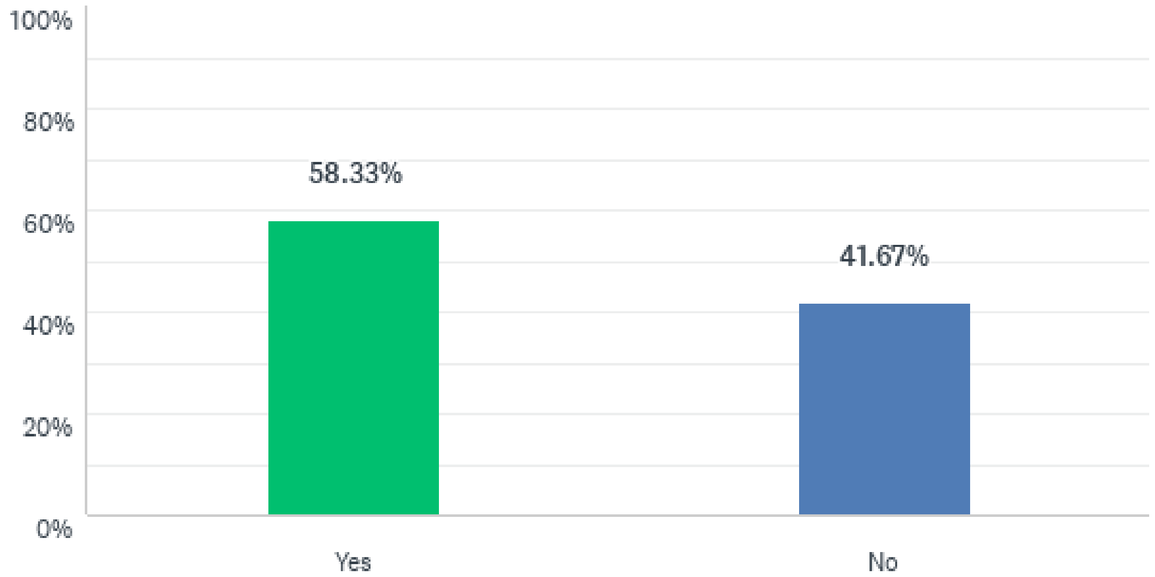
Q8 Do you provide Swing Bed patients with a choice of providers?



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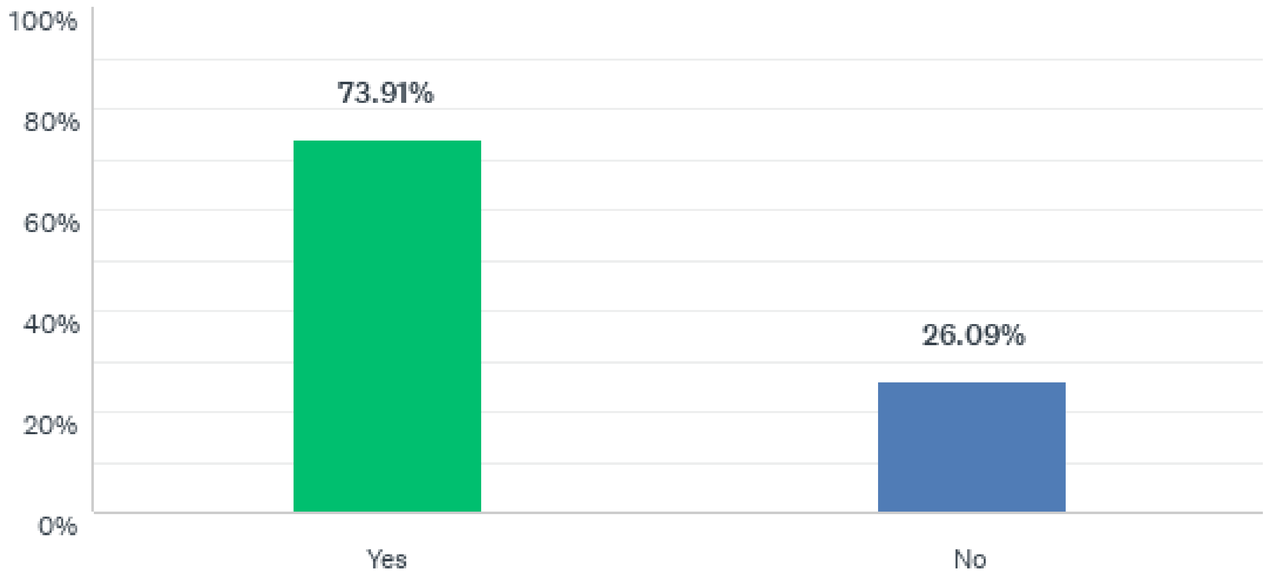
Q9 Do you provide patients with information on how to contact their providers, including consulting physicians?



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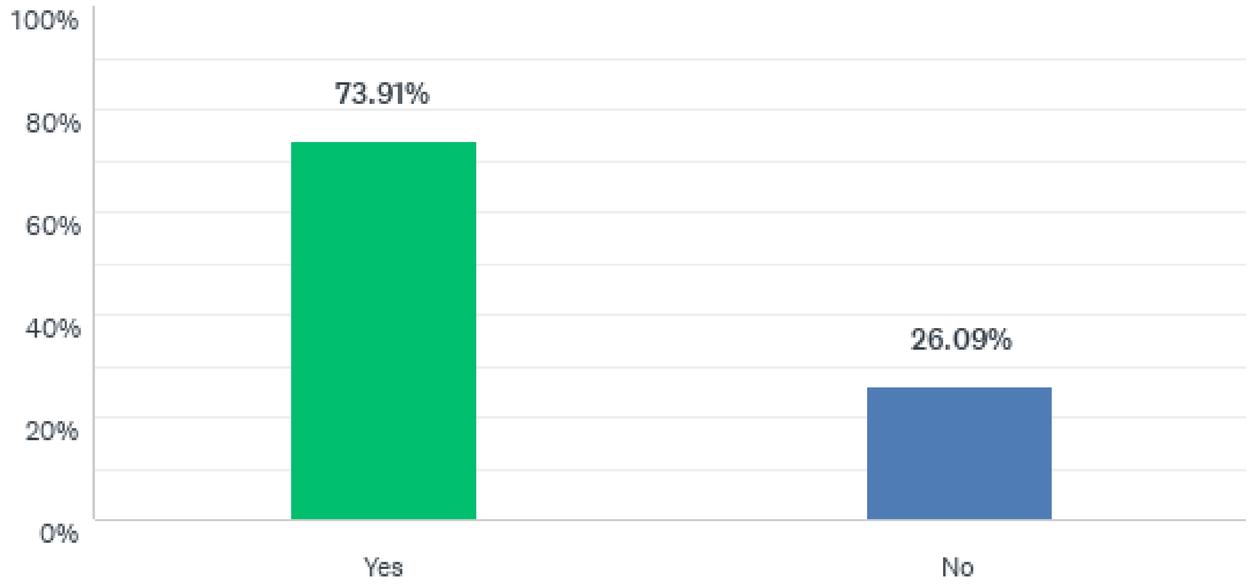
Q10 Are patients provided with information about expected financial obligations? (Not generic hospital costs but those costs associated with the Swing Bed stay.)



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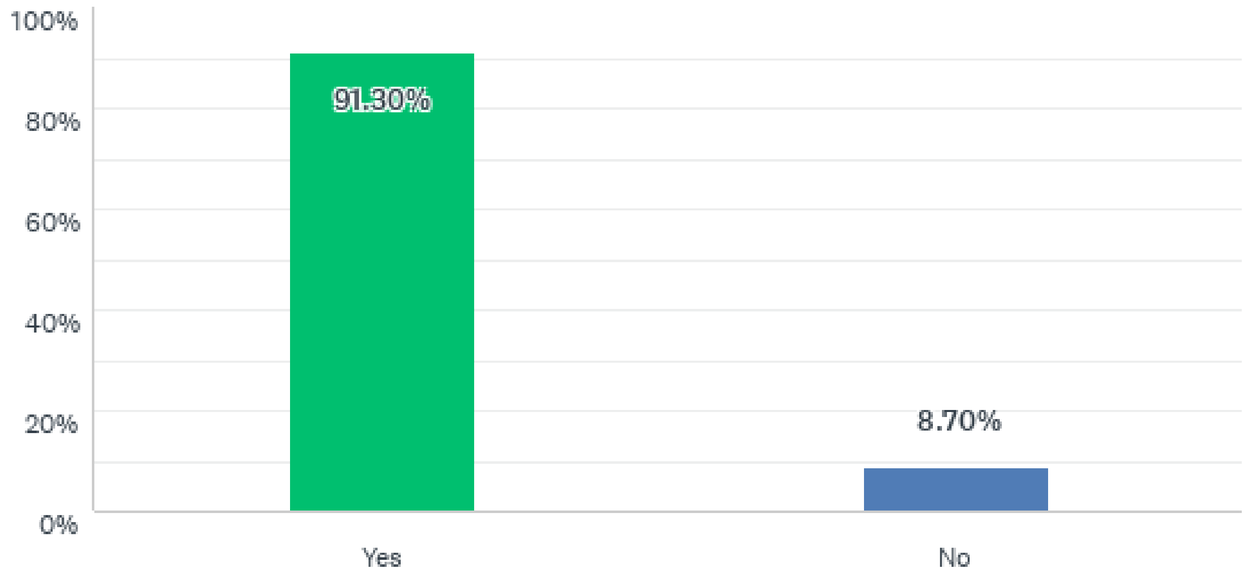
Q11 Are Swing Bed patients provided with their Rights and Responsibilities specific to Swing Bed?



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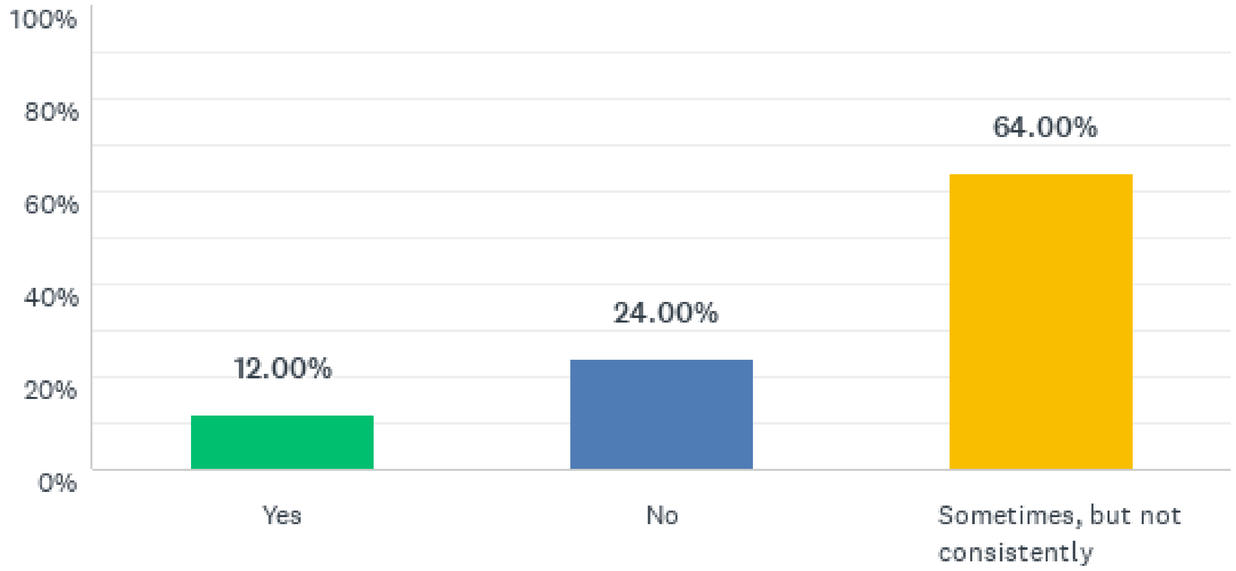
Q12 Are Swing Bed patients assessed for trauma at the time of admission? (Culturally Competent / Trauma Informed Care)



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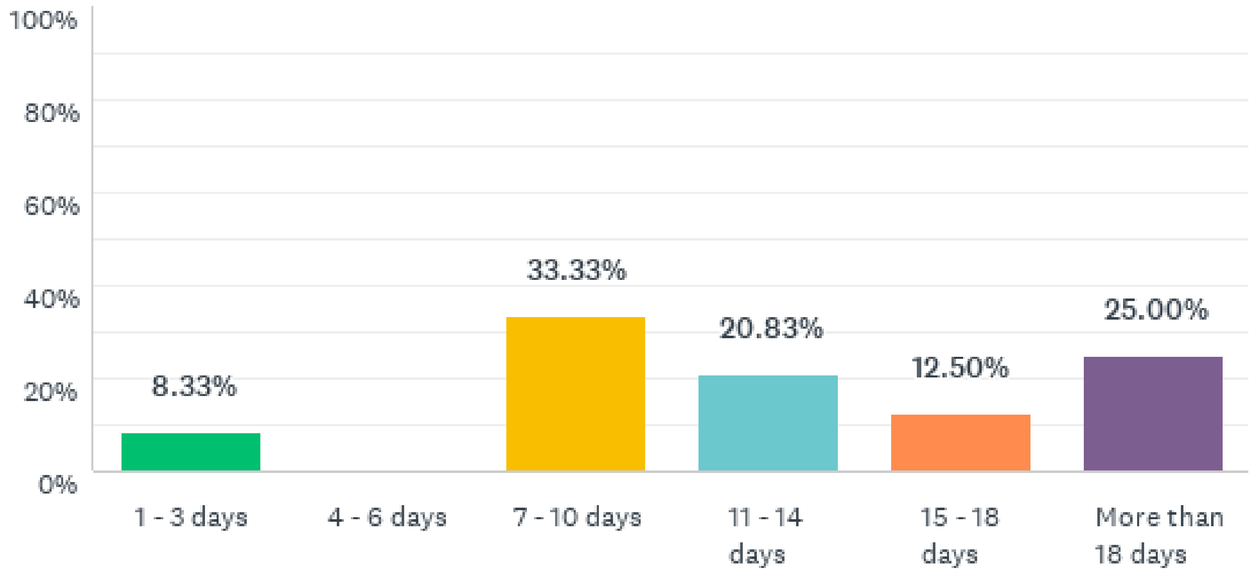
Q13 For the last 12 months, what was the average length of stay (ALOS) in Swing Bed?



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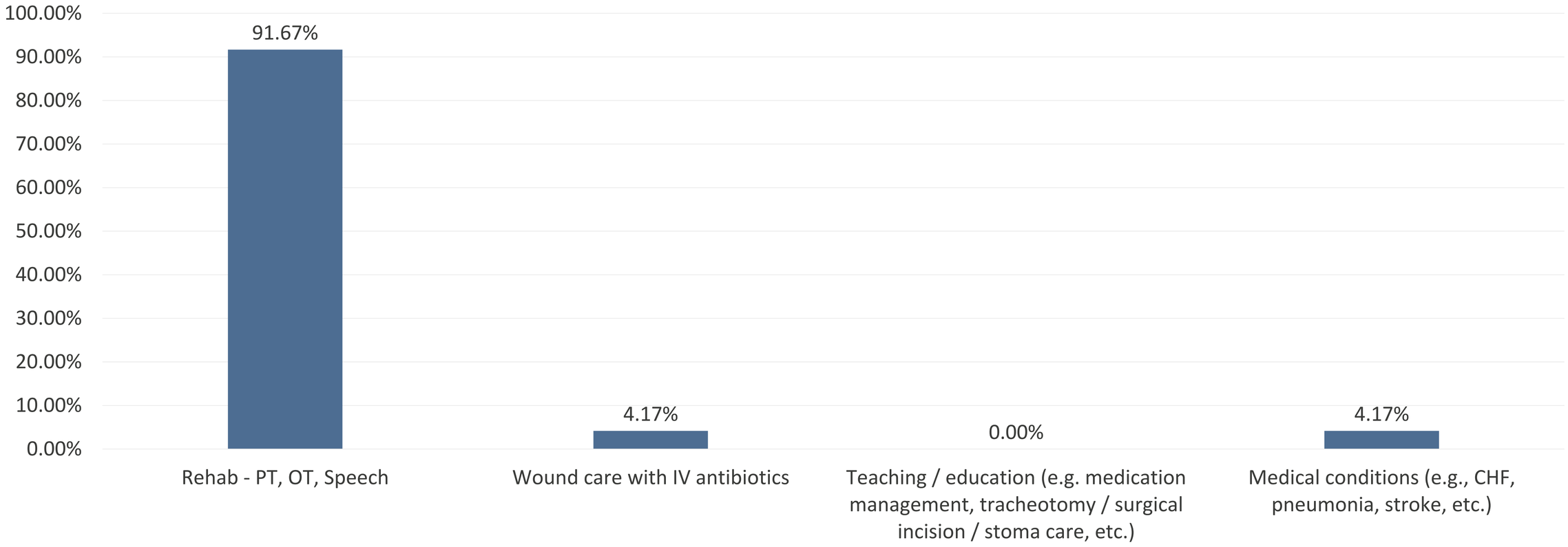
Q 14 What is the primary reason for admission to Swing Bed?



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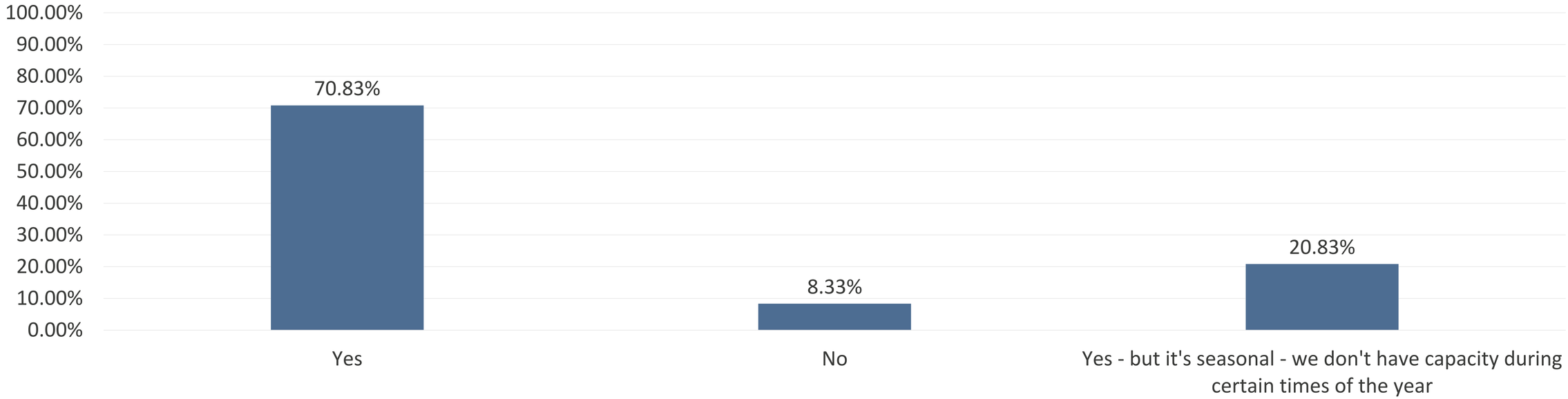
Q15 Would you like to increase your Swing Bed volume?



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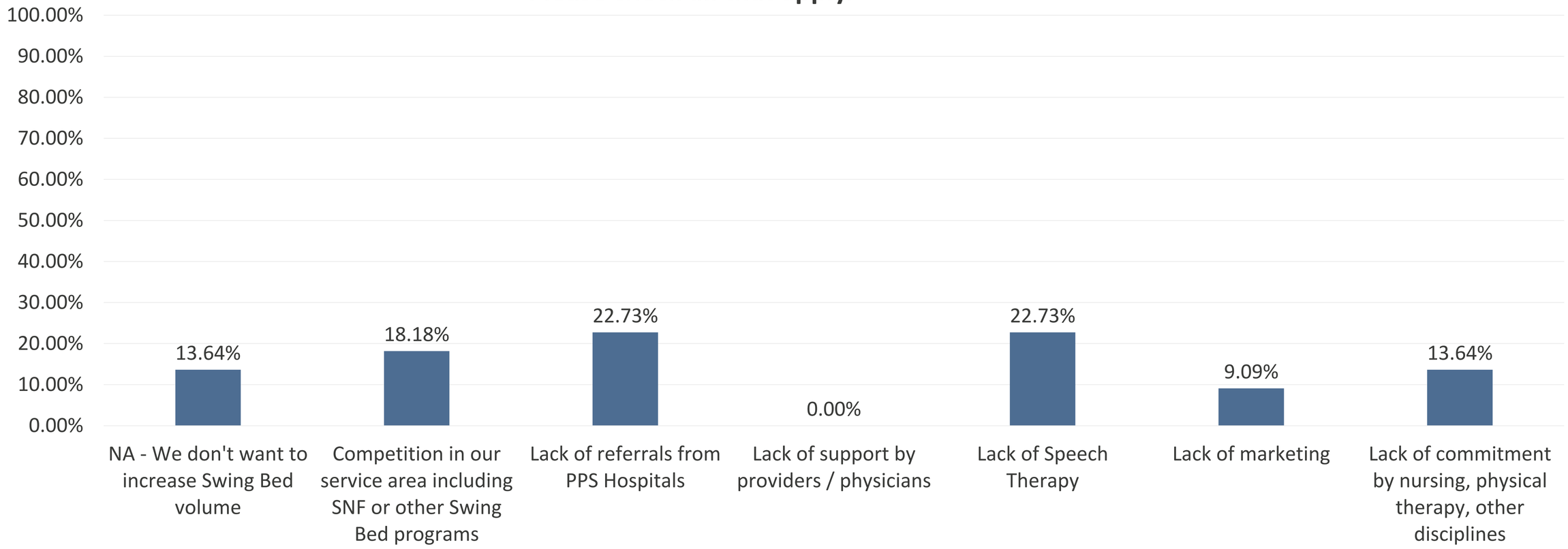
Q 16 What are the primary reasons preventing you from increasing Swing Bed volume? Please check all that apply.



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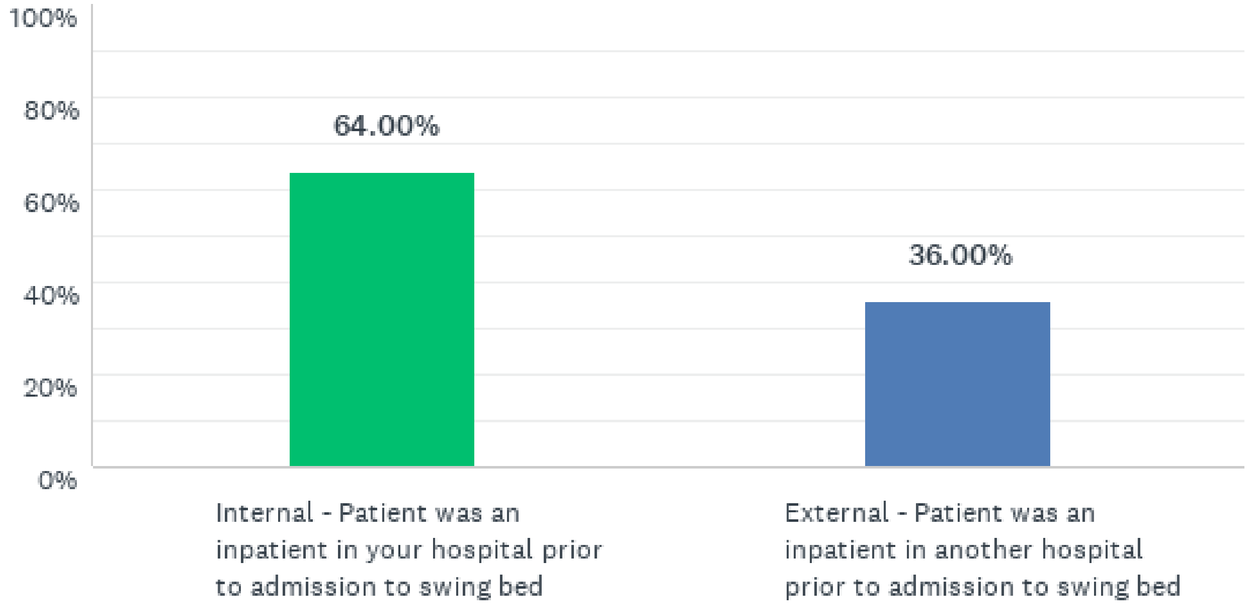
Q17 What is the primary source of admissions to Swing Bed?



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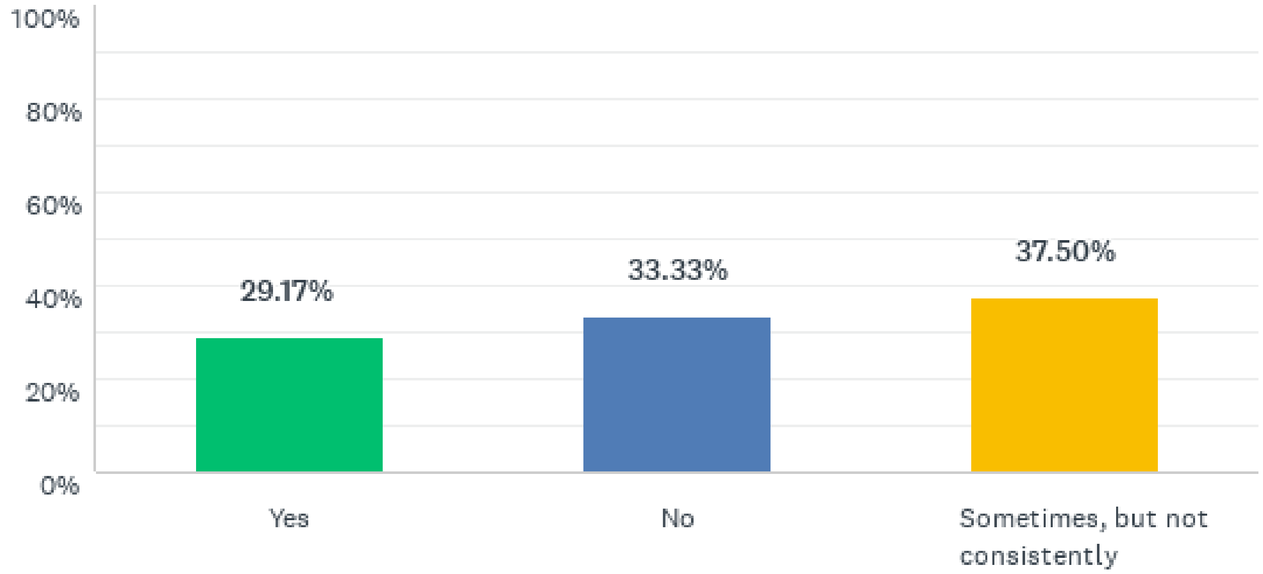
Q18 Is a Certified Nursing Assistant (CNA) involved in developing the Swing Bed patient's plan of care?



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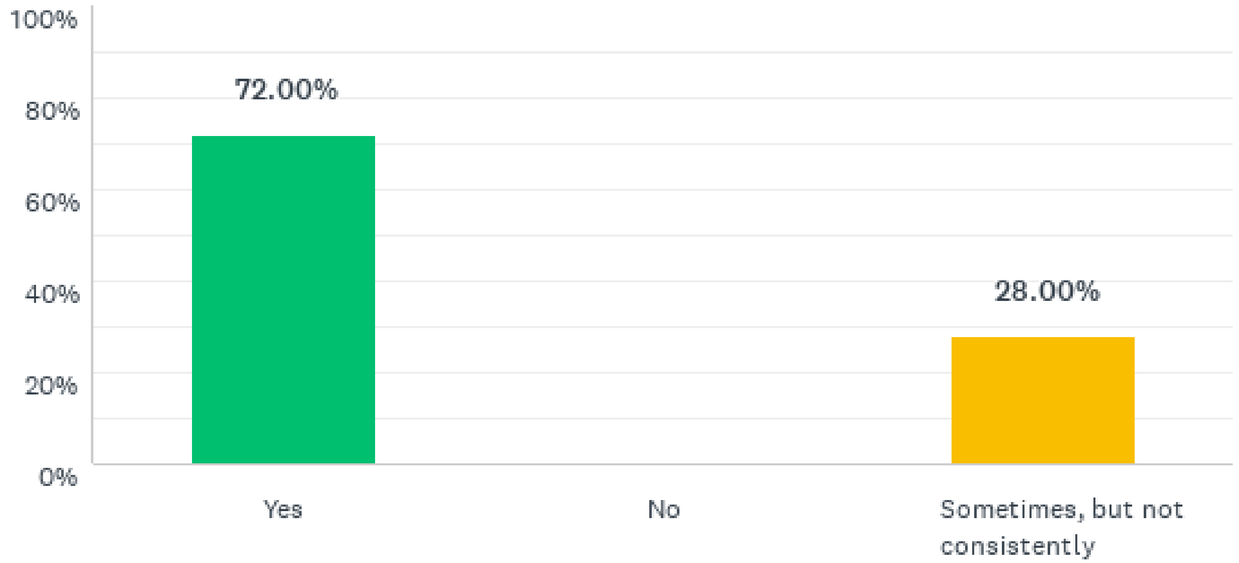
Q19 Is the RN assigned to the Swing Bed patient involved in developing the patient's plan of care?



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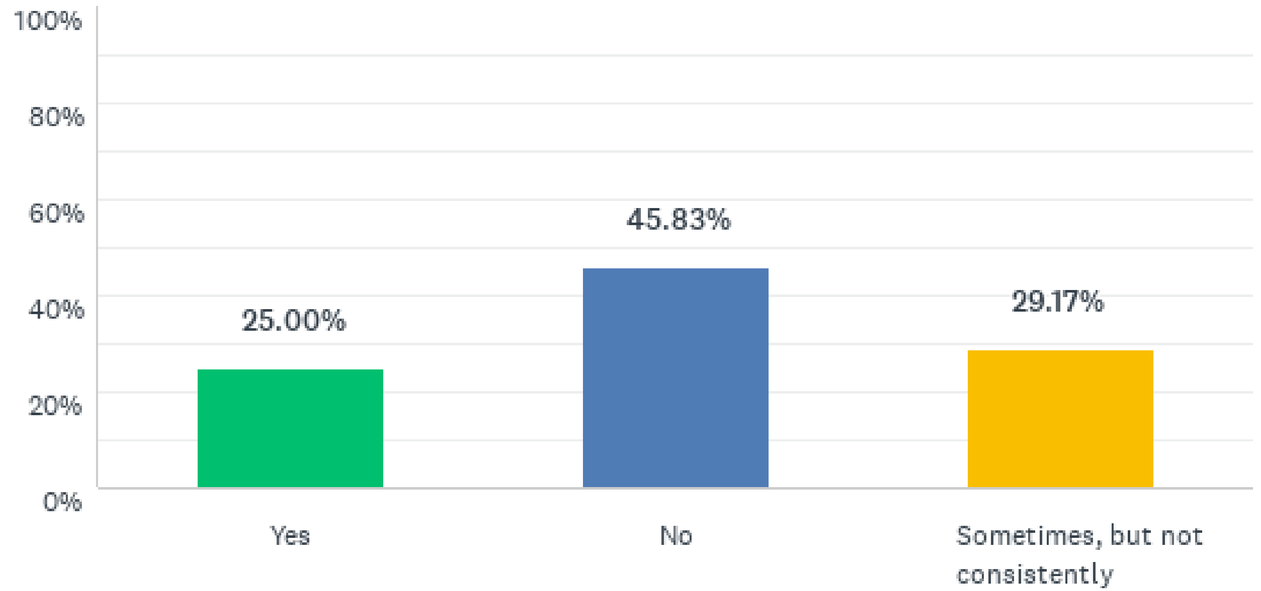
Q20 Does the CNA caring for the patient attend the Swing Bed multi-disciplinary conference(s)?



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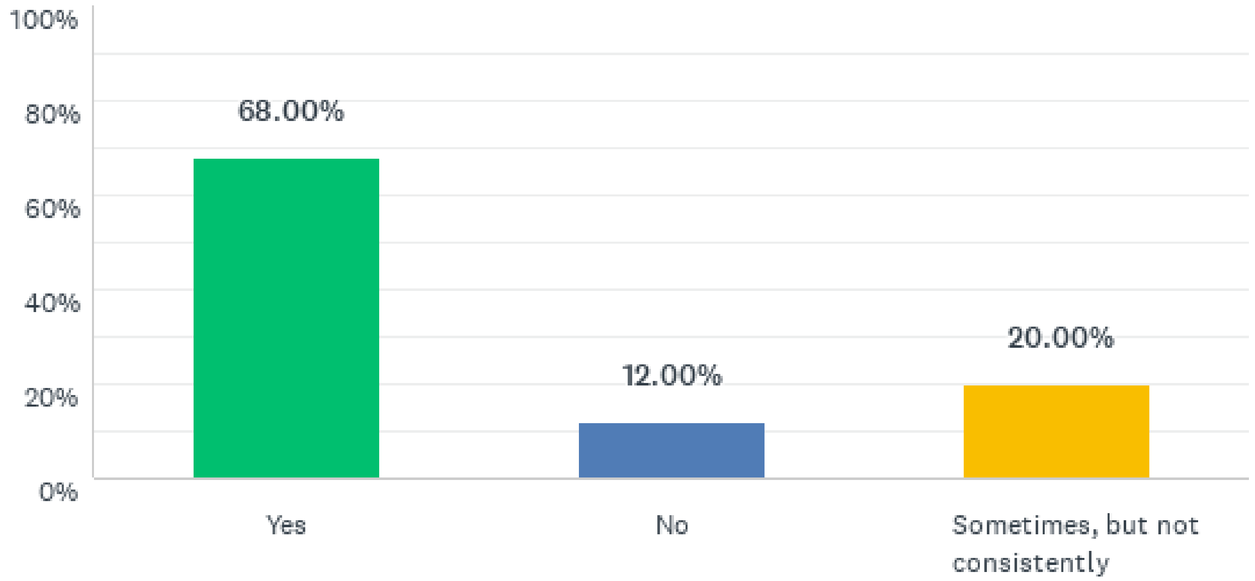
Q21 Does the RN caring for the Swing Bed patient attend the multi-disciplinary conference(s)?



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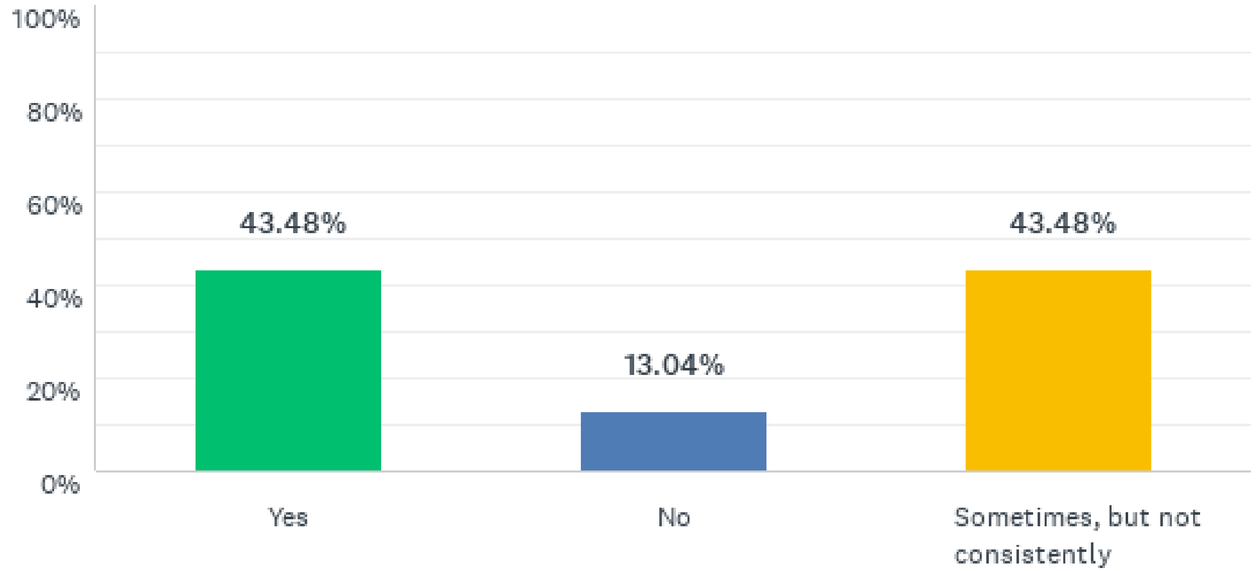
Q22 Are providers expected to attend the Swing Bed multi-disciplinary conference(s)?



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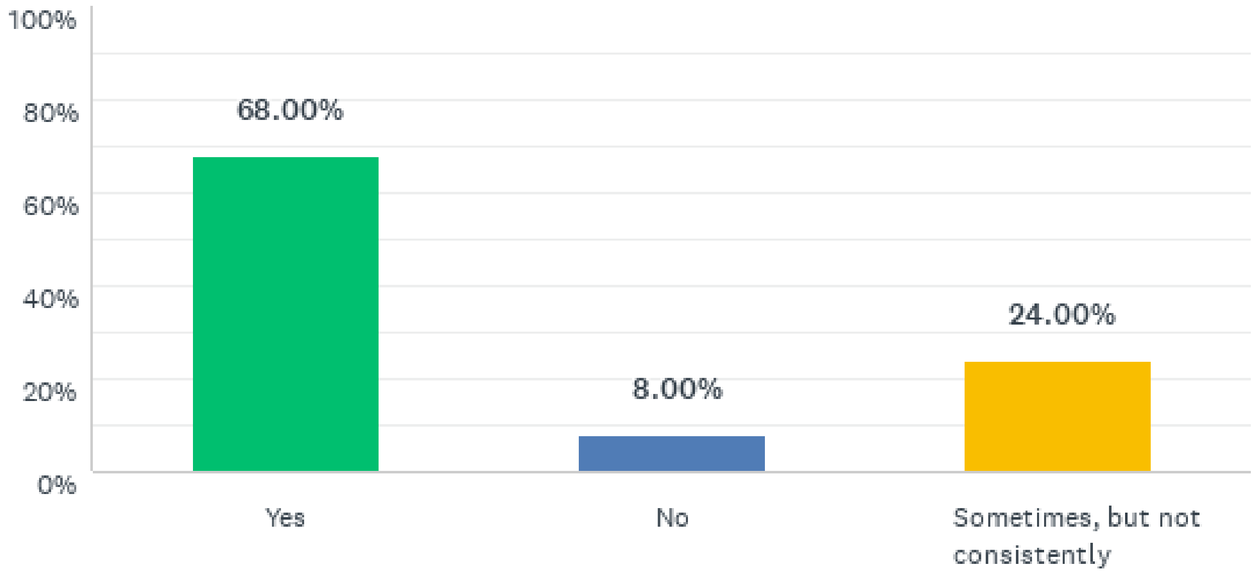
Q23 Is the Swing Bed patient, or patient's representative, involved in developing the plan of care?



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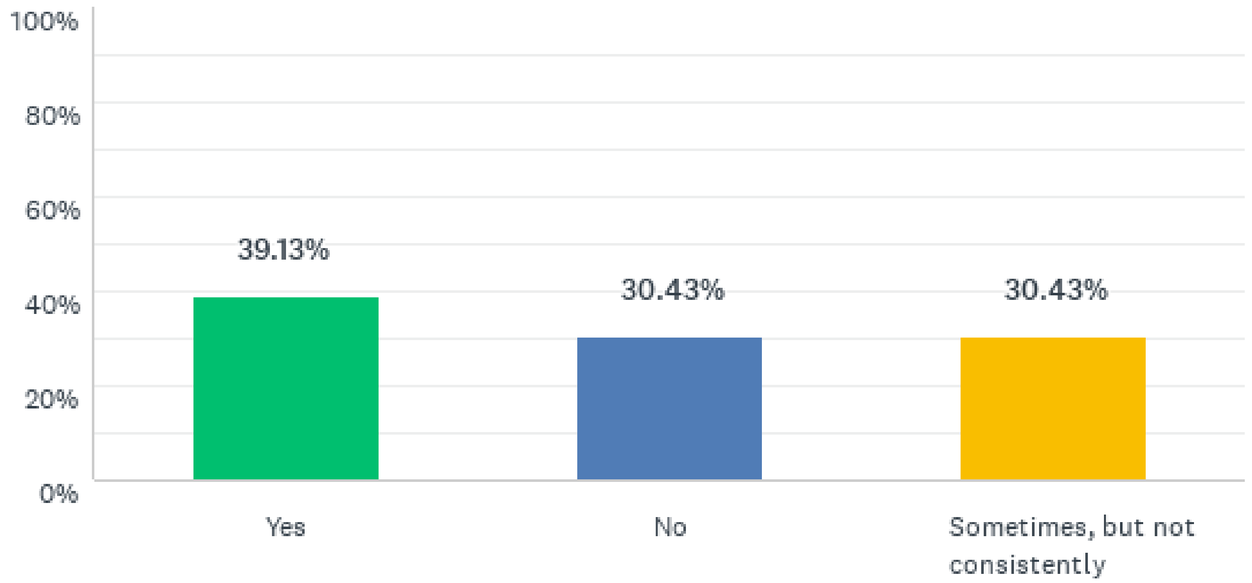
Q24 Does the Swing Bed patient, or patient's representative, attend multi-disciplinary conference(s)?



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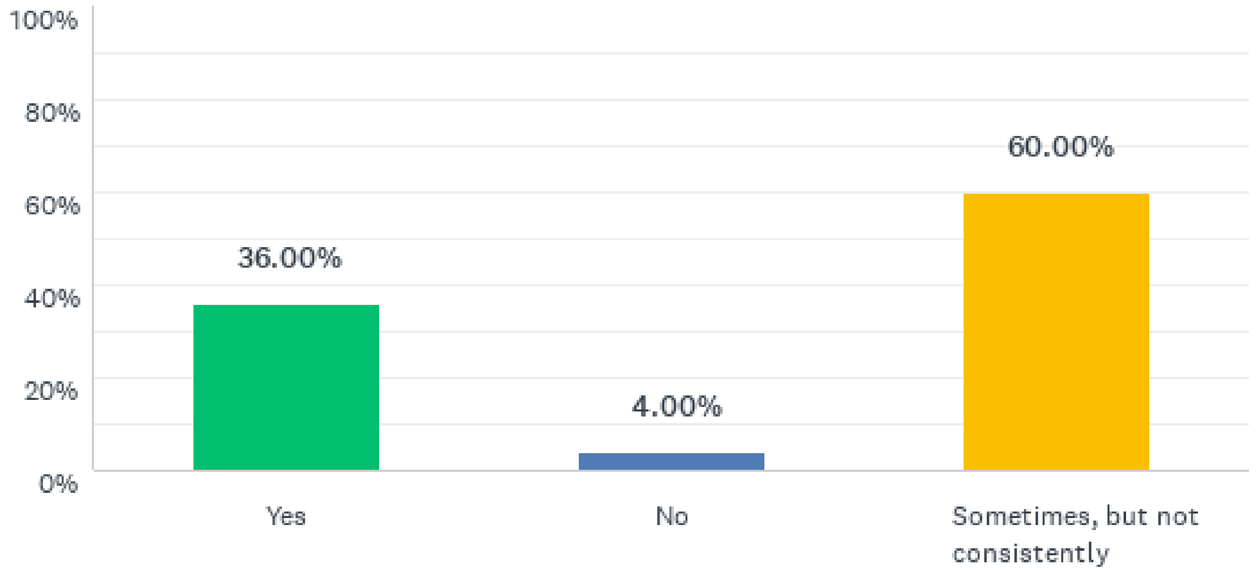
Q25 Does the Swing Bed multi-disciplinary plan of care include measurable objectives and timelines?



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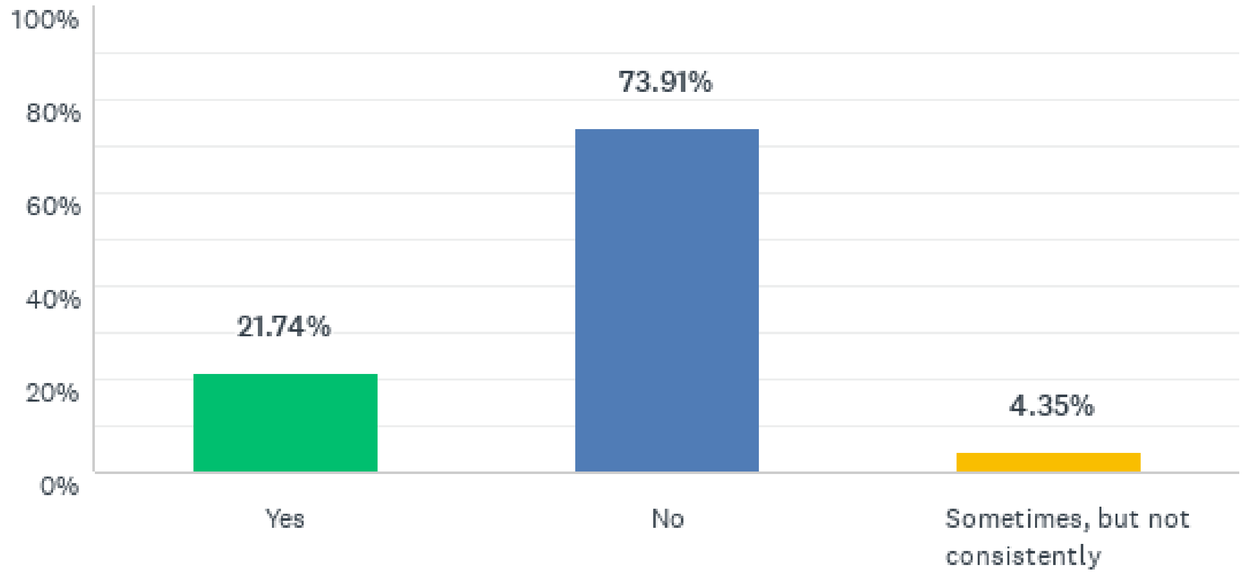
Q26 Is the Ombudsman notified when a Swing Bed patient is discharged?



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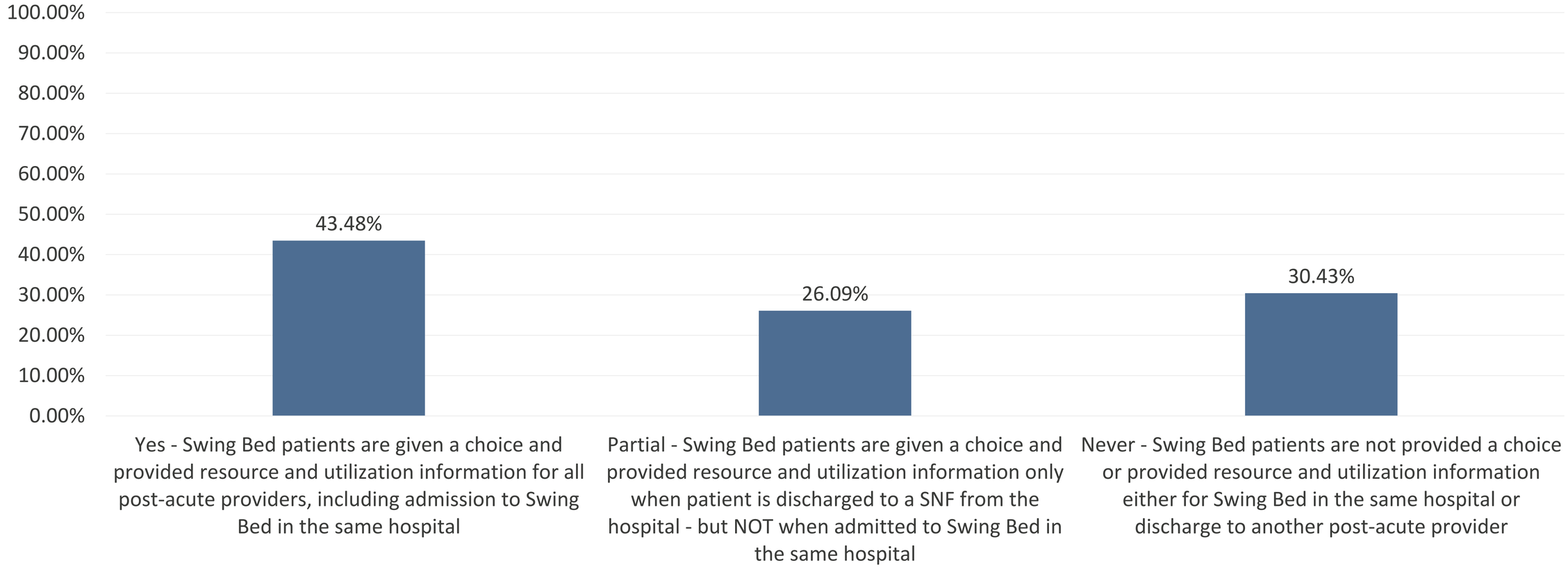
Q27 Are Swing Bed patients given a choice of post-acute providers (Swing Bed, SNF, Home Health, IRF) including information about quality and resource utilization? This includes when a patient is discharged from acute and admitted to Swing Bed in the sam



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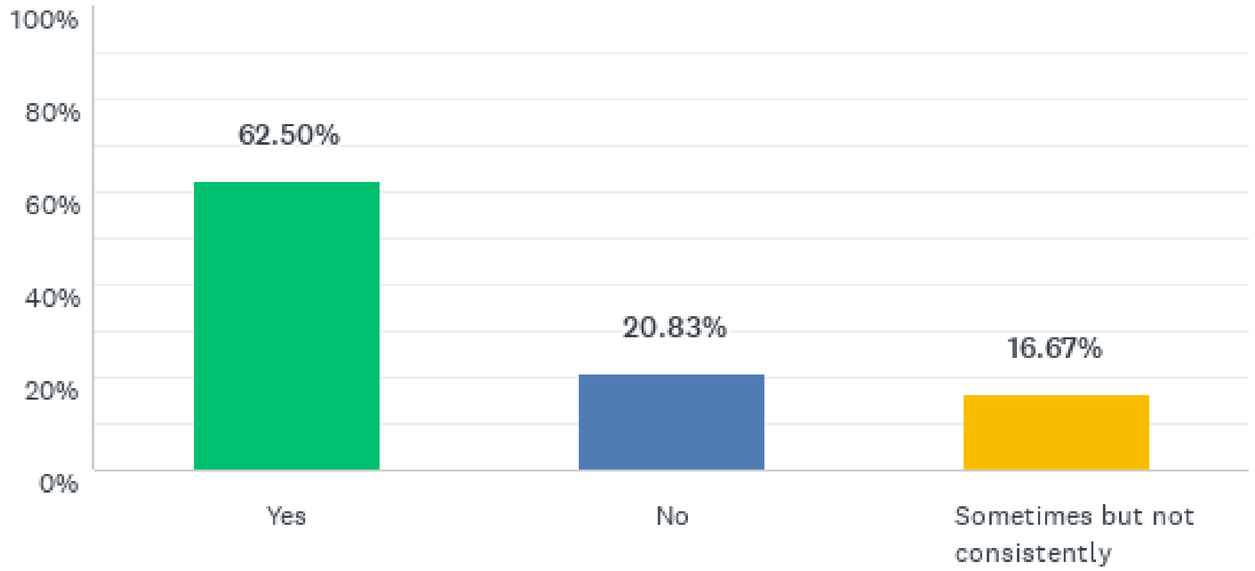
Q28 Are Swing Bed resource and utilization data collected internally?



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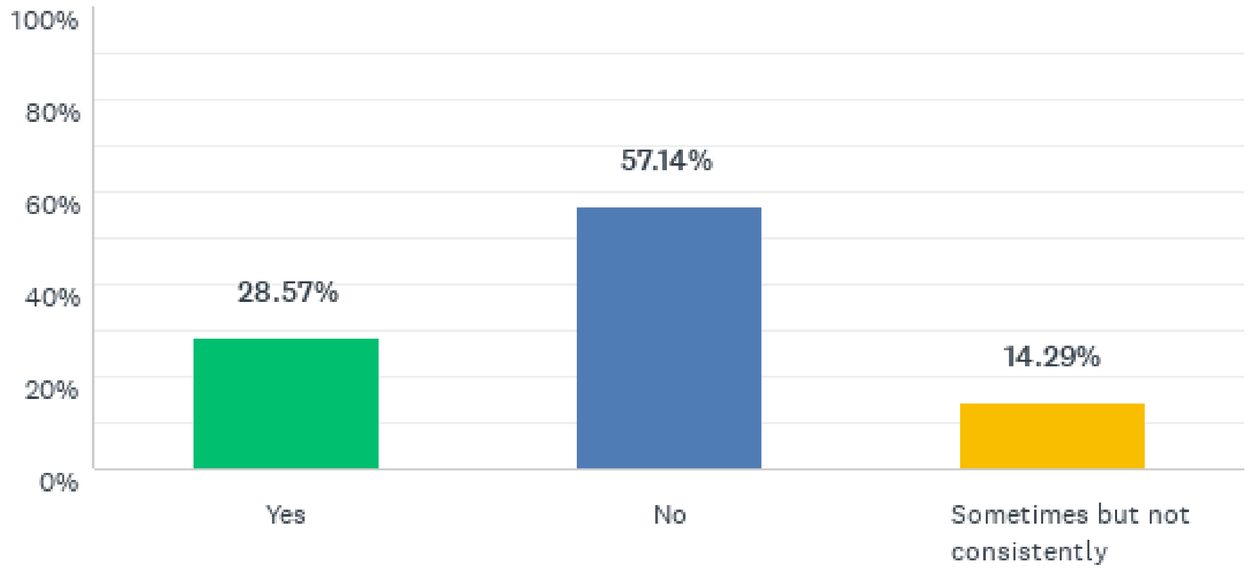
Q29 Are internal Swing Bed resource and utilization data shared with external referral sources?



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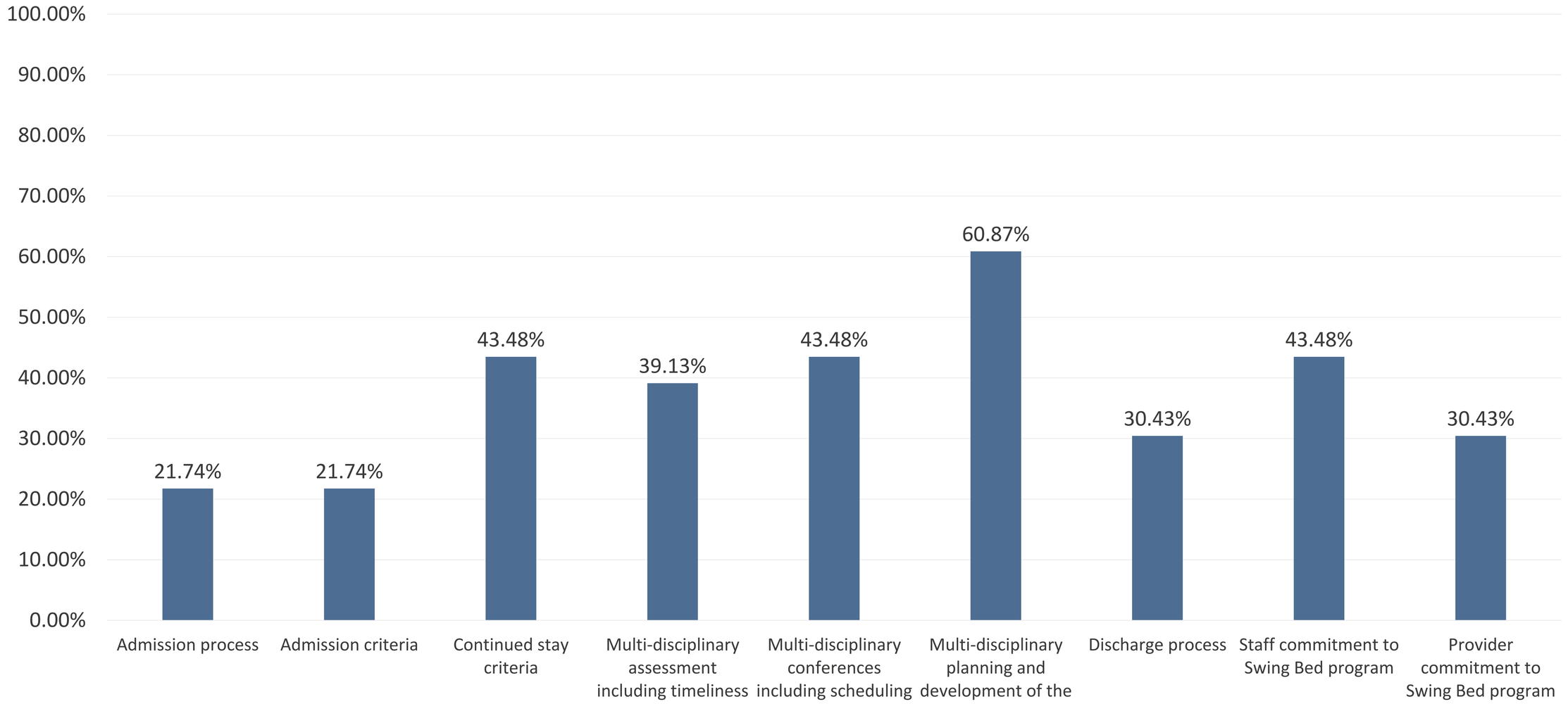
Q30 Please choose the process you find most challenging related to Swing Bed (select all that apply)



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THANK YOU

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I hope this information has been helpful!

Please contact me if you would like to discuss the information provided in the presentation.

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