HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, HealthTechS3 provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. HealthTechS3 has the right mix of experienced professionals that service hospital clients across the nation. HealthTechS3 offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.
GOVERNANCE & STRATEGY
- Affiliation Consulting
- Executive & Management Leadership Development
- Strategic Planning & Market share Analysis
- Community Health Needs Assessment
- Compliance Consulting Services

FINANCE
- Performance Optimization / Margin Improvement
- Revenue Cycle & Business Office Operations
- Productivity & Staffing Consulting - Optimum Productivity Toolkit

CLINICAL CARE & OPERATIONS
- Continuous Survey Readiness
- Quality Assurance Performance Improvement
- Lean Culture
- Customer Experience
- Clinical Resource Management
- Care Coordination – Primary Care Practice
- Physician Practice & Clinic Assessment
- Long Term Care Consulting
- Swing Bed Consulting
- Perioperative Services Consulting

RECRUITMENT
- Executive Recruitment
- Manager and Clinical Positions
- Physician / Provider Recruitment
- Information Technology Professionals
- Interim Placement
INSTRUCTIONS FOR TODAY’S WEBINAR

☑️ You may type a question in the text box if you have a question during the presentation.

☑️ We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.

☑️ You may also send questions after the webinar to our team (contact information is included at the end of the presentation).

☑️ The webinar will be recorded and the recording will be available on the HealthTechS3 web site: www.healthtechs3.com

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

www.healthtechs3.com
Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St.Charles is the lead consultant for development of Community Health Needs Assessments and conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.
Our Agenda

1. Swing Bed Overview
2. Swing Bed Research
3. Swing Bed Conditions of Participation
Swing Bed Overview

• Hospitals, as defined in Section 1861(e) of the Social Security Act, and CAHs with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish swing bed services may use their beds as needed to furnish either acute or Skilled Nursing Facility (SNF)-level care.

• Rural hospitals and CAHs with swing bed approval increase Medicare patient access to post-acute SNF-level care and maximize the efficiency of operations by meeting unpredictable demands for acute and long-term care.

• Hospitals paid under the Acute Care Hospital Inpatient Prospective Payment System (IPPS) and CAHs with approval to furnish swing bed services may use any acute care bed within the hospital or CAH for the provision of swing bed services, with the exception of acute care beds:™
  – Within their IPPS-excluded rehabilitation or psychiatric distinct part unit
  – In an intensive care-type unit
  – For newborns

http://www.medicare.gov/coverage/skilled-nursing-facility-care.html
Swing Bed Overview

- **Payment**
  - CAHs that offer swing bed services are exempt from SNF PPS. These CAHs are paid for their SNF-level services based on 101 percent of the reasonable cost of the services.
  - PPS Hospitals with Swing Beds are paid a per-diem rate which is case-mix adjusted using a resident classification system (Resource Utilization Groups IV) based on data from resident assessments (MDS 3.0) and relative weights developed from staff time data.

- **Length of Stay**
  - There is no length of stay restriction for swing-beds – HOWEVER, criteria for swing bed must be met!

- **Swing bed may be used even if a SNF bed is available in the community**
  - 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
Medicare Benefits

• 100 days total of skilled care per spell of illness
  – Days are cumulative for the same or different condition in a consecutive stretch of days
  – Requires 3-day inpatient qualifying stay

• New set of 100 skilled days after 60 days have elapsed with no Medicare Part A services

Benefit
• Days 1–20 $0 for each benefit period
• Days 21–100 $164.50 coinsurance per day
• Days 101 and beyond All Costs

https://www.medicare.gov/coverage/skilled-nursing-facility-care.html
Skilled Nursing Utilization

*Healthcare Cost and Utilization (2013)

• 22.3% of all hospital discharges were admitted to Post Acute Care
  – 11% Home Health
  – 9% Skilled Nursing Facility
  – 1.6% Inpatient Rehabilitation Facility
  – 0.5% Long Term Care Hospitals

• *Medicare accounted for nearly three-quarters of inpatient discharges to post acute care (2013)
  – 84.9 percent of discharges to SNFs
  – 76.2 percent of discharges to LTCHs
  – 68.7 percent of discharges to IRFs
  – 64.6 percent of discharges to HHAs

• **Average Length of Stay – 27 days


**Grabowski, 2010; Herndon, Bones, Kurapati, Rutherford, & Vecchioni, 2011)
### Top 10 Conditions / Procedures with Discharge to SNF (2013)

<table>
<thead>
<tr>
<th>Conditions / Procedure</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip &amp; Femur Procedures</td>
<td>68.9%</td>
</tr>
<tr>
<td>Kidney &amp; Urinary Tract Infection</td>
<td>56.6%</td>
</tr>
<tr>
<td>Septicemia or Severe Sepsis</td>
<td>53.5%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>50.1%</td>
</tr>
<tr>
<td>Simple Pneumonia &amp; Pleurisy</td>
<td>47.2%</td>
</tr>
<tr>
<td>Stroke</td>
<td>40.0%</td>
</tr>
<tr>
<td>Heart Failure and Shock</td>
<td>38.0%</td>
</tr>
<tr>
<td>Total Hip / Knee Joint Replacement</td>
<td>37.3%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>34.4%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>32.6%</td>
</tr>
</tbody>
</table>

Use of Swing Beds IS NOT restricted to Medicare and Medicaid patients – just like admission to acute care is not restricted to only Medicare or Medicaid

(Reimbursement may be different – of course)
In order to bill Medicare the following criteria must be met:

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 inpatient qualifying stay
4. Swing Bed admission condition is the same as the qualifying stay condition
5. Patient must be admitted to Swing Bed within thirty days of discharge from acute care
6. The patient’s condition meets criteria to necessitate inpatient skilled nursing services

Medicare Benefit Policy Manual – (Rev. 228, 10-13-16)
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
1. **The patient has Medicare Part A and has benefit days available**

2. **Medicare age or disability/disease eligibility requirements must be met**

   The hospital discharge must have occurred on or after the first day of the month in which the individual attained age 65 or, effective July 1, 1973, became entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.
3. Three-day qualifying stay

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

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

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

Medicare Benefit Policy Manual  Chapter 8 – 20.1
Medicare collects data for qualifying stays of exactly 3-days! (PEPPER Report)

Short-Term Acute Care Hospital
Quarterly, on or about December 5, 2016, March 6, 2017, June 5, 2017, August 31, 2017 (Quality Net)

Critical Access Hospital
Annually, on or about April 14, 2017 (Quality Net)
Three-day Skilled Nursing Facility-qualifying Admissions (3-day SNF)
*revised as of the Q4FY15 release
  - $N$: count of discharges to a SNF with a three-day length of stay
  - $D$: count of all discharges to a SNF (identified by patient discharge status code of 03 (discharged or transferred to a SNF), 83 (discharged or transferred to a SNF with a planned acute care hospital inpatient readmission), 61 (discharged or transferred to a swing bed)) or 89 (discharged or transferred to a swing bed with a planned acute care hospital inpatient readmission))

Swing Bed Transfers
*revised as of the Q4FY15 release
  - $N$: count of discharges with a length of stay equal to three or four days with patient discharge status code 61 or 89
  - $D$: count of discharges with a length of stay equal to three or four days
4. Patient’s Swing Bed admission condition is the same as the qualifying stay condition

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

In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary’s admission to the hospital, but could be any one of the conditions present during the qualifying hospital stay.
5. Patient admitted to swing bed within 30 days of discharge from acute care

**Exception**

An elapsed period of more than 30 days is permitted for SNF admissions where the patient’s condition:

- makes it medically inappropriate to begin an active course of treatment in a SNF 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 period.
Swing Bed Research
Lessons Learned:
A Mixed Methods Analysis of Barriers to Swing Bed Utilization in Critical Access Hospitals in Montana

Faith Jones, Tawnie Sabin, Karen L. Roper, Samuel Crocker, Roberto Cardarelli

DOI: http://dx.doi.org/10.14574/ojrnhc.v15i2.366
Why Swing Bed

• Having swing beds increase access to post-acute Skilled Care in rural communities.
• Allows patients to be re-immersed within their social networks and families to transition back home
Benefit to Rural Communities

• Approximately 20 percent of Medicare beneficiaries are discharged to SNFS, with an average length-of-stay of 27 days (Grabowski, 2010; Herndon, Bones, Kurapati, Rutherford, & Vecchioni, 2011).
  – For a rural and frontier patient, this lengthens the time away from one’s community, family, and social network, potentially impairing the restorative process.

• Repeated research has found a strong sense of independence by rural elders and an influential family support network that may influence the decision-making process to seek care that is distant from one’s home (Craig, 1994; Johnson, Weinert, & Richardson, 1998; Magilvy, Congdon, & Martinez, 1994).

• Older rural populations depend on family and their social network during time of acute or advanced chronic care (Long & Weinert, 1991), and one qualitative study found that many of these individuals consider transition of care away from home as “crises”, and decisions were often made “hastily” (Magilvy & Congdon, 2000).
Swing Bed Categories of Care

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

  – Skilled Restorative Care – Skilled Nursing Services
  – Skilled Rehabilitative therapy
  – Maintenance therapy
Daily Requirement

- 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 6 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.
Daily Requirement

• A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue, which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

• In instances when a patient requires a skilled restorative nursing program to positively affect his functional well-being, the expectation is that the program be rendered at least 6 days a week. (Note that when a patient’s skilled status is based on a restorative program, medical evidence must be documented to justify the services. In most instances, it is expected that a skilled restorative program will be, at most, only a few weeks in duration.)

• The daily basis requirement can be met by furnishing a single type of skilled service every day, or by furnishing various types of skilled services on different days of the week that collectively add up to “daily” skilled services. However, arbitrarily staggering the timing of various therapy modalities though the week, merely in order to have some type of therapy session occur each day, would not satisfy the SNF coverage requirement for skilled care to be needed on a “daily basis.” To meet this requirement, the patient must actually need skilled rehabilitation services to be furnished on each of the days that the facility makes such services available.

• It is not sufficient for the scheduling of therapy sessions to be arranged so that some therapy is furnished each day, unless the patient’s medical needs indicate that daily therapy is required. For example, if physical therapy is furnished on 3 days each week and occupational therapy is furnished on 2 other days each week, the “daily basis” requirement would be satisfied only if there is a valid medical reason why both cannot be furnished on the same day. The basic issue here is not whether the services are needed, but when they are needed. Unless there is a legitimate medical need for scheduling a therapy session each day, the “daily basis” requirement for SNF coverage would not be met.

Source: 30.6 Medicare Benefit Policy Manual. Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 228, 10-13-16)
Consider admitting the patient to Swing Bed for Nutrition Management if:

- The patient was hospitalized for inpatient care for not less than 3 consecutive days AND
- One or more of the following issues exist:
  - Patient was admitted for malnutrition
  - Patient had unplanned weight loss during hospitalization
  - Patient had serum albumin levels of less than 3.5 g/dl at time of discharge
  - Patient had decreased nutrition intake during hospitalization as evidenced by documented meal consumption below average and consumed less than two oral nutritional supplements daily
  - Patient score on nutritional assessment remains at risk at time of discharge
  - Patient was admitted with a pressure ulcer or a pressure ulcer formed during hospitalization
  - Patient underwent surgery without receiving nutritional support for 10-14 days prior to surgery
• Polypharmacy can be defined as taking multiple unnecessary medications, or when a person takes more than 5 medications. Twenty-eight percent of hospitalizations in the United States were related to medication “mishaps” and two-thirds of those could have been prevented (Conry, 2000).

• Skilled Restorative care may be valuable for patients who are:
  – Recovering from an adverse medication event,
  – Initiating medication therapy,
  – Require additional monitoring of vital signs during medication titration or
  – Require teaching to self-administer injectable medications.
Consider admitting the patient to Swing Bed for Medication Management if:

• The patient was hospitalized for inpatient care for not less than 3 consecutive days **AND**

• One or more of the following exists:
  
  – Patient experiencing unresolved pain management issues
  
  – Patient has experienced adverse medication effects – associated with medications with anticholinergic properties, opiates, benzodiazepines, antidepressants,
  
  – Patient experienced changes in cognitive function secondary to medication administration (dementia, delirium or depression)
  
  – Management of uncontrolled diabetes or congestive heart failure (monitoring of vital signs)
  
  – Initial administration of medical gases and/or bronchodilator therapy
  
  – Teaching or training for self-administration of injectable medications
End of Life Care

Question:

Can Swing bed be used for:

- Hospice Care
- Terminal Care
- Comfort Care

Answer:

DEPENDS

Medication Management and End of Life Care

- If a patient is on hospice then all decisions are made by the hospice care team
- Making medication adjustments and/or teaching family members may be an indication for Swing Bed
- Straight comfort care does not typically require professional or technical level of care
  - usually does not qualify for swing care
Bringing Patients Back Home:
Improving Patient Outcomes in Rural Montana by Standardizing Swing Bed Restorative Care Guidelines

Faith Jones, MSN, RN, NEA-BC and Tawnie Sabin, JD, BSIE

• Swing Bed Lit Review References with Abstracts
• Nutrition Lit Review Reference with Abstracts
• Medication Management Lit Review References with Abstracts
Regulations

- **State Operations Manual** *(Rev. 165, 12-16-16)*  
  Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

- **State Operations Manual** *(Rev. 137, 04-01-15)*  
  Appendix T - Regulations and Interpretive Guidelines for Swing Beds in Hospitals (paid under PPS)

- **State Operations Manual** *(Rev. 168, 03-08-17)*  
  Appendix PP - Guidance to Surveyors for Long Term Care Facilities

- **Medicare Claims Processing Manual**  
  - Chapter 4 - Physician Certification and Recertification of Services *(Rev. 3685, 12-22-16)*
  - Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing *(Rev. 3612, 09-16-16)*

- **Medicare Benefit Policy Manual** *(Rev. 228, 10-13-16)*  
  Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
Appendix W C-0360 §485.645(d)

1) Resident rights (§483.10(b)(3) through (b)(6), (d), (e), (h), (i), (j)(1)(vii) and (viii), (1), and (m) of this chapter)

2) Admission, transfer, and discharge rights (§483.12(a) of this chapter)

3) Resident behavior and facility practices (§483.13 of this chapter)

4) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy

5) Social services (§483.15(g) of this chapter).

6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter)

7) Specialized rehabilitative services (§483.45 of this chapter)

8) Dental services (§483.55 of this chapter)

9) Nutrition (§483.25(i) of this chapter)
PASRR is a screening tool to identify residents with serious mental illness (SMI), mental retardation (MR), or a related condition (RC).

Federal regulations do not require that a PASRR is completed for Swing Bed Patients.

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

http://www.pasrrassist.org
If the patient does not change facilities, the same chart can be utilized but the swing-bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents.
Responsibilities – Case Management / Swing Bed Coordinator

<table>
<thead>
<tr>
<th>What To Do Pre-Admission</th>
<th>Tips</th>
</tr>
</thead>
</table>
| 1. Review record for medical necessity | • If patient is being transferred from another facility – review the chart. Don’t just rely on “verbal report”.
| 2. Ask for input from other team members | • Patient / Family Buy is very important. Will they agree to actively participating in the Swing Bed program? |
|   • Physician – Provider | |
|   • Nursing | |
|   • Rehab | |
|   • Pharmacy | |
|   • Social Work | |
| 3. Ensure you have the services that the patient will need (i.e. Speech??) | |
| 4. Determine attending physician and that they will accept patient | |
| 5. Obtain Pre-authorization for services (if not Medicare Part A) | |
| 6. Discuss Swing Bed stay with patient and/or family to ensure they are willing to participate in a Swing Bed program | |
### Responsibilities – Case Management / Swing Bed Coordinator

<table>
<thead>
<tr>
<th>What To Do At Admission</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide admission information to patient including resident rights, etc.</td>
<td>• Some information must be provided orally</td>
</tr>
<tr>
<td>2. Review with patient (orally)</td>
<td>• If patient cannot sign, review with decision maker and obtain signatures</td>
</tr>
<tr>
<td>3. Ensure signatures / documentation are in the medical record</td>
<td>• Designate responsibility for after-hours / weekends</td>
</tr>
<tr>
<td>4. Notify team members</td>
<td></td>
</tr>
<tr>
<td>5. Schedule first multi-disciplinary meeting</td>
<td></td>
</tr>
</tbody>
</table>
### Responsibilities - Physician

<table>
<thead>
<tr>
<th>What To Do</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Write admission orders to swing</td>
<td>Certification</td>
</tr>
<tr>
<td>- Orders should not be carried over – different focus of care</td>
<td>• The admission order is not sufficient</td>
</tr>
<tr>
<td>2. Complete new H&amp;P or update H&amp;P</td>
<td>• Certification or recertification statements may be entered on or included in forms, notes or other records that a physician, NP or PA normally sign in caring for a patient, or on a separate form</td>
</tr>
<tr>
<td>3. Complete certification at admission or as soon as possible thereafter</td>
<td>• Include reasons for extended care skilled care, estimated time required for skilled care and any plans for home care</td>
</tr>
</tbody>
</table>

Complete re-certification within 14 days and every 30 days thereafter.
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Admission Date:</th>
<th>Health Insurance:</th>
</tr>
</thead>
</table>

Reason for Admission:

Goals for Admission:

Expected Length of Stay:

**Admission to swing bed is for the same condition(s) for which the Patient received inpatient hospital services**

☐ YES ☐ NO (if no, please explain)

**CERTIFICATION Required at time of admission**

I certify that services are required to be given on a daily basis which, as a practical matter, can be only be provided in a swing bed or skilled nursing facility.

_________________________  ________________________
Physician Signature        Date and Time
Within 14 days and every 30 days thereafter
Surveyors may use progress notes as evidence

<table>
<thead>
<tr>
<th>Patient Name: ________________________</th>
<th>Admission Date: ________________________</th>
</tr>
</thead>
</table>
| RECERTIFICATION of continued swing bed inpatient care. To be completed on or before the 14th day after admission to swing bed. | I certify that continued swing bed inpatient care is necessary for the following reason(s):
I estimate that the additional period of swing bed Care will be ____ days or ____ weeks. |

Plan for post-swing bed care:
- [ ] Home
- [ ] Home Health Care
- [ ] Office / Physician Follow-up
- [ ] Long Term Care
- [ ] Other

______________________  ________________________
Physician Signature    Date and Time
1. Resident Rights §483.10(b) & §483.10(b)(3)
   - List of Resident Rights *We will go over these in detail later in the presentation*
   - NOT THE SAME AS FOR ACUTE CARE!
2. Resident Responsibilities and Expectations
   - Include information about what is expected from patient in a swing bed. It is important that patient's and families realize swing bed is about getting ready to function independently and they will be asked to actively participate in their care.
3. Advance Directives
   - Facility responsibilities and willingness to honor advance directives
   - Information about how to formulate an advance directive
   - Include copy of resident advance directive in medical record
4. Free Choice – Choose a personal physician
   - Include list of attending physicians with name, address and phone
   - Document resident’s choice
   - Physician is not “required” to accept – document if physician does not accept
5. How to file a grievance or complaint (internally and externally)
   - Contact information for State Dept. of Health
   - Contact information for Ombudsman

6. Information about what constitutes abuse and how to report if abuse is suspected ---- Include information about right to be free from restraints

7. Facility Practices
   - Include information about such things as: smoking policy; personal appliances; absence from facility

8. Consent
   - Include information regarding medical condition, benefits and reasonable risks about treatments and reasonable alternatives to swing bed
(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of--

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate.
Resident Rights and Responsibilities
The facility must inform the resident both **orally and in writing** in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act.

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

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

A facility must promote the exercise of rights for all residents, **including those who face barriers such as communication problems, hearing problems and cognition limits.**
In a language that the resident understands

...........orally and in writing

I often see resident rights that have been copied so many times – and in such small print – they are basically illegible!!
In a language that the resident understands
orally and in writing

**Think creatively!**

Hey doc, how are you?
Resident Rights

1. The Right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. (§483.10)

2. The Right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (§483.13(a))

3. The Right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. (§483.13(a))

4. The Right to have privacy in sending and receiving mail including the right to send and promptly receive mail that is unopened; (§483.10(i)) “Promptly” means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours of regularly scheduled postal delivery and pickup service.

5. The Right to Access all records within 24 hours (excluding weekends and holidays); and (ii) to purchase copies of the records with 2 working days advance notice to the facility. (§483.10(b))
6. The Right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition (§483.10(b))

7. The Right to choose a MD/DO (§483.10(d))

8. The Right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect your well-being. (§483.10(d)(2))

9. The Right to participate in decisions about treatment and care planning (§483.10(d))

10. The Right to personal privacy and confidentiality of personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups (§483.10(e))

11. The Right to refuse release of personal and clinical records to any individual outside the facility except when you are transferred to another health care institution or required by law. (§483.10(e))
12. The Right to refuse to perform services for the facility. If you choose to perform services, to have needs or
desire for work document in the plan of care, to know whether the services are voluntary or paid, and, if paid, to
be paid at the prevailing rate. (§483.10(h))
13. The Right, with your consent, to be visited and be visited by others from outside the facility with immediate
access provided by the facility. Visitation is subject to reasonable restrictions and your right to deny or withdraw
consent at any time. (§483.10(e))
14. The Right to retain and use personal possessions (§483.10(l))
15. The Right to share a room with a spouse (§483.10(m))
16. The Right to refuse treatment (§483.10(b)(4))
17. The Right to refuse to participate in experimental research (§483.10(b)(4))
18. The Right to formulate an advance directive (§483.10(b)(4))
19. The Right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary
seclusion (§483.13(b))
Resident Rights

20. The Right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience not required to treat your medical symptoms. (§483.13(a))

21. The right to be notified in advance of any planned transfer or discharge. (§483.12(a)(4))

22. The Right to access a representative of the Department of Health or the State long term care ombudsman. (§483.12(a)(6))

When was the last time you discussed resident rights with your staff? (All disciplines who provide care – not just nursing.)

Does your staff understand resident rights? Can they explain them?

Does your staff understand how the rights are actually applied in your organization? Can they give examples?
in a language that the resident understands \textit{orally and in writing}
The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

Critical Access Hospitals with swing beds do not need to use the MDS

CAH Comprehensive assessment must be completed within 14 days of admission!

14 DAYS IS TOO LONG FOR MOST SWING BED PATIENTS! CMS intent is that assessment must be “timely”.
PPS Swing Bed Assessment

Hospitals with swing beds paid under PPS must utilize and submit the Swing Bed MDS to CMS.

There are 11 different item subsets for nursing homes and 8 for swing bed providers:

The following assessments are required:

- PPS (SP) 5-Day – within 6 – 8 days
- PPS (SP) 14-Day – within 15 – 18 days
- PPS (SP) 30-Day – within 30 – 33 days
- PPS (SP) 60-Day – within 60 – 63 days
- PPS (SP) 90-Day – within 90 – 93 days
- Swing Bed Clinical Change Assessment

Important Note
This is not JUST A NURSING ASSESSMENT – It’s Multi-disciplinary

Important Note
This is not AN ACUTE CARE ASSESSMENT

Important Note
Assessment must include direct OBSERVATION and COMMUNICATION with the patient

Important Note
Assessment must include communication / input with licensed and non-licensed DIRECT CARE STAFF MEMBERS ON ALL SHIFTS
The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

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
(xvi) Discharge potential
(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols
(xviii) Documentation of participation in assessment
ii. Customary Routine and Activities
Obtain information regarding the resident's preferences for his or her daily routine and activities.
Source: May be a combination of activities assessment and nursing assessment

iii. Cognitive Patterns (and Memory)
Determine the resident's ability to remember both recent and long-past events (i.e., short-term and long-term memory) and to think coherently. These items are crucial factors in many care-planning decisions.
Source: Consider Allen Cognitive Level Screen

iv/v. Communication --- Hearing, Speech, and Vision
Document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties.

vi. Mood and Behavior patterns
Identify signs and symptoms of mood distress. Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
vii. Psychosocial well being
Cultural or environmental influences including social and family relationships.

viii. Physical functioning and structural problems
Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

ix. Continence
Information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

x. Disease diagnoses and health conditions
Identify any diseases that have a relationship to the resident’s current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

xi. Dental and Nutritional Status
Assess conditions that could affect the resident’s ability to maintain adequate nutrition and hydration. Identify any oral or dental problems present

Source: Training Video on CMS web site on Dental / Oral exam by nursing
xii. Skin condition
Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also include any skin injury or methods to avoid injury.

xiii. Activity pursuit
Identify what resident likes to do for fun / relaxation.
Source: Usually part of activities assessment

xiv. Medications
Current medications including over the counter medications.

xv. Special Treatments and procedures
Identify any special treatments, procedures, and programs that will be required.

xvi. Discharge potential
Residents discharge potential and to what setting (LTC, Home, Home with Home Health, etc.)

xvii. Summary Information
Information that summarizes ALL of the individual assessment components.

xviii. Participation in assessment
Documentation regarding the way in which the resident participated in the assessment.
Who is responsible for completing the assessment?

- Provider – Physician, NP, PA
- Nursing
- Other professionals as determined by patient’s needs
  - Social Work
  - Rehab (OT/PT/Speech)
  - Pharmacist
    - A pharmacist should review EVERY patient
  - Dietician
    - A dietician should review EVERY patient regardless of nutritional risk
  - Activities Coordinator
Who is responsible for completing the assessment?

- Provider – Physician, NP, PA
- Nursing
- Other professionals as determined by patient’s needs
  - Social Work
  - Rehab (OT/PT/Speech)
  - Pharmacist
    - A pharmacist should review *EVERY patient*
  - Dietician
    - A dietician should review *EVERY patient* regardless of nutritional risk
  - Activities Coordinator
The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

“And what is as important as knowledge?”
Asked the mind.

“Caring and seeing with the heart”
Answered the Soul

Flavia Weeden
<table>
<thead>
<tr>
<th>Assessment Component</th>
<th>Source of Information</th>
<th>Discipline responsible for Documenting Assessment or summarizing information</th>
<th>By When (Date)</th>
<th>Completed (Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customary routine</td>
<td>Patient Interview / Family Interview</td>
<td>Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive patterns</td>
<td>Physician H&amp;P / Physician Progress Notes / Nursing Assessment / Patient / Family Interview</td>
<td>Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Physician H&amp;P / Physician Progress Notes / Nursing Assessment / Patient / Family Interview / Speech Therapy</td>
<td>Nursing or Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood and behavior patterns</td>
<td>Physician H&amp;P / Physician Progress Notes / Nursing Assessment / Patient / Family Interview / Social Work</td>
<td>Nursing or Social Work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Develop grid with each assessment component and who (what discipline) is responsible. Don’t forget to include all disciplines nursing - dietician – pharmacist – occupational therapist, social work, etc.

2. Identify timelines for each discipline to complete assessment \( (24 \text{ to } 48 \text{ hours}) \)

3. Modify EMR if necessary

4. Develop Input sheets at nursing station

5. Identify one individual to summarize information (progress notes, multi-disciplinary note) as part of care plan meeting

BORROW LIBERALLY FROM YOUR PEERS IN SNF OR LTC
A “significant change” may include, but is not limited to, any of the following, or may be determined by a MD/DO’s decision if uncertainty exists.

- **Deterioration in two of more activities of daily living (ADLs)**, or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent. For example, pronounced deterioration in function and communication following a stroke.

- **Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself**, such as spoon, toothbrush, or comb. Temporary loss of ability, such as during an acute illness, is not included.

- **Deterioration in behavior or mood**, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident’s psychosocial status are not likely to improve without staff intervention.

- **Deterioration in a resident’s health status**, where this change places the resident’s life in danger (e.g., stroke, heart disease, metastatic cancer); where the change is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or change that is associated with an initial diagnosis of a condition that is likely to affect the resident’s physical, mental, or psychosocial well-being over a prolonged period of time (e.g., Alzheimer’s disease or diabetes); or the onset of significant, unplanned weight loss (5% in the last 30 days, 10% in the last 180 days).
Comprehensive Multi-Disciplinary Plan of Care
(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following--

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

(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).
An interdisciplinary team, in conjunction with the resident, resident’s family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment.

The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident’s ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care.

- The requirements reflect the facility’s responsibility to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care.

- However, in some cases, a resident may wish to refuse
Assessment  ➔ Plan of Care

1. Measurable objectives and timelines
2. Multi-disciplinary
3. Patient involvement
4. Developed within 7 days of the comprehensive assessment
5. Describe services to help patient achieve highest level of functioning

Important Note:
7 days is TOO LONG based on average length of stay
Plan must be “timely”

Plan of Care is based on comprehensive assessment
NOT JUST NURSING
In general ----- EMR “canned” care plans do not meet the requirements specified in the CoPs for swing bed
<table>
<thead>
<tr>
<th>Goal: Mrs. Jones will be independent in medication management within 10 days of admission to swing bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Goal: Mrs. Jones will correctly identify each medication and why it has been prescribed within 3 days of admission</td>
</tr>
<tr>
<td>Goal: Mr. Smith will dress himself, including shoes, without assistance each morning by 8:00 AM within 5 days of admission</td>
</tr>
<tr>
<td>Intermediate Goal: Mr. Smith will dress himself, except for shoes, without assistance each morning by 8:00 AM within 3 days of admission</td>
</tr>
</tbody>
</table>
White Board in Room

NURSE:  
CNA:  

NEXT TIME PAIN MED. AT  
BLOOD WORK DONE AT 5:30  
VITALS DUE EVERY 4 HOURS  

KNEES  

CPM  2-3X/DAY  
CPM  

GOALS FOR TODAY  

DISCHARGE PLAN  

JOINT  

WT.  FLUID  

PT:  
OT:  

PT TIME  OT TIME  
WALKED  FT.  
SIT IN CHAIR  

HIPS  

Room# C361  
Phone Ext.# 4761
• In skilled restorative care, the creation of an individualized plan of care is the most essential component
• Goals should be established with the end result in mind of the patient returning to their home with the ability to maintain care safely
• Constant attention should be given to the progress the patient is making to those goals
• Adjustments should be made to the goals if needed
Survey Procedure

How would you do?

1. Does the care plan address the needs, strengths and preferences identified in the comprehensive assessment?
2. Is the care plan oriented toward preventing avoidable declines in functioning or functional levels?
3. How does the care plan attempt to manage risk factors?
4. Does the care plan build on resident strengths?
5. Do treatment objectives have measurable outcomes?
6. Does the care plan reflect standards of current professional practice?
7. Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents; especially those identified as refusing treatment.
8. Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.
9. If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?
Activities – Dental - Abuse
The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

The activities program must be directed by a qualified professional who –

(i) Is a qualified therapeutic recreation specialist or an activities professional who --

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

(iv) Has completed a training course approved by the State.

In a Critical Access Hospital, the services at §483.15(f) may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.
(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident:

(i) Routine dental service (to the extent covered under the State plan); and

(ii) Emergency dental services;

Prompt referral” means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

§483.55(b)(2) Must, if necessary, assist the resident--

(i) In making appointments; and

(ii) By arranging for transportation to and from the dentist’s office; and

§483.55(b)(3) Must promptly refer residents with lost or damaged dentures to a dentist.
Abuse - §483(c)(1)(ii)

Not employ individuals who have been—

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) 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 to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

**AND YOU MUST EDUCATE / TRAIN STAFF**

**IT’S NOT ENOUGH TO JUST HAVE A POLICY**
The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

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

(ii) 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;

(iii) The safety of individuals in the facility is endangered;

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

(v) 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. 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

(vi) The facility ceases to operate.

**Interpretive Guidelines §483.12(a)(2)**

- If transfer is due to a significant change in the resident’s condition, the facility must conduct the appropriate assessment, prior to any transfer or discharge to determine if a new care plan would allow the facility to meet the resident’s needs.
- If the significant change in the resident’s condition is an emergency, immediate transfer should be arranged.
Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.
Timing of Notice - §483.12(a)(5)

(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least **30 days** before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) **The resident’s health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;**

(D) An immediate transfer or discharge is required by the resident’s urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.
The written notice specified in paragraph (a)(4) 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 that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.
<table>
<thead>
<tr>
<th>Date:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td>Medicare #:</td>
</tr>
</tbody>
</table>

Dear

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

If you disagree with your discharge plan, you have the right to appeal this action with the State of _____Division of Health (State contact). To do so, contact:
- Division of Quality Assurance
  - Address and Phone
- or the long-term care ombudsman: (Ombudsman contact).
  - Board on Aging and Long Term Care
  - Address and Phone

Sincerely,
Name and Title

_________________________  ______________________  _______________
Patient Signature            Date                    Time
Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

“Sufficient preparation” means the facility informs the resident where he or she is going and assures safe transportation. The facility should actively involve the resident and the resident’s family in selecting the new residence. Some examples of orientation may include trial visits by the resident to a new location; working with family; and orienting staff in the receiving facility to the resident’s daily patterns.
All beneficiaries receiving services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC) before their services end:

- Home Health Agencies (HHAs); Compréhensive Outpatient Réhabilitation Services (CORFs); Hospice; Skilled Nursing Facilities

Skilled Nursing Facilities include beneficiaries receiving Part A and B services in Swing Beds.
The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).
- When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).
- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).
- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).
The NOMNC should be delivered to the beneficiary 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. For example, if the last day of covered SNF care is a Friday, the NOMNC should be delivered no later than the preceding Wednesday.

**Note:** The two day advance requirement is NOT a 48 hour requirement. For example, if a patient's last covered home health service is at 10AM on Wednesday and the notice is delivered at 4PM on the prior Monday, it is considered timely.

The NOMNC may be delivered earlier than two days preceding the end of covered services. However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

The notice may not be routinely given at the time services begin. An exception is when the services are expected to last fewer than two days. In these instances, the notice may be given by the provider when services begin.
Delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice delivery must be determined by the individual NOMNC requirements per this section and ABN delivery requirements per §1879 of the Act and per guidance in this chapter. Both the NOMNC and an ABN may be required in certain instances.
Notice of Medicare Non-Coverage

Patient name: Patient number:

The Effective Date Coverage of Your Current {insert type}

Services Will End: {insert effective date}

Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.

You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
Patients may be discharged home:

- Once all of the goals are met
- Determined that the patient and caregivers have the skills to repeatedly meet them
- Build into your plan of care – FOLLOW UP CARE
  - Interactive with the primary care provider
  - Making phone calls to check on them
  - Providing them with tools or resources to address concerns
What is the Opportunity to Increase the Swing Bed Days in your Facility?

What is your Revenue Opportunity?
Opportunity Questions

1. What is your current length of stay? How does it compare to the average?

2. What are the most frequent diagnosis you admit to swing bed? How do they compare to the examples in this presentation?

3. What are you referral sources? Are you actively marketing your program to other facilities? Are you actively marketing to patients in your community that you refer for services at other hospitals? Are you actively marketing to providers?

4. How is your internal marketing? Does nursing, social services, utilization review and/or rehab advocate for swing bed services with providers?

5. How are you communicating your outcomes / results to patients – community – providers?

6. Do your providers and staff understand the types of patients that may benefit from swing bed?
Transforming Patient Engagement through Family Centered Care
Host: Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA
Regional Chief Clinical Officer HealthTechS3
Date: July 14, 2017
Time: 12:00pm CT

Caring for the Patient – Not the Technology
Hosts: Faith M Jones, MSN, RN, NEA-BC & Brad Putnam, CrossTx, Director of Customer Success
Date: July 20, 2017
Time: 12:00pm CT
Register: http://bit.ly/2sDtn1r

Data Driven Approach to Medicare Wellness: Good for the Patient, Good for the Practice
Host: Faith M Jones, MSN, RN, NEA-BC
Date: August 17
Time: 12:00pm CT

National Patient Safety Goals – Improving Hospital Safety and Quality – Part I
Host: Carolyn St.Charles, RN, BSN, MBA, Regional Chief Clinical Officer HealthTechS3
Date: September 8, 2017
Time: 12:00pm CT
<table>
<thead>
<tr>
<th>Webinar Title</th>
<th>Host</th>
<th>Date</th>
<th>Time</th>
<th>Register Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Practical Approaches for Interim Leaders</td>
<td>Mike Lieb, Vice President - Interim Services HealthTechS3</td>
<td>September 14, 2017</td>
<td>12:00pm CT</td>
<td><a href="http://bit.ly/2sDrO3A">http://bit.ly/2sDrO3A</a></td>
</tr>
<tr>
<td>Hiring Executives To Fit The Outcomes Needed – Moving Way Beyond The Title</td>
<td>Peter Goodspeed, Vice President of Executive Search HealthTechS3</td>
<td>September 28, 2017</td>
<td>12:00pm CT</td>
<td><a href="http://bit.ly/2rkJCfS">http://bit.ly/2rkJCfS</a></td>
</tr>
<tr>
<td>The New Health Care Innovation Model: Is It All Hocum?</td>
<td>Diane Bradley, PhD, RN, NEA-BC, CPHQ, FACHE, FACHCA</td>
<td>September 22</td>
<td>12:00pm CT</td>
<td><a href="http://bit.ly/2sDNKvF">http://bit.ly/2sDNKvF</a></td>
</tr>
</tbody>
</table>
It is easy to sit up and take notice, What is difficult is getting up and taking action.

Honoré de Balzac
Thank you!

Dallas Office
2745 North Dallas Parkway, Suite 100, Plano, TX 75093

Brentwood Office
5110 Maryland Way, Suite 200
Brentwood, TN 37027

Our Phone
Main Office: 615.309.6053
Executive Placement: 972.265.4549

Email / Website
Carolyn St.Charles
Carolyn.stcharles@healthtechs3.com
360-584-9868