MHA
MONTANA HOSPITAL ASSOCIATION

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MONTANA SWING BED MANUAL

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Introduction

The Montana Swing Bed Manual is published as a resource for Critical Access Hospitals with Swing Beds in Montana. This Manual has been developed using funds from the Rural Hospital Flexibility Program at the Montana Health Research and Education Foundation (MHREF) at the Montana Hospital Association (MHA).

MHA recognizes how important Swing Beds are to the viability of Critical Access Hospitals (CAHs) and the essential service they provide to rural communities.

The Montana Swing Bed Manual is organized in easily searchable sections, including frequently asked questions, regulatory information, and tools that can be individualized to your organization.

You will notice that the manual uses resident and patient interchangeably. Regulatory guidelines continue to use the term residents, but hospitals typically use patients.

We are proud to include some of the Swing Bed improvement projects from the Montana Flex Swing Bed Quality Improvement Project from 2022 in Section 9.

We sincerely hope this manual provides resources and information to help you provide the best possible Swing Bed services for your community.

If you have any questions, please contact Jennifer Wagner at jennifer.wagner@mtha.org.

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Advancing Health in Montana

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SECTION 1

Introduction to Swing Beds

Chapter 1
Swing Bed History

In the fall of 1969, Dr. Bruce Walter, who at the time was Utah's Director of Medicare Services, was traveling through Utah with three other state officials performing rural hospital surveys. During the trip, the group began discussing the status of rural hospitals and nursing homes. They were brainstorming ideas for how to keep a rural hospital, which provided much needed acute care to the local community and was critical to the local economy, open and while at the same time accommodate the elderly population who were being displaced by the lack of bed availability.[1]

At the time, Federal regulations required that skilled and intermediate-level care be provided in a physically distinct part of the hospital. According to Richardson & Kovner[2] (1987), this distinct part had to be used "…*exclusively for these purposes and with different health, safety, and staffing requirements and reimbursement*" (pg. 62). With physical plant limitations and limited staff, rural hospitals found it difficult to meet the requirements and were therefore unable to implement a distinct-part service. The demand for acute care was not as strong as expected, and beds remained open, putting a financial strain on hospitals.

Nursing homes were experiencing high occupancy rates. There were lengthy waiting lists forcing people to move to nursing homes that were long distances from their homes and families. The surveyors felt that there should be a way to utilize the empty hospital beds to decrease the nursing home waiting lists, allow people to find care closer to home, and decrease the financial burden felt by rural hospitals. When the trip ended, and Dr. Walter returned home, he wrote a letter to the regional Medicare Office in Denver outlining the problem and a potential solution. He indicated that the shortage of beds on a regional level did not justify expansion, but due to high occupancy rates and long waiting lists in existing long-term care facilities, access was limited. Dr. Walters argued that there were acute care hospital beds sitting empty that could help ease this burden.[3]

Medicare agreed and the Health Care Financing Administration (HCFA), now known as CMS, sponsored a demonstration project entitled the *1973 Utah Cost Improvement Project*. This project was a three-year demonstration involving twenty-five hospitals designed to "…*assess the viability of providing long-term care in acute care hospital beds without the requirement that participating rural hospitals meet all regulations normally required*…"[4] Additional hospitals were added to the project in 1976-1977 under the

[1] Begley, Sharon (2003). The swing-bed program. Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Volume VI. https://www.rwjf.org/en/library/research/2003/01/to-improve-health-and-health-care-volume-vi.html?cid=xsh_rwjf_em

[2] Richardson, H. & Kovner, A.R. (1987). Swing-beds: current experience and future directions. Health Affairs *6 (3).*

[3] Begley, Sharon (2003). The swing-bed program. Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care, Volume VI. https://www.rwjf.org/en/library/research/2003/01/to-improve-health-and-health-care-volume-vi.html?cid=xsh_rwjf_em

[4] Parrish, J., Turner, A. & Woeppel, M. (2016). Impact of Swing Beds. National Rural Health Association Policy Brief. Pg. 2. https://www.ruralhealth.us/getattachment/Advocate/Policy-Documents/NRHAImpactofSwingBedsPolicyPaperFeb2016-(1).pdf.aspx?lang=en-US

Reducing Acute Care Costs (RACC) project, bringing the total to eighty-two hospitals. HCFA funded four demonstration projects, all of which supported swing-bed as a cost-effective solution.[5] These demonstration projects led to legislation in 1980 establishing swing-bed programs.

In 1981, the Robert Wood Johnson Foundation and the Program in Health Policy and Management at New York University collaborated on a project to create Swing Bed models in rural hospitals. Eventually, the American Hospital Association (AHA) and other rural health associations joined the effort.[6] John Supplitt, AHA senior director for Rural Health Services, said that "*What inspired and drove Swing Beds was the patient-centered approach to care and the ability to coordinate that care at different levels."* Supplitt indicated that swing-beds were a way to maximize resources through inpatient to discharge to Swing Bed and address social determinants of health.[7]

Sources of Regulatory Requirements

Section 904 of The Omnibus Reconciliation Act of 1980[8] amended the Social Security Act to permit inpatient hospitals to furnish services that, if furnished by a skilled nursing facility, would be considered extended care services. The hospitals needed to be in rural areas, have less than 50 beds and be granted a certificate of need for the provision of long-term care services. Included in the Act was a stipulation that the Secretary of Health & Human Services could enter into an agreement, on a demonstration basis, with hospitals that had more than fifty beds. States were given the option of covering swing-bed services for intermediate care level patients under Medicaid.

The Act included a provision that "…*within three years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report evaluating the programs established by the amendments*…." The report was to include the effect and to what extent the programs had on long-term care services, whether the programs should be continued, the results of demonstration projects, and if the programs should be extended to other hospitals with greater than fifty beds and in urban areas.

In July of 1982, the regulations governing Medicare coverage for swing-bed hospitals were issued. The assumption was that the increased cost to hospitals to provide these services would be low considering they would use personnel, equipment and facilities that were already in place. However, hospital costs to the Medicare program began to rise and several measures were put into place to control these costs. These measures included The Tax Equity and Fiscal Responsibility Act (TEFRA), which restructured hospital reimbursement; the Social Security Amendments of 1983 that established the prospective payment system (PPS), and the Deficit Reduction Act (DEFRA) of 1984, reinstating reimbursement limits

[5] Parrish, J., Turner, A. & Woeppel, M. (2016). Impact of Swing Beds. National Rural Health Association Policy Brief. Pg. 2. https://www.ruralhealth.us/getattachment/Advocate/Policy-Documents/NRHAImpactofSwingBedsPolicyPaperFeb2016-(1).pdf.aspx?lang=en-US

[6] Miller-Temple, K. (2021a). History of the Swing Bed: a look through the rural rearview mirror. The Rural Monitor. https://www.ruralhealthinfo.org/rural-monitor/swing-bed-history/

[7] Miller-Temple, K. (2021b). Understanding the rural Swing Bed: more than just a reimbursement policy. The Rural Monitor. https://www.ruralhealthinfo.org/rural-monitor/swing-beds/

[8] Omnibus Reconciliation Act, H.R.7765 - 96th Congress (1979-1980): Omnibus Reconciliation Act of 1980. (1980, December 5). https://www.govinfo.gov/content/pkg/STATUTE-94/pdf/STATUTE-94-Pg2599.pdf

to both hospital-based and freestanding Skilled Nursing Facility (SNF) care that had previously been eliminated.[9] Health and Human Services contracted with the Center for Health Services Research at the University of Colorado to complete the study required by the Omnibus Reconciliation Act of 1980. The study was published in the Health Care Financing Review in the fall of 1988. Based on the report,[10] HCFA made the following recommendations:

- The rural swing-bed program should be continued.
- Eligibility should not be extended to urban hospitals.
- Current payment methodology should be continued.
- Ancillary services should continue to be reimbursed at cost.
- Hospitals furnishing more than 1,000 days of LTC to patients with stays of ≤60 days should meet the Conditions of Participation (CoPs) for SNFs.
- Consider extending the swing-bed option to larger hospitals with <100 beds.
- HCFA will:
    - Continue to monitor cost behavior of hospitals and nursing homes
    - Review current visit screens for physician services by place of service
    - Determine the need for surveys
    - Determine the feasibility of developing guidelines for acute to swing-bed transition

The Balanced Budget Act of 1997 created the Medicare Rural Hospital Flexibility Program which directed the state to designate at least one facility within the state as a critical access hospital if the facility met certain criteria. The law provided for the continuation of Swing Bed programs within critical access hospitals provided the number of beds used to provide either type of service did not exceed twenty-five beds.

[9] Silverman, H.A. (1990). Health Care Financing Note: Swing Bed services under the Medicare program, 1984-1987. Health Care Financing Review/Spring 1990 *11*(3)

[10] Shaughnessy, P. W., Schlenker, R. E., & Silverman, H. A. (1988). Evaluation of the national swing-bed program in rural hospitals. *Health care financing review*, *10*(1), 87–94

Figure 1 provides a timeline of regulations through the 1980s and 1990s that helped shape the Swing Bed program.

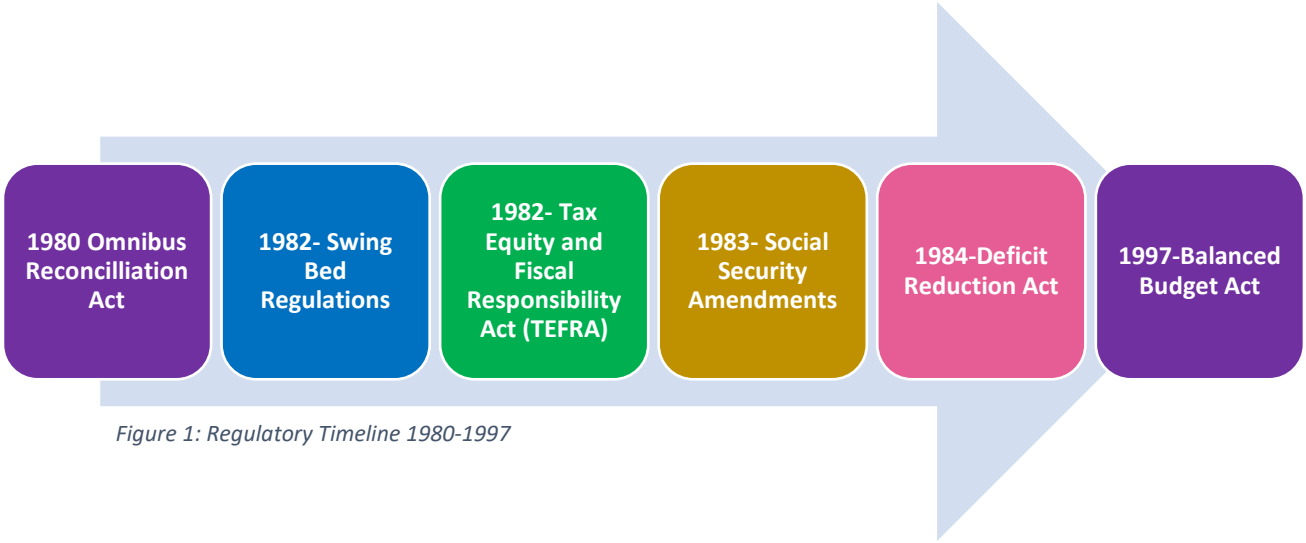

Figure 1: Regulatory Timeline 1980-1997

Between 2000 and 2020, Swing Bed programs continued to evolve into the programs seen today. The Benefits Improvement and Protection Act of 2000 established payment for CAHs on a reasonable cost basis. Other clarifications were provided within the Act to include the reimbursement of clinical diagnostic tests based upon a reasonable cost basis when the individual is an outpatient and hospitals must have a provider agreement in place to provide Medicare services in order to apply for a CAH designation.[11] The Medicare Modernization Act of 2003 established a cost-based reimbursement of 101% of reasonable costs for skilled nursing services provided in a critical access hospital.[12]

Final rules related to changes to the Medical Severity Diagnostic Related Groups (DRGs) were published in 2007. These modifications were an attempt to refine the diagnostic-related groups under the inpatient prospective system to recognize severity of illness. This included a structure of the MS-DRG system for the long-term care prospective payment system and their relative weights.[13]

The Improving Medicare Post-Acute Care Transformation Act of 2014 was a quality initiative that required Long-term Care Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Inpatient Rehabilitation Facilities to submit standardized data. The data included quality measures, patient assessment elements, and resource use. The Act required the information to be standardized and

[11] Health Care Financing Administration (HFCA). (2001). Medicare program; provisions of the benefits improvement and protection act of 2000. Available from https://www.federalregister.gov/documents/2001/06/13/01-14732/medicare-program-provisions-of-the-benefits-improvement-and-protection-act-of-2000-inpatient

[12] Public Law 108-173- H.R.1 Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (2003-2004). Summary H.R.1- 108th Congress (2003-2004). Available at https://www.congress.gov/bill/108th-congress/house-bill/1

[13] Medicaid Program: Prescription Drugs; Final Rule. 42 C.F.R. §447 (2017)

interoperable so that it could be easily shared among providers.[14] The intent was to "…*improve Medicare beneficiary outcomes through shared-decision making, care coordination, and enhanced discharge planning."* Swing Bed programs that are in non-CAH rural hospitals are subject to these requirements, while CAH Swing Bed programs are not. The SNF QRP [Quality Reporting Program] applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-CAH swing-bed rural hospitals."[15]

In March 2020, blanket waivers went into effect due to the impact of the 2019 Novel Coronavirus Disease (COVID-2019). These waivers were intended to allow healthcare providers to focus on containing the virus. Several of the waivers applied to Critical Access Hospitals and remained in effect at the time of publishing. The waivers apply to specific sections within the following areas. For up-to-date information related to the continuation or termination of these rules please refer to the CMS publication COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers available at https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf.

[14] Centers for Medicare & Medicaid Services (CMS). 2021. IMPACT Act of 2014 data standardization & cross setting measures. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures

[15] https://www.federalregister.gov/documents/2022/08/03/2022-16457/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

Chapter 2
Swing Bed Overview

Swing Beds
The Swing Bed concept allows a CAH to use its beds interchangeably for either acute care or post-acute care. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.

The Centers for Medicare & Medicaid Services (CMS) is clear that Swing Beds must not be confused with beds in a skilled nursing facility or nursing facility (NF) including a distinct section that SNF or NF that may share the same building or campus. The CAH is a separately certified provider with its own Medicare provider agreement.[16]

A CAH with Medicare Swing Bed approval may use any of its inpatient beds for either inpatient or skilled nursing level services. However, some states limit the number of Swing Beds.

Location
Swing Beds are not required to be in a special or distinct section of the CAH and the patient does not need to physically change beds when they transition from an acute level of care to a skilled level of care in a Swing Bed.[17]

Admission
Discharge orders from acute care and admission orders to Swing Bed are required. The same clinical record may be used, but it must include discharge orders from acute care, admission orders to Swing Bed, and the Swing Bed services must be clearly delineated within the clinical record.[18]

Many facilities choose to open a new medical record to ensure that the acute care stay, and Swing Bed stay are kept separate.

Length of Stay
If the patient meets skilled criteria, there is no length of stay restrictions for Medicare Swing Bed patients.[19] However, the CMS' Conditions of Participation (CoPs) state that although there is no length of stay limit for patients in Swing Bed, the intended use of Swing Beds is for a transitional time to allow the patient to fully recover to return home or while awaiting placement into a nursing facility.[20]

Other payors typically authorize a specific number of days.

[16] Appendix W C-1600 §485.645
[17] Appendix W C-1600 §485.645
[18] Appendix W C-1600 §485.645
[19] Appendix W C-1600 §485.645
[20] Appendix W C-1600 §485.645

Medicare Swing Bed Benefit

The Medicare Swing Bed benefit includes 100 days of skilled care per benefit period. There is a co-pay from days 21 – 100 and the patient is responsible for all costs after day 100.[21]

The Medicare General Information, Eligibility, and Entitlement Manual (Chapter 3, Deductibles, Coinsurance Amounts and Payment Limitations) outlines when a lapse in care requires a new benefit period. Essentially, Medicare will not cover additional skilled days if the break in skilled services was more than 30 days unless there is a new 3-day hospital stay.

Transfer Agreements

There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.

Reimbursement

Swing Bed is a skilled nursing level of service. CAHs are exempt from the SNF PPS requirements under the Benefits Improvement and Protection Act of 2000 and the Medicare Modernization Act of 2003 and are paid 101 percent of reasonable costs. Swing Bed patients receive a skilled nursing facility level of care, and the CAH is reimbursed for providing a skilled nursing facility level of care. CAHs are not required to complete a Resident Assessment Instrument (RAI) which is required for Swing Bed patients in an acute care (PPS) hospital or SNF.

Payors other than traditional Medicare, including Medicaid, pay at a rate established by the payor.

Policies and Procedures

Policies and Procedures (P&Ps) establish the framework for the Swing Bed program and standardize processes. CAHs are required to review existing P&Ps at least every two years. The review must include members of the CAH's professional healthcare staff including one or more Doctor of Medicine or Osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff.

P&Ps must be reviewed and revised more frequently when required, for example in response to a change in Federal or State regulations. The final decision on the content of the written policies must be made by the CAH's governing body or individual responsible for the CAH.[22]

The P&Ps include references to both Appendix W and Appendix PP. A separate policy is not needed for each regulatory requirement, but each element should be assessed. Hospitals will also have organizational policies that apply to Swing Beds. For those requirements that apply only to Swing Bed the policies should not be combined with other facility policies.

Appendix 1:

- Swing Bed Policy & Procedure Checklist
- Other Hospital Policies Checklist

[21] https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
[22] Appendix W C-1008 §485.635(a)(2)

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SECTION 2

Regulatory Requirements

Chapter 3
Regulatory Requirements

Substantial Compliance

Critical Access Hospitals providing Swing Beds must be in substantial compliance with the Conditions of Participation. A list of patient rights is included in Appendix 5 as part of the Swing Bed Admission Packet.

- Patient Rights: §485.645(d)(1), §483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d)(1-5), (e)(2), (e)(4), (f)(4)(ii-iii), (g)(8)(i-ii), (g)(17)(i-ii), (g)(18), (h)(1-3)
- Admission, transfer, and discharge rights: §483.5 definition of transfer & discharge, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), (c)(9)
- Freedom from abuse, neglect, and exploitation: §483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), (c)(4)
- Social Services: §483.40(d)
- Comprehensive assessment, comprehensive care plan, and discharge planning requirements: §485.645(d)(5), §483.20(b)(1-2), §483.21(b)(1-3), §483.21(c)(2)

  CAHs are not required to use the Resident Assessment Instrument (RAI) §483.20(b) or comply with frequency, scope, and number of assessments §413.343(b).
- Specialized rehabilitation services: §485.645(d)(6), §483.65(a)(1-2)
- Dental services: §485.645(d)(7), §483.645(d)(7), §483.55(a),(2),(3),(4),(5),(b)
- Nutrition: §485.645(d)(8), §483.25(g)(1-2)

For hospitals that are surveyed by the Center for Improvement in Healthcare Quality (CIHQ), DNV GL Healthcare (DNV), Healthcare Facilities Accreditation Program (HFAP) or, The Joint Commission (TJC), Swing Bed regulatory requirements are incorporated in the standards of the deeming organization. However, when CMS makes changes to the CoPs, they are not always included right away in the deeming organization's manual, so it is important to stay current with CMS changes.

State Operations Manual Appendix W

The Critical Access Hospital Swing Bed requirements in the State Operations Manual begin at C-1600. The CoPs, except for those related to admission criteria, continued stay and payment, apply to all payors including Medicare Advantage Plans, Medicaid, and other third-party payors. The table of contents (TOC) is included in Appendix 2.

There are no Interpretive Guidelines or Survey Procedures for Swing Bed in Appendix W, only a statement, "*Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines."* A similar statement is included for Survey Procedures, "*Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures*." Unfortunately, the crosswalk between Appendix W and Appendix PP is not always straight-forward and can be difficult to navigate.

Appendix 2: Table of Contents for Appendix PP
Appendix 3: Crosswalk for State Operations Manual Appendix W and Appendix PP

State of Montana Administrative Rules

The State of Montana publishes administrative rules (ARM) for hospitals that provide Swing Bed services. The index is included in Appendix 2.

Many of the Montana requirements for Swing Bed are the same as the CMS requirements, but there are several significant differences including:

- Preadmission screening to determine the level of care is required for Medicaid patients using form DPHHS-SLTC-61. 37.40.405(1)(a)
- Except when a waiver is in place, and when there is no appropriate nursing facility bed available within a 25-mile radius, discharge to an appropriate nursing home with a bed within a 25-mile radius within 72 hours of an appropriate bed becoming available. 37.40.405(1)(b) and (2)
- An ongoing program of activities directed by a qualified professional. CMS no longer requires a formal activities program. 37.40.412 (1-3)
- Patient Rights that are not included in Appendix W but are in Montana ARM include:
    - Right to refuse to perform services. 37.40.416 (6)(a)
    - Receive compensation if services are performed. 37.40.416 (6)(b)
    - Right to be informed in writing of the policies and procedures developed by the facility. 37.40.416 (13)

Medicare Benefits and Claims Processing Manuals

Most of the requirements related to Swing Bed admission and continued stay criteria, as well as rules regarding eligibility and billing are included in four Medicare manuals:

- Medicare Claims Processing Manual Chapter 3 - Duration of Covered Inpatient Services (Rev. 261; Issued: 10-04-19)
- Medicare Claims Processing Manual Chapter 4 - Benefits and Beneficiary Protections (Rev. 121, Issued: 04-22-16)
- Medicare Claims Processing Manual Chapter 6 - Hospital Services Covered Under Part B (Rev. 10541, 12-31-20)
- Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 10880; Issued: 08-06-21)

The Medicare Benefits Policy Manual Chapter 8 includes information related to admission criteria, continued stay and many examples of skilled care. The table of contents is included in Appendix 2.

Chapter 4
Swing Bed Criteria

Criteria for admission and continued stay in the Medicare Benefits Manual Chapter 8 are Medicare specific. They do not apply to Medicare Managed Care Plans, Medicaid, or other third-party payors. Montana criteria for Swing Bed are published in the ARM at 37.40.202, 37.40.205, 37.40.405, and 37.40.420.

Medicare Swing Bed Criteria

The Medicare Benefits Manual, Chapter 8, Section 30.2.1 includes criteria for admission to Swing Bed for patients with traditional Medicare. The patient can only be admitted for skilled nursing care if all the following four factors are met. If any of the four factors are not met, the stay, even though it might include the delivery of some skilled services, is not covered.[23]

1. The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services.

The Medicare Benefits Manual clarifies that general supervision requires initial direction and periodic inspection of the actual activity. However, the supervisor must not always be physically present or on the premises. This primarily applies when a physical therapist or occupational therapist completes the assessment and treatment plan, and a Physical Therapy Assistant (PTA) or Certified Occupational Therapy Assistant (COTA) provides therapy. Periodic inspection is not defined. However, the timeframes should be appropriate to review the patient's progress towards goals and establish new goals if applicable.

2. The patient requires these skilled services on a daily basis.

Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis."

The Medicare Benefits Manual clarifies that for a patient whose stay is based solely on the need for skilled rehabilitation services, the daily requirement would be met when the patient needs and receives those services at least five days a week. However, the Medicare Benefits Manual Chapter 8, 30.6 also states, "*This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical*."[24]

[23] Medicare Benefits Manual Chapter 8, 30.0
[24] Medicare Benefits Manual Chapter 8, 30.6

3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

Part of the preadmission process is to determine if services can be provided as an outpatient rather than inpatient. Medicare Benefits Manual, Chapter 8 clarifies when the patient may qualify for Swing Bed care even though the services are available on an outpatient basis, including if transportation to the closest facility would be an excessive physical hardship, less economical, or less efficient or effective than an inpatient setting. The lack of effective home care can also be considered.[25]

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 are accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

The Medicare Benefits Manual, Chapter 8 clarifies that the frequency of rehabilitation services must be based on the patient's needs, but at least five days per week[26]. However, that is the minimum and therapy must be based on the patient's clinical needs. If the patient needs physical therapy (PT) twice per day, it must be provided at that frequency at least five days a week. If the patient requires speech therapy, including a swallow exam, then that service must be available.

Additional Medicare Criteria

There are additional criteria required by Medicare for Swing Bed admission.[27]

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.*
   The inpatient stay commences with the calendar day of hospital admission. Time in observation does not count towards the qualifying stay.

4. *A hospital-related medical condition treated during the qualifying 3-day inpatient hospital stay, even if it wasn't the reason the patient was admitted to the hospital.*
   To be covered, the Swing Bed admission must have been for the treatment of a condition for which the patient was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in a SNF for treatment of a condition for which the beneficiary was previously hospitalized.

5. *Admitted to Swing Bed within thirty days of discharge from acute care.*

[25] Medicare Benefits Manual Chapter 8, 30.7
[26] Medicare Benefits Manual Chapter 8, 30.6
[27] Medicare Benefits Manual Chapter 8, 30.0

Medicare Benefits Manual, Chapter 8, Section 20.2.2 states that more than 30-days is permitted in cases where the patient's condition makes it medically inappropriate to begin an active course of treatment immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he or she will require covered care within a predeterminable time.

6. *The patient's condition meets criteria to necessitate inpatient skilled nursing services.*

Definitions of Skilled Care

The Medicare Benefits Manual, Chapter 8 includes the following definition of skilled care:

> *"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. 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."*[28]

Skilled Nursing

The Medicare Benefits Manual, Chapter 8 defines skilled nursing care as follows:

> *"Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse.*
>
> *Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse are necessary.*
>
> *Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided, and all other requirements for coverage under the SNF benefit are met.*
>
> *Coverage does not turn on the presence or absence of an individual's potential for improvement from nursing care, but rather on the beneficiary's need for skilled care. A condition that would not ordinarily require skilled nursing services may nevertheless require them under certain circumstances. In such instances, skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services."*[29]

[28] Medicare Benefits Manual Chapter 8, 30.2.2
[29] Medicare Benefits Manual Chapter 8, 30.3

Skilled Rehabilitation

The Medicare Benefits Manual, Chapter 8 requires that skilled physical therapy services meet all of the conditions listed below.

> *"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 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.*
>
> *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 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."*[30]

The requirements for speech and occupational therapy are not as specific as physical therapy. They can be found at Sections 30.4.2 and 30.4.3 respectively.

Maintenance Therapy

Medicare Benefits Manual, Chapter 8, Section 30.4.1 clearly states that 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.[31]

Diagnosis or Prognosis

When considering a patient for admission, it is important not to look only at the diagnosis or prognosis but if the patient will benefit from skilled care. Medicare Benefits Manual, Chapter 8 states,

[30] Medicare Benefits Manual Chapter 8, 30.4.1.1
[31] Medicare Benefits Manual Chapter 8, 30.4.1.2

> "*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…A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient."*[32]

Examples of Skilled Care

The following table includes categories and examples of skilled care from the Medicare Benefits Manual, Chapter 8. However, please note that the overall definitions of skilled care still apply, and the examples should not be viewed in isolation of being provided, "*under the general supervision of skilled nursing or skilled rehabilitation personnel."*[33]

Table 1. Examples of Skilled Care

Examples of Skilled Care
Teaching and Training Medicare Benefits Manual, Chapter 8, Section 30.2.3.3
1. Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen. 2. Teaching self-administration of injectable medications or a complex range of medications 3. Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and s observe foot-care precautions. 4. Teaching self-administration of medical gases to a patient. 5. Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation. 6. Teaching patients how to care for a recent colostomy or ileostomy. 7. Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings. 8. Teaching patients how to care for and maintain central venous lines, such as Hickman catheter. 9. Teaching patients the use and care of braces, splints and orthotics, and any associated skin care. 10. Teaching patients the proper care of any specialized dressings or skin treatments.
Management and Evaluation of a Patient Care Plan Medicare Benefits Manual, Chapter 8, Section 30.2.3.1
1. Care of patient with pneumonia with multiple co-morbid conditions, debilitated, lethargic, disoriented, and with residual chest congestion. 2. Care of patient with history of diabetes and angina recovering from hip fracture. Requires careful skin care, medications, diabetic diet, therapeutic exercise program and observing to notice signs of deterioration or complications resulting from restricted mobility.

[32] Medicare Benefits Manual Chapter 8, 30.2.2
[33] Medicare Benefits Manual Chapter 8, 30.2.2

Observation and Assessment of Patient's Condition Medicare Benefits Manual, Chapter 8, Section 30.2.3.2
1. Close observation / monitoring of vascular supply of legs of patient who has undergone peripheral vascular disease treatment including revascularization. 2. A patient with congestive heart failure who may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures.
Direct Skilled Nursing Care Medicare Benefits Manual, Chapter 8, Section 30.3
1. IV or IM injections and intravenous feeding. 2. Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day. 3. Nasopharyngeal and tracheotomy aspiration. 4. Insertion, sterile irrigation, and replacement of suprapubic catheters. 5. Application of dressing involving prescription medications and aseptic techniques. 6. Treatment of decubitus ulcers, of a severity rated at State 3 or worse, or a widespread skin disorder.
Skilled Rehabilitation Medicare Benefits Manual, Chapter 8, Section 30.4.1.1
1. Assessment of patient's rehabilitation needs and potential. 2. Strengthening post-surgical or post-hospitalization. 3. Therapeutic Exercises. 4. Gait Training. 5. Wheelchair mobility. 6. Range of Motion. 7. Therapy to prevent deterioration or to develop maintenance program. 8. Self-Care skills (i.e., bathing, dressing, toileting). 9. Speech therapy, including oral motor/speech functions, and language/communication. 10. Swallow and dysphagia exams.

Non-Skilled Care

The Medicare Benefits Manual, Chapter 8 provides multiple examples of what is considered non-skilled care. However, CMS does allow a service that is ordinarily regarded as nonskilled to be skilled when because of special medical complications, skilled personnel are required to perform or supervise the service or to observe the patient.

Table 2: Examples of Non-Skilled Care

Examples of Non-Skilled Care Medicare Benefits Manual, Chapter 8, Section 30.5
1. Administration of routine oral medications 2. General maintenance care of colostomy and ileostomy 3. Routine services to maintain functioning of bladder catheters 4. Change of dressing for uninfected post-operative or chronic conditions 5. Prophylactic and palliative skin care 6. Routine care of the incontinent patient 7. Routine care in connection with braces and similar devices 8. Use of heat as a palliative and comfort measure, such as whirlpool or steam pack 9. 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) 10. Assistance in dressing, eating, and going to the toilet 11. Periodic turning and positioning in bed 12. 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

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

SECTION 3

Admission
Continued Stay
Discharge

Chapter 5
Pre-Admission

Referrals for Swing Bed can come from another hospital or in the same hospital where the patient is receiving acute care. Ideally, if the patient is an inpatient at your hospital, the interdisciplinary team and the provider have already discussed the potential for Swing Bed admission.

Internal Admission Criteria

The first step in determining whether a patient can be accepted or not accepted is to review your facility admission criteria. The criteria should be developed and approved by the Swing Bed interdisciplinary team. An example of admission criteria is provided in the table below.

Table 3: Example Hospital Swing Bed Admission Criteria

Example Hospital Swing Bed Admission Criteria	

Payors:
Will consider all patients with Medicare, Medicare Advantage, Medicare / Medicaid, or other private payors.
 	
Patients with the following care needs can be accepted:
• Physical Therapy
• Occupational Therapy
• Speech Therapy
• IV Antibiotics
• Wound Care
• Education / Training
  o Diabetic teaching
  o Care of colostomy
  o Complex medication management
  o Monitoring signs & symptoms (weight, blood pressure, etc.)
• Tube Feedings / PEG
	Patients with the following diagnosis can be accepted:
	• Weakness / Failure to Thrive / Weight Loss
	• Orthopedics (Fractures, Post-Surgery)
	• Post-Stroke
	• CHF
	• Pneumonia
	• Covid-19
	
	Patients with the following care needs will be reviewed on a case-by-case basis:
	• Dialysis (incidental to other reason for admissions) only if patient is sufficiently mobile to be transported by family in private car or by public transportation.
	• TPN – IF pre-made from manufacturer
	
	Patients with the following care needs cannot be accepted:
	• Ventilator dependent
	• Pediatrics
	• Severe or unmanaged mental illness
	• History of violent behavior

If there are questions about accepting the patient, a good strategy is to ask, "*How can we accept this patient?*" rather than "*We can't accept this patient*." Or "*How can we accept this type of patient in the future?*"

Eligibility and Payor Authorization

Medicare admission criteria are published in the Medicare Benefits Manual, Chapter 8. Criteria for Medicaid patients are published by each state. The State of Montana requires pre-approval for Medicaid patients.

For other payors, payor authorization will be needed once you have determined that you can meet the patient's care needs.

Pre-Admission Checklist

Using a pre-admission checklist can help develop a comprehensive picture of the patient and their needs.

If possible, ask to speak to the provider or staff taking care of the patient to make sure the patient is, in fact, over the acute phase of their illness and is ready for discharge to skilled care. If the patient is still in the acute phase of their hospitalization, the chances are that readmission to acute care will occur.

Appendix 4: Pre-Admission Checklist Example

Admission Decision

Although it is ideal to include the participation of the interdisciplinary team in deciding if the patient will be accepted, some hospitals who have developed robust admission criteria, require only the concurrence of the provider after the initial review by the Case Manager or Swing Bed Coordinator.

Reducing the time from referral to patient acceptance is particularly important because most acute care hospitals want to discharge the patient as soon as possible once the patient no longer has an acute care need. Assuming the patient agrees of course, the acute care hospital will typically choose the hospital that responds first to a referral!

Sometimes the care team may feel that a patient would benefit from a Swing Bed stay, but the patient is not interested and wants to go home. Although the care team can certainly provide information about the benefits of a Swing Bed admission, it is the patient's decision.

If the patient is being referred from another acute care hospital, try to speak to the patient before the admission. This allows you to provide information about your Swing Bed program including expectations, but also to ensure the patient is interested in Swing Bed.

Choice of Post-Acute Providers

In September of 2019, the Centers for Medicare & Medicaid Services (CMS) published the Burden Reduction and Discharge Planning Final Rules Guidance and Process.[34] The requirements include providing the patient with a choice of post-acute care providers including providing quality and resource data so that the patient can make an informed decision. This applies to Critical Access Hospitals who admit a patient to Swing Bed that was an acute care patient in the hospital.

> 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."*
>
> Federal Register: *"Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC 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. We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process."*

There was additional information published in the Federal Register clarifying that the requirement applies to patients in the CAH who may be appropriate for Swing Bed.

> Comment: *"One commenter stated that the requirement to utilize data on quality measures and data on resource use measures could be utilized to discourage the use of CAH Swing Beds in rural communities. Since the CAH Swing Bed program does not have to report data on its performance, referring facilities will list CAH Swing Bed on their referral list delivered to patients, but would have no data to include on the list. The commenter suggested that we require referring facilities to note on their discharge provider list that CAH Swing Beds are not required to report data similar to freestanding SNFs."*
>
> Response: *"The CAH's responsibility is to advise and assist patients with their choices based on quality data and the patient's goals of care and treatment preferences. As such, we do not believe that any provider will be disadvantaged with this requirement."*

For Skilled Nursing Facilities (SNF) quality and resource data is published on Care Compare (https://www.medicare.gov/care-compare/). The information is not organized as quality and resource use measures. Resource use is typically defined as spending per beneficiary and preventable readmissions. Quality measures are generally related to care processes and outcomes, including functional status, skin integrity, falls or injuries, cognitive function, and medication management. It is

[34] Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

important to note that out of the seventeen indicators listed on Care Compare, six of the seventeen (35%) are related to improvements in functional status.

An example of the information that is available on Care Compare can be found on Table 4.

Quality and Resource Use Measures for Swing Bed

There are no publicly available data for Swing Bed. However, every CAH should be collecting quality and resource use measures and sharing those with patients who need Swing Bed care along with other providers of SNF care. Information about Swing Bed measures are included in Section 6.

Table 4: Example Nursing Home Compare

Example Nursing Home Compare
Overall Rating – 5 STARS The overall rating is based on a nursing home's performance on three sources: health inspections, staffing, and quality of resident care measure
Short Stay Quality of Resident Care – 5 STARS The short-stay quality of care rating reflects the quality of care delivered to temporary residents, and whose typical goal is to improve their health status so they can return to their previous setting, like their home. • Percentage of short-stay residents who were re-hospitalized after a nursing home admission • Percentage of short-stay residents who have had an outpatient emergency department visit • Percentage of short-stay residents who got antipsychotic medication for the first time • Percentage of residents with pressure ulcers/pressure injuries that are new or worsened • Percentage of short-stay residents who improved in their ability to move around on their own • Percentage of short-stay residents who needed and got a flu shot for the current flu season • Percentage of short-stay residents who needed and got a vaccine to prevent pneumonia • Percentage of residents whose medications were reviewed and who received follow-up care when medication issues were identified • Percentage of SNF residents who experience one or more falls with major injury during their SNF stay • Percentage of SNF residents whose functional abilities were assessed, and functional goals were included in their treatment plan • Percentage of residents who are at or above an expected ability to care for themselves at discharge • Percentage of residents who are at or above an expected ability to move around at discharge • Change in residents' ability to care for themselves • Change in residents' ability to move around • Rate of a successful return to home and community from a SNF • Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF • Medicare Spending Per Beneficiary (MSPB) for residents in SNFs

Staffing – 5 STARS
Higher staffing levels in a nursing home may mean a higher quality of care for residents. Staffing hours of different types of staff are reported by nursing homes and are used to calculate a ratio of staffing hours per resident per day.

The staffing rating is based on these measures:
1) Registered Nurse (RN) hours per resident per day; and 2) total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day

- Average number of residents per day
- Total number of licensed nurse staff hours per resident per day
- Registered Nurse hours per resident per day
- LPN/LVN hours per resident per day
- Nurse aide hours per resident per day
- Physical therapist staff hours per resident per day

Chapter 6
Physician Certification

Physician Certification
The Medicare Benefits Manual Chapter 8, Section 40, states that payment for covered post-hospital extended care services may be made only if a physician or physician extender certifies that the patient:

- *"Requires daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition); and*
- *Will require skilled care on a daily basis which as a "practical matter," can only be provided in a SNF on an inpatient basis."*[35]

CMS defines as a practical matter to mean," *If daily skilled services can be provided only in a SNF or if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:*

- *An excessive physical hardship;*
- *Less economical; or*
- *Less efficient or effective than an inpatient institutional setting"*[36]

Timing of Initial Certification
Certification must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. CMS is clear that the routine admission order established by a physician is not a certification of the necessity for post-hospital extended care services. There must be a separate signed statement indicating that the patient will require on a daily basis skilled level care.[37]

Certification Format
There is no requirement for a specific format for the certification. Medicare Benefits Manual, Chapter 8 states, "*Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form*."[38]

Many hospitals develop a separate form or incorporate a form into the electronic medical record (EMR) to ensure that the certification is not missed. An example of a certification and recertification form are included on the next page.

[35] Medicare Benefits Manual Chapter 8, 40.0
[36] Medicare Benefits Manual Chapter 8, 30.7
[37] Medicare General Information, Eligibility, and Entitlement Chapter 4, 40.2
[38] Medicare Benefits Manual Chapter 8, 40.0

Table 5: Example Physician Initial Certification

Example Physician Initial Certification	
Patient Name	Admission Date
Reason for Admission	
Goals for Admission	
Expected Length of Stay	
Admission to Swing Bed is for the same conditions for which the patient received inpatient hospital services ☐ Yes ☐ No (if no, please explain)	
I certify that services are required to be given on a daily basis which, as a practical matter can only be provided in a Swing Bed or skilled nursing facility.	
Physician Signature	**Date and Time**

Recertification

The first recertification is required no later than the 14th day. Subsequent recertifications must be made at intervals not exceeding 30 days. The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated timeframe required for the patient to remain in the facility, and any plans, where appropriate, for home care. CMS states that the recertification statement does not have to include this entire statement if, for example, all of the required information is included in progress notes. However, CMS also says that a statement that only states that continued extended care services are medically necessary is not, in and of itself, sufficient.[39]

Table 6: Example Physician Recertification

Example Physician Recertification	
Patient Name	Admission Date
Reason for Continued Stay	
Expected Length of Stay Discharge Plan, including plan for home care if applicable	
Physician Signature	**Date and Time**

[39] Medicare General Information, Eligibility, and Entitlement Chapter 4, 40.3 and 40.4

Chapter 7

Patient Required Disclosures and Patient Information

CMS requires certain disclosures to be provided at the time of admission, or as soon as possible after admission. The information is generally provided as part of a Swing Bed admission packet. Other patient disclosures such as the Conditions of Admission and Consent to Treat, are generally provided by admitting staff.

The admission packet typically includes the following information, including a patient signature page.

- Overview of Swing Bed Program
- Patient Rights and Responsibilities
- Advance Directives
- Financial Obligations
- Choice of Physicians
- Contact information for physician and primary care providers
- Dental Services
- Visitation Policy
- Privacy and Confidentiality
- Abuse, Neglect, Exploitation and Misappropriation of Property
- How to file a Grievance or Complaints
- Contact Information for state licensing agency, and regional or state Ombudsman

Overview of Swing Bed Program

Although not required by CMS, an overview and description of the Swing Bed program is a way to provide patients and their families with information about your program. Include information about visitors, provider visits, care conferences, activities, as well as patient expectations such as participating in the development of the plan of care. An example of a Swing Bed brochure can be found on the National Rural Health Resource Center web site.[40]

Appendix 5: Sample Admission Packet

Patient Rights and Responsibilities

The patient rights for Swing Bed are not the same as those for hospitals or long-term care. In addition to the Swing Bed rights published by CMS, Montana ARM includes several additional patient rights including:

- Right to refuse to perform services. 37.40.416*(6)(a)*

[40] Swing Bed Campaign | National Rural Health Resource Center (ruralcenter.org) https://www.ruralcenter.org/drchsd/communications-toolkit/swing-bed

- Receive compensation if services are performed. 37.40.416*(6)(b)*
- Right to be informed in writing of the policies and procedures developed by the facility. 37.40.416*, 13*

The patient rights must be reviewed verbally with the patient (or representative) in a language and manner in which they can understand. Although some facilities have the nursing staff provide the admission packet and review the information with the patient, in most organizations it is the responsibility of the Swing Bed Coordinator or Case Manager.

Advance Directives

The admission process must include a review of advance directives, and documentation related to that review included in a prominent part of the patient's medical record.[41]

C-0812 §489.102 requires the facility to provide written notice of its advance directive policies including the right of the patient to make decisions concerning medical care and the right to formulate an advance directive. §489.102(e) and §489.102(b)(1) require that the notice of the advance directive policy be provided at the time an individual is admitted as an inpatient (which includes Swing Bed). The notice must include a clear and precise statement of limitation if the CAH cannot implement an advance directive on the basis of conscience. At a minimum, a statement of limitation should:

- Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians or other practitioners;
- Identify the State legal authority permitting such an objection; and
- Describe the range of medical conditions or procedures affected by the conscience objection.

If there is a No Code or Do Not Resuscitate Order, the provider must document the discussion with the patient in the medical record prior to writing an order, even if the patient has an Advance Directive.

Financial Obligations

C-1608 §483.10(g)(17) and C-1608 §483.10(g)(18) require disclosure of financial obligations to patients with Medicare and Medicaid.

Disclosure includes informing Medicaid eligible patients, in writing, at the time of admission and when the patient becomes eligible for Medicaid of the items and services included under the State plan for which the patient may not be charged and those services that the patient may be charged including the amount of the charges. The information can be found on the Medicaid website for each state.

In addition, for both Medicare and Medicaid, the facility must inform each patient before, or at the time of admission, and periodically during the stay, of services available in the facility and the charges for those services, including any charges for services not covered under Medicare and Medicaid or by the facility's per diem rate.

[41] Appendix W C-0812 §489.102

Disclosure of financial information includes informing Medicare patients of the co-pay for days 21 – 100 and responsibility for all costs after day 100. The co-pay changes every year in January. For 2023. Medicare has set the co-pay for days 21 – 100 at $200 per day.[42] Although some patients may have secondary insurance that will cover some or all of the co-pay, informing the patient of the co-pay amount is still required.

Choice of Physician and Provider Contact Information

Patients have a right to choose their attending physician. If the physician chosen by the patient is unable or unwilling, the facility must inform the patient and determine if the patient would like to choose another physician. The physician must be a member of the medical staff.

In addition, the facility must ensure that each patient remains informed of the name, specialty, and way of contacting the attending physician and other primary care practitioners responsible for his or her care. This would include any physician assistants or nurse practitioners, as well as covering physicians.[43]

For facilities that have a hospitalist group, or specific providers that care for Swing Bed patients, it is admissible to disclose that information to the patient. However, the patient must still be given the option to choose another physician on the medical staff.

Dental Care

Appendix W C-1624 §483.55(a)(2-5) and (b) outline responsibilities for dental care. The facility must assist patients with appointments and transportation.

A referral to a dentist is required within 3-days for lost or damaged dentures. In addition, interventions must put in place (and documented) to ensure adequate nutrition and hydration is provided while waiting for dental care. In addition, a dietician assessment should be completed for any patient waiting for dental care.

The facility is also required to have a policy identifying when the loss or damage of dentures is the facility's responsibility.

Visitation Policy

Subject to appropriate restrictions, such as an infectious disease outbreak, the patient has the right to 24-hour access by any visitor of their choice. You may want to ask the patient for a list of individuals they wish to have visit during their Swing Bed stay, especially if they are not immediate family members.[44]

[42] https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
[43] Appendix W C-1608 §483.10(d)
[44] Appendix W C-1608 §483.10(f)(4)(iii)

Privacy and Confidentiality

A statement of the organization's privacy and confidentiality policies should be included in the admission packet.

Abuse, neglect, exploitation, and misappropriation of property

Include information about the facility policy for preventing abuse as well as information about how to report any potential incidents.

The general hospital policy for recognizing and reporting abuse is most often not adequate, as it does not cover the specific reporting requirements and timelines required for Swing Bed. Chapter 11 includes additional information.

Grievance or Compliant

Information about filing both an internal and external grievance or complaint must be included and should include contact information for the Risk Manager and for both the State Licensing Agency and the Ombudsman.

Contact Information

A list of names and phone numbers is recommended for select staff including Case Management, Discharge Planning and Risk Management. You may also want to include the CEO, CNO, and Nursing Manager.

Chapter 8

Admission Assessment

Admission Assessment Timeframe

The CoPs state that the admission assessment must be completed within 14 days of admission. However, the timeframe does not apply to Critical Access Hospitals.[45] To be appropriate for the length of stay in a Swing Bed of approximately 12 – 15 days, the admission assessment should be completed within 48 hours of admission which then allows the multi-disciplinary plan of care to be developed as early as possible in the Swing Bed stay.

The maximum length of time for each discipline to complete their assessment is recommended at no more than 72 hours, if necessary to span a weekend.

Admission Comprehensive Assessment

The CoPs require a comprehensive assessment that includes an assessment of a patient's needs, strengths, goals, life history and preferences including:[46]

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. History of trauma
8. Psychosocial well-being
9. Physical functioning and structural problems
10. Continence
11. Disease diagnoses and health conditions
12. Dental
13. Nutritional status
14. Skin condition
15. Activity pursuit
16. Medications
17. Special treatments and procedures
18. Discharge planning

[45] Appendix W C-1620 §413.343(b)
[46] Appendix W C-1620 §485.645(d)(5)

Additional components that are required include: 1) assessment of culture and trauma (culturally competent trauma-informed care),[47] and 2) review of the Preadmission Screening and Resident Review (PASRR)[48] if the patient has one in place.

The assessment process must include direct observation and communication with the patient, as well as communication with licensed and non-licensed direct care staff members on all shifts.[49]

The assessment categories are relatively general. Appendix 6 includes recommended assessment elements within each category. A cognitive assessment tool is included in Appendix 7, although this type of in-depth assessment is usually not appropriate for a Swing Bed patient.

C-1620 §485.645(d)(5) states that the CAH is not required to use the resident assessment instrument (RAI), or to comply with the requirements for frequency, scope, and number of assessments. It is strongly recommended that the CAH assess each of the eighteen (18) elements.

Assessment Responsibility

The comprehensive assessment does not need to be completed solely by nursing. It is appropriate to assign each assessment category to the discipline with the appropriate expertise and knowledge. For example, assign the nutrition assessment to the dietician, physical functioning to physical therapy, cognition and behavior to social work or case management, and disease diagnoses and health conditions to the provider.

Reassessment

If there is a significant change in physical or mental condition a reassessment is required. CMS defines a significant change as 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.*"[50]

Appendix PP has additional information regarding the definition of a significant change.
"A significant change may include, but is not limited to, any of the following, or may be determined by a MD/DO 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.*

[47] Appendix W C-1620 §483.21(b)(iii)
[48] Appendix W C-1620§483.21(b)(ii)(1)
[49] Appendix W C-1620 §483.20(b)
[50] Appendix W C-1620 §483.20(b)(ii)

- *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)."*[51]

[51] Appendix PP F-637 §483.20(b)(2)(ii)

Chapter 9

Multi-Disciplinary Plan of Care

The Multi-Disciplinary Plan of Care is the roadmap for the care provided during a patient's stay for both the care team and the patient. The requirements for the Plan of Care are found in Appendix W, *C-1620 §483.21(b)* and Appendix PP.

Baseline Plan of Care

Appendix PP requires that a baseline Plan of Care be developed within 48 hours of admission. Remember that Appendix W does not have Interpretive Guidelines and refers to Appendix PP.

> "*The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary.*
>
> *Baseline care plans are required to address, at a minimum, the following: Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social Services, PASRR recommendation, if applicable."*[52]

Scheduling the Multi-Disciplinary Care Plan Meeting

As soon as possible after admission, the first Multi-Disciplinary Care Plan Meeting should be scheduled. With an average length of stay of only 12 -15 days, the meeting should be scheduled within 72 hours of admission and sooner if possible. If Care Plan meetings are only scheduled once per week, an additional care planning meeting should be scheduled for any new patients.

Scheduling the meeting so that the Care Team, provider, and the patient can attend is often challenging. The time of day will vary by facility but communicating the importance of the meeting and requesting leadership support may sometimes help. In some facilities the CEO, CFO, or CNO attend the meetings, which reinforces the importance.

Appendix PP includes language regarding scheduling the meeting relative to the patient.

> "*…staff support and encourage participation in the care planning process. This may include ensuring that residents, families, or representatives understand the comprehensive care planning process, holding care planning meetings at the time of day when a resident is functioning best, providing sufficient notice in advance of the meeting, scheduling these meetings to accommodate a resident's representative (such as conducting the meeting in-person, via a conference call, or video conferencing), and planning enough time for information exchange and decision making".*[53]

[52] Appendix PP F-655 §483.21(b)(3)
[53] Appendix PP §483.10(c)(2)(3)

Required Attendance

C-1620 §483.21(b) requires the following disciplines to develop the Multi-Disciplinary Plan of Care:

- Attending physician
- Registered nurse with responsibility for the patient
- CNA with responsibility for the patient
- Member of the food and nutrition services staff
- Others as appropriate (PT, OT, Speech, Pharmacy, etc.)
- Patient or representative to the extent practicable

Person-Centered Plan of Care

The primary focus of the Care Plan Meeting is to develop the Plan of Care. The Plan of Care must include *"measurable objectives and timeframes to attain or maintain the patient's highest practicable physical, mental, and psychosocial well-being that were identified in the comprehensive assessment."*[54]

Developing a person-centered Plan of Care means that the patient's goals for admission, desired outcomes, and preference for discharge are included. In some instances, the patient's goals may not appear to be realistic, such as wanting to go home and live independently. Regardless, the Plan of Care must represent the patient's wishes for discharge.

It is important to remember that the Plan of Care is not a duplicate of the nursing care plan. The Plan of Care should include only those focused goals specific to the Swing Bed stay.

Appendix 8: Examples Multi-disciplinary Plan of Care

Measurable Goals

Goals and interventions must be measurable and time limited. Rehabilitation staff are used to writing these types of goals, but other disciplines, including nursing, have generally not been taught how to write measurable goals and may need education and coaching. Tables 7 and 8 provide examples.

[54] Appendix W C-1620 §483.21(b)

Table 7: Example 1 - Measurable Goals

Example 1: Measurable Goals
Discharge Goal: Mr. Jones's goal is to be discharged home, with home health if needed. He will be living with his wife. **Long Term Goal** (*to be achieved before discharge):* Mr. Jones will be able to dress and undress independently before discharge. **Responsible Discipline(s):** Occupational Therapy and Nursing **Short Term Goals** 1) Mr. Jones will be able to put on his shirt and pants independently within five days of admission. 2) Mr. Jones will be able to put on his shoes independently within seven days of admission.

Table 8: Example 2 - Measurable Goals

Example 2: Measurable Goals
Discharge Goal: Ms. Love's goal is to be discharged to the Assisted Living where she resided before the hospital admission. **Long Term Goal** (*To be achieved before discharge):* Ms. Love will check blood sugars and administer insulin independently before discharge. **Responsible Discipline(s):** Nursing and Pharmacy **Short Term Goals** 1) Ms. Love will demonstrate appropriate techniques and times for checking blood sugar within two days of admission. 2) Ms. Love will identify the correct dose of insulin based on blood sugar within three days of admission. 3) Ms. Love will demonstrate drawing up insulin and administering insulin using sterile technique within four days of admission. 4) Ms. Love will identify signs and symptoms of hypoglycemia and hyperglycemia and what actions to take within five days of admission.

Documentation

Most electronic medical records (EMRs) do not have a template for documenting a Swing Bed Plan of Care. There are several options to consider, although none of them are ideal.

1. Document the Plan of Care in a progress note or other free form text
2. Develop an EMR template
3. Document on paper and scan in the medical record

Post the Plan of Care in the Patient's Room

Posting both the long-term goal, which must be achieved prior to discharge, and daily or weekly goals helps the patient and the care team stay on track.

The goals should be updated at least every week, but more often if new goals are added or current goals are modified.

Remember to assign someone responsibility for updating the information in the patient's room, so it does not get missed.

Facilitating Multi-Disciplinary Care Plan Meetings

Ideally, the multi-disciplinary meeting is held twice per week, but at a minimum should be scheduled once per week. The focus of the meeting should be reviewing the patient's progress and determining if goals have been achieved or if goals need to be modified.

The individual leading the meeting, typically the Case Manager or a provider, can facilitate the discussion by following the outline below. It's important to schedule a certain amount of time for each patient. If more in-depth discussion is needed, schedule a follow-up meeting between specific disciplines or the whole team.

Table 9: Care Plan Meeting Outline

<table>
<tr><th colspan="2">Outline for Care Plan Meeting</th></tr>
<tr><th colspan="2">Ask patient for input after each discussion item</th></tr>
<tr><td>1. Discharge Plan
Any update on discharge plans?
Has anything changed?
Does the discharge place or timeline need to be modified?
2. Long Term Goals
Review Long Term Goals
Have the goals been met?
Do the goals need to be modified?
Can the patient sustain the goals if they are discharged today, or do they need additional time in the hospital to ensure there is a safe discharge?</td><td>3. Short Term Goals
Review Short Term Goals
Have the goals been met?
Do the goals need to be modified?
Are there any other goals that need to be added?
If there are rehabilitation goals, how is nursing supporting the goals?
4. Nutrition and Hydration
Has the patient experienced a weight loss or gain since the last meeting, and how much has the weight changed?
If more than 5% has the dietician assessed the patient and what are the recommendations?</td></tr>
<tr><td colspan="2">5. Patient Input
Ask if the patient agrees with the goals and plan
Ask the patient to discuss any issues or provide feedback for the team</td></tr>
</table>

If the patient does not attend, the Care Team's recommendations must be reviewed with the patient and concurrence or requested modifications with the plan documented.

Significant Change

If the patient experiences any significant change, there must be a comprehensive reassessment and the plan of care modified. Definition of significant change is included in Section 8 of this manual.

Chapter 10

Discharge

Discharge Criteria

The facility is required to allow a patient to remain in the facility and not transfer or discharge unless one of the following occurs:

1. *"The transfer or discharge is necessary for the patient's welfare, and the patient's needs cannot be met in the facility.*
2. *The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the facility.*
3. *The safety of individuals in the facility is endangered due to the clinical or behavioral status of the patient.*
4. *The health of individuals in the facility would otherwise be endangered*
5. *The patient has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.*
6. *The facility ceases to operate*."[55]

The physician responsible for the patient is required to complete the transfer or discharge documentation if (1) or (2) occurs. Any physician can complete the documentation if the transfer or discharge occurs because of (3), (4), or (5).[56]

When the patient is transferred because their needs cannot be met, the physician must document in the medical record the following information:

- *"The patient need(s) that cannot be met,*
- *Facility attempts to meet the patient's needs, and*
- *Services available at the receiving facility to meet the need(s) of the patient."*[57]

Discharge Appeal

The facility may not transfer or discharge when an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of the patient or other individuals in the facility. If transfer or discharge does occur under these circumstances, there must be documentation that failure to transfer or discharge would endanger the health or safety of the patient or other individuals and the danger that failure to transfer or discharge would pose.[58]

Discharge Plan

The discharge plan starts at admission by identifying the patient's goals for discharge. The plan must include where the patient intends to reside, any arrangements that have been made for the patient's follow-up care, and any post-discharge medical and non-medical services.[59]

[55] Appendix W C-1610 §483.15(c)(1)
[56] Appendix W C-1610 §483.15(c)(1)
[57] Appendix W C-1610 483.15(c)(2)
[58] Appendix W C-1610 §483.15(c)(2)(ii)
[59] Appendix W C-1620 §483.21(c)(2)

It is important to note that even if the patient is returning to their prior place of residence and may not have additional services such as home health, a discharge plan is still required.

Choice of Post-Acute Care Provider

Part of the discharge planning process is providing the patient with a choice of post-acute care providers. If the patient is being discharged to a Skilled Nursing Facility, Long Term Care Facility, Independent Rehab Facility, or receiving Home Health Services, they must be provided with data on quality measures and data on resource use measures so that they can make an informed choice.[60] For additional information see Chapter 5.

Discharge Documentation

When a patient is transferred or discharged, specific information must be communicated to the receiving health care organization or provider, including:

1. *Contact information of the practitioner responsible for the care of the patient.*

2. *Patient representative information, including contact information.*

3. *Advance Directive information.*

4. *Comprehensive care plan goals.*
   The Care Plan goals are goals developed, with the patient's participation, as part of the Multi-Disciplinary care planning process. At the time of discharge, the status of the goals must be part of the communication to the receiving health care organization or provider. To ensure the goals are updated before discharge, a final care plan meeting should be held with the Multi-Disciplinary team and the patient.

5. *Final summary of patient status including all elements of the comprehensive assessment.*
   The summary of the comprehensive assessment includes the same elements that were assessed at admission. The easiest way to review each element is to do so at the final care plan meeting and document in the medical record.

6. *Discharge summary that includes a recapitulation of the patient's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.*

7. *Reconciliation of all pre-discharge medications with post-discharge medications, both prescribed and over the counter.*

8. *Post-discharge plan of care.*

9. *All special instructions or precautions for ongoing care and any other necessary information to ensure a safe and effective transition of care*."[61]

[60] Appendix W C-1425
[61] Appendix W C-1610 §483.15(c)(2), and C-1620 §483.21(c)(2)

Patient Required Notices

Two notices are required at discharge: Notice of Medicare Non-Coverage (NOMNC) and Notice of Patient Discharge.

Notice of Medicare Non-Coverage

The requirement for the NOMNC to be provided for patients receiving skilled services under a part A stay can be found on the CMS web site. Medicare Claims Processing Manual, Chapter 30 clarifies that the NOMNC must be given to patients in a Swing Bed. §260.3.4 requires the notice to be given at least two calendar days before Medicare-covered services end.

> *"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 B services in Swing Beds."*[62]

Notice of Discharge

There is no Medicare form for the Notice of Discharge. The Notice of Discharge must include:

- The reason for transfer or discharge
- The effective date of transfer or discharge
- The location to which the patient is transferred or discharged
- A statement of the patient's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request
- The name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman
- For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities 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.)
- 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.[63]

The notice of transfer or discharge must be made at least 30 days before the patient is transferred or discharged unless one of the following applies. However, if one of the following does apply, the notice must be provided as soon as practicable.

- The safety of individuals in the facility would be endangered
- The health of individuals in the facility would be endangered
- The patient's health improves sufficiently to allow a more immediate transfer or discharge

[62] Medicare Claims Processing Manual, Chapter 30 §260.2
[63] Appendix W C-1610 §483.15(c)(3), C-1610 §483.15(c)(5)

- An immediate transfer or discharge is required by the patient's urgent medical needs
- A patient has not resided in the facility for 30 days[64]

Ombudsman Notification

The notice of transfer or discharge provided to the patient must be sent to the Office of the State Long-Term Care Ombudsman.[65] The information should be sent as soon as possible after the discharge notice is provided to the patient.

[64] Appendix W C-1610 §483.15(c)(4)
[65] Appendix W C-1610 §483.15(c)(3)

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SECTION 4

Other Swing Bed Requirements

Chapter 11
Other Swing Bed Requirements

Abuse, Neglect, Exploitation and Misappropriation of Property

C-1612 §483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) outline the requirements related to abuse. This includes the right of the patient to be free from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the patient's medical symptoms. In addition, when the use of restraints is indicated, the facility must use the least restrictive alternative.

The facility must not employ or otherwise engage individuals who:

(i) *"Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;*

(ii) *Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility must also report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff."*[66]

A background check should be done prior to employment. If staff have been employed for an extended period of time, a background check should be completed if one has never been done.

Appendix PP defines staff as follows: "*Staff includes employees, the medical director, consultants, contractors, volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs*."[67]

C-1612 §483.12(b)(c) is very specific about the steps to take in response to allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of patient property. The requirements in Appendix W are essentially the same requirements as found in Appendix PP.

The facility policy regarding abuse reporting, generally does not have the same requirements as those required for Swing Bed. The Swing Bed requirements include:

1. Reported immediately to the administration and to other officials, including State agencies, 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.

2. Have evidence that all alleged violations are thoroughly investigated.

[66] Appendix W C-1612 §483.12(a)(3)
[67] Appendix PP F-606 §483.12(a)

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 five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Trauma-Informed Care

C-1620 §483.21(b)(3)(iii) requires that the comprehensive care plan be culturally competent and trauma-informed. Appendix PP states, "*The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident*."[68]

The Trauma Informed Care Project defines trauma informed care as follows, "*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."*[69]

Appendix PP requires competency and skill sets for staff caring for patients with a history of trauma and/or post-traumatic stress disorder.[70]

There are no required questions or method for the assessment of trauma in the CoPs. The following is an example of questions.

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?

If trauma is identified, strategies must be included as part of the Plan of Care to prevent re-traumatization. Trauma may be long-standing such as PTSD, or more recent such as loss of a family member, friend, or pet.

[68] Appendix PP F-699 §483.25(m)
[69] Trauma Informed Project http://traumainformedcareproject.org/index.php
[70] Appendix PP F-741 §483.40(a)(1)

Preadmission Screening & Resident Review (PASRR)

The Plan of Care must include any specialized services or specialized rehabilitative services that will be provided as the result of PASRR recommendations. CMS does not require a PASRR for Swing Bed patients unless required by the state. Montana ARM requires a Level 1 screening for all Medicaid patients.[71]

If the patient has a PASRR, any specialized services or specialized rehabilitative services the facility will provide as a result of PASRR recommendations must be incorporated in the Plan of Care. If the facility disagrees with the findings of the PASRR, the rationale must be documented in the medical record.[72]

Nutrition and Hydration

Hydration and nutritional status of the patient must be closely monitored. There should be a dietician assessment at admission, even though the patient may not have any current nutritional risk factors, and then weekly.

If the dietician cannot attend the Care Plan meetings, the representative from dietary must be able to address any recommendations from the dietician and provide an update on goals related to nutrition and hydration.

Appendix W states,

"*Based on a resident's comprehensive assessment, the facility must ensure that a resident—*

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) *Is offered sufficient fluid intake to maintain proper hydration and health*."[73]

Appendix PP has multiple references to maintaining nutrition and hydration.

Daily weights for patients with nutritional deficits and weekly weights for all other Swing Bed patients is appropriate to identify any changes in weight.

Social Work

C-1616 §485.645(d)(4) requires that the facility provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient. This does not require a licensed social worker. Examples of medically related social work include:

- Assist or arrange for a patient to obtain needed items and services from outside entities, including psychosocial and mental counseling services
- Promoting non-pharmacological approaches to care
- Addressing grief and stressful events

[71] Montana ARM 37.40.405(1)(a)
[72] Appendix W C-1620 §483.21(b)
[73] Appendix W C-1626 §483.25(g)(1-2)

- Assisting patients with financial and legal matter including advance care planning
- Providing social services or obtaining needed services from outside entities when the patient experiences or exhibits:
    - Lack of effective support
    - Psychological or mental distress
    - Abuse of any kind
    - Difficulty coping with change or loss
    - Emotional support

Activities

An activities program developed by an activity professional or occupational therapist is no longer required by CMS. However, if an activities program is needed, CMS expects that a program is provided.

Montana ARM 37.40.412 does require an activities program.

(1) "The facility must provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.
(2) The activities program must be directed by a qualified professional who:
(a) is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990;
(b) has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting;
(c) is a qualified occupational therapist or occupational therapy assistant; or
(d) has completed a training course approved by the state.
(3) The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

Once an activities program has been established by a qualified individual, activities may be provided by nursing staff, therapy, volunteers, or even visitors and family members.

The intent is to ensure that patients in Swing Bed, many of whom only receive therapy or skilled nursing once or twice a day, do not just lay in bed without any mental stimulation.

Although group activities may be offered, most CAHs do not have enough patients to provide group activities and may not have an activities room. The following is a list of potential activities, although certainly not exhaustive, of what can be offered.

- Manicures
- Crochet and knitting
- Puzzle books
- Board games
- Reminiscing
- Hard cover books
- Books on tape

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SECTION 5

Intermediate Non-Skilled Swing Bed

Chapter 12
Intermediate Non-Skilled Swing Bed

Some hospitals in Montana have a waiver that allows them to care for long-term Medicaid patients in their Swing Bed program.

Substantial compliance with the CMS Swing Bed and Montana Swing Bed regulations are required, just like for any other Swing Bed patient.

However, because these are long-stay patients, following the guidelines in Appendix PP for Long Term Care is recommended. The following paragraphs outline some of the requirements in Appendix PP for consideration, but others may also apply.

Frequency of Nursing Assessment
Appendix PP is not specific about the frequency of nursing assessments, in part due to the requirement of long-term care facilities to complete the Resident Assessment Instrument (RAI).

A comprehensive nursing assessment is recommended at least weekly and with any change of condition, in addition to a daily CNA assessment.

Restorative Nursing Program
Restorative nursing is defined as person-centered nursing care designed to improve or maintain the functional ability of patients so they can achieve their highest level of well-being possible.

F-688 includes the components of a restorative program.

1) *"Ensuring that a patient with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further reduction in range of motion.*
2) *Including specific interventions, exercises and/or therapy in the Care Plan."*[74]

A restorative program is typically developed by physical therapy and implemented by nursing staff.

Nutrition and Hydration
Appendix PP states that weight can be a useful indicator of nutritional status within the context of the individual's personal history and overall condition. Recommendations include:

- *"Establishing a consistent method of weighing a patient (e.g., using the same scale, wearing the same clothes, weighing at the same time of day, adjusting for use of a prosthetic, etc.)*
- *Verifying the resident's weight upon admission*
- *Monitoring weight over time to identify weight loss/gain*
- *Verifying weight measurements when changes in weight occur*
- *Reassessing interventions when appropriate"*[75]

[74] Appendix PP F-688 §483.25(c)(1-2)
[75] Appendix PP F-692 §483.25(g) §483.25(g)(1); §483.25(g)(2); §483.25(g)(3)

Appendix PP also recommends weights weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss.[76]

Medication Regimen Review

F-756 §483.45(c) requires monthly drug review by a licensed pharmacist, and any irregularities reported to the attending physician. Irregularities include any unnecessary drugs are defined as:

1. *In excessive dose (including duplicate drug therapy); or*
2. *For excessive duration; or*
3. *Without adequate monitoring; or*
4. *Without adequate indications for its use; or*
5. *In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or*
6. *Any combinations of the reasons stated in 1-5*.[77]

Psychotropic Drugs

Appendix PP requires that patients who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Gradual dose reduction (GDR) is required for patients who are receiving psychotropic drugs including anti-psychotic, anti-depressant, anti-anxiety, and hypnotic.[78]

If a GDR is contraindicated there should be documentation by the provider in the medical record as to why a GDR is contraindicated.

When a patient is receiving psychotropic drugs, maintaining a behavior flow sheet is highly recommended. This allows the opportunity to review the effectiveness of the psychotropic drug and to document behaviors with dosage changes.

Education and Training

Appendix PP requires the facility to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles.[79]

Training topics include:

- Communication. §483.95(a)
- Patient rights and facility responsibilities. §483.95(b)
- Abuse, neglect, and exploitation. §483.95(c)
- Quality Assurance Performance Improvement (QAPI). §483.95(d)

[76] Appendix PP F-692 §483.25(g) §483.25(g)(1); §483.25(g)(2); §483.25(g)(3)
[77] Appendix PP F-757 §483.45(d)(1-5)
[78] Appendix PP F-758 §483.45(c)(3)
[79] Appendix PP F-940 §483.95

Required training for nursing aides includes:

- At least 12-hours per year. §483.95(g)(1)
- Dementia management training and abuse prevention training. §483.95(g)(2)
- Address areas of weakness as determined in nurse aides' performance reviews and facility assessment. §483.95(g)(3)
- Special needs of patients as determined by the facility staff. §483.95(g)(3)
- Care of the cognitively impaired. §483.95(g)(4)

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SECTION 6

Improving Swing Bed Care

Chapter 13

Swing Bed Measures

Outcome and Process Measures

Every CAH should be collecting internal quality and resource-use measures. A list of recommended measures is included in the Table below. If you are able to measure improvement in functional status, that is also highly recommended.

If you do not have information for all the recommended measures, start with a few and then build from there. At a minimum, measure those recommended by Montana Flex including Readmissions and Return to Prior Living arrangement. An example of data definitions is included in Appendix 9.

Table 10: Swing Bed Measures

Swing Bed Measures
Resource Measures 1. Readmissions within 30 days to Inpatient, Observation or Swing Bed at the same hospital (*Montana Flex Measure)* 2. Length of Stay **Quality Measures** 3. Current Plan of Care posted in patient room 4. Attendance at Care Plan Meetings by Patient or Patient Representative, Provider, RN caring for patient, CNA caring for patient, Representative from dietary, others as appropriate 5. Return to prior living arrangement (*Montana Flex Measure)* 6. Falls with injury 7. Post Discharge follow up call completed within 3 days of discharge 8. Patient satisfaction **Finance and Growth** 9. Time from referral to accept/decline patients less than two (2) hours 10. Patient Days

The Swing Bed measures should be shared with medical staff, administration, and the Swing Bed team. An example of a scorecard is included in Appendix 10. If you already have a quality scorecard, consider adding Swing Bed metrics.

Appendix 10: Sample Scorecard

Chapter 14
Readmissions

Readmissions

A key Swing Bed metric is readmissions.

Swing Bed Readmissions generally fall into three categories: (1) Controllable, (2) Potentially Controllable and (3) Not Controllable. Some of the reasons for readmission and strategies to prevent readmissions are included in the Table below.

Table 11: Readmissions

Readmissions
Readmissions – Controllable
Reason 1: Patient admitted to Swing Bed while still needing acute level of care – or – patient care needs not able to be met d/t inaccurate or missing information from referral facility
Strategy 1: Prior to admission: Talk to nursing, rehab, social work. Staff can often give you a better picture of the patient than what you may get from the medical record. Strategy 2: Prior to admission: Talk to the patient and/or family. Talking to the patient can gain critical information about not only the patient's commitment to Swing Bed – but also – any barriers to discharge Strategy 3: Use an admission checklist. See Appendix 4 for an example. Strategy 4: Understand and review Medicare Criteria to ensure patient no longer has an acute care need and qualifies for Swing Bed. Strategy 5: Develop facility-specific admission criteria that includes the types of patients that you can take care of.
Reason 2: Patient discharged before they can successfully function at the next level of care – or lack of a comprehensive discharge plan
Strategy 1: Develop a comprehensive discharge plan and start discharge planning as soon as possible after admission. At a minimum, by the time of the first care conference. Strategy 2: Schedule twice weekly multidisciplinary meetings to update progress / goals / discharge plan. Once per week may not be sufficient to revise discharge plans if needed. Strategy 3: Ensure the patient can sustain goals. Develop a maintenance program before discharge.

Strategy 4: Schedule a home visit to determine how the patient can function safely in the home environment. Schedule a trial period at home of a few hours or overnight if possible. Strategy 5: Have family or caregiver assume some or all care in the hospital. This will allow the care team to identify any gaps or education that may be needed. Strategy 6: Coordinate with PCP and schedule first provider visit within one week of discharge from hospital. Strategy 7: Follow-up weekly post-discharge for at least the first 30 days. If available, refer to Chronic Care Management program.
Reason 3: Patient discharged and readmitted for outpatient procedure, physician office visit, etc.
Strategy 1: Do not discharge and readmit (assuming patient does not meet acute care criteria). Swing Bed Medicare billing includes all care provided while a Swing Bed patient.
Readmissions – Potentially Controllable
Reason 1: Patient / Family request for discharge
Strategy 1: Schedule a trial home visit. Allowing the patient to a home visit is an ideal way for the patient and family to experience if the patient is ready for discharge.
Strategy 2: Allow the patient and/or patient with family support to function independently in the hospital before discharge. This allows the patient and family to experience if the patient is ready for discharge, especially when a home visit is not feasible.
Reason 2: Third party payor length of stay requirements
Strategy 1: Send information to the third-party payor as soon as it appears the patient will not be ready for discharge within the allocated days. If necessary, have the attending physician write a letter to the payor.
Readmissions – Not Controllable
Unexpected deterioration or change in condition requiring admission to higher level of care

Rehospitalization Risk Assessment

The Health Services Advisory Group (HSAG) developed a Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment based on the LACE Index Scoring Tool. The tool may be helpful in identifying those patients that may need a little longer in acute care or careful and more frequent monitoring in Swing Bed. The tool is included on the next page.

Table 12: Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment

Skilled Nursing Facility (SNF) Rehospitalization Risk Assessment

Date: Anticipated Date of Discharge:

Patient Name: Primary Physician:

Prior Pattern —Patient has had:	
☐ An acute care length of stay (LOS) ≥7 days	☐ An intensive care unit (ICU) utilization during stay
☐ >1 hospital or emergency room (ER) visit in the past three months	

Active / Chronic Conditions – Patient has:	
☐ Congestive Heart Failure (CHF)	☐ Diabetes
☐ Chronic Obstructive Pulmonary Disease (COPD	☐ Renal Failure
☐ Sepsis	☐ Traumatic brain injury

Risk Factors – Patient has (or is):	
☐ >2 active comorbid conditions	☐ ≥2 advanced care needs (e.g., trach, IV, colostomy)
☐ Non-compliant with disease management	☐ A poor prognosis
☐ Poor pain control	☐ A short life expectancy
☐ A history of falls	☐ Poly-pharmacy – takes ≥ 7 medications
☐ Psychiatric/behavioral issues	☐ Non-compliant with medication regimen
☐ Home safety risk	☐ Dyspnea
☐ Utilizing an opioid, diabetic agent, and/or blood thinner	

Total number of boxes checked:

Five or more boxes checked indicates the patient is at high risk for rehospitalization.

Source: Information based on 2018 input and best-practice experience from skilled nursing facility professionals, and elements of the LACE Index Scoring Tool for Risk Assessment of Death and Readmission (Length of Stay, Acuity of Admission, Comorbidities, Emergency Department Visits).

LACE developed by researchers at the Ottawa Hospital Research Institute, Institute for Clinical Evaluation Sciences, University of Toronto, University of Ottawa, and University of Calgary, 2010.
See also, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3659212/

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Chapter 15

Understanding and Utilizing Lean to Improve Swing Bed Processes

Lean is a process improvement methodology that began in the manufacturing industry with the work of W. Edwards Deming (1900-1993) as a foundation. Much of the work done related to Lean has traditionally been in manufacturing. Using a National Science Foundation Grant from 2001-2004, research was conducted regarding its application to healthcare, and as a result Lean principles and thinking are being used at some healthcare facilities. Lean focuses on reducing waste in processes, improving efficiency, and focusing on what is valuable to the patient in the provision of quality care. The goal of Lean is to eliminate steps that are not value added to the patient. Lean practitioners are common in the front line and other levels of the organization. Skilled Lean practitioners involve all stakeholders, communicate widely, analyze a process, test solutions, and implement changes to solve problems that add value for patients in all setting, including the Swing Bed Processes.

Why Lean?

At first glance, it may seem strange to translate an auto manufacturing model, such as the Toyota Production System (TPS), into healthcare. However, the two pillars used to describe the culture behind Toyota are continuous improvement and respect for people. In a highly complex and human industry such as healthcare, these two pillars are certainly relevant. With the dynamic atmosphere of healthcare, it is essential to tap into the talents and expertise available at all levels of an organization. Executives must create and communicate a vision, managers must mentor and coach staff, and staff must be empowered to solve problems and make improvements in real time. Creating a Lean culture provides the common language and tools to reframe how we think about solving problems at all levels. Those closest to the work, such as nurses, must be encouraged, educated, and allowed to implement improvements.

What Is Lean?

Lean is a process improvement methodology begun in the manufacturing industry by W. Edwards Deming (1900-1993). As an engineer, statistician, and academic, Deming focused on process and design. He believed that if a company's products were badly made, it was because the bosses designed an inferior manufacturing process. To further complicate things, he was known for asking company executives, "Do you have a constancy of purpose?"[80] Although public vision statements are commonplace in today's businesses, that was not the case at the time. Although we now have vision statements, we are not always diligent in ensuring that our process designs and redesigns are in line with the vision or direction of the organization.

[80] McInnis D. W. Edwards Deming of Powell, Wyoming: the man who helped shape the world. WyoHistory.org Web site. http://www.wyohistory.org/encyclopedia/w-edwards-deming

After World War II, Deming took his ideas to Japan. Taiichi Ohno, the father of the TPS, an industrial engineer, and a businessman, embraced the quality work of Deming.[81] Japan and its manufacturing operations were in a state of chaos and needed to refocus and rebuild to survive.

Unfortunately, we have similarities in healthcare — with high costs, inefficiencies, medical errors, and patient dissatisfaction. For our healthcare system to survive, we must redesign our processes. A large part of this redesign for Toyota was the identification of waste and the need to cut waste out of processes. The same could be said for our healthcare system: We must identify the areas of waste and inefficiencies to make improvements in care.

Through the work of Jim Womack, who worked with Toyota for many years, the TPS became known as Lean Manufacturing. In 1997, Womack started Lean Enterprise Institute, which has revolutionized manufacturing in the U.S.[82] He coined the term "Lean." Lean is not an acronym, but a term signifying efficiency and the cutting of waste.

As this body of work continued to progress, Steven Spears and H. Kent Bowen from Harvard Business School studied Toyota plants in Asia and North America and observed the culture firsthand. They authored a landmark paper, *Decoding the DNA of the Toyota Production System,* in 1999. Based on their observations, they articulated four basic rules that they determined to guide the design, operation, and improvement of every product and service in the TPS culture.[83]

Lean Translated to Healthcare

Up to this point, much of the work done related to Lean was in manufacturing. Over time, some have translated this body of knowledge into other disciplines. Using research grant support, Cindy Jimmerson, RN, and Durward Sobek, PhD, translated the principles defined by Bowen and Spear into healthcare. Jimmerson and Sobek conducted their research at Community Medical Center in Missoula, MT. The research was funded by a grant to Montana State University by the National Science Foundation.[84] Jimmerson used the results of the research and began working with healthcare facilities to implement Lean principles and Lean thinking in healthcare. She was the founder of Lean Healthcare West, who provided education for Lean implementation designed for healthcare.

Some may see Lean as a new concept or even view it as the "flavor of the month." However, reviewing the background and the evidence-based history of Lean reveals the long-standing results-oriented research of this body of work. Lean is a process, a methodology, and a way of thinking with an ability to transform a culture into a safe, efficient, and quality environment for patients and healthcare workers.[85]

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[81] JLiker JK, Convis GL. *The Toyota Way to Lean Leadership: Achieving and Sustaining Excellence Through Leadership Development*. New York, NY: McGraw-Hill; 2012

[82] James P Womack. Lean Enterprise Institute Web site. http://www.lean.org/WhoWeAre/LeanPerson.cfm?LeanPersonId=1

[83] Spears S, Bowen HK. Decoding the DNA of the Toyota Production System. *Harvard Business Rev*. 1999;77(5):96-106

[84] Jimmerson C. *Value Stream Mapping for Healthcare Made Easy*. New York, NY: Taylor & Francis Group; 2010

[85] Jimmerson C. *A3 Problem Solving for Healthcare: A Practical Method for Eliminating Waste*. New York, NY: Productivity Press; 2007

Lean Basics

A Lean culture is a culture that liberates the people doing the work to make improvements.[6] Front-line staff members are given tools, resources, and education on the principles and the proper use of the tools. The basic components of Lean are divided into concepts and tools. The four concepts used in creating, evaluating, and potentially redesigning a process are identifying ideal, identifying "muda" (a Japanese term to describe waste), using the four rules, and the power of observation. The two main tools include Value Stream Maps and A3 Problem Solving.

Concepts

Ideal: The concept of ideal goes hand-and-hand with vision setting. Ideal is viewed from the perspective of the patient. However, ideal must align with direction. It is essential to have a clear understanding of the direction or vision of the organization, department, or work group before taking any action. As the saying goes, "If you don't know where you are going, any road will take you there." If the concept of ideal goes hand-and-hand with a vision statement, why is it not simply a vision statement? What sets ideal apart from a vision statement is the fact that ideal must be defined from the perspective of the patient.

Muda: Ohno is credited with first describing types of waste, or muda. Waste is anything that causes inefficiencies, such as having too much stock or not enough, taking extra time, or having to rework a process due to mistakes or a defect. The sources of waste Ohno identified were:

- **Conveyance:** This refers to unnecessary movement of products from place in place. In healthcare, we can relate this to the unnecessary transport of our patients from place to place. Is it more efficient and patient centered to bring the patient to the service or the service to the patient? If a patient in your organization is discharged from acute and admitted to swing, do you move the patient or keep them in the same bed?
- **Motion:** Motion waste is typically assigned to the extra travel that staff do to complete a task. There is a reason nurses are wearing devices to count their steps, but are all those steps really needed? Rearranging supplies and equipment can reduce motion waste.
- **Waiting:** Waiting waste is typically related to time between process steps that is not value added to the patient. An example is telling a patient that his or her appointment is at 9 a.m. but please come in 15 minutes early. Those 15 minutes are not value added to the patient and have become common practice because our appointment check-in processes are filled with inefficiencies.
- **Overprocessing:** If one is good, then two is better. Not necessarily. An example of overprocessing is the assembling of educational materials or handouts. Just because someone appears to have time, they compile stacks and stacks of educational materials or handouts only to have some of the materials change or become outdated before being used. In the long run, this creates more waste as items need to be changed, tossed out, or refiled.
- **Inventory:** Inventory waste can occur when there is too little or too much inventory. Too little inventory creates waste in expenses, such as overnight shipping costs, and in revenue if procedures need to be canceled. Too much inventory creates wastes, as it signifies many dollars just sitting on the shelf that may never be used if items become outdated or practices change.

Identifying the right level of inventory provides patients with the services needed when they need them with cost controls.

- **Defects:** Defect wastes in manufacturing means parts and pieces need to be thrown out. In healthcare, it can translate to unwanted suffering and even loss of life.
- **Overproduction:** Overproduction waste is manifested in redundant work: doing the same thing more than once. In the life of a nurse, this is often brought to light in charting systems, with duplicate — and even triplicate — documentation on bedside forms, in assessment checklists in the electronic medical record, and in narrative notes in the electronic medical record all documenting the same information being examples.(Footnote 70 & 71)

In healthcare, defects or mistakes can lead to extremely costly outcomes, not just in dollars but in lives. As part of her research and translation into healthcare, Jimmerson identified an additional waste unique to healthcare. That waste is "confusion waste."[5] It is easy to see how confusion can bring about waste in healthcare. Confusion could range from having to take additional time to clarify an order to having to provide additional treatments to counteract mistakes caused by the confusion. It can also affect your reimbursement when terms such as Swing Bed and skilled care are not defined accurately.

In a Lean culture, duplication is eliminated as it is often seen as waste, but that is not to say that safety double checks are eliminated. The goal of Lean is to eliminate steps that are not value added to the patient. Double checking for safety is valuable from the patient's perspective. The goal with Lean is not to do more with less, but rather to increase the capacity for work. This is not simply semantics. Doing more with less implies that staff continue to do what they are doing, but just do more of it. In our healthcare environment, staff hit the ground running, and the thought of doing more is simply overwhelming. To increase the capacity for work, an evaluation of the current work being done is needed to look for areas of waste that can be eliminated from the workflow to free up time that can be spent on processes that are more valuable to the patient.[6]

Four Rules

As discussed, there are four rules that must be followed when creating or redesigning processes as a Lean practitioner.[4] The rationale to change a process is based on the identification of one or more of these rules being broken. If no rule is broken, there is usually no need to change the process.

Rule 1 speaks to decreasing variation. When creating or redesigning a process, begin by answering the following questions:

- Is the process specified or outlined for all members of the team to follow?
- Are the content, timing, sequence, and outcomes of the process clearly communicated?

These may be in the form of a policy, a procedure, instruction, or simply a posted sign, but it must be specific. If the answers to these questions are "no," rule one is broken and must be addressed. This rule is often broken in healthcare as we often have learned through the teachings of others through precepting. Preceptors pass on their knowledge on how to do tasks, but often the process taught is not specified in a standard fashion for all to have the benefit of following.

Rule 2 focuses on connections, such as communication. Direct communication often yields the best outcomes. Processes with excessive connections, such as multiple layers of a phone tree or excessive handoffs, are fraught with opportunities to make mistakes, causing poor outcomes ranging from patient and staff frustrations to patient adverse events. In a Swing Bed admission, how many hand offs occurs and how much waiting is involved before an outside facility is informed if the patient will be accepted for a Swing Bed admission? Can you decrease those handoffs and be more direct in the response?

Rule 3 centers on process design or evaluation is pathway. Just as the shortest distance between two points is a straight line, the beginning to the end of a process should also follow a straight path. Eliminating interruptions or workarounds in a process improves continuity and consistency. Rule 3 is frequently broken in healthcare. While trying to complete the care of a patient, nurses do not always have all the supplies they need in one location or are often interrupted and pulled in many directions, making it difficult to complete a process on one patient from start to finish.

Rule 4 provides a framework for adjusting a process when conditions change, or issues arise. The framework is scientific in nature and is designed to include support from experts in the workplace. Nurses and other front-line staff are well suited to become Lean practitioners and to provide support when such adjustments are required.

Power of Observation

At times, someone has an idea to change a process just to change it. The reason for the change may be because that was how things were done where the person used to work — or perhaps because someone learned a new way in a book or at a conference. Making changes to processes for change's sake is not Lean.

Processes that *should* be changed are identified in several ways. New evidence, safety issues, patient complaints, staff frustrations, or new ideas are all events that can trigger process changes. In a Lean culture, when any of these events occur, the first step is to use the power of observation to truly understand the current process. Too often in the fast-changing world of healthcare, when someone encounters one of the aforementioned events, a quick fix or quick change is made. A quick fix is a Band-Aid approach. Often, the quick fix creates more layers, takes more time, adds more frustrations for staff, increases the potential for errors, and adds unnecessary complexity to the problem. Most importantly, the fix does not add value in the process to the patient.

Using the power of observation allows for a process to be evaluated to its fullest and considers all aspects of the process, from what happens upstream to what happens downstream. All this information is used to drill down into the process and to determine if and how a process should be changed. The concept of observation is to truly observe a process from beginning to end several times.
When conducting an observation, the observer must act as a fly on the wall. The observer must not intervene, offer advice, or make assumptions, but rather document everything that the person being observed is doing. By observing a process, you can see exactly how the process is done; not how the policy says it should be done, not how one person says it is done, but how it is actually done.

After a process has been observed several times; variations, frustrations, wastes, workarounds, and safety issues can be identified. This identification process is powerful and can open the eyes of all workers in the process both up and down stream. It allows for healthcare professionals as members of our increasingly diverse multidisciplinary teams with varying professional backgrounds and viewpoints to gain an understanding of how each person's work affects someone else's. This allows the team to come together to make the change that will be in everyone's best interest and that will add value to the patient's outcome.

Although the concept of watching someone, documenting what is happening, and looking for those areas of waste may sound simple, it can be difficult for both the observer and the person being observed. The key to success is communication. Communication regarding the purpose of observation should be clearly articulated to all staff when an organization begins a Lean journey.

Being observed is uncomfortable for most human beings. The first thought is "Am I doing this right?" even if professionals have done the task thousands of times; having someone watch makes them self-conscientious. People skilled at observation are trained to set the stage. They request permission to observe the person doing the task, set up an appointment or an agreed upon time, and share the results of what was observed to confirm accuracy, avoid assumptions, and build positive working relationships.

Being an observer is no easy task, either. When observers see a colleague having to run to get a supply that was not readily available or having to change out a piece of equipment because of a malfunction, it is difficult not to offer to get the supply or the new piece of equipment. However, observers are observing the process as if they were not there. By inserting themselves into the process, they change how the process happens. Of course, in the event of a safety issue, observers jump in and help. But in all other instances, they are trained to be a "fly on the wall" to ensure that they can get a true reflection of how the work is currently done.

Lean Tools

The observation process usually brings many issues to light, and it ensures that the work is deeply understood before any fixes or changes are considered. The observation is the bridge between identifying a process to change and beginning to pinpoint what exactly needs to be changed. As stated earlier, there are two main tools that are employed in a Lean culture. To be sure, there are several tools that can be used to help implement a process change once an area of change has been identified. But the two tools discussed here are the basic tools that help identify exactly what needs to be changed. Those two tools are the Value Stream Map (VSM) and the A3 Problem Solving tool. Both tools are simple and as inexpensive as a piece of 11 × 17 paper and a pencil.

Value Stream Map: Once several observations of a process have been conducted, it is time to start to communicate how the process happens. In Lean, this communication starts with a Value Stream Map. "The term VSM refers to a graphic representation of the trail of activities that occur from the moment a request is made for a service or product until the moment the request is satisfied."[5] Examples of a service or product include accepting a patient to be admitted to Swing Bed, performing services such as

medication administration, assisting with self-administration of medications, preparing a patient for therapy, involving family and care givers in education and procedures, and the list goes on.
A VSM is drawn on one piece of 11 × 17 paper divided into three sections. The top section represents the request phase, the middle section the process phase, and the bottom section the data phase. You do not have to be an artist to draw a VSM. The components of a VSM can be communicated easily with stick figures, arrows, boxes, storm cloud bubbles. A VSM is used for each process. It is best to look at each process individually. A good rule of thumb is if the process cannot be drawn on one sheet of paper, the process to too big and should be broken down into a smaller segment of the process.

When drawing or reading a VSM, always start in the upper right-hand corner to read the title to understand exactly what product or service is requested. Stay in the upper right-hand corner and begin the request phase with the patient. All processes, no matter where they occur, begin with the patient — including processes such as billing, supply ordering, housekeeping, and maintenance. Keep in mind that all work done in healthcare is done because we have patients to care for. The request phase is drawn in the top third of the VSM, it is important to draw out all the options, and arrows help the reader follow the process.

The process phase is represented in the middle portion. Each part of the process is represented by a process box. The title in each process box indicates the action to be completed in that step of the process. Within each process box, all of the tasks are listed that are required to complete that process step. If there is more than one option that can selected, processes boxes are represented in a stacked configuration indicating that one of two paths may be taken. The tasks in each of the stacked process boxes are different depending on action that needs to be completed.

Before moving on to the data section in the bottom third, any issues that were uncovered during the observation portion are represented on the VSM as “storm clouds.” The storm clouds represent issues that occurred throughout the process that deviated from the normal flow of the process. The storm clouds are drawn on the VSM where the issue was observed to have occurred.
Once the top two portions of the VSM are complete, the Lean practitioner must validate the process as drawn with everyone else involved in the process to assess accuracy, achieve buy-in, and gather any additional storm clouds as noted by other members of the team.

Then the Lean practitioner will measure the process related to time. A data-gathering tool is developed, and the process is again observed, and each process step is timed. The gathered data is analyzed. The time for each process step is measured; the longest or high, the shortest or low, and the average of all of the data. These three data points are recorded on what is called “the sawtooth” for each process step, with the average on the top. The time between the process steps is calculated, and those same data points of high, low, and average are recorded in the valleys of the sawtooth. With this information, a value quotient can be calculated.

The value quotient is the overall value of the process to the patient. It is calculated as the process time divided by the total time and converted to a percentage; the higher the number, the more valuable the process is to the patient in terms of time.[5]

With all the data added to the VSM, additional issues can be identified and placed in storm clouds. Analyzing the variations in the highs, lows, and averages and digging into why these variations occurred will flush out additional storm clouds.

With a completed VSM, we now understand how the current process flows and the issues that occur in the process. We can begin to solve the issues. Issues must be solved one at a time. There is no quick fix to solving the entire process. Each issue, or storm cloud, must be solved, the process reevaluated, and then the next identified issue can be worked on. The process to solve a storm cloud or issue is A3 Problem Solving.

A3 Problem Solving: A3 Problem Solving begins by selecting a storm cloud, or issue. There are many preprinted forms available; however, they are not required. The key is to ensure this methodology for problem solving is completed step by step. The steps include:[86]

- The Issue — the storm cloud statement (Unable to provide direct response to inquiry regarding accepting an admission to Swing Bed[87]
- Background — all of the data and input that highlight the significance of the problem
- Current Condition — a picture of the issue or the storm cloud situation with smaller sub-issues identified using the storm cloud pictorial
- Problem Analysis — using the 5-Why methodology to drill down each of the sub-issues in the current condition until the reason identified is an actionable item
- Target Condition — a picture of how the issue could be better
- Countermeasures — What is the identified action?
- Implementation Plan — the step-by-step plan outlining how the action be accomplished
- Cost and Cost Benefit — a calculation of what it will cost to implement the countermeasure and a calculation of the savings and benefits from implementing it
- Test — Before a full rollout of the plan, a small test should be conducted to ensure the plan works and any small adjustments made before adjusting the process for many people

The Grassroots of Lean

In a Lean culture, Lean methodology and Lean thinking are intended to create Lean practitioners from the front-line staff. Many may have heard of "Six Sigma." Lean and Six Sigma work well together, but they are two different methodologies with different foci. In general, Lean focuses on reducing waste in processes, and Six Sigma focuses on reducing variations in processes. It is typical to see Six Sigma practitioners in the higher-level manager and executive ranks, while Lean practitioners are common in the front line and other levels of the organization.[88]

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[86] Jimmerson C. *A3 Problem Solving for Healthcare: A Practical Method for Eliminating Waste*. New York, NY: Productivity Press; 2007

[87] Jones F, Sabin T, Roper K, Crocker S, and Cardarelli R (2015). Lessons Learned: A mixed methods analysis of barriers to Swing Bed utilization in critical access hospitals in Montana. *Rural Nurses Organization Journal.* Vol. 15. No 2. Available: https://rnojournal.binghamton.edu/index.php/RNO/article/view/366

[88] Nave D. How to compare Six Sigma, Lean and the theory of constraints: a framework for choosing what is best for your organization. Lean Enterprise Institute Web site. https://nzbef.org.nz/wp-content/uploads/2019/05/Guide-How-To-Compare-Six-Sigma-Lean-and-TOC.pdf Published March 2002

Quality improvement is everyone's job. Lean transforms quality from an organizational assumption to an expectation valued by CEOs. A Lean culture allows and expects every worker to participate in improvement in the normal course of work. Lean ensures that when looking at a process, input is sought from all of the areas that touch the pieces of the process. One person or one department having a great idea and making a change, even an evidence-based change, without a complete understanding of how a current process works and the people who are impacted by the process creates only chaos and, ultimately, an anti-change culture. Healthcare must embrace change, but the right change. Skilled Lean practitioners involve all stakeholders, communicate widely, analyze a process, test solutions, and implement changes to solve problems that add value for patients.

Chapter 16

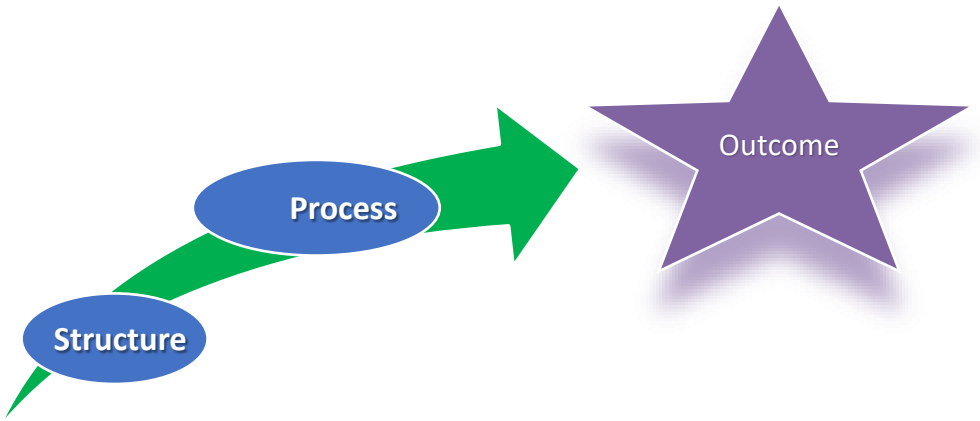
Compliance Tips

The compliance tips in this chapter are intended to help your Swing Bed program stays compliant with regulatory requirements and function smoothly.

Compliance Tip 1

Understand the importance of structure and process to achieve outcomes

Although it may sound simplistic --- you cannot have a successful program and achieve the outcomes you are looking for without having a solid foundation



Examples of structure include:

- Current policies & procedures
- Accurate and up-to-date patient disclosures
- Defined job roles and responsibilities
- Care Plan meetings

Examples of processes include:

- Review of referrals
- Patient disclosures (admission and discharge)
- Multi-disciplinary assessment
- Care Planning
- Discharge planning and information to next provider of care

If any of these structures or processes are broken or not functioning properly, outcomes will not be as good as they could be.

Compliance Tip 2

Keep up with changes

Regulatory standards for Swing Bed are published in Appendix W, Appendix PP, Medicare Benefits and Policy Manuals 3, 4, 6 and 8, and of course the State.

Check periodically for updates. You can sign up for alerts from CMS and from the Federal Register to be notified whenever there are changes to the regulatory requirements.

Although ideally everyone on the team stays current with changes, you may want to consider having one person responsible for monitoring the various sources to ensure changes are not missed.

Compliance Tip 3

Define roles and responsibilities

It is difficult, if not impossible, to effectively perform your job – if you do not know what is expected. Consider the following strategies:

- Include responsibilities related to Swing Bed in job descriptions
- Include responsibilities related to Swing Bed in contracts for contract services such as dietary or rehab
- Develop competencies for all clinical staff specific to Swing Bed

Compliance Tip 4

Establish clear expectations and time frames for key processes

Establish time frames for key processes including:

- Pre-Admission
    - Response time for referrals
- Admission and Continued Stay
    - Completion of initial assessment by each member of the multidisciplinary team
    - Development of the plan of care with measurable goals that are time-limited
    - Attendance at IDT meetings
- Discharge
    - Development of the discharge plan of care
    - Patient discharge notices
    - Information to next provider of care
    - Ombudsman notification

Compliance Tip 5

Educate team members

Education about Swing Bed regulatory requirements is essential for compliance. Ideally this is ongoing, but a minimum, schedule annual education and if possible, quarterly on specific topics.

Compliance Tip 6

Conduct audits

Audits work best if they are done with the Swing Bed team and/or staff caring for the patient. Start with a comprehensive audit of several records – then drill down to areas of concern. Implement changes – then re-audit.

Appendix 11: Pre-Admission, Admission, and Discharge Audit Tool
Appendix 12: CMS Conditions of Participation Audit Tool

Compliance Tip 7

Collect and share outcome data

Outcome data has been an essential component of the Montana Flex project. See Section 6, Chapter 13 for more about Swing Bed measures.

Compliance Tip 8

Identify formal and informal leaders

Typically, we think about the Swing Bed Coordinator, Chief Nursing Officer, Director of Quality, or the Director of Case Management – when we think about Swing Bed leaders. The success of a Swing Bed program, however, relies on not just formal but informal leaders as well. Take the time to identify who the informal leaders are in your organization, involve them in decision making and recognize their contribution.

> *"Change no longer cascades solely top down within the organization and is best achieved through networks accommodating both formal and informal leaders as change agents."*

Compliance Tip 9

Set goals

A successful Swing Bed program requires developing a plan for what you want to achieve.

- Develop Swing Bed goals (Include both formal and informal leaders)
- Communicate goals to the organization
- Establish an action plan (Include both formal and informal leaders)
- Celebrate success!

Compliance Tip 10

It takes a village

The success of a Swing Bed program can only be achieved if providers, senior leaders, managers, and staff work together collaboratively.

Ensure that each team member understands the key role they play in Swing Bed success.

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

SECTION 7

Strategies to Increase Swing Bed Volume

Chapter 17
Swing Bed Growth

Assessment
Increasing volume is a goal of most Swing Bed programs. The first step is to assess your current program and set goals. The following paragraphs are a list of recommended steps.

Step 1
Form an Assessment Team
Identify a team of key stakeholders to complete the assessment. Ideally, this will include providers and staff most involved in the Swing Bed program, including a provider (physician, nurse practitioner, and/or physician assistant), case management, nursing, rehabilitation, dietary, and pharmacy. You may also want to consider a representative from the business office or admitting.

The team can help drive the assessment process, develop goals, and monitor the action plan.

Step 2
Gather Basic Data
Gather data about your program that includes at least the following eight elements.

- Annual Admissions in total and by payor
- Average Daily Census in total and by payor
- Average Length of Stay in total and by payor
- Source of admissions (internal and external including referral source)
- Financial analysis by payor
- Time from referral to accept or decline
- Patient outcomes
- Patient, family, provider, staff, and referral source satisfaction

Step 3
Complete a SWOT Analysis
A SWOT analysis is an objective way of assessing your program. Include both internal (strengths and weaknesses) and external (opportunities and threats) factors.

The SWOT analysis should include interviews with key stakeholders and a review of available data. Table 13 is an example of interview questions.

Appendix 13: Interview Questions for SWOT Analysis

Table 13: SWOT Analysis

SWOT Analysis	
Internal	**External**
Strengths Areas in the internal environment that you want to leverage – get better at.	Opportunities Factors in the external environment that you want to take advantage of.
Weaknesses Areas in the internal environment that you want to minimize and eliminate.	Threats Factors that may not be controllable, but that you want to reduce the impact on the program if possible.

Step 4
Develop Strategic Goals

Sometimes the goal for increasing Swing Bed volume is established before you start the assessment process, and that is okay. For example, increasing volume by five (5) patients a day.

However, once you have completed the SWOT analysis, you will be better positioned to determine a realistic goal and the timeline for achieving that goal. If it is different from the established goal, then obviously, a discussion needs to occur, and a new goal agreed to before moving forward.

Step 5
Develop Strategies

The SWOT analysis will identify strengths you need to get better at, weaknesses you need to minimize or eliminate, opportunities you need to take advantage of, and threats you need to mitigate. But everything is not created equal. It is important to look at your data and the SWOT analysis, and determine which strategies will have the most impact, what resources will be needed, and the timeframe for implementation.

Table 14: Initiatives

New Initiatives **What do you need to start doing?**	
High probability of meeting goal Timeline 6 – 12 months Low to moderate investment in resources	High probability of meeting goal Timeline 6 – 12 months Significant investment in resources
Current Initiatives **What do you need to keep doing?**	

For each strategy, develop an action plan that includes:

- What needs to be done (including a target if applicable)
- Who is responsible
- Who will provide support
- What is the timeline

And of course, once an action plan has been developed, it is critical to monitor and report progress at least monthly to the Swing Bed Tam and Senior Leaders.

Strategies for Growth

The following are some examples of increasing volume that other Swing Bed programs have found to be successful.

Strategy 1

Increase Length of Stay

As you know, there is no length of stay restrictions for Swing Bed. Of course, the patient must continue to meet skilled criteria. A maintenance program may be applicable if a patient needs a few more days to ensure that the goals they have achieved can be sustained before they are discharged. An effective way to check if you are discharging patients too soon is to look at your readmission rate and why patients are readmitted.

> 30.4.1: *"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."*
>
> 30.4.1.2: *"Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist."*
>
> 30.0: *"Coverage of nursing care and/or therapy to perform a maintenance program does not turn on the presence or absence of an individual's potential for improvement from the nursing care and/or therapy, but rather on the beneficiary's need for skilled care."*

Strategy 2

Expand the Type of Patients you Accept

Reviewing the types of patients, you accept to determine if you can accept more complex patients is an excellent way to grow your program. Especially if it differentiates you from competitors. Consider:

- Complex wound care
- Bariatric

- Stroke
- Spinal Cord Injury
- Ventilator Weaning
- In-house Dialysis

Strategy 3

Streamline the Process for Accepting Patients

Often a referral hospital will send the patient to the first accepting facility. (Understanding, of course, that the patient has a choice.) That makes it paramount that you have reliable and efficient processes for reviewing and accepting patients.

As part of your SWOT assessment, take an in-depth review of your admission processes and how they can be streamlined. Consider, for example, developing acceptance criteria that only require the physician's approval and not the entire team. Or consider a timeline for the team to respond with concerns or questions. Set a goal for responding to the referring facility and measure against your goal (i.e., 2 hours, 4 hours, 6 hours). The shorter, the better.

And, although not always possible, consider accepting patients on weekends. PPS Hospitals are always anxious to discharge patients as soon as they are ready and do not want to wait 2 – 3 extra days. If you are in a competitive market and/or have aggressive growth goals, consider accepting patients on the weekend.

Strategy 4

Measure and Improve Outcomes

A key component of growing volume is ensuring that you measure outcomes and continue to improve. See Section 6 for more information about Swing Bed measures.

Strategy 5

Make Swing Bed a Strategic Service Line

Although it may sound like a simple strategy, often, Swing Bed is seen as "just another patient on the Med-Surg unit."

Identifying Swing Bed as a service line can bring awareness and focus to the program and help to ensure success.

Service lines typically have more visibility in the organization, both with staff and providers.
To ensure a successful service line approach, appoint a leader to oversee the Swing Bed program. Ideally, this is a full-time person, but if it is part-time, there should be sufficient time to focus on the program, including marketing and outreach, staff and provider education, regulatory compliance, collecting and analyzing outcome data, and developing strategies for growth.

Strategy 6

Invest in Marketing

Marketing can take different forms. However, remember that marketing is essential to both internal and external stakeholders.

Patients and their family, community members, staff, providers, and referral sources can be your best evangelists and the best way to expand your market if they are happy with the services you provide. If at all possible, monitor Swing Bed patient satisfaction.

Your hospital website is crucial. Make sure information about Swing Bed is included and is easy to find. Include the types of patients you can accept, patient testimonials, and a number to call for more information. Emphasize that a patient who receives care at another hospital but lives in your community can always return for Swing Bed care.

If you have an internal newsletter, use it to talk about Swing Bed and the benefits to both your facility and the community.

Provide every patient that leaves your hospital for a higher level of care with information about your Swing Bed program and let them know they can return if needed to receive "*care close to home.*"

The National Rural Health Resource Center[89] has excellent marketing materials.

- Toolkit Overview and User Guide
- Swing Bed Campaign Brochure
- Swing Bed Campaign Newspaper Script #1
- Swing Bed Campaign Newspaper Script #2
- Swing Bed Campaign Summary of Care
- Swing Bed Campaign Poster

[89] Swing Bed Campaign | National Rural Health Resource Center (ruralcenter.org)
https://www.ruralcenter.org/drchsd/communications-toolkit/swing-bed

Image 1: Amenity Health Swing Bed Brochure pg. 1

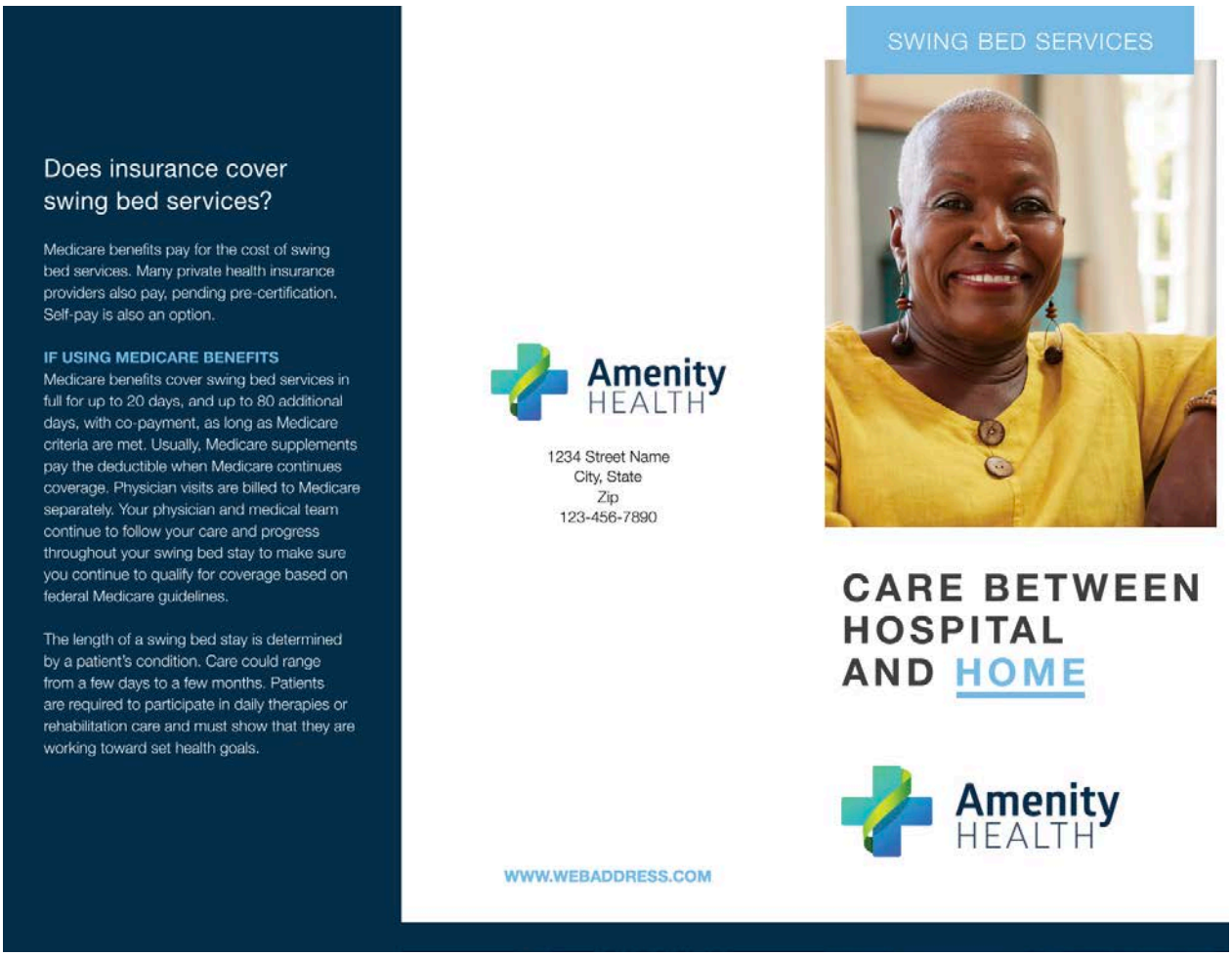


Image 2: Amenity Health Swing Bed Brochure pg. 2

What is swing bed?

Swing bed services are a stop between hospital and home, where patients get the continued care they need while recovering from an illness, injury or surgery. Our skilled staff provides on-site care, 24 hours a day, to help patients return home safely.

Patients enjoy the comforts of home, while family has the comfort of knowing their loved one is receiving the help they need. The length of stay varies, but the quality of care is consistent. After meeting therapy goals, patients can return home stronger and with more confidence.

HELPING YOU FIND YOUR WAY HOME.
Care is here, even if a hospital stay was elsewhere. To learn more about swing bed, call **123-123-1234** or visit **HOSPITALADDRESS.COM**.

What can I expect in swing bed care?

NURSING
Provides recovery care, pain management and education.

PHYSICAL THERAPY
Provides injury rehabilitation and helps patients build strength to prevent falls and gain movement, balance and flexibility to resume activities like walking or exercising.

OCCUPATIONAL THERAPY
Focuses on daily living skills that may include dressing and bathing.

RESPIRATORY THERAPY
Provides respiratory care and education about oxygen use.

NUTRITION SERVICES
Offers nutritional education and support.

SPEECH THERAPY
Helps with communication skills, reading and safe swallowing.

PHARMACY
Works with medical team to meet medication needs.

SOCIAL WORK
Helps patients, and families, find additional services and resources for further education. Can also coordinate advance healthcare directives for patients.

Why do patients need swing bed care?

Our goal is to help patients return home safely. Swing bed services can help patients who need:

- Long-term IV antibiotics
- Wound care
- Rehabilitation after surgery
- Therapy after a stroke, accident or injury
- Rehab or skilled care after a recent hospitalization

Here to help you home

When therapy goals are met, we make the transition home easier for patients and their families. As patients leave swing bed, help may include:

- Arranging in-home care if needed.
- Helping find alternate living arrangements.
- Coordinating community services and help.
- Providing guidance if a patient needs home medical equipment and supplies (shower bench, walker, wheelchair, etc.).

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SECTION 8

Frequently Asked Questions

Chapter 18
Frequently Asked Questions

1. ***If a patient is an acute care patient in the same hospital as Swing Bed, do they have to be given a choice of other post-acute care providers or can the physician just write an order to admit to Swing Bed?***

   Patients must be given a choice. Data for both quality and resource measures for skilled nursing facilities as well as other Swing Bed providers in your geographic area must be provided and the patient's choice documented.

   Since Swing Bed's do not have publicly available data, providing information about your internally collected measures is acceptable.

2. ***Can you admit a patient to Swing Bed if there is a SNF bed available?***

   Maybe. There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.[90]

   However, the State of Montana requires Medicaid patients to be discharged to an appropriate nursing home with a bed within a 25-mile radius within 72 hours of an appropriate bed becoming available. This does not apply when a waiver is in place, and when there is no appropriate nursing facility bed available within a 25-mile radius.[91]

3. ***Can a patient at end of life receiving terminal or palliative care be admitted to Swing Bed?***

   Potentially. The patient must have a skilled need and meet the Medicare admission and continued stay requirements. Other payors may approve a Swing Bed stay for terminal care.

4. ***Can you admit a patient to Swing Bed if they only require skilled nursing and not physical therapy or occupational therapy?***

   *Y*es. The Medicare Benefits Manual, Chapter 8 has multiple examples of skilled nursing care.

5. ***How do you document choice of physician if you only have two or three physicians or just one hospitalist group who provide Swing Bed care?***

   It is permissible to disclose to the patient that you have only a few providers, or a hospitalist group, which provide Swing Bed care. However, if you have other providers on your medical staff, you MUST allow the patient to choose one of those providers.

[90] Appendix W C-1600 §485.645
[91] ARM Rule 37.40.405(1)(b) and (2)

6. ***Is it appropriate to tell the patient to let the nursing staff know if they want to contact their physician?***

   No. The patient has the right to contact their physician directly.

7. ***How often are care planning meetings required?***

   There is no specific requirement for the frequency of care plan meetings. However, there are requirements for a comprehensive assessment and a comprehensive care plan. With a patient stay of only 12-15 days, care plan meetings should occur a minimum of once per week, and ideally twice per week. If care plan meetings are only held once per week, an additional meeting should be scheduled for new admissions.

8. ***Does the physician have to attend the care plan meetings?***

   Generally, yes. C-1620 §483.21(b) requires that the attending physician participate in development of the plan of care. Participation in the plan of care meetings facilitates discussion and input from all team members, including the patient. If the provider cannot attend, you may consider documenting their concurrence with the plan before or after the Care Plan meeting. However, this should be an isolated occurrence and not routine.

9. ***Does the dietician have to attend the care plan meetings?***

   No. However C-1620 §483.21(b) requires a representative from dietary. If the dietician cannot attend the representative from dietary should be knowledgeable and able to speak to nutritional goals.

10. ***It seems like the Care Planning meeting is redundant and includes what each discipline has already documented in their notes. Why does it need to be documented again?***

    The purpose of the Care Plan Meeting is for each discipline to discuss their assessment and goals so that the whole team can be involved and provide feedback, including the patient. Or to put it another way, "*The whole is greater than the sum of the parts.*"

11. ***We have trouble getting the various disciplines to attend the care planning meeting, including the physician. Any thoughts?***

    A few strategies to consider:
    - Ask for administration support. In some facilities the CEO or CFO attend
    - Track attendance by the required disciplines as part of the Swing Bed scorecard
    - Find a time that most disciplines are available
    - Schedule at the same time and then cancel if no patients
    - If necessary, block the physician or therapy schedules
    - Keep the meetings focused and concise
    - Expect documentation updates by each discipline prior to the meeting

12. Is there a minimum or maximum length of stay in Swing Bed?

No. There is no limit to length of stay for Medicare patients as long as the patient continues to meet skilled criteria.[92]

In Montana, some hospitals have been granted a waiver to care for Long-Term Non-Skilled Swing Bed patients, in which the length of stay may be several years.

13. If the patient is receiving rehabilitation therapy and the goals have been met or the patient is not progressing, should they be discharged right away?

It depends. The Medicare Benefits Manual, Chapter 8, Section 30.4.1 clearly states that Medicare allows time to develop a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration. You may want a period of time after the goals are initially met to ensure that the goals can be maintained, and the patient can function independently or safely when they are discharged.

14. Do you have to provide patient activities?

Maybe. Although the requirement for a formal activities program was eliminated from the CoPs, CMS still requires that if the patient needs activities they will be provided and included in the plan of care. This does not require an assessment by a qualified occupational therapist or activities professional but can be assessed by nursing or rehabilitation staff.

However, the State of Montana requires an activities program by a qualified occupational therapist or activities professional.[93]

15. Who can provide patient activities?

Once there has been an activities assessment, any staff member, volunteer, family, or friend, can provide activities. However, activities must be documented.

16. Is a Social Worker required?

No. However, medically related social services are required and include:

- Arranging services outside of the facility
- Assessing social and emotional factors
- Identifying discharge plans
- Assisting or arranging for a patient to obtain needed items and services from outside
- Assisting patients with financial and legal matters including advance care planning

[92] Appendix W C-1600 §485.645
[93] ARM Rule 37.40.412 (1-3)

17. How often should the physician see the patient?

Other than the certification at admission and recertification at 14 days and every 30 days thereafter, there is no specific requirement for how often the physician must see the patient. Most facilities establish a policy of at least weekly. However, the physician should see the patient as often as necessary to assess and evaluate treatment.

18. Do you have to provide speech therapy?

No. Speech therapy is not required. However, if patients require speech therapy, including some stroke patients, the facility should not admit the patient unless speech therapy is available.

19. Do you have to provide rehabilitation therapy on the weekend?

Maybe. The requirement for rehabilitation therapy is a minimum of five (5) days per week.[94] However, if a patient requires therapy more than five days per week based on the assessment, treatment plan, and provider orders, then therapy must be provided on the weekends.

20. *Does Rehabilitation (PT, OT, Speech) have to see the patient more than once per day?*

It depends. The frequency of therapy must be determined by the individual discipline's assessment and ordered by the physician.

21. Our staff treat the Swing Bed patients like an acute care patient and do not seem to understand the difference. They also frequently say they were not hired to take care of nursing home patients. Any thoughts?

This can be difficult since the patients almost always stay in the same bed and have many of the same treatments or therapy that they received while in acute care. Some ideas to consider might include:

- Promote Swing Bed as a strategic service line
- Relate the difference in Swing Bed in the same way you would talk about the differences between ICU and Acute Care
- Provide education about skilled care and why it is critical not only to the facility but to the patient who can stay in their own community
- Tell patient stories about the benefits of Swing Bed

22. Can you bill for Part B services while a patient is in Swing Bed, such as if the patient needs a CT or MRI?

The first question to ask is if the patient should be discharged from Swing Bed and admitted to acute care because they have an acute care need.

[94] Medicare Benefits Manual Chapter 8, 30.6

However, if the patient continues to meet Swing Bed criteria, and the patient is insured by Medicare, all services are included in the per-diem rate and cannot be billed separately. "*CAHs are exempt from the SNF PPS and instead are paid based on 101 percent of reasonable cost for swing-bed services. CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3))*."[95]

23. If the patient is discharged from Swing Bed and comes to the ED three days later, can they be admitted directly to Swing Bed without another acute care stay?

Yes, as long as there was an admission to acute care within the last 30 days, and the reason for admission to Swing Bed is for the same condition or reason that they previously received Swing Bed care.

24. Can the patient have a leave of absence from Swing Bed?

Yes. If the leave is ordered by the physician, is in compliance with hospital policies, and the patient receives all appropriate information and education during the leave of absence, such as how to take scheduled medications. However, the leave of absence should be for a short period of time such as to go to a dentist or doctor's appointment.

25. How do you navigate Appendix PP and figure out which of the numerous tags apply?

It is not easy. Hopefully, the cross walk in Appendix 3 will help.

[95] Medicare Benefit Policy Manual Chapter 3, 60

SECTION 9

Lessons from the Field

Swing Bed Admission Processes

Clark Fork Valley Hospital, Plains, MT

Background

This project was chosen via review of policies and procedures as well as swing bed conditions of participation (COP). This project will not only prepare CFVH for regulatory surveys and compliance but also increase the value of our Swing Bed Program.

CFVH electronic medical record, Epic, includes .dotphrase, which captures documentation of required elements to be reflected in the patient record. Epic's .dotphrase was identified as a potential for high impact to improvement of documentation.

Project Aim

Increase the percentage of swing bed admissions with dotphrase use to ensure required CoP elements are met.

Increase the percentage of swing bed admissions with Swing Bed Packet components completed and signed documents scanned to Epic's Media Section.

Chart review to occur concurrently to capture required elements. Chart review initially to be completed by PI Manager and then transition to Unit Manager for ongoing monitoring.

A three-pronged approach to improvement includes:

- Revision of Epic .dotphrase.
- Revamp of Swing Bed Admission Packet
- Process Redesign for Epic Media section.

Project Design & Methods

Epic .dotphrase revision includes: "The following documentation has been provided and reviewed with the patient at admission":

- Swing Bed General Information
- *Advance Directives
- Rights and Responsibilities
- *Choice of Physician (Scan Required)
- Physician Contact Information
- Conditions of Admission (Signature & Scan Required)
- Privacy Practices
- Grievances and Complaints
- Abuse and Neglect
- Transfer and Discharge
- Contact information for Hospital, QIO, and State Ombudsman

The Swing Bed (SB) Admission packet includes new and updated materials:

- Hospitalist Explanation Flyer - New! Listing of available providers to support patient preference
- SWB Explanation Brochure - Updated

- In-depth SWB Patient Rights & Responsibilities Forms – New! Duplicate copies
- Abbreviated, easy to understand SWB Patient Rights & Responsibilities Flyer – New! Easy to read and understand version developed.
- CFVH Consent for Treatment and Conditions of Admission form – no change.
- Required "Medicare Message" form – New! Added to packet.
- Activity calendar – Revised to reflect current activities and CoP requirements.
- Advance Directive and POLST information.

Process redesign for copies to be scanned to Media attached to admission:

- SWB Patient Rights & Responsibilities Forms
- CFVH Consent for Treatment and Conditions of Admission form
- Required "Medicare Message" form – New! Added to packet.
- Activity assessment

Results

Improvement has been observed with increased, consistent, and complete .dotphrase use.

Evaluation of baseline data reflected two different .dotphrases; 1 with appropriate information and 1 that lacked elements. Removed incomplete .dotphrase to establish a clear signal for staff. Increased compliance and data capture noted.

Checklist helped support staff to complete all of the process steps including scanning documents to media

Next Steps & Conclusions

This has been a great project worthy of focus. CFVH has committed and caring staff who are very flexible to changes amidst a pandemic, staffing challenges and competing projects. This outcome reflects their engagement.

The initial Swing Bed admission process was time intensive and is more time intensive after the project. The statement "*if it isn't documented, it isn't done*" applied to the baseline data collection. Elements were happening, we were not capturing the documentation in a concise manner. Now, we are through the .dotphrase development and scanning signed documents to media "*Now it is done and documented in the record.*"

Adapt revised .dotphrase. Discovered there were two and the wrong one was being used so duplicates removed and training provided for staff. Policies pulled out from Observation to Inpatient as stand-alone policies. This helps new staff find the policies.

We believe our comprehensive care plan process may need further focus to fully comply with the CoP's. Continue efforts to return to their previous residents as much as possible.

Credit: Clark Fork Valley Hospital Plains, MT, 2022

Using Readmission Interviews to Reduce Readmissions

Central Montana Medical Center, Lewistown, MT

Background

CMMC chose this project to increase our compliance with the Swing Bed Conditions of Participation and reduce our number of readmissions while ensuring a safe transition of care.

Project Aim

The goal is to decrease our percentage of swing bed discharges readmitted to any status within CMMC (5% or less) and to implement and maintain swing bed readmission interviews when readmissions do occur (100% of readmissions).

We will measure the total number of swing bed patients readmitted to any status within 30 days of discharge out of the total number of swing bed discharges, as well as the total number of readmitted patients who received a readmission interview out of total readmissions from swing bed discharges.

Project Design & Methods

Readmission interviews were implemented to monitor and act on any readmission trends. The Utilization Review (UR)/Discharge Planning/Swing Bed Coordinator completed the readmission interviews and Quality Improvement staff were able to view the results through the electronic health record.

By interviewing readmitted Swing Bed patients, staff was able to identify potential areas of improvement in the discharge process to prevent future readmissions.

Results

CMMC successfully implemented readmission interviews with all readmitted patients (100%), aiding in improvement of discharge planning.

CMMC's readmission rate for discharged Swing Bed patients improved from 33% in June 2021, to 0% in May 2022.

Next Steps & Conclusions

CMMC will adapt interventions developed in this project and take a more collaborative approach to future projects with regular meetings to discuss findings. The project was successful for both measures from baseline to remeasurement.

Quality Improvement and Discharge Planning teams will communicate on identification of readmission trends and subsequent action. Once the transition within the discharge department is complete, it would be advantageous to train nursing staff to assist in the readmission interviews.

The implementation of readmission interviews positively affected the percent of subsequent readmissions as CMMC staff was able to identify patient needs and causes of past readmissions to help prevent future readmissions.

Credit: Central Montana Medical Center, Lewistown, MT, 2022

Patient Discharge Experience

Frances Mahon Deaconess Hospital, Glasgow, MT

Background

This project was chosen to improve Swing Bed processes within the facility and swing bed quality measures.

Project Aim

Improve collective expectations of staff, providers, patients and families on discharge readiness and timelines.

We aim to achieve this by:

- Documenting short and long-term goals in our Care Management intervention
- Documenting short and long-term goals on the Swing Bed white board in patient's rooms.

Project Design & Methods

Interventions:

- Purchased separate white boards for individual Swing Bed patient rooms.
- Improved consistency in documenting short term goals in the EMR
- Our Multidisciplinary Care rounds have been consistently at the bedside every week, including family in person and/or via telephone if they are willing and available.

Results

At the start of the project in October 2021, there were variations in expectations of discharge readiness by staff and patients.

By May 2022, patients and families were verbalizing satisfaction and readiness for discharge.

Next Steps & Conclusions

Adopt, we have incorporated it into our process and will continue and work toward increasing patient family/caregiver participation.

Multidisciplinary Care rounds at the bedside allows for questions and explanations of patient progress and goals. It is our further goal that these process will lead to successful transitions to the next living situation for our patients.

Patients, families, and care-givers have provided positive feedback to process changes.

Credit: Frances Mahon Deaconess Hospital, Glasgow, MT, 2022

Swing Bed Patient Satisfaction

Sidney Health Center, Sidney, MT

Background

Sidney Health Center received feedback from patients and families that they wanted more frequent showers and/or baths while in the swing bed program.

Project Aim

Our goal is to increase the number of offered or scheduled showers to 2 out of 7 days per week for swing bed patients as measured by documented hygiene tasks.

Project Design & Methods

Nursing, CNA, and staffing were consulted with this feedback and asked how they would like to approach this project. It was decided that shower days would be written on the white board in the patient room and the task would be documented in the chart.

Results

Shower days increased from 2 showers for every 11 days to 2 showers for every 7 days.

Next Steps & Conclusions

Sidney Health Center will adopt interventions developed in this project. Staff will continue to make sure shower days are written on the white board in the patient room.

It is essential to include frontline staff in the change process. Focusing on small changes can lead to big improvements in patient care and satisfaction.

Credit: Sidney Health Center, Sidney, MT, 2022

Improving Discharge Planning to Reduce Readmissions

St. Luke Community Healthcare, Ronan, MT

Background

We chose reducing readmissions after discharge from swing bed because reducing readmissions to any part of the hospital is a priority for the organization in terms of patient safety and appropriate plans of care.

Project Aim

Our goal is to have less than 5 readmissions after discharge from swing bed for 6 months from July 2022 through December 2022.

Project Design & Methods

Swing bed policy and procedures were examined to identify for any gaps in regulatory requirements that may result in opportunities of improvement in readmissions from discharges after swing bed.

Policies and procedures were reviewed by a consultant and a team of hospitals employees including Director of Nursing, Med/Surg Nurse Manager, and Case Managers.

Results

In July 2022, the swing bed admission packet and policy was fully evaluated and updated to meet regulatory requirements.

Next Steps & Conclusions

We will adapt these interventions.

Upon restarting swing bed admission and policy review and changes, we will reexamine how those impact our readmissions in particular, within multidisciplinary care team meetings.

We will track and trend readmission data to evaluate other avenues to improve readmissions since we have long periods of no readmissions followed by a flurry of readmissions in a short time period and then back to no readmissions.

We will implement deep dive looks into readmission cause at the time of readmissions.

Credit: St. Luke Community Healthcare, Ronan, MT, 2022

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APPENDIXES

Appendix 1: Swing Bed Policies and Procedures

Policies Required by Appendix W

1. Criteria and Initial Determination of Swing Bed Eligibility
   - ☐ Hospital admission criteria for the types of patients you can accept
   - ☐ Criteria for admitting a Medicare patient: *Medicare Benefits Manual Chapter 8*
   - ☐ Medicaid criteria if you accept Medicaid patient: *State regulations*
   - ☐ What information should be reviewed and by whom prior to making an admission decision
   - ☐ Time frames for making an admission decision

2. Admission Processes
   - ☐ Admission orders
   - ☐ New medical record account number
   - ☐ Patient required notices and disclosures
     - Individual(s) responsible for providing notices and disclosures
     - Patient Rights: *C-1608; F-550*
     - Patient Responsibilities
     - Choice of Physicians: *C-1608; F-555*
     - Advanced Directives: *C-0812; F-578*
     - Financial Obligations: *C-1608; F-620*
     - Abuse and Neglect: *C-1612; F-585; F-602*
     - Contact information including Ombudsman*: C-1608; F-585*

3. Physician certification and recertification: *Medicare Program Integrity Manual Chapter 6 – 6.3*
   - ☐ Initial Physician Certification
   - ☐ Periodic Physician Certification

4. Assessment
   - ☐ Comprehensive admission assessment: *C-1620; F-636*
   - ☐ Review of PASRR at admission: *C-1620; F-645*
   - ☐ Assessment of Trauma at admission: *C-1620; F-659; F-659; F-741; F-7422*
   - ☐ Reassessment after significant change: *C-1608; F-637*

5. Plan of Care
   - ☐ Baseline care plan within 48 hours: *F-655*
   - ☐ Multi-disciplinary plan of care: *C-1620; F-553; F-655; F-656*
     - Responsibility for facilitating development of plan of care
     - Required participation in development of plan of care
     - Frequency of care planning meetings
     - Patient involvement – include how you involve patient including posting goals in room
     - Care plan with measurable goals that are time-limited

6. Abuse, Neglect, Exploitation and Misappropriation of Property: *C-1612; F-600*
   - ☐ Patient's right to be free from abuse, neglect, and exploitation
   - ☐ Not employ staff who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law
   - ☐ Prohibit abuse, neglect, exploitation, and misappropriation of property
   - ☐ Timelines for reporting, investigation, and follow-up both internally and to the State
   - ☐ Staff and provider education and competency: *F-838*

7. Choice of Physicians: *C-1609*
   - ☐ Patients are given a choice of physicians
   - ☐ Patients are provided with contact information for providers, including any consulting physicians

8. Financial Obligations: *C-1608*
   - ☐ Medicare: Any charges for services not covered under Medicare or by the facility's per diem rate.
   - ☐ Medicaid:
     - o The items and services that are included in services and for which the patient may not be charged
     - o The items and services for which the patient may be charged, and the amount of charges for those services

9. Rehabilitation
   - ☐ Assessment Timeframe
   - ☐ Documentation

10. Nutrition: *C-1626; F-800; F-803*
    - ☐ Dietician assessment (even if patient not at nutritional risk)
    - ☐ Maintaining acceptable nutritional status including body weight and fluid intake
    - ☐ Diet orders
    - ☐ I&O
    - ☐ Frequency of weights

11. Dental Care: *C-1624; F-791*
    - ☐ Routine and emergency dental care
      - o Assist with appointments and transportation
      - o Refer within 3-days if lost or damaged dentures
      - o Documentation of what was done to ensure adequate nutrition and hydration awaiting dental services and extenuating circumstances
    - ☐ When loss or damage of dentures is the facility's responsibility
12. Discharge or Transfer: *C-1610; C-1620; F-622; F-623; F-624*
    - ☐ Reasons for transfer or discharge
    - ☐ Documentation in the medical record by a physician

- ☐ Information provided to receiving provider
- ☐ Patient notice
- ☐ Timing of patient notice
- ☐ Content of patient notice
- ☐ Orientation before transfer or discharge
- ☐ Discharge Summary
- ☐ Post-Discharge plan of care
- ☐ Ombudsman notification

13. Visitation: *C-1608; C-1054; C-1056; C-1058*
    - ☐ Notification of visitation policies
    - ☐ Immediate access for visitors per patient choice

14. Social Service: *C-1616*
    - ☐ Medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being

15. Staff Education
    - ☐ Communication*: F-941*
    - ☐ Patient Rights: *F-941*
    - ☐ Abuse, Neglect and Exploitation: *F-943*

16. Swing Bed Outcome Measures. May be part of the facility Quality Assurance and Performance Improvement (QAPI) Plan.

Partial List of Facility Policies

- ☐ Advance Directives
- ☐ Billing
- ☐ Case Management and Discharge Planning
- ☐ Discharge Planning
- ☐ Emergency Preparedness
- ☐ Fall Prevention and Post-Fall Follow-Up
- ☐ HIPPA and Privacy
- ☐ Human Resources
- ☐ Infection Control
- ☐ Life Safety
- ☐ Medical Records
- ☐ Medication Administration
- ☐ Organ Procurement
- ☐ Pain Assessment and Reassessment
- ☐ Right to be photographed or refuse

- ☐ Restraints
- ☐ Staffing
- ☐ Transportation for outside medical care

Administrative Rules of Montana (ARM) Required Policies

1. Participation Requirements
   - ☐ Number of Swing Beds: *37.40.402(c)*

2. Special Services
   - ☐ Preadmission Screening: *37.40.405(1)(a)*
   - ☐ Availability of nursing facility bed: *37.40.405(1)(b))*
   - ☐ Discharge to appropriate nursing home bed within a 25-mile radius when becomes available within 72 hours: *37.40.405(2)*
   - ☐ Notice to patient before discharge*: 37.40.405(3)*
   - ☐ Right to request waiver of transfer: *37.40.405(4)*

3. Abuse
   - ☐ Mistreatment, neglect, abuse, and misappropriation of property: 37. *40.408*

4. Specialized Rehabilitative Services
   - ☐ Specialized Rehabilitative Services required to be provided: *37.40.409*

5. Activities
   - ☐ Ongoing program of activities provided by a qualified professional: *37.40.412*

6. Patient Rights
   - ☐ Patient Rights (*Not included in Appendix W*): *37.40.416*
     - o Right to refuse to perform services: *(6)(a)*
     - o Receive compensation if services are performed: *(6)(b)*
     - o Right to be informed in writing of the policies and procedures developed by the facility*: (13)*

7. Transfer and Discharge Rights: *37.40.420*
   - ☐ Transfer or Discharge under specific circumstances
   - ☐ Notice of Discharge

8. Post-Discharge Rights: *37.40.421*
   - ☐ Recapitulation of patient's stay
   - ☐ Final summary of patient's status
   - ☐ Post discharge plan of care

Long Term or Intermediate Swing Bed Patients (Recommended Policies)

1. Activities Program: *F-679*
   - ☐ Frequency
   - ☐ Activities Calendar
   - ☐ Documentation of Participation
2. Bathing and Personal Hygiene
   - ☐ Frequency
3. Assessment
   - ☐ Frequency of daily / weekly assessments (CNA and RN)
   - ☐ Reassessment with significant change
   - ☐ Quarterly Assessments: *F-657*
4. Provider
   - ☐ Frequency of visits
   - ☐ Recertification
5. Plan of Care
   - ☐ Frequency of Inter-disciplinary team meetings
   - ☐ Required attendance
   - ☐ Development of Plan of Care
   - ☐ Documentation
6. Medication and Psychotropic Drug Review: *F-757; F-758*
   - ☐ Frequency
   - ☐ Documentation
   - ☐ review by physician
7. Patient or Family Council: *F-565*
   - ☐ Frequency
   - ☐ Attendance
   - ☐ Minutes
8. Restorative Program: *F-688*
   - ☐ Frequency
   - ☐ Elements of program
9. Patient Funds
   - ☐ Availability
   - ☐ Security

Appendix 2: Regulatory Index

State Operations Manual Appendix W

- C-1600 §485.645: Special Requirements for CAH Providers of Long-Term Care Services
- C-1602 §485.645(a): Eligibility
- C-1604: §485.645(b): Facilities Participating as Rural Primary Care Hospitals (RPCHs)
- C-1606 §485.645(c): Payment
- C-1608 §485.645(d): SNF Services
- C-1608 §485.645(d)(1): Resident Rights
- C-1610 §485.645(d)(2): Admission, Transfer and Discharge Rights
- C-1612 §485.645(d)(3): Freedom from abuse, neglect, and exploitation
- C-1616 §483.15(d)(4): Social Services
- C-1620 §483.645(d)5): Comprehensive assessment, comprehensive care plan, and discharge planning
- C-1622 §485.645(d)(6): Specialized Rehabilitative Services
- C-1624 §485.645(d)(7): Dental Services
- C-1626 §485.645(d)(8): Nutrition

State Operations Manual Appendix PP

- §483.5 Definitions
- §483.10 Resident Rights
- §483.12 Freedom from Abuse, Neglect, and Exploitation
- §483.15 Admission Transfer and Discharge Rights
- §483.20 Resident Assessment
- §483.21 Comprehensive Person-Centered Care Plans
- §483.24 Quality of Life
- §483.25 Quality of Care
- §483.30 Physician Services §
- 483.35 Nursing Services
- Physical Environment §483.95 Training Requirement
- §483.40 Behavioral health services
- §483.45 Pharmacy Services
- §483.50 Laboratory Radiology and Other Diagnostic Services
- §483.55 Dental Services
- §483.60 Food and Nutrition Services
- §483.65 Specialized Rehabilitative Services
- §483.70 Administration
- §483.75 Quality Assurance and Performance Improvement
- §483.80 Infection Control
- §483.85 Compliance and Ethics Program §483.90

State of Montana Administrative Rules

- 37.40.401 Definitions
- 37.40.402 Provider Participation Requirements
- 37.40.45 Special Service Requirements
- 37.40.406 Reimbursement
- 37.40.408 Facility Policy Requirements
- 37.40.409 Specialized Rehabilitative Services
- 37.40.412 Resident Activities Program
- 37.40.416 Resident Rights
- 37.40.420 Resident Transfer and Discharge Rights
- 37.40.421 Resident Post Discharge Rights
- 37.40.422 Direct Care and Ancillary Services Workers' Wage Reporting/Additional Payments Including Lump Sum Payments for Direct Care and Ancillary Services Workers' Wage and Benefit Increases

Medicare Benefit Policy Manual, Chapter 8

10 – Requirements – General
10.1 – Medicare SNF PPS Overview
10.2 – Medicare SNF Coverage Guidelines Under PPS
10.3 - Hospital Providers of Extended Care Services

20 – Prior Hospitalization and Transfer Requirements
20-1 - Three-Day prior Hospitalization
20.2 – Thirty-Day Transfer
20.3 – Payment Bans

30 – Skilled Nursing Facility Level of Care – General
30.1 – Administrative Level of Care Presumption
30.2 - Skilled Nursing and Skilled Rehabilitation Services
30.3 – Direct Skilled Nursing Services to Patients
30.4 – Direct Skilled Therapy Services to Patients
30.5 – Nonskilled Supportive or Personal Care Services
30.6 – Daily Skilled Services Defined

40 – Physician Certification and Recertification for Extended Care Services
40.1 – Who May Sign the Certification tor Recertification for Extended Care Services

50 – Covered Extended Care Services
50.1 Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse
50.2 – Bed and Board in Semi-Private Accommodations Furnished in Connection with Nursing Care
50.3 – Physical Therapy, Speech-Language Pathology and Occupational Therapy
50.4 – Medical Social Services to Meet the Patient's Medically Related Social Needs
50.5 – Drugs and Biologicals
50.6 – Supplies, Appliances, and Equipment
50.7 – Medical Service of an Intern or Resident-in-Training
Other Services

60 – Covered Extended Care Days

70 – Medical and Other Health Services Furnished to SNF patients
70.1 – Diagnostic Services and Radiological Therapy
70.2 - Ambulance Service
70.3 - Inpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services
70.5 - Services Furnished Under Arrangements with Providers.

Appendix 3: Crosswalk Appendix W and Appendix PP

The crosswalk includes most of the interpretive guidelines for the Swing Bed regulations in Appendix W and related standards, interpretative guidelines, and guidance in Appendix PP. However, the references to Appendix PP may not be all included.

Appendix W	Appendix PP
C-1608 §485.645(d) Patient Rights	§483.10(a) (1-2) §483.10(b) (1-2) §483.10(c) (1-5)(7) §483.10(e) (2-8) §483.10(f) (1-3)(8) §483.10(g) (1-4)(6-10)(16) §483.10() (1-3) §483.10(i) (1-6) §483.10(j) (1-4) §483.12(a)(1) §483.15(a)(2) (Nurse Aide competency)
C-1610 §485.645(d) Admission, Transfer and Discharge C-1620 §483.645(d)(4) Comprehensive assessment, comprehensive care plan, and discharge planning	§483.15(c) (2-9) 483.15(b) (1-3)(9)
C-1610 §483.15(c)(3) Ombudsman	§483.15(c)(8)
C-1612 §485.645(d)(3) Freedom from abuse, neglect, exploitation, and misappropriation of property	§483.10(e)(1) §483.12 §483.12(a)(2)(3)(4) §483.12(b) (1-4) §483.12(c) (2-4) §483.95(c) (1-3) (Training) §483.156(c)(1)(iv)(A) to (c)(1)(iv)(D)
C-1620 §485.645(d)(5) Comprehensive Assessment	§483.20(b)(1)(2)(i) & (iii) §483.20(g) §483.20(h)-(i)
C-1620 §485.645(d)(5) Culturally Competent Trauma Informed Care	§483.21(b)(3) §483.25(m) §483.40(a) Competencies and Skills §483.40(b) & §483.40(b)(1)

Appendix W	Appendix PP
C-1620 §483.21(b) Comprehensive care plans	§483.10(c)(2)-(3) §483.21(a) §483.21(b)(2) §483.21(b)(3)(ii)
C-1620 §483.21(b) PASRR	§483.20(e)(1)(2) §483.20(k) (1-3)
C-1622 §485.645(d)(6) Specialized Rehabilitative Services	§483.20(g) §483.40(c)(1)(2) §483.65(a)(1)(2) §483.70(e)(2)
C-1624 §485.645(d)(7) Dental Services	§483.55(a) (1-5) §483.55(b) (1-5) §483.55(g)
C-1626 §485.645(d)(8) Nutrition	§483.25(g) (1-3) §483.60(a) (1-2) §483.60(c) (1-7) §483.60(d) (1-2)(6)

Appendix 4: Pre-Admission Checklist

Patient Information If possible, request the entire medical record and not just the history and physical (H&P) or discharge summary for any external referrals.	
Name and Age	
Attending physician	
Date of admission and reason for admission to acute care	
Anticipated discharge date from acute care	
Stated reason for admission to Swing Bed	
Acute Care Stay ☐ Surgical procedures ☐ Major complications or adverse events that occurred during the hospital stay ☐ Medications including IVs ☐ Nutritional status ☐ Functional status ☐ Continence	☐ Skin (including any skin breakdown) ☐ Wounds ☐ Mental status / Cognition ☐ Behavior ☐ Fall risk ☐ Ventilator weaning record (if applicable) ☐ Restraints during any point in hospital stay
Swing Bed Care Needs ☐ IV Therapy ☐ Simple Wound Care ☐ Complex Wound Care ☐ Ventilator Weaning ☐ Teaching / Training ☐ Nutrition Deficit	☐ PT/OT to increase ADLs / Functional status ☐ Speech Therapy thru-out Swing Bed stay ☐ Swallow exam(s) ☐ Special Equipment (i.e., specialty bed, wound vac, etc.) ☐ Non-formulary medications ☐ Other (i.e., dialysis, etc.)
Prior Living Arrangement ☐ Home ☐ Assisted Living ☐ Group Home ☐ Long Term Care ☐ Homeless ☐ Other	Anticipated Living Arrangement ☐ Home ☐ Assisted Living ☐ Group Home ☐ Long Term Care ☐ No clear plan ☐ Other
Family support structure and willingness to accept Swing Bed admission	
Payor authorization obtained if needed. If traditional Medicare, benefit days are available.	

Medicare Criteria
☐ The patient requires skilled nursing or skilled rehabilitation services
☐ There is a physician order for skilled services
☐ Services are 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
☐ Services are required at least 7 days per week for skilled nursing
☐ Rehabilitation if required, is available at least 5 days per week
☐ If Physical Therapy is required, it is available at the frequency and duration required by the patient
☐ If Occupational Therapy is required, it is available at the frequency and duration required by the patient
☐ If Speech Therapy is required, it is available at the frequency and duration required by the patient
☐ As a practical matter, the daily skilled care can only be provided on an inpatient basis
☐ The services are reasonable and necessary for treatment of the patient's illness or injury
☐ 3-Day inpatient qualifying stay within the last 30 days

Appendix 5: Admission Packet Example

Section 1 - Signature Page

The Hospital is required to provide you with certain information at the time you are admitted to a Swing Bed. By signing this document, you acknowledge that the Hospital has gone over the documents listed below, verbally and in a language that you can understand and provided you with a written copy. The Hospital has given you the opportunity to ask any questions you may have. You may also ask questions anytime during your stay.

- ☐ Welcome Letter
- ☐ Overview of Swing Bed Services
- ☐ Privacy Practices
- ☐ Patient Rights
- ☐ Patient Responsibilities
- ☐ Financial Obligations
- ☐ Advance Directives
- ☐ Hospital Responsibility for Preventing Abuse
- ☐ Grievance and Complaints
- ☐ Transfer or Discharge
- ☐ Contact Information

☐ Choice of Physician: Please choose the physician you would like to be your primary physician while you are a patient in Swing Bed. The physician must be on staff at the Hospital.

Physician contact information and contact information for other primary care providers that may be involved in your care are listed below.

Patient or Representative Printed Name / Signature:

Date/Time:

Name and title of person who reviewed information with patient or representative

Date/Time:

MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

Section 2 - Welcome Letter

On behalf of the entire staff, we are happy that you have selected our facility to meet your healthcare needs. Whether you will be with us for a long or brief time, we want you to know how proud we are of our hospital and how we work extremely hard to maintain high standards.

Let me introduce you to our Swing Bed Program, the services we offer, and the dedicated professional staff who are committed to making your stay here as pleasant and comfortable as possible. We would also like to make you aware of the rights and responsibilities you have as a patient.

If you would like any additional information not included in this packet, please feel free to ask. Any member of our staff will be happy to assist you.

Name and Signature of CEO

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

Section 3 - Overview of Swing Bed Services

Swing Bed Information

Medicare covers swing bed services in certain hospitals and critical access hospitals (CAHs) when the hospital or CAH has entered into a "swing-bed" agreement with the Department of Health and Human Services, under which the facility can "swing" beds and provide either acute hospital or skilled nursing facility-level care, as needed.

When your physician has determined that you have recovered from the acute phase of your illness, accident, or surgery, but you are not able to go home yet, he or she may recommend transfer to Swing Bed. Some types of patients who may benefit from skilled services in a Swing Bed include patients who are:

- Recovering from joint replacement or other types of surgery
- Recovering from a stroke, cardiac or respiratory illness, or other medical condition
- Require management of complex wounds that need long-term antibiotic therapy that can't be treated in an outpatient setting
- Require assistance to learn how to manage medications

Swing Bed Services

The following services may be provided as part of a Swing Bed program.

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Intravenous Therapy
- Wound Care
- Medication Management
- Nutritional Counseling
- Patient & Family Education

Financial Obligations

Your costs will depend on your insurance coverage. You will receive separate information about financial obligations.

Doctor Visits

Similar to your acute care stay, you will receive around-the-clock nursing care, and your physician oversees your care. However, since you are no longer in the acute phase of your care, your physician may not make daily rounds but will visit with you at the very minimum at least once every week. Nursing staff will communicate any concerns or questions with your physician.

Planning your Care

Your Care Team, including your physician, nursing staff, and therapists, will work with you to set up personalized treatment goals and will share your progress with you throughout your stay. During the day, you will receive treatment(s) based on your condition and recovery goals. As a Swing Bed patient, you'll be encouraged to do as much as you can for yourself.

You have the right to be fully informed in advance about care and treatment and of any changes in that care or treatment. You also have the right to participate in planning your care and treatment and any changes in care and treatment, including planning for discharge.

There will be a care planning meeting at least once each week. We encourage you or your family to attend. This is the opportunity to ask questions and provide input to your care team. If you can't or choose not to participate, someone will meet with you after the conference to discuss the recommendations of your care team.

Family / Support Person Involvement

Your family or support person(s) are encouraged to play an active role in your recovery. They can help by providing emotional support and encouragement as well as by participating in any education that will help you care for yourself once you are discharged.

Clothing

While you are a patient in Swing Bed, we want you to be as comfortable as possible, so we expect you to wear your own clothes every day. Please have your family or friend bring clothes that are loose-fitting and a pair of comfortable and supportive shoes.

Length of Stay

How long you are in the hospital will depend on your progress toward the goals set by you and by the care team.

If you have traditional Medicare, you may remain in a Swing Bed as long as you are making progress toward your goals. Other insurance companies may have different limits on how long you can stay.

A member of the care team will meet with you to discuss discharge plans and options, which may include discharge back toto home, assisted living, or other options. The care team will be actively involved in this process and may provide recommendations and alternatives for future care when necessary.

We will give you notice, at least two (2) days before you are discharged or transferred, letting you know the discharge date, the place you will be discharged to, and who to contact if you think you are being discharged too early. You have the right to appeal this decision ifyou feel you are being discharged too soon.

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

Section 4 - Your Rights

As a swing bed patient, you have certain rights and protections under federal and state law.

1. If you are adjudged incompetent under the laws of a State by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under State law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

2. Your wishes and preferences must be considered in the exercise of rights by the representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process.

3. In the case of a patient representative whose decision-making authority is limited by State law or court appointment, you retain the right to make decisions outside the representative's authority.

4. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

5. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights. You have the right to be supported by the facility in the exercise of your rights.

6. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

7. You have the right to be informed, in advance, of changes to your plan of care.

8. You have the right to request, refuse, and/or discontinue treatment.

9. You have the right to participate in or refuse to participate in experimental research

10. You have the right to formulate an advance directive.

11. You have the right to choose an attending physician. You have the right to be informed if the physician you have chosen is unable or unwilling to be your attending physician, and to have alternative physicians discussed with you, and to honor your preferences, if any, in identifying options.

12. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

13. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other patients.

14. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

15. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.

16. You have the right to immediate access by others who are visiting with your consent, subject to reasonable clinical and safety restrictions, and your right to deny or withdraw consent at any time.

17. You have the right to secure and confidential personal and medical records.

18. You have the right to personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each patient.

19. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

20. You have the right to be informed in writing, if you have Medicaid insurance, at the time of admission or when you become eligible for Medicaid of:
    - The items and services that are included in nursing facility services under the State plan and for which you may not be charged
    - Those other items and services that the Hospital offers and for which you may be charged, and the amount of charges for those services
    - Be informed when changes are made to items and services

21. You have the right to be informed before, or at the time of admission, and periodically during your 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.

22. You have the right to access stationery, postage, and writing implements at your own expense.

23. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with State law.

24. You have the right to contact the Office of the State Long-Term Care Ombudsman.

25. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility are endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if you do not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claims and you refuse to pay for your stay.
    - The facility ceases to operate

26. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility.

27. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.

Additional patient rights required in Montana

28. Right to refuse to perform services.

29. Receive compensation if services are performed.

30. Right to be informed in writing of the policies and procedures developed by the facility.

Section 5 - Your Responsibilities

1. To provide, to the best of your knowledge, accurate and complete information about your present illness, past illnesses, hospitalizations, medications, mobility, and other matters relating to your health.

2. To report unexpected changes in your condition to your physician or other members of the Health Care Team.

3. To let us know if you clearly understand your plan of care or need further explanation.

4. To actively participate in your plan of care.

5. To follow hospital rules and regulations.

6. To be considerate of the rights of other patients and facility personnel.

7. To be respectful of the property of other patients and of the hospital.

8. To follow the smoke-free campus policy.

Section 6 - Choice of Physician

The Physician Group are designated as the attending physician(s) for Swing Bed patients. On nights and weekends coverage is provided by Emergency Department (ED) physicians. If you are okay with the Physician Group, please check below:

☐ **NAME OF HOSPITAL Physician Group**
The Physician Group includes:

If you prefer a different physician, please let us know which physician you prefer. Please note that the physician must have privileges to practice at our hospital and must agree to be your primary physician.

I would like _____to be my physician while I am a patient in Swing Bed.

Physician Contact Information

We understand you may want to contact your physician or other providers that are caring for you. You may let the nursing staff or any member of the care team you would like to speak to your physician, and they will call the physician for you.

You may also contact the physician(s) or other provider(s) directly by calling the number(s) below:

Provider Name:
Contact Info:

Provider Name:
Contact Info:

Provider Name:
Contact Info:

Section 7 - Financial Obligations

The following information shows what we may charge you for and your financial obligations based on your insurance.

***Medicaid**

If you have Medicaid insurance or when you become eligible for Medicaid, we may charge you for any of the following items:

- Telephone
- Television/radio for personal use
- Personal comfort items including notions, novelties, and confections
- Cosmetic and grooming items and services in excess of those for which payment is made
- Person clothing
- Personal reading matter
- Gifts purchases on behalf of a patient
- Flowers and plants
- Social events and entertainment offered outside the scope of the activities program
- Non-covered special care services such as privately hired nurses or aides
- Private room, except when therapeutically required, for example, isolation for infection control
- Specially prepared or alternative food you request, not ordered by your physician

*This will be specific for each State. Review the State Medicaid web site.

Medicare

If you have Medicare insurance, Medicare will cover 100% of Medicare covered charges, as outlined below, for the first 20 days as long as you meet Swing Bed criteria. You will receive a separate bill from your physician. Continued stay in a Swing Bed is always based on meeting Swing Bed criteria for skilled care.

Days 1 – 20	$0 for each benefit period
Days 21 – 100	$200.00 patient responsibility per day in 2023
Days 100 and beyond	All costs

Medicare-Covered Services include:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Physical and occupational therapy
- Medical social services
- Medications
- Medical supplies and equipment in the facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available in the swing bed
- Dietary counseling

If you have private insurance, your policy may cover the coinsurance after the first 20 days based on your plan's benefits. Case Management will call your insurance company to see what benefits you have, but it is always a good idea for you to call as well. If you do not have secondary insurance, you will be responsible for the copayment. If you are here longer than 100 days, Medicare will no longer cover your stay.

Section 8 - Freedom from Abuse and Neglect

As a patient you have the right to be free from verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and/or involuntary seclusion.

To prevent abuse, we completes a criminal background check of all employees. In addition, we provide education which includes, but is not limited to:

- Patient rights
- Abuse prevention
- Appropriate interventions to deal with aggressive behaviors
- Mandatory reporting procedure without fear of reprisal
- Recognizing signs of burnout, frustration, and stress that may lead to abuse
- What constitutes abuse, neglect, and misappropriation of property

We will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source, and misappropriation of patient property are reported immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.

If the events that cause the allegations do not involve abuse and do not result in serious bodily injury, the violation will be reported no later than 24 hours, to the administrator of the facility and other officials in accordance with State law including the State survey agency.

We have zero-tolerance for any behavior on the part of anyone who could encounter a patient that could be perceived to constitute verbal abuse, sexual abuse, mental abuse, physical abuse, corporal punishment, and/or involuntary seclusion.

If you or your family believe that you have been subject to any type of abuse, please contact:

Insert Facility Contact Information

Contact Information

If you wish to file a complaint about any type of abuse, neglect, misappropriation of property, or involuntary restraint, you may file a complaint any of the agencies listed below.

Insert Contact Info State DHS and Ombudsman

Section 9 - Transfer or Discharge

You will be given as much advance notice as possible before you are transferred or discharged.
The reasons you may be transferred or discharged include:

1. The transfer or discharge is necessary for your welfare, and your needs cannot be met.
2. The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided.
3. The health and/or safety of individuals are endangered.
4. You have failed, after reasonable and appropriate notice, to pay for your stay or to pay under Medicare or Medicaid.
5. The hospital ceases to operate.

You will be notified at least 30 days before you are transferred or discharged unless one of the following occurs:

1. The health or safety of individuals is endangered
2. Your health has improved sufficiently to allow a more immediate transfer or discharge
3. An immediate transfer or discharge is required due to urgent medical needs
4. You have not been in a Swing Bed for at least 30 days

The notice of discharge will include:

- Date of transfer or discharge
- Reason for transfer or discharge
- The place where you will be transferred or discharged to
- Right to appeal the discharge or transfer to the State, including the State Long-Term Ombudsman

Section 10 - Contact Information

Case Management

Risk Management

Chief Nursing Officer

Administrator

Ombudsman

- Local:
- Area:
- State:

Long-Term Care Office of Regulatory Services

Department of Health

Quality Improvement Organization (QIO)

Appendix 6: Comprehensive Assessment

Customary Routine

- ❑ Time wakes up
- ❑ Time goes to sleep
- ❑ Naps
- ❑ Time eats meals (Breakfast / Lunch / Dinner)
- ❑ Other

Cognitive Patterns

- ❑ Cognition Measurement Tool

Communication

- ❑ Ability to express ideas and wants, consider both verbal and non-verbal expression
- ❑ Able to make self-understood
- ❑ Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time
- ❑ Sometimes understood - ability is limited to making concrete requests
- ❑ Rarely/never understood

Vision

- ❑ Corrective Lenses
- ❑ Cataracts
- ❑ Blind

Mood

- ❑ Little interest or pleasure in doing things
- ❑ Feeling down, depressed, or hopeless
- ❑ Trouble falling or staying asleep, or sleeping too much
- ❑ Feeling tired or having little energy
- ❑ Poor appetite or overeating
- ❑ Feeling bad about yourself – or that you are a failure or have let yourself or your family down
- ❑ Trouble concentrating on things such as reading the newspaper or watching television
- ❑ Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual
- ❑ Thoughts that you would be better off dead, or of hurting yourself in some way

Behavior

- ❑ Hallucinations
- ❑ Delusions
- ❑ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others)
- ❑ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing)

- ❑ Other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste

History of Trauma

- ❑ Has there been anything within the last six months to a year that has caused you to be upset or very worried?
- ❑ Have you experienced the loss of a close friend, relative or a pet that you loved recently?
- ❑ Have you had any past trauma in your life that we should know about so we can better care for you?
- ❑ If you have experienced trauma is there something that helps you feel better?
- ❑ Is there anything we can do to help while you are in the hospital?

Culturally Competent Care

- ❑ Are there any cultural beliefs / customs that we need to know about?

PASRR

- ❑ If patient has a PASRR (usually completed if patient was a resident of LTC) review PASRR

Physical Functioning and Structural Problems

- ❑ Independent
- ❑ Setup or cleaning / washing assistance
- ❑ Supervision or touching assistance
- ❑ Partial/moderate assistance
- ❑ Substantial/maximal assistance
- ❑ Dependent

Continence

- ❑ Urinary incontinence (Is this always or sometimes)
- ❑ Bowel incontinence (Is this always or sometimes)

Medical Care

- ❑ Active Diagnosis
- ❑ Health Conditions
- ❑ Special Treatments and Procedures (Orders)

Dental

- ❑ Dentures (fitting / loose)
- ❑ Broken Teeth
- ❑ Overall dentation

Swallowing

- ❑ Loss of liquids/solids from mouth when eating or drinking
- ❑ Holding food in mouth/cheeks or residual food in mouth after meals
- ❑ Coughing or choking during meals or when swallowing medications
- ❑ Complaints of difficulty or pain with swallowing

Nutrition

- ❑ Nutrition Assessment
- ❑ Loss of 5% or more in the last month or loss of 10% or more within last 6 months

Skin

- ❑ Braden Scale
- ❑ If pressure ulcers or skin breakdown, describe

Activities

What do you like to do?

- ❑ Reading – print or audio books
- ❑ Puzzles
- ❑ Word games
- ❑ Watching TV
- ❑ Knitting / Crocheting
- ❑ Visiting with friends
- ❑ Other

Medications

- ❑ Medication Reconciliation

Goals

- ❑ Patient's desired discharge plan (where they would like to reside after discharge)
- ❑ Patient's goals for Swing Bed stay

Appendix 7: Cognitive Assessment Tool

1. Ask patient: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are sock, blue, and bed. Now tell me the three words.”

   Number of words repeated after first attempt.

0. None 1. One	2. Two 3. Three

2. After the patient’s first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

3. Ask patient "Please tell me what year it is right now." Able to report correct year

0. Missed by > 5 years or no answer 1. Missed by 2-5 years	2. Missed by 1 year 3. Correct

4. Ask patient: "What month are we in right now?" Able to report correct month.

0. Missed by > 1 month or no answer. 1. Missed by 6 days to 1 month.	2. Accurate within 5 days.

5. Ask patient: "What day of the week is today?" Able to report correct day of the week.

0. Incorrect or no answer	1. Correct

6. Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Able to recall "sock".	
0. No - could not recall. 1. Yes, after cueing ("something to wear").	2. Yes, no cue required.
Able to recall “blue”	
0. No - could not recall. 1. Yes, after cueing ("a color")	2. Yes, no cue required.
Able to recall "bed”	
0. No - could not recall. 1. Yes, after cueing ("a piece of furniture")	2. Yes, no cue required.

Appendix 8: Multi-Disciplinary Plan of Care

Example 1

Date	Patient Name	MR Number
Date of Admission	Reason for Admission	Expected Date of Discharge

Attendees by Name (Attendance required for those in **BOLD)**

☐ **Provider**	☐ **Patient or Patient Representative**
☐ **RN caring for patient**	☐ Swing Bed Coordinator / Case Manager
☐ **CNA caring for patient**	☐ Rehabilitation
☐ **Representative from Dietary**	☐ Pharmacist

Patient's Discharge Goal *(Stated in patient's own words)*

Long Term Goal *(What needs to occur for patient to be discharged in measurable terms)*

Discharge Planning

Nutrition and Hydration

Weight at Admission Current Weight

Weight/Gain or Loss (If more than five (5) pounds requires a specific nutritional plan)

IDT Meeting Date	Current Weight	Loss / Gain	Goal	Interventions By Discipline

Long-Term Goal: *One section for each Long-Term Goal*

IDT Meeting Date	Short-Term Goal	Interventions by Discipline	Progress
			☐ Met ☐ Not Met ☐ Progressing Notes:
			☐ Met ☐ Not Met ☐ Progressing Notes:

Multi-Disciplinary Plan of Care

Example 2

Date	Patient Name	MR Number
Date of Admission	Reason for Admission	Expected Date of Discharge

Attendees by Name (Attendance required for those in **BOLD**)

☐ **Provider**	☐ **Patient or Patient Representative**
☐ **RN caring for patient**	☐ Swing Bed Coordinator / Case Manager
☐ **CNA caring for patient**	☐ Rehabilitation
☐ **Representative from Dietary**	☐ Pharmacist

Significant History:

Problem(s):

Patient's Discharge Goal (Patient's own words)

Long Term Goal(s) (What needs to occur for patient to be discharged in measurable terms)

Interventions	**Responsible Discipline**	☐ Met ☐ Not Met ☐ Progressing ☐ Modifications Needed to Goal/Interventions Notes:

Appendix 9: Data Definitions

Return to Prior Living Arrangement

Exclude from both numerator and denominator

- Patients who leave against medical advice
- Patients who die while a patient in Swing Bed
- Patient admitted to another hospital or higher level of care

Numerator

Include all patients who return to where they resided immediately prior to the qualifying acute care admission. This may include Skilled Nursing Facility, Long Term Care Facility, Group Home, Assisted Living, Shelter, Home (including if patient was living with another person or relative in any home environment).

Denominator

- Count patient discharged from Swing Bed

Examples

1. Patient admitted to Swing Bed after orthopedic procedure. Complications occur and the patient must be readmitted to acute care in the same hospital. Count as NOT returning to prior residence.
2. Patient resided at home prior to acute care stay. Patient discharged to assisted living. Count as NOT returning to prior residence.
3. Patient resided in assisted living prior to acute care stay. Patient discharged to SNF. Count as NOT returning to prior residence.

Readmission within 30 Days to Inpatient or Swing Bed

Exclude from both numerator and denominator

- Patients who leaves against medical advice
- Patients who dies while a patient in Swing Bed
- Patients who have a planned admission to acute care in the same hospital where the patient is receiving Swing Bed care, or to another acute care facility, within 30 days from the date of discharge from Swing Bed. To be excluded, the planned readmission must have been determined at the time of admission to Swing Bed.

If the patient has more than one unplanned admission (for any reason) within 30 days after discharge from the Swing Bed admission, only count one readmission.

Numerator

- Include patients discharged from Swing Bed and admitted to observation, inpatient status, or Swing Bed status in the same hospital where the patient is receiving Swing Bed care within 30 days of discharge from Swing Bed

Denominator

- Count all patients who are discharged alive

Examples

1. Patient admitted to Swing Bed after orthopedic procedure. Complications occur and the patient must be readmitted to acute care in the same hospital. Count as readmission.
2. Patient admitted to Swing Bed after orthopedic procedure. Surgeon plans to take the patient back to surgery after 7 – 14 days, then to return the patient to Swing Bed. Do not count as readmission.
3. Patient admitted from Swing Bed to inpatient and back to Swing Bed three times during hospital stay. Only count as one readmission.
4. Patient discharged from Swing Bed and readmitted 45 days later. Do not count as readmission.

Post Discharge Follow Up Call Completed Within 3 Days of Discharge

Definition: 3 days is defined as the third day after the patient was discharged, counting the day of discharge. If the patient discharged on Friday, 3 days would be the following Monday

Exclude from both numerator and denominator

- Patients who leave against medical advice
- Patients who die while a patient in Swing Bed
- Patients admitted to same hospital or another hospital or higher level of care
- Patients admitted to Long Term Care or Skilled Nursing Facility

Numerator

- Include all patients discharged alive from Swing Bed
- Include any calls in which a message was left for patient to call back, even though the patient was not contacted directly
- Include calls made to guardian or caretaker

Denominator

- Count patients discharged alive from Swing Bed

Examples

1. Call made within 3 days but unable to reach patient and message left. Count as met
2. Call made within 3 days to guardian or caretaker. Count as met
3. Patient discharged on Tuesday. Call made on Friday. Count met
4. Patient discharged on Monday. Call made on Friday. Count as not met

Time from Referral to Accept / Decline Patient < 2 hours

Definition

- Referral times are from 9AM Monday – 4PM Friday.
  - Referrals received after 4PM on Friday will be considered met if they are responded to by 11AM the following Monday.
  - Referrals after 4PM Monday – Thursday, will be considered met if they are responded to by 11AM the following day.
- Information to the referring organization that the referral is pending is considered met if it is within the 2-hour time period.
- Count the start time when the referral is received by email, fax or phone call.

Exclude from both numerator and denominator

- Internal referrals

Numerator

- Count all external referrals

Denominator

- Count all external referrals

Examples

1. Referral at 5PM on Friday. Decision by 11AM the following Monday. Count as met.
2. Referral at Noon on Tuesday. Decision by 4PM on Friday. Count as not met.
3. Referral at 5PM on Wednesday. Decision by 11AM on Thursday. Count as met.

Attendance at Plan of Care Meeting

Numerator

- Count as CNA attendance if no CNA working the day of the care plan meeting
- Count as patient or patient representative attended if there is documentation that the patient or patient representative had an opportunity to review the plan of care and provide input

Denominator

- Count all Care Conferences. If more than one Care Conference, count each Care Conference

Examples

1. CNA working day of Care Conference but did not attend Care Plan meeting. Count as not met.
2. Representative from dietary attended via Zoom. Count as met.
3. Provider did not attend or document concurrence with plan. Count as not met.
4. No evidence in documentation that patient or designated representative agreed with plan of care and had an opportunity for input. Count as not met.

Appendix 10: Scorecard Example

	Resource Measures				Quality Measures												Growth			
	Readmission <30 days		Length of Stay		Plan of care posted in patient room		Return to prior living arrangement		Falls with injury		Attendance Care Plan Mtgs		Post-Discharge Call <3 days of discharge		Patient Satisfaction		Time from referral to accept / decline < 2 hours		Patient Days	
Baseline																				
YTD																				
	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal
Jan																				
Feb																				
March																				
April																				
May																				
June																				
July																				
Aug																				
Sept																				
Oct																				
Nov																				
Dec																				
Monthly Trend Graph																				

Appendix 11: Audit Tool

PRE-ADMISSION			
For patients in same facility moving from inpatient to Swing Bed: Quality and Resource information for post-acute providers in the geographic area provided in writing and discussed with patient.	MR #	MR #	MR #
ADMISSION			
For patients in same facility moving from inpatient to Swing Bed: Patient choice of skilled nursing provider documented in the medical record	MR #	MR #	MR #
Provider: Discharge order from inpatient *if in the same facility*	MR #	MR #	MR #
Provider: Admission order to Swing Bed	MR #	MR #	MR #
Provider: Reason for admission to Swing Bed documented in H&P	MR #	MR #	MR #
Provider: Attestation for Swing Bed Stay: 1. Certification that patient requires skilled care on a daily basis 2. Expected Length of Stay 3. Expected Discharge disposition	MR #	MR #	MR #
Provider: History and Physical within time frame specified in bylaws (usually 48 hours)	MR #	MR #	MR #
Patient Notices: 1. Patient Signature 2. Choice of Physician 3. Contact Info for physicians involved in care 4. Rights and Responsibilities 5. Advance Directives 6. Transfer and Discharge Rights	MR #	MR #	MR #

7. Financial obligations 8. Hospital Responsibility for preventing abuse and how to report 9. Contact information for State licensing agencies and Ombudsman			
Assessment: Nursing Assessment completed within 24 hours of admission	MR #	MR #	MR #
Assessment: History of Trauma	MR #	MR #	MR #
Assessment: Review of PASRR (if a PASRR has been done prior to admission. Will have been done if patient LTC resident)	MR #	MR #	MR #
Assessment: Dietician assessment within 72 hours of admission	MR #	MR #	MR #
Reassessment: Comprehensive reassessment with any significant change of condition	MR #	MR #	MR #
Plan of Care: Baseline Plan of Care developed within 24 hours of admission	MR #	MR #	MR #
Plan of Care: Multi-disciplinary Plan of Care developed within 3 days of admission	MR #	MR #	MR #
Plan of Care developed by Multi-disciplinary team that includes at a minimum: 1. Attending physician 2. CNA with responsibility for the patient 3. Registered Nurse with responsibility for the patient 4. Member of food and nutrition staff 5. To the extent practicable, the participation of the patient and the patient's representative(s) *(If do not attend – signs that they are in concurrence with plan)* 6. Other appropriate staff or professionals in disciplines as determined by the patient's needs or as requested by the patient. *(If patient is being seen by rehab, then they should attend. If there are complex medication issues, pharmacist should attend)*	MR #	MR #	MR #
Plan of Care: An explanation must be included in a patient's medical record if the participation of the patient and their representative is determined not practicable for the development of the care plan.	MR #	MR #	MR #
Plan of Care: Includes measurable objectives and timeframes to meet patient's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment	MR #	MR #	MR #

Plan of Care: Includes any specialized services or specialized rehabilitative services provided as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, it must indicate its rationale in the patient's medical record.	MR #	MR #	MR #
Plan of Care: Includes in consultation with the patient and the patient's representative(s), the patient's goals for admission and desired outcomes. Includes the patient's preference and potential for future discharge. Facilities must document whether the patient's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose	MR #	MR #	MR #
Plan of Care: Plan of Care updated at least weekly with input from the interdisciplinary team and the patient	MR #	MR #	MR #
Dietician assessment and recommendations implemented (For example, if dietician recommends weekly weights – check and see if they were done; if dietician recommends snack at bedtime – check and make sure snack was offered)	MR #	MR #	MR #
DISCHARGE			
Provider Documentation: Discharge Summary that includes a recapitulation of the patient's stay that includes, but is not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results	MR #	MR #	MR #
Patient Choice: *For patients being discharged to a post-acute provider (SNF, LTC, Home Health, IRF).* Quality and Resource information for post-acute providers in the geographic area provided in writing, discussed with patient, and documented in the medical record	MR #	MR #	MR #
NOMNC: Patient provided with Notice of Medicare Non-Coverage 2 days before discharge	MR #	MR #	MR #

Patient Notice provided within 24 hours of discharge Patient notified of transfer or discharge and the reasons for the move. The patient notice includes: • The reason for transfer or discharge • The effective date of transfer or discharge • The location to which the patient is transferred or discharged • A statement of the patient's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request • The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman • For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities	MR #	MR #	MR #
Copy of the patient notice of transfer or discharge sent to the State Ombudsman	MR #	MR #	MR #
Reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescribed and over the counter).	MR #	MR #	MR #
A post-discharge plan of care that is developed with the participation of the patient and, with the resident's consent, the patient representative(s), which will assist the patient 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.	MR #	MR #	MR #
Final summary of patient goals.	MR #	MR #	MR #

Additional information provided to next *post-acute care provider* 1. Contact information of the practitioner responsible for the care of the resident 2. Patient representative information including contact information 3. Advance Directives 4. All special instructions or precautions for ongoing care, as appropriate 5. Comprehensive Care Plan Goals 6. Discharge Summary	MR #	MR #	MR #

Appendix 12: CMS Conditions of Participation Audit Tool

COP Sections	# Met	Total Elements	Section Rate
Eligibility to Furnish Swing-Bed Services		**5**	**%**
Resident Rights		**23**	**%**
Admission, Transfer, and Discharge Rights		**12**	**%**
Freedom from Abuse, Neglect, and Exploitation		**10**	**%**
Social Services		**2**	**%**
Comprehensive Assessment, Care Plan, and Discharge Planning		**6**	**%**
Specialized Rehabilitative Services		**3**	**%**
Dental Services		**6**	**%**
Nutrition		**3**	**%**
Total		**70**	**%**

COP Section	# Met	Total Elements	Section Rate
Eligibility to Furnish Swing-Bed Services		**5**	**%**
Is the CAH in compliance with specific requirements for Swing-Bed services used to obtain approval from CMS to provide post-CAH SNF care, and to be paid for SNF-level services?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Does the CAH meet the following eligibility requirements: 1. The CAH has a Medicare provider agreement; and 2. The CAH does not provide more than twenty-five inpatient beds.			
Does the CAH receive payment in accordance with: 1. 42 C.F.R. § 413.70 for inpatient services; or 2. 2 C.F.R. § 413.114 for post-CAH, SNF-level of care services.			
Does the CAH meet the following reimbursement criteria for inpatient services: 1. Effective for cost reporting periods beginning on or after 1/1/2004, payment is 101% of the reasonable costs of the CAH in providing CAH services to its inpatients. The following payment principles are excluded when			

determining payment for CAH inpatient services: (i) lesser of cost or charges; (ii) ceiling on hospital operating costs; (iii) reasonable compensation equivalent (RCE) limits for physician services to providers; and (iv) the payment window provisions for preadmission services.		
Does the CAH meet the following reimbursement criteria for post-CAH, SNF-level of care services: *(Only Check if BOTH are met)* 1. For cost reporting periods beginning prior to July 1, 2002, the reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. 2. The CAH does not seek payment for posthospital SNF care after the end of the 5-day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient's physician has certified, within that 5-day period, that the transfer of the patient to the SNF was not medically appropriate		

COP Section	# Met	Total Elements	Section Rate
Resident Rights		23	%
When a resident is deemed incompetent, do that person's rights devolve to a representative appointed to act on the resident's behalf within the scope of decision-making authority granted by the State?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Notwithstanding whether a resident has been deemed incompetent: (Check only if ALL are met) 1. Is the resident extended the right to make decisions outside the representative's authority? 2. Are the resident's wishes and preferences considered by the representative? 3. Is the resident provided with opportunities to participate in his or her care? 4. to the extent that the resident understands the risks, benefits, and alternatives to their proposed care and expresses a preference, are the resident's wishes reasonably considered?			
Specifically, does the CAH: 1. Maintain the appropriate legal documentation for a court-appointed resident representative is present in the resident's medical record. 2. Review court orders or other legal documentation to determine the extent of the court-appointed resident representative's authority to make decision on behalf of the resident and any limitations on that authority that may have been ordered by the court.			

3. Ensure the court-appointed representative is making decisions for the resident within the scope of the resident representative's decision-making authority (e.g., health care treatment, managing resident funds, discharge decision). 4. Determine if the resident was involved in care planning activities and able to make choices, to the extent possible. 5. Ensure the resident representative is reported under State law when not acting in the best interests of the resident.		
Are residents fully informed of their health status or treatment in a language, this includes communicating in plain language, that the resident can understand.		
Specifically does the CAH: 1. Explain technical and medical terminology in a way that makes sense to the resident, 2. Offer language assistance services to residents with limited English proficiency; 3. Provide qualified sign language interpreters or auxiliary aids if hearing is impaired (provision of hearing aids is not required)		
Are residents and their representative(s) afforded the opportunity to participate in their care planning process by being informed, in advance, of changes to the plan of care?		
Specifically, does the CAH: 1. Involve residents and/or representatives in care planning (e.g., inclusion in care planning meetings and scheduling to accommodate residents and their representatives). 2. Provide residents and representatives the right to see the care plan and sign after significant changes are made? 3. Address questions or concerns raised by a resident or representative? 4. If the resident or representative is unable to participate in care planning does the facility staff consult with them in advance about care treatment changes?		
Does the facility provide information to residents, at a time in which they are able to receive such information, regarding their right to: 1. request (if medically necessary or appropriate), refuse, and/or discontinue treatment; 2. participate in or refuse to participate in experimental research; and 3. formulate an advance directive?		

Specifically, 1. If a resident or representative requests, refuses, or discontinues treatment, does the facility honor that decision? 2. Maintain a current copy of the resident's advance directive in the resident's medical record? 3. Does the facility establish, maintain, and implement written policies and procedures regarding the residents' rights to formulate and advance directive and refuse medical or surgical treatment? 4. Document in the comprehensive care planning process the resident's wishes? 5. Establish mechanisms for documenting and communicating the resident's choices to the interdisciplinary team and staff responsible for the resident's care?		
Are residents given the right to choose his or her attending physician?		
Are all attending physicians chosen by patients licensed to practice?		
Are residents informed of the name, specialty, and way of contacting their chosen physician or other primary care professionals that are responsible for his or her care?		
If the physician chosen by the resident does not meet licensure or qualification requirements or is unable or unwilling to provide care, does the facility discuss alternative physician participation with the resident?		
If the resident selects another attending physician, does the facility honor the resident's choice?		
Are residents given the right to retain and use personal possessions, including furnishings, and clothing, as space permits, and to the extent that such would not infringe upon the rights or health and safety of other residents?		
Are residents given the right to share a room with their spouse (including same-sex spouses) when both residents live in the same facility and both consent to the arrangement?		
Subject to the resident's right to deny or withdraw consent at any time and providing that it would not impose on the rights of another resident or unreasonably affect clinical and safety restrictions, does the facility provide the following persons with immediate access to a resident: 1. Immediate family and other relatives of the resident? 2. Others who are visiting with the consent of the resident?		
Are residents given the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service including the right to: 1. Privacy of such communications; and 2. Access to stationery, postage, and writing implements at the resident's own expense?		

Does the facility notify each Medicaid-eligible resident, in writing, at the time of admission and when the resident becomes eligible for Medicaid, of the items and services which are and are not covered under Medicaid or by the facility's per diem rate?		
Does the facility inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility, of any changes to the items and services covered, and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate?		
In the event that a resident died, was hospitalized, or transferred and did not return to the facility, does the facility refund applicable funds to the resident, representative, or estate?		
Are residents given the right to privacy and confidentiality in all aspects of their care, including 1. Personal privacy including accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; 2. Personal privacy including the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service; 3. Secure and confidential personal and medical records, including the right to refuse the release of such records in accordance with applicable federal and state laws.		
Does the facility allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical social, and administrative records in accordance with State law?		

COP Section	# Met	Total Elements	Section Rate
Admission, Transfer, and Discharge Rights		12	**%**
Does the CAH: 1. Permit each resident to remain in the facility and not transfer/discharge the resident from the facility unless: o the transfer/discharge is necessary for the resident's welfare and the resident's needs cannot be met in the CAH; o the transfer/discharge is appropriate because the resident's health has improved sufficiently;		1. Enter an "X" if your facility meets the element or the element is Not Applicable.	

o the safety or health of individuals in the facility is at risk due to the clinical/behavioral status of the resident; o the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility o the facility ceases to operate. 2. Pause transfer or discharge activities while a resident appeal is pending. 3. Provide the resident with at least thirty (30) notice before the facility transfers or discharges the resident. 4. Provide residents with notice in advance of facility closure.		2. Only enter an "X" if ALL subpoints are met.
When the facility transfers or discharges a resident, does the facility ensure that the transfer or discharge is documented in the resident's medical record, and appropriate information is communicated to the receiving healthcare institution, or provider?		
Does the documentation in the resident's medical record include the basis for the transfer, or the specific resident needs that cannot be met?		
Is the documentation in the resident's medical record made by the resident's physician when transfer or discharge is necessary for any reason other than nonpayment or facility closure?		
Does the information provided to the receiving provider include the following: 1. Contact information of the practitioner responsible for the resident; 2. Resident representative information including contact information; 3. Advance directive information; 4. All special instructions or precautions for ongoing care, as appropriate; 5. Comprehensive care plan goals; and 6. All other necessary information to meet the resident's needs, including a copy of the resident's discharge summary.		
Before the facility transfers or discharges a resident, does the facility: 1. Provide notice to the resident and the resident's representatives of the transfer or discharge and the reasons for the move in writing in a language that they understand? 2. Record the reasons for the transfer or discharge in the resident's medical record? 3. Send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman?		
Before the facility transfers or discharges a resident, does the facility provide timely notice, specifically:		

1. At least 30 days before the resident is transferred or discharged: or 2. As soon as practicable before the transfer or discharge when: a. The health or safety of individuals in the facility would be endangered;		
b. The resident's health improves sufficient to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is needed to address the resident's urgent medical needs; or d. The resident has not resided in the facility for 30 days.		
Does the written notice provided by the facility contain the following information: 1. The reason for the transfer or discharge; 2. The effective date of the transfer or discharge; 3. The location to which the resident is transferred or discharged; 4. A statement of the resident's appeal rights; 5. The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman; 6. 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; 7. 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;		
Before the facility transfers or discharges a resident, does the facility provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer and discharge, and in a form and manner that the resident can understand?		
Specifically, does the CAH: 1. Document the preparation an orientation in nursing notes prior to discharge? 2. Ensure that the resident's needed/requested possessions are transferred with the resident to the new location? 3. Ask the resident or representative if they understand why the transfer or discharge occurred?		
In the case of facility closure, does the individual who is the administrator of the CAH provide written notification prior to the impending closure as well as the plan for the transfer and adequate relocation of the residents to:		

1. the State Survey Agency, 2. the Office of the State Long-Term Care Ombudsman, 3. residents of the facility, and the resident representatives.		
If the resident is changing rooms in a facility that is a composite distinct part (a distinct part of a facility consisting of two or more noncontiguous components that are not located within the same campus) does the facility only move the resident within the same building in which the resident currently resides, unless the resident voluntarily agrees to move to another location?		

COP Section	# Met	Total Elements	Section Rate
Freedom from Abuse, Neglect and Exploitation		10	**%**
Does the facility protect a resident's right to be free from: 1. Verbal, mental, sexual, or physical abuse 2. Neglect 3. Misappropriation of resident property 4. Exploitation 5. Corporal punishment 6. Involuntary seclusion 7. Physical or chemical restraint not required to treat the resident's medical symptoms. 8. Any other conduct that results in, or has the likelihood to result in physical harm, pain, or mental anguish.		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Does the facility ensure residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms?			
When restraints are used, does the facility 1. use the least restrictive alternative for the least amount of time, 2. identify the medical symptoms being treated with the use of any chemical restraints, 3. document ongoing re-evaluation of the need for restraints, and 4. discontinue the use of any chemical restraint when the medical symptom is no longer being treated?			

Does the facility ensure it does not hire or engage individuals who: 1. Have been found guilty of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property by a court of law; 2. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property?		
Does the facility report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff?		
Does the facility develop and implement written policies and procedures to prevent abuse, neglect, and exploitation of residents and misappropriation of resident property that includes the following components: 1. screening potential employees for a history of such conduct; 2. training for new and existing employees on prohibiting, preventing, identifying, and reporting such conduct; 3. identification of such conduct 4. investigation of such conduct; 5. the protection of residents during an investigation; and 6. reporting/responding to such conduct?		
Does the facility ensure through its procedures that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, are reported immediately to the administrator of the facility and to other officials? 1. Within 2 hours for allegations of abuse or result in serious bodily injury. 2. Within 24 hours for allegations not involving abuse and do not result in serious bodily injury.		
Does the facility initiate and complete thorough investigations of alleged violations of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property, maintain evidence/documentation of that an investigation?		
While investigations of alleged violations of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property are in progress, does the facility take steps to prevent any further misconduct?		
Does the facility report the results of all investigations to the administrator or a designated representative and to other officials in accordance with State law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, does the facility take appropriate corrective action?		

COP Section	# Met	Total Elements	Section Rate
Social Service		2	%
Does the CAH provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Specifically, does the CAH: 1. Identify the need for medically related social services through care planning processes and ensure that these services are provided (It is not required that a qualified social worker necessarily provide all of these services, unless required by State law). 2. Assist or arrange for a resident to obtain needed items and services from outside entities, including psychosocial and mental counseling services; 3. Promoting non-pharmacological approaches to care; 4. Addressing grief and stressful events; 5. Assist residents with financial and legal matter including advance care planning; 6. Provide social services or obtain needed services from outside entities when the resident experiences or exhibits: o Lack of effective support; o Psychological or mental distress, o Abuse of any kind, o Difficulty coping with change or loss, or o Need for emotional support.			

COP Section	# Met	Total Elements	Section Rate
Comprehensive Assessment, Care Planning, and Discharge Planning		7	%
Does the CAH make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences that includes at least the following information: 1. Identification and demographic information.		1. Enter an "X" if your facility meets the element	

2. Customary routine. 3. Cognitive patterns. 4. Communication. 5. Vision. 6. Mood and behavior patterns. 7. Psychosocial well-being. 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 planning. 17. Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). 18. Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.		or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.
Does the facility conduct a comprehensive assessment of a resident in accordance with the appropriate length of stay in a Swing Bed (approximately 12-15 days). 1. Admission assessment completed within 48 hours of admission which then allows the multi-disciplinary plan of care to be developed as early as possible in the Swing Bed stay. The maximum length of time for each discipline to complete their assessment is recommended at no more than 72 hours, if necessary to span a weekend. 2. After the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition: or		

Does the facility develop and implement a comprehensive person-centered care plan for each resident 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?		
Does the comprehensive care plan describe the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; 2. Any services that would otherwise be required but are not provided due to the resident's refusal of treatment (as a protected exercise of the resident's rights). 3. Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, it must indicate its rationale in the resident's medical record. 4. In consultation with the resident and/or representative: a. Goals for admission and desired outcomes, b. Preferences and potential for future discharge c. Documentation of whether the resident's desire to return to the community was assessed and referrals made to local contact agencies for this purpose. d. Discharge plans.		
Are the CAH's comprehensive care plans: 1. Developed within 7 days after completion of the comprehensive assessment: 2. Prepared by an interdisciplinary team, which includes but is not limited to the following: 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); f. other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.		

3. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment.		
Does the CAH ensure that the services provided or arranged by the CAH, as outlined in the comprehensive care plan: 1. Meet the professional standards of quality; 2. Are provided by qualified persons in accordance with the written care plan; and 3. Are culturally-competent and trauma-informed?		
When the facility anticipates discharge of a resident, does the facility have a discharge summary that includes, but is not limited to, the following: 1. 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; 2. A final summary of a resident's status at the time of discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; 3. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); 4. 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.		

COP Section	# Met	Total Elements	Section Rate
Specialized Rehabilitative Services		3	%
If specialized rehabilitative services are required in the resident's comprehensive plan of care, has the facility provided the required services; or obtained the required services from an outside resource that is a provider of specialized rehabilitative services?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Are specialized rehabilitative services provided under the written order of a physician by qualified personnel?			
Additionally, does the CAH: 1. Monitor specialized rehabilitative services for their effectiveness 2. Assist residents to attain or maintain their highest practicable level of physical, mental, functional, and psychosocial well-being or to prevent or slow a decline in condition.			

COP Section	# Met	Total Elements	Section Rate
Dental Services		6	%
Does the CAH assist residents in obtaining, provide, or obtain from outside providers routine and 24-hour emergency dental care?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Does the CAH have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility, so that they may not charge a resident for the loss or damage of dentures?			
If necessary or if requested, does the CAH assist the resident in making appointments and by arranging for transportation to and from the dental services location?			
Does the CAH refer residents with lost or damaged dentures for dental services within 3 days?			
If not within 3 days, does the facility provide documentation of what the facility did to ensure that the resident could still eat and drink adequately while awaiting dental services, and the extenuating circumstances that led to the delay?			
Does the CAH assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State Plan (including Medicaid)?			

COP Section	# Met	Total Elements	Section Rate
Nutrition		3	%
Does the facility, based on the resident's comprehensive assessment, ensure that the resident maintains acceptable parameters of nutritional status and that the resident is offered sufficient fluid intake to maintain proper hydration and health?		1. Enter an "X" if your facility meets the element or the element is Not Applicable. 2. Only enter an "X" if ALL subpoints are met.	
Does the facility, based on the resident's comprehensive assessment, ensure that the resident is offered sufficient fluid intake to maintain proper hydration and health?			
Additionally, does the CAH: 1. Accurately and consistently assess a resident's nutritional status on admission and as needed thereafter; 2. Identify a resident at nutritional risk and address risk factors for impaired nutritional status, to the extent possible;			

3. Identify, implement, monitor, and modify interventions (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards of practice, to maintain acceptable parameters of nutritional status;		
4. Notify the physician as appropriate in evaluating and managing causes of the resident's nutritional risks and impaired nutritional status;		
5. Identify and apply relevant approaches to maintain acceptable parameters of residents' nutritional status, including fluids;		
6. Provide a therapeutic diet when ordered;		
7. Offer sufficient fluid intake to maintain proper hydration and health.		

Appendix 13: Swing Bed Assessment Questions

Admissions

What is the length of stay? Is the LOS shorter or longer than other Swing Bed programs? Why is the LOS shorter or longer?
What are the opportunities to increase internal admissions (patients in inpatient status)?
What types of patients are being admitted now? Are there other types of patients that could be admitted? If other types of patients could be accepted, what additional resources would be required? *(i.e., stroke patients – but would need speech therapy)*

Staffing

Is there a dedicated Swing Bed coordinator?
What is the nurse-to-patient ratio? Is this better or worse than skilled nursing facilities in the area?
Are PT, OT, and Speech available to meet patient needs?
If you do not have Speech therapy, does this impact the types of patients you can take?
Is there enough staff to allow for an increase in the census? Why or why not?

Satisfaction

Is the patient experience (satisfaction) measured?
What do patients and families say about the Swing Bed program? Have they identified any opportunities for improvement?
What do referral sources say about the Swing Bed Program? Have they identified any opportunities for improvement?
What do providers, senior leaders, and staff say about the Swing Bed program? Have they identified any opportunities for improvement? *Important Note: It is essential to conduct interviews with staff and providers as part of the analysis. Listen to what they say without contradicting – it is their opinion! Only ask clarifying questions such as, "tell me more," "can you give me an example of when that happened." Also, ask for ideas on how to improve.*

Staff and Provider Knowledge

Are staff and providers knowledgeable regarding the types of Swing Bed patients that can be admitted to Swing Bed, including patients that may need teaching and training?
Are staff and providers knowledgeable about the length of stay requirements?
Are staff and providers knowledgeable about the maintenance therapy standards?

Swing Bed Processes

How long does it take to accept or decline a referral?
Are admission processes efficient?
Does the Swing Bed program meet regulatory requirements?

Patient Outcomes

Are you measuring patient outcomes? Why or why not?
What opportunities have been identified in the outcome data?
Is patient outcome data shared with patients and families? Why or why not.
Is patient outcome data shared with providers and staff? Why or why not.
Is patient outcome data shared with referral sources? Why or why not.

Marketing

Is there a professional-looking brochure about Swing Bed?
Are Swing Beds prominently displayed on the Hospital web page?
Do referral sources know what types of patients you can accept?
Are patients transferred from the ER to a higher level of care provided information about returning to Swing Bed?
Is Swing Bed part of the Hospital's social media presence (Facebook, Twitter, etc.)

Opportunities

Who are the competitors for Swing Beds? Skilled Nursing Facilities? CAHs with Swing Beds? Other?
For each competitor, review their strengths and vulnerabilities: Level of care provided (identify any special services that may be provided) Star rating (if SNF) from nursing center compare (CMS) Patient choice (if known)
What are the admission sources? What are the opportunities to increase admissions from one or more external admission sources?
What is the payor mix? Are there any opportunities to change the payor mix? Are there any opportunities to increase reimbursement thru contractual agreements?

Threats

Are there potential (future) changes in reimbursement from Medicare?
How is the payor mix shifting? Will this impact reimbursement? (i.e., more Managed Medicare plans)

Appendix 14: Resources

CMS Swing Bed Website
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed

Noridian Critical Access Hospital Billing Guide, Updated Feb 02, 2021
https://med.noridianmedicare.com/web/jea/provider-types/cah/cah-swing-bed-billing-chart

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance Table of Contents (Rev. 10880; Issued: 08-06-21)
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/bp102c08.pdf

Medicare Claims Processing Manual Chapter 1 - General Billing Requirements Table of Contents (Rev. 10236, 07-31-20)
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clm104c01.pdf

Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) Table of Contents (Rev. 10186, 06-19-20)
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clm104c04.pdf

Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing Table of Contents (Rev. 4491, 01-09-20)
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clm104c06_0.pdf

Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections Table of Contents (Rev. 10862, 07-14-21)
https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/clm104c30.pdf

MLN Matters Fact Sheet Swing Bed Services, MLN006951 July 2022
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//SwingBedFactsheet.pdf

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. A Rule by the Centers for Medicare & Medicaid Services on 09/30/2019
https://www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals

Rural Health Hub, Critical Access Hospitals (CAHs) Overview
https://www.ruralhealthinfo.org/topics/critical-access-hospitals

State & Regional LTC Ombudsmen Directory
https://dphhs.mt.gov/assets/sltc/Ombudsman/OmbudsmanDirectory.pdf

State Operations Manual Appendix W. Survey Protocol, Regulations, and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs (Rev. 200, 02-21-20)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_w_cah.pdf

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 207, 09-30-22)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf