HealthTech

Swing Bed Education for Montana Flex

Session 1: Swing Bed Admission & Discharge

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Six Sessions

Session 1: Swing Bed Admission and Discharge

Session 2: Patient-Centered Multi-Disciplinary Plan of Care

Session 3: Beyond Basics

Session 4: Navigating Appendix PP and Intermediate Long Term Swing

Session 5: Working as a Team

Session 6: Frequently Asked Questions

Presenter

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Admission

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Qualifying for Swing Bed – Medicare

Skilled Level of Care

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

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

1. The patient requires skilled nursing services or skilled rehabilitation services,
    - i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4);
    - are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services

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

Skilled Level of Care cont.

3. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)

4. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury,
    - i.e., are consistent with the nature and severity of the individual's illness or injury,
    - the individual's particular medical needs,
    - and accepted standards of medical practice.

The services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

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

3-Day Stay

20.1 - Three-Day Prior Hospitalization (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

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

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

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

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

Treatment of Condition Received During Hospital Stay

20.1 - Three-Day Prior Hospitalization (Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized.

In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital but could be any one of the conditions present during the qualifying hospital stay.

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

Principles for Determining if Service is Skilled

30.2.2 - Principles for Determining Whether a Service is Skilled

If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;

e.g., the administration of intravenous feedings and intramuscular injections; the insertion of suprapubic catheters; and ultrasound, shortwave, and microwave therapy treatments.

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

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

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

Medicare Daily Skilled Care

30.6 - Daily Skilled Services Defined (Rev. 249, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

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

Skilled Restorative Nursing – Skilled Nursing

- A skilled restorative nursing program to positively *affect* the patient's functional well-being, **the expectation is that the program be rendered at least 7 days a week.**

Skilled Rehabilitative Therapy

- A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when they need and **receive those services on at least *5* days a week**. (If therapy services are provided less than *5* days a week, the "daily" requirement would not be met.)

Maintenance Therapy

- Even if no improvement is expected, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration.

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

Jimmo Settlement Agreement
No Improvement Standard

Jimmo Settlement Agreement – 2013

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the *Jimmo* Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the *Jimmo* Settlement Agreement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

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.

Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the **specialized judgment, knowledge, and skills of a qualified** therapist ("skilled care") are necessary for the performance of a **safe and effective maintenance program**. **Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.**

The *Jimmo* Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The *Jimmo* Settlement Agreement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

Non-Skilled Supportive or Personal Care

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

General supervision of exercises, which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance.

This includes the actual carrying out of maintenance programs where the performances of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel.

It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)

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

Non-skilled Supportive or Personal Care Services

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

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

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

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

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Categories and Examples of Skilled Care

Skilled Care Examples

1. Management and Evaluation of Plan of Care

2. Observation and Assessment of the Patient Condition

3. Teaching and Training

4. Direct Skilled Therapy

5. Other Considerations

- Services Provided on an Inpatient Basis As a Practical Matter
- Availability of Alternative Facilities or Services

Management and Evaluation of Plan of Care

Generally requires skilled nursing.

The development, management, and evaluation of a patient care plan, based on the physician's orders and supporting documentation, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety.

This can apply to any patient in which skilled nursing is needed to assess and evaluate the patient based on the treatment plan (plan of care) developed by the provider and care team.

Management and Evaluation of Plan of Care

30.2.2 - Management and Evaluation of a Patient Care Plan (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.C.1, SNF-214.1.C.1

An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent, has a Stage 1 decubitus ulcer, and is unable to communicate and make her needs known.

Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

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

Management and Evaluation of Plan of Care

30.2.3.1 - Management and Evaluation of a Patient Care Plan (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.C.1, SNF-214.1.C.1

An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing.

While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety. The documentation in the medical record as a whole is essential for this determination and must illustrate the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

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

Observation and Assessment of Patient's Condition

Generally requires skilled nursing.

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized.

This might include:

- Assessment of patient response when the provider is adjusting medications to determine the most appropriate therapeutic dose.
- Assessing the patient with multiple co-morbidities for a change in condition or deterioration

Observation and Assessment of Patient's Condition

30.2.3.2 - Observation and Assessment of Patient's Condition (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.C.2, SNF-214.1.C.2

A patient with congestive heart failure 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.

Rationale for Skilled Care: The medical documentation must describe the skilled services that require the involvement of nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition, to maintain the patient's current condition, or to prevent or slow further deterioration in the patient's condition.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility. Information from the patient's medical record must document that there is a reasonable potential for a future complication or acute episode sufficient to justify the need for continued skilled observation and assessment.

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

Teaching and Training Activities

Generally requires skilled nursing – but also may required physical therapy or occupational therapy.

This might include:

- Teaching a new diabetic (or his care-giver) to manage medications, including checking blood sugars
- Teaching a patient (or a care-giver) with a new colostomy to care for the colostomy
- Teaching a patient (or a caregiver) to manage a complex medication regimen

Teaching and Training Activities

30.2.3.3 - Teaching and Training Activities (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.1.C.3, SNF-214.1.C.3

A newly diagnosed diabetic patient is seen in order to learn to self-administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions.

Even though the patient voices understanding of the nutritional principles of his diabetic diet, he expresses dissatisfaction with his food choices and refuses to comply with the education he is receiving.

Rationale for Skilled Care: This refusal continues, notwithstanding efforts to counsel the patient on the potentially adverse consequences of the refusal and to suggest alternative dietary choices that could help to avoid or alleviate those consequences.

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

Direct Skilled Therapy Services to Patients

Generally Physical Therapy, Occupational Therapy or Speech Therapy

This might include:

- Physical Therapy for strengthening and ambulation
- Occupational Therapy to assist with activities of daily living
- Speech Therapy for swallow exams, use of adaptive equipment

Direct Skilled Therapy Services to Patients

30.4.1 – Skilled Physical Therapy (Rev. 1, 10-01-03) A3-3132.3A, SNF-214.3.A

A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level.

If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary and must be documented in the medical record (see §30.2.2.1).

Physical therapy services are not reasonable and necessary and would not be covered if the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results. Some SNF inpatients do not require skilled physical therapy services but do require services, which are routine in nature.

When services can be safely and effectively performed by supportive personnel, such as aides or nursing personnel, without the supervision of a physical therapist, they do not constitute skilled physical therapy. Additionally, services involving activities for the general good and welfare of the patient (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

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

Direct Skilled Therapy Services to Patients

30.4.1.2 – Skilled Physical Therapy - Application of Guidelines (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14) A3-3132.3.A.2, SNF-214.3.A.2

A patient with Parkinson's disease may require the services of a physical therapist to determine the type of exercises that are required to maintain his present level of function.

The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, would constitute skilled physical therapy and must be documented in the medical record (see §30.2.2.1).

While a patient is receiving a skilled physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out independently or with the aid of supportive personnel to maintain the function being restored.

Consequently, by the time it is determined that no further skilled therapy services are needed, i.e., by the end of the last skilled session, the physical therapist will have already designed any maintenance program required and instructed the patient or supportive personnel in the carrying out of the program.

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

Other: Services Provided on an Inpatient Basis As a Practical Matter

30.7 - Services Provided on an Inpatient Basis as a "Practical Matter" (Rev. 261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19) A3-3132.6, SNF-214.6

A patient undergoing skilled physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training.

Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk for further injury from falling, because sufficient supervision and assistance could not be arranged for the patient in his home.

Rationale Skilled Care: In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

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

Other: Availability of Alternative Facilities or Services

30.7.1 - The Availability of Alternative Facilities or Services (Rev. 261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19) A3-3132.6.A, SNF-214.6.A

Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community.

Rationale Skilled Care: Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed. In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases.

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

Other: Availability of Alternative Facilities or Services

30.7.2 - Whether Available Alternatives Are More Economical in the Individual Case (Rev. 261, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19) A3-3132.6.B, SNF-214.6.B

If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

Rationale for Skilled Care: If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in a SNF might be a more economical alternative.

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

Other: Availability of Alternative Facilities or Services cont.

HOWEVER -----

The fact that Medicare cannot cover such care is irrelevant. The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist.

However, the fact that Medicare payment could not be made for the services because an expense limitation (if applicable) to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF. In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

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

Documentation Essentials

In all of the examples – the common element is **documentation that a skilled need exists**.

For Medicare – Utilization Review (UR) functions for determining medical necessity and continued stay, are internal processes.

Typically we do this quite well for observation and acute stay patients – but not so well for Swing Bed patients.

Without adequate documentation – the stay MAY be denied if there is an audit by the fiscal intermediary.

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Case Studies

Case Studies

For each of the case studies at the end of the presentation ------ review and answer the following questions:

1. How many met Medicare Skilled Criteria?

2. How many didn't meet Medicare Skilled Criteria?

3. How many are questionable?

Send me your answers --- or --- send to Jen and we will send out an email about each of the scenarios.

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Pre-Admission Processes – 5 Steps

Step 1: Develop Admission Criteria specific to your facility

Review and ensure concurrence from

- CEO – CFO – CNO
- Providers
- Nursing
- Rehab (PT, OT, Speech)
- Dietician
- Pharmacist
- Case Management

Ensure that you have the staff and equipment to care for the patients included. If you do not have the capacity currently – ask what it would require to take these types of patients in the future.

Step 1: Develop Admission Criteria specific to your facility cont.

Example of Hospital Swing Bed Admission Criteria	

Payor
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*
  ○ *Diabetic teaching*
  ○ *Care of colostomy*
  ○ *Complex medication management*
  ○ *Monitoring signs & symptoms (weight, blood pressure, etc.)*
• *Management of Plan of Care / Skilled Observation*
• *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
	• *Pediatrics*
	• *Severe or unmanaged mental illness*
	• *History of violent behavior*

Step 2: Determine WHO needs to review before the patient can be accepted

- Provider
- Nursing
- Rehab (PT, OT, Speech)
- Dietician
- Pharmacist
- Case Management

Note: The fewer individuals that have to review the patient information – the more quickly a decision can be made. Consider separating admission criteria into three categories:
1 – Concurrence of Case Management required (only)
2 – Concurrence of Case Management and Provider required
3 – Concurrence from all team members required

Step 3: Provide Choice of Post-Acute Providers

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."*

Source: 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

Quality and Resource Use Data

Identify facilities that provide skilled care in your geographic area:

1. Long Term Care facilities with skilled beds
2. Other CAHs with Swing Bed
3. Inpatient Rehabilitation Facilities (usually more complex long-term patients)
4. Long-Term Care Hospitals (usually more complex long-term patients)

CMS does not specify for what geographic area you are required to provide data – but typically, it is your county – or – your service area.

Quality and Resource Use Data

Data Sources:

1. Nursing Home Compare (CMS)
https://www.medicare.gov/what-medicare-covers/what-part-a-covers/compare-nursing-home-quality

2. Inpatient Rehab Facility (CMS)
https://www.medicare.gov/care-compare/?providerType=LongTermCare&redirect=true

3. Long-Term Care Hospitals
https://www.medicare.gov/care-compare/?providerType=LongTermCare&redirect=true

Quality and Resource Use Data

Swing Bed: There is NO comparable / publicly available data for Swing Beds.

Options

1. Provide patients with your internally collected data (recommended)

2. Provide patients with information from Hospital Compare (if available)
https://www.medicare.gov/care-compare/

3. Disclose that Swing Beds do not have publicly available data

Nursing Home Compare

For Skilled Nursing Facilities (SNF) quality and resource data is published on Nursing Home Compare (https://www.medicare.gov/care-compare/).

The information is not organized as quality and resource use measures. However, 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 important to note that out of the seventeen indicators listed on Nursing Home Compare, six of the seventeen or 35% are related to improvements in functional status.

Nursing Home Compare - Example

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

Nursing Home Compare - Example

Short Stay Quality of Resident Care – 5 STARS

Short-stay Quality of Resident Care. 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

Nursing Home Compare - Example

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

Step 4: Set timelines for accepting / denying external referrals

Set an internal target for responding to external referrals.

Ideally – not more than 2 hours – from referral to acceptance.

Step 5: Use a Pre-Admission Checklist

If possible, request the entire medical record and not just the H&P or discharge summary for 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 or Medicare benefit days available

Step 5: Use a Pre-Admission Checklist cont.

MEDICARE	
☐	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
☐	Benefit Days available

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Discharge

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Choice of Post-Acute Providers

Choice of Post-Acute Providers

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."*

Source: 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

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Discharge Rights

Discharge Rights

C-1610 §485.645(d)(2) Admission, Transfer and Discharge Rights
§483.5 definition of transfer & discharge: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

§483.15(c)(1) Transfer and discharge—(1) Facility requirements—
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

Discharge Rights cont.

C-1610 §485.645(d)(2) Admission, Transfer and Discharge Rights

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has 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 the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose

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Information to Post-Acute Care Provider at Transfer or Discharge

Required Information

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

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

Required Information

C-1610 §483.15(c)(2)
…… appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

(B) Resident representative information including contact information.

Required Information

C-1610 §483.15(c)(2)
…… appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

(C) Advance Directive information.

Required Information

C-1610 §483.15(c)(2)
….. appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

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

Required Information

C-1610 §483.15(c)(2)
….. appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

E) Comprehensive care plan goals.

Required Information

C-1610 §483.15(c)(2)
…..appropriate information is communicated to the receiving health care institution or provider.

(iii) Information provided to the receiving provider must include a minimum of the following:

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

Required Information

C-1620: §483.21(c)(2)

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

Required Information

C-1620 §483.21(c)(2):

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

§483.20(b)(1) Comprehensive assessments—..... The assessment must include at least the following:
(i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.

Required Information

C-1620 §483.21(c)(2):

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

Required Information

C-1620 §483.21(c)(2):

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.

The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services

Patient Required Notices

Have a weekend and holiday plan

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Patient Notices

Notice Before Discharge

C-1610 §483.15(c)(5)
Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge

(ii) The effective date of transfer or discharge

(iii) The location to which the resident is transferred or discharged

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

Notice Before Discharge

<u>Revised</u> Appendix PP/F623: Content of Discharge Notice

- Discharge notice must include all of the following
  - The specific reason for the transfer or discharge
  - The effective date of the transfer or discharge;
  - The **specific** location (**such as the name of the new provider or description and/or address if the location is a residence**) to which the resident is to be transferred or discharged;
  - An explanation of the right to appeal **the transfer or discharge** to the State;
  - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
  - Information on how to **obtain** an appeal form;
  - Information on obtaining assistance in completing and submitting the appeal hearing request; and
  - The name, address (**mailing and email),** and phone number of the representative of the Office of the State Long-Term Care ombudsman

Notice Before Discharge Example

Date: **Name:** **Admission Date:**

Your discharge from the Swing Bed program is expected to occur _____ (*When)*

You are being transferred or discharged because: (*Specific reason)*

You are being transferred or discharged to _____ *(Location*) (*If the location is a residence the location must be included)*

If you disagree with the transfer or discharge, you can file an appeal by contacting:
State Division of Health (*name/ mailing address / email address),* or
State-Long Term Care Ombudsman (*name/mailing address/email address/phone)*

You can access an appeal form at**:** *(name/web site/Email/phone)*

If you need assistance in obtaining, completing, or submitting the appeal request you can contact (*name/mailing address/email address/phone)*

Patient Signature / Date

Timing of Discharge Notice

C-1610 §483.15(c)(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least **30 days** before the resident is transferred or discharged.

§483.15(c)(1) Transfer and discharge—(1) Facility requirements— (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (**B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility**; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has 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 the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.

Notice of Medicare Non-Coverage

CMS Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 2711
260.2
The expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings. All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end: For purposes of this instruction, the term "beneficiary" means either beneficiary or representative, when a representative is acting for a beneficiary.

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy).

A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending. For example, a beneficiary exhausts the SNF Part A 100-day benefit, but remains in the facility under a private pay stay and receives physical and occupational therapy covered under Medicare Part B.

A NOMNC must be delivered by the SNF when both Part B therapies are ending. Skilled Nursing Facilities includes beneficiaries receiving Part A and Skilled Nursing Facilities **includes beneficiaries receiving Part A and B services in Swing Beds.**

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

Notice of Medicare Non-Coverage

CMS Form Instructions for NOMNC

The NOMNC must be delivered at least **two calendar days** before Medicare covered services end or the second to last day of service if care is not being provided daily. Note: The two day advance requirement is not a 48 hour requirement.

Appeal

C-1610 §483.15(c)(1)

The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

Notify the Ombudsman

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

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

Appendix PP §483.15(c)(3)-(6)

Guidance - Notice of Transfer or Discharge and Ombudsman Notification

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

Send the Discharge Notice you provide to patient

Patient Required Notices

Have a weekend and holiday plan

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Discharge Planning Processes

Patient Planning Essentials

Key elements of IDEAL Discharge Planning

Include the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home:

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps throughout the hospital stay.

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's are to the patient and family and use teach back.

Listen to and honor the patient's and family's goals, preferences, observations, and concerns.

This process will include at least one meeting to discuss concerns and questions with the patient, family of their choice, and [identify staff].

Source: AHRQ: Guide to Patient and Family Engagement
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Patient Planning Essentials

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event but a process that takes place throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Patient Planning Essentials

Discuss with the patient and family five key areas to prevent problems at home.

1. Describe what life at home will be like. Include the home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.

2. Review medications. Use a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it, and potential side effects.

3. Highlight warning signs and problems. Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.

4. Explain test results. Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should get the results and identify who they should call if they have not gotten results by that date.

5. Make followup appointments. Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Patient Planning Essentials

Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay. Getting all the information on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay, not a one-time event. You can:

- Elicit patient and family goals at admission and note progress toward those goals each day
- Involve the patient and family in bedside shift report or bedside rounds
- Share a written list of medicines every morning
- Go over medicines at each administration: What it is for, how much to take, how to take it, and side effects
- Encourage the patient and family to take part in care practices to support their competence and confidence in caregiving at home

Patient Planning Essentials

Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach-back.

- Provide information to the patient and family in small chunks and repeat key pieces of information throughout the hospital stay
- Ask the patient and family to repeat what you said back to you in their own words to be sure that you explained things well

Patient Planning Essentials

Listen to and honor the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in their room to write questions or concerns
- Ask open-ended questions to elicit questions and concerns.
- Use Be Prepared to Go Home Checklist and Booklet (Tools 2a and 2b) to make sure the patient and family feel prepared to go home
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers

Patient Planning Essentials

The article has an excellent templates and checklists for:

- Initial assessment
- Daily tasks
- Discharge Planning Meeting
- Day of discharge

Source: AHRQ: Guide to Patient and Family Engagement
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Discharge Planning is a Family Affair

You Tube Video: Discharge Planning is a Family Affair

Do you think this patient will be readmitted?

https://youtu.be/Un7As1R2-HU

Bedside Discharge Planning

You Tube Video: Bedside Discharge Planning

Do you think this patient will be readmitted?

https://youtu.be/urp2CpXRKoQ

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Tools

Tools Provided for Module 5

1. Admission P&P
2. Discharge & Transfer P&P
3. Pre-Admission Checklist
4. Audit Tool

Let me know if you have questions.....

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Case Studies Test Your Knowledge

Assignment - if you choose to accept it ☺

For each of the Case Studies review the scenarios with one other person involved in Swing Bed care and answer the following questions:

Does this patient meet Medicare criteria for skilled care?

- ❑ **Yes**
- ❑ **No**
- ❑ **Unsure**

Why or Why Not?

The case studies are somewhat brief --- so use the information provided.

Case Study 1

Patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He was admitted to Swing Bed after a five (5) day acute hospital stay. Prior to the hospital admission, he lived alone and was independent in all activities of daily living, including driving.

Summary of Admission Orders

1 – Oral medications for diabetes and cardiac disease
2 – Restricted calorie and carbohydrate diet
3 – Weight twice per week
4 – Physical Therapy for strengthening and mobility

Does this patient meet Medicare criteria for skilled care?

❑ Yes
❑ No
❑ Unsure

Why or Why Not?

Case Study 2

Patient with a (3) day acute hospital stay after a myocardial infraction. Prior to the MI, patient was independent and active Lived with his wife. He is in good physical condition and is ambulating independently. The physician is monitoring response to various cardiac drugs.

Summary of Admission Orders

1 – Oral medications for cardiac disease
2 – Regular Diet
3 – Activity as tolerated

Does this patient meet Medicare criteria for skilled care?

- ❑ **Yes**
- ❑ **No**
- ❑ **Unsure**

Why or Why Not?

Case Study 3

Patient with a bowel restriction and colostomy admitted after a seven (7) day acute hospital stay. The patient has periodic episodes of confusion and is unaware he is in the hospital. He does recognize family members. He has lost weight, is quite debilitated and is unable to stand without assistance. A preliminary evaluation by PT found he was not a candidate for therapy due to his debilitated condition.

Chronic conditions include depression and anxiety; cardiac disease; diabetes. Prior to the admission he was semi-independent and lived with his daughter. His daughter would like to take him home after the Swing Bed stay.

<u>Summary of Admission Orders</u>
1 – Weight twice per week
2 – High calorie diet
3 - Colostomy Care
2 – Oral medications to treat cardiac disease, diabetes and depression
3 – Physical Therapy
4 – Colostomy Care teaching

Does this patient meet Medicare criteria for skilled care?
❑ Yes
❑ No
❑ Unsure
Why or Why Not?

Case Study 4

A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs safely. The patient lives alone in a second-floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are available one mile away from her apartment in outpatient rehab.

Summary of Admission Orders

1 – Weight twice per week
2 – Regular Diet
3 - Oral medications
4 – Physical Therapy
5 – Occupational Therapy
6 - Speech Therapy

Does this patient meet Medicare criteria for skilled care?

❑ Yes
❑ No
❑ Unsure

Why or Why Not?

Case Study 5

Patient hospitalized for five (5) days with a diagnosis of sepsis.

Summary of Admission Orders
1 – Regular Diet
2 – Activity as tolerated
3 - IV Antibiotic Therapy for fourteen (14) days

Does this patient meet Medicare criteria for skilled care?
❑ Yes
❑ No
❑ Unsure
Why or Why Not?

Case Study 6

Patient with a new colostomy after bowel surgery. Patient lives with his wife and adult daughter. Prior to surgery patient relied on wife or daughter to monitor his medications and to assist with ADLs (bathing, cooking, etc.)

Summary of Admission Orders
1 – Regular Diet
2 - Oral medications
3 – Colostomy Care

Does this patient meet Medicare criteria for skilled care?
❑ Yes
❑ No
❑ Unsure
Why or Why Not?

Case Study 7

Patient requires daily (3-5 days per week) physical therapy and occupational therapy after a total joint replacement. Patient cannot afford the co-pay for outpatient therapy.

Does this patient meet Medicare criteria for skilled care?

- ❑ **Yes**
- ❑ **No**
- ❑ **Unsure**

Why or Why Not?

Case Study 8

Patient is receiving hospice benefits and has been given less than six (6) months to live. Patient was hospitalized after she fell and broke her hip. An internal fixation surgery was performed.

Summary of Admission Orders
1 – Regular Diet
2 – Total Hip Precautions
3 – IV Pain medication
4 - DNR

Does this patient meet Medicare criteria for skilled care?
❑ Yes
❑ No
❑ Unsure
Why or Why Not?

Case Study 9

Patient hospitalized for four (4) days for pneumonia. History of COPD with limited lung capacity. Prior to hospitalization patient had very limited mobility and required continuous oxygen by nasal cannula. Patient has been a resident of a LTC facility for several years.

Summary of Admission Orders

1 – Regular Diet
2 – Oxygen per cannula per RT protocol to maintain oxygen saturation.
3 - Inhaler
4 – Oral medications
5 – Oral antibiotic
6 – No Code

Does this patient meet Medicare criteria for skilled care?

- ❑ **Yes**
- ❑ **No**
- ❑ **Unsure**

Why or Why Not?