UNCOMPLICATING SWING BEDS – IS IT REALLY POSSIBLE?

NOVEMBER 3, 2017
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.
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<th>RECRUITMENT</th>
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<td>• Executive Recruitment</td>
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4TH QUARTER WEBINARS

Transforming Case Management for the Future; The Future is Now
Host: Diane Bradley  
Date: November 10, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2y6riOP

Passing the Baton: Transitional Care Management and Beyond
Host: Faith Jones  
Date: November 16, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2xyMN7B

Interim Leadership as a Career Path
Host: Mike Lieb  
Date: November 30, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2wjZBqK

Creating a Culture of Performance to Support Continual Improvement
Host: Diane Bradley  
Date: December 8, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2fxaecY

Community Health Needs Assessment – Are you ready for 2018
Host: Carolyn St.Charles  
Date: December 15, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2yrF2Qn

Understanding Team Based Care in the Primary Care Setting
Host: Faith Jones  
Date: December 21, 2017  
Time: 12:00 Central  
Registration Link: http://bit.ly/2xDMAlf

Challenges/Opportunities in Population Health Management IT
Host: Diane Bradley  
Date: 1st quarter 2018  
Time: 12:00 Central  
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.
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 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.

Carolyn has extensive experience in working with rural hospitals to both develop and strengthen their Swing Bed program.

carolyn.stcharles@healthtechs3.com
360-584-9868
AGENDA FOR TODAY

Six Reasons


2. Same Patient – Same Bed – Same Nurse – Same Therapist – Same Medications – So Nothing’s Different

3. I Work in Acute Care


5. Resistance: Why Do I Have To Do All This Extra Stuff?

6. It’s Not My Job – And I Don’t Know How Anyway – And Joe Takes Care of Swing Beds
IS SWING BED REALLY SO COMPLICATED?
WHY CAN’T WE GET IT RIGHT?
There is often confusion about who can be placed in a swing bed by clinical staff and providers – which can result in:

- Patients who meet criteria for skilled care – are not placed in Swing Bed
- Patients who do not meet criteria for skilled care – are placed in Swing Bed
1. Identify a facility resource who is knowledgeable – who is responsible for actively reviewing patients for Swing Bed admission – and – for continued stay reviews. Consider:
   – Utilization Review
   – Case Management
   – Social Services
   – Swing Bed Coordinator
2. Develop written admission and continued stay guidelines -- Don’t rely on opinion.
3. Educate staff and providers – DON’T ASSUME THEY KNOW.
**SWING BED CRITERIA**

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 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
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.
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.

Medicare Benefit Policy Manual Chapter 8 – 20.1
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.

Medicare Benefit Policy Manual  Chapter 8 – 20.1
A WORD ABOUT SWING BED CRITERIA

Not just Rehab!

Skilled Restorative Care (SRC) also qualifies – for example:

- Nutrition Management
- Medication Management
- Skilled Nursing (IV therapy / Wound Care, etc.)

The Medicare Benefit Policy Manual has MANY examples of the types of patients that qualify for Swing Bed (SNF) care.

*Medicare Benefit Policy Manual – (Rev. 228, 10-13-16) Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance*
EXAMPLE OF NUTRITION MANAGEMENT CRITERIA DEVELOPED AS PART OF SWING BED RESEARCH PROJECT

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

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
Online Journal of Rural Nursing and Health Care http://www.rno.org/journal/
EXAMPLE OF MEDICATION MANAGEMENT CRITERIA DEVELOPED AS PART OF SWING BED RESEARCH PROJECT

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

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## Swing Bed Utilization by Condition / Procedure

<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>
Length of Stay is contingent on meeting skilled criteria

Average Length of Stay
• *Average of 27 days in SNF
• Usually lower length of stay in Swing Bed

*Grabowski, 2010
*Herndon, Bones, Kurapati, Rutherford, & Vecchioni, 2011
When a patient transitions from acute to swing (especially in the same hospital), staff don’t always see any real difference between what they did yesterday – and what they need to do today. Most of the time, patients don’t either!

As a consequence – patients may not receive the skilled care they need – and swing bed regulatory requirements may not be met.
SOLUTIONS FOR CONSIDERATION

Do everything possible to make sure EVERYONE – INCLUDING THE PATIENT – knows they are now in another level of care – and it’s DIFFERENT!

1. Move the patient to a new room – even if it’s down the hall.

2. Put a sign on the door or by the patient’s bed ----- **SKILLED CARE.**

3. Put a big note on the front of the paper chart ----- **SKILLED CARE.**

4. Make sure the patient is dressed in their own clothes every day (no hospital gowns).

5. Post the Care Plan Goals for EACH DAY in the patient’s room.

6. Post the Discharge Plan ---- When (By November 15) and Where (Home) in the patient’s room.
WHAT’S DIFFERENT
PREADMISSION SCREENING AND RESIDENT REVIEW -- PASRR

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.

Most facilities create a new medical record.
**PHYSICIAN CERTIFICATION – EXAMPLE**
**SPECIFIC FORM IS NOT REQUIRED**

<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
RECERTIFICATION - EXAMPLE

Within 14 days and every 30 days thereafter (Progress Notes are OK)

Patient Name: ____________________  Admission Date: ____________________

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 ____________________
State and Federal laws require _____ Medical Center, a Critical Access Hospital with Swing Beds, to provide patients with certain information at the time of admission.

This packet is intended to comply with those laws. By signing this document, you acknowledge that _____ Medical Center has informed you orally and provided a written copy of the following documents.

Also, _____ Medical Center has given you an opportunity to ask any questions you may have regarding the documents listed below. You may ask any further questions you may have at any time during your stay.

I received copies of the following documents at the time of my admission to _____ Medical Center Swing Bed and have had them explained to me in a language that I could understand.

Printed Name
Patient / Legal Representative
Signature__________Date

Witness signature
Signature__________Date

- Swing Bed Brochure
- Resident Rights and Responsibilities
- A description of _____ Medical Center’s policies regarding advance directives
- A list of attending physicians who treat patients and choice of physicians
- Financial Obligations
- Notice of privacy practices
- _____ Medical Center’s Transfer and Discharge policies
- A description of _____ Medical Center’s policy regarding grievances and complaints
- _____ Medical Center’s responsibility for preventing patient abuse including information for reporting Abuse and Neglect
- Contact information for Hospital and State Agencies including State Ombudsman
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.

Resident Rights and Responsibilities detail in section at the end of presentation.
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!!
FINANCIAL OBLIGATIONS §483.10(B)(5)

(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.
COMPREHENSIVE ASSESSMENT
C-0388 §483.20 -18 ELEMENTS

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

Detail in section at the end of the presentation
COMPREHENSIVE 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
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).
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
COMPREHENSIVE CARE PLAN
C-0395 §483.20(k)

(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
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
<table>
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<tr>
<th>Goal:</th>
<th>Mrs. Jones will be independent in medication management within 10 days of admission to swing bed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intermediate Goal:</strong></td>
<td>Mrs. Jones will correctly identify each medication and why it has been prescribed within 3 days of admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Mr. Smith will dress himself, including shoes, without assistance each morning by 8:00 AM within 5 days of admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intermediate Goal:</strong></td>
<td>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

- Date
- 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

Room# C361
Phone Ext.# 4761

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TRANSFER AND DISCHARGE REQUIREMENTS
§483.12(a)(2)

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 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.
CONTENTS OF NOTICE
§483.12(a)(6)

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

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>
NOTICE OF NON-COVERAGE
CMS 260.2

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 includes beneficiaries receiving Part A and Part B services in Swing Beds.
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.
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).
Other Required Notices

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.
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.
Rarely do staff in acute care have Rehab or SNF experience. As such, they have little to no context to understand the difference between acute and skilled care.
SOLUTIONS FOR CONSIDERATION

1. Develop an agreement with a Rehab / SNF to rotate staff for training.

2. Visit Rehab / SNF facilities – including your own!!! What do they do? What can you steal as best practice?

3. Define specific responsibilities.

4. Create education and training with competency checklists – for all disciplines – don’t assume they know! Rarely – if ever – is this done for Swing Bed (at least that I’ve seen).
It’s not sufficient to educate leaders (or just a few people) ---- it’s the direct care staff and providers that need to be educated.

Providers – RNs -- LPNs -- CNAs / PCTs -- PT / OT / Speech -- Pharmacist – Dietary / Dietitian -- Social Worker -- Activities

*LEAST  Congruence with Actual Job Performance  MOST

WRITTEN TEST - COMPUTER TEST - RECORDS REVIEW - ANATOMIC MODEL - JOB SIMULATION - JOB SAMPLE (OBSERVATION)

Source: Measuring the Competence of Healthcare Providers, Kak, Burkhalter, and Cooper
Source: HealthTechS3 Clinical Connection Newsletter, Understanding and Measuring Competency, May/June 2017
## Registered Nurse Job Responsibilities

<table>
<thead>
<tr>
<th>Pre-Arrival</th>
<th>Arrival</th>
<th>Swing Bed Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Review potential admission with Swing Bed Coordinator (Can care that is needed be provided? Are there any concerns?)</td>
<td>- Request new orders from physician if not already completed (cannot carry over acute orders). &lt;br&gt; - Move to new room (based on facility policy). &lt;br&gt; - Orient to room. &lt;br&gt; - Review differences with resident between Acute and Swing bed stay. &lt;br&gt; - Complete Swing Bed Admission Assessment. (New Assessment – not carry over from Acute). &lt;br&gt; - Develop nursing plan of care specific to Skilled Nursing Needs. (Note --- some facilities only require a multi-disciplinary plan of care and not a separate nursing plan of care).</td>
<td>- Solicit input from staff on all shifts including CNA/PCT, regarding resident care needs prior to any multi-disciplinary conference. &lt;br&gt; - Attend and participate in multi-disciplinary care conferences and update plan of care as needed. &lt;br&gt; - Ensure plan of care and discharge plans are posted in resident's room. &lt;br&gt; - Follow and document plan of care. &lt;br&gt; - Encourage resident to be up and dressed each day. &lt;br&gt; - Encourage resident to do as much as possible for themselves – based on plan of care.</td>
<td>- Educate for Discharge. Provide discharge instructions / training / education as needed. This needs to be done WITH SUFFICIENT TIME PRIOR TO DISCHARGE TO ENSURE RESIDENT AND FAMILY ARE ADEQUATELY PREPARED. &lt;br&gt; - Document education / training / discharge instructions</td>
</tr>
</tbody>
</table>
## SOCIAL WORK – CASE MANAGEMENT – SWING BED COORDINATOR

<table>
<thead>
<tr>
<th>PRE-ADMISSION</th>
<th>ADMISSION</th>
<th>SWING BED STAY</th>
<th>DISCHARGE</th>
</tr>
</thead>
</table>
| - Initial review to determine if patient meets – or - doesn’t meet Swing Bed Criteria. If transfer from another facility – review medical record and other pertinent documents. | - Review all admission forms with patient or legal representative verbally:  
  - Financial Obligations  
  - Choice of Providers  
  - Resident Rights  
  - Resident Responsibilities  
  - Facility Practices  
  - Advance Directives  
  - Grievance  
  - Abuse | - Review at least weekly or more often as needed for continued stay criteria.  
  - Schedule and facilitate multi-disciplinary care conferences, including resident.  
  - Document multi-disciplinary care conferences in medical record.  
  - Review care conference and team recommendations with resident.  
  - Ensure Daily and/or Weekly Goals are posted in resident’s room.  
  - Develop discharge plan in coordination with multi-disciplinary team. | - Provide written discharge notices as soon as discharge is anticipated but within 2-days of discharge:  
  - Written Notice of Discharge  
  - Notice of Medicare Non-Coverage (Medicare)  
  - Arrange for any needed equipment, etc. for discharge. |
| - Review potential admission with other disciplines to ensure that patient needs can be met: Nursing – Rehab – Pharmacy – Dietitian – Other | - Obtain signatures that documents have been provided and reviewed - and document in medical record. | | |
| - Discuss admission with provider. Review admission, goals, expected length of stay. If transfer review admission, ensure provider will accept patient. | | | |
| - Discuss admission with patient or legal representative to ensure that they are aware of expectations and agree to Swing Bed. | | | |
| - If in-facility, provide choice of Swing Bed Facilities. | | | |

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## Registered Nurse Competency

<table>
<thead>
<tr>
<th>Mission Vision Values</th>
<th>Specific Competency</th>
<th>References Learning Activities</th>
<th>Applicable Staff Frequency</th>
<th>Method Scoring</th>
<th>Assessment Responsibility</th>
<th>Proficiency Circle One</th>
<th>Follow-Up</th>
</tr>
</thead>
</table>
Understanding and Measuring Competency

PART 1: DEVELOPING A FRAMEWORK FOR COMPETENCY ASSESSMENTS

Welcome to our two-part summer series on Competency. Part 1, May/June will focus on a framework for measuring competency. Part 2, July/August will focus on examples of competency including cultural competency.

Introduction

As healthcare providers we often struggle with how to measure competency effectively and to ensure that we are providing safe, effective, and culturally appropriate patient care to the populations we serve.

In their article, Measuring the Competence of Healthcare Providers, Kolb, Kolb, and Cooper define competence as, “the ability to perform a specific task in a manner that yields desirable outcomes.” In their newsletter, Developing a Competency Framework, defines competency as “the integrated knowledge, skills, judgment, and attitude that people need to perform a job effectively.” Unfortunately, we sometimes confuse formal or informal education and/or years of experience with competency. Although both education and experience may have a positive impact — they are not in and of themselves reliable indicators of competency.

Patterson’s book in her I.Q. book. From Novice to Expert, describes five levels of skill:

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert

Although written for nursing, these levels can apply to any discipline. Adding information to the competency assessment regarding the level of skill can help establish realistic expectations. It can also help us think about competencies as a continuum and not a set point in time.

Cultural Competency

PART 2: DEVELOPING A FRAMEWORK FOR CULTURAL COMPETENCY

Welcome to Part 2 of our two-part summer series on Competency. In Part 2, we are focusing on developing a framework for measuring competency. In Part 1, we looked at developing cultural competency.

INTRODUCTION

The 2016 National Healthcare Quality and Disparities report published by AHRQ looks at health disparities among populations. Health disparities are defined as “a difference in rate of illness, disease, or conditions among different populations. Disparities not only means difference, but also inequality. In the report goes on to say:

“Overall, some disparities were getting smaller from 2007 through 2014 – 2015, but disparities persist, especially for poor and uninsured populations in all areas.

White women’s rates of mortality from breast and cervical cancer have improved significantly in recent years.

Most non-Hispanic Whites actually did not change significantly for any racial and ethnic groups.

Between 2007 and 2014 – 2015, the proportion of people who smoke has decreased from 23% to 18%.

Developing cultural competencies within your organization is one way to begin reducing the health disparities that exist in your community and improving the effectiveness and quality of care provided.

Available at

http://www.healthtechs3.com/newsletters-bulletins/
REASON # 4: LACK OF KNOWLEDGE ABOUT - REGULATORY GUIDELINES – POLICIES – PROCEDURES – FORMS – NOTICES

Swing Bed regulations, policies, procedures, forms, notices, etc. are different from acute care - but staff (and providers) are frequently not aware of the differences.
SOLUTIONS FOR CONSIDERATION

1. Provide Easy to Read – Easy to Understand Resources
   - Admission and Continued Stay Criteria
   - Patient required notices
   - Documentation requirements
   - Roles and Responsibilities of each Team Member

Policies and Procedures are necessary, of course. However, to help staff on a day-to-day basis, a “Cliff Notes” version may result in better compliance.

2. Identify a Resource ---- Who to go to with questions (24 hours / day)
## Social Work – Case Management – Swing Bed Coordinator

<table>
<thead>
<tr>
<th>Pre-admission</th>
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<th>Discharge</th>
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| - Initial review to determine if patient meets – or - doesn’t meet Swing Bed Criteria. If transfer from another facility – review medical record and other pertinent documents. | - Review all admission forms with patient or legal representative verbally  
  - Financial Obligations  
  - Choice of Providers  
  - Resident Rights  
  - Resident Responsibilities  
  - Facility Practices  
  - Advance Directives  
  - Grievance  
  - Abuse | - Review at least weekly or more often as needed for continued stay criteria.  
  - Schedule and facilitate multi-disciplinary care conferences, including resident.  
  - Document multi-disciplinary care conferences in medical record.  
  - Review care conference and team recommendations with resident.  
  - Ensure Daily and/or Weekly Goals are posted in resident’s room.  
  - Develop discharge plan in coordination with multi-disciplinary team. | - Provide written discharge notices as soon as discharge is anticipated but within 2-days of discharge  
  - Written Notice of Discharge  
  - Notice of Medicare Non-Coverage (Medicare)  
  - Arrange for any needed equipment, etc. for discharge. |
| - Review potential admission with other disciplines to ensure that patient needs can be met: Nursing – Rehab – Pharmacy – Dietitian – Other | - Obtain signatures that documents have been provided and reviewed - and document in medical record. | | |
| - Discuss admission with provider. Review admission, goals, expected length of stay. If transfer review admission, ensure provider will accept patient. | | | |
| - Discuss admission with patient or legal representative to ensure that they are aware of expectations and agree to Swing Bed. | | | |
| - If in-facility, provide choice of Swing Bed Facilities. | | | |

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# Physician / Provider - Responsibilities

<table>
<thead>
<tr>
<th>Pre-Admission</th>
<th>Admission</th>
<th>Swing Bed Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review potential admission with Swing Bed Coordinator.</td>
<td>Write new orders for Swing Bed.</td>
<td>See patient at least weekly, or more often as needed. Document in the medical record:</td>
<td>Write discharge orders.</td>
</tr>
<tr>
<td>Identify goals, plan and anticipated length of stay – and discuss with patient.</td>
<td>Complete new H&amp;P or update current H&amp;P.</td>
<td>• Evaluation of progress</td>
<td>Write discharge summary.</td>
</tr>
</tbody>
</table>
| If patient from outside the facility, discuss with Case Manager and agree to accept patient if appropriate. | Document:  
• Diagnosis  
• Prognosis  
• Rehab potential  
• Resident awareness of diagnosis and expectations for discharge  
• Discharge Plans  
• Course of treatment | • Care objectives  
• Anticipated length of stay | • Reason resident was placed in Swing Bed  
• Course of treatment  
• Discharge plan  
• Condition at discharge |
| Complete Swing Bed Certification. | | Write / Update orders as needed. | |
| | | Participate in the Multi-Disciplinary Care Conferences – or – provide feedback to the team. | |
| | | Communicate with Case Manager and other disciplines about goals and expected length of stay. | |
## Registered Nurse - Responsibilities

<table>
<thead>
<tr>
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<th>Discharge</th>
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</thead>
<tbody>
<tr>
<td>Review potential admission with Swing Bed Coordinator (Can care that is needed be provided? Are there any concerns?)</td>
<td>Request new orders from physician if not already completed (cannot carry over acute orders).</td>
<td>Solicit input from staff on all shifts including CNA/PCT, regarding resident care needs prior to any multi-disciplinary conference.</td>
<td>Educate for Discharge. Provide discharge instructions / training / education as needed. This needs to be done WITH SUFFICIENT TIME PRIOR TO DISCHARGE TO ENSURE RESIDENT AND FAMILY ARE ADEQUATELY PREPARED.</td>
</tr>
<tr>
<td></td>
<td>Move to new room (based on facility policy).</td>
<td>Attend and participate in multi-disciplinary care conferences and update plan of care as needed.</td>
<td>Document education / training / discharge instructions.</td>
</tr>
<tr>
<td></td>
<td>Orient to room.</td>
<td>Ensure plan of care and discharge plans are posted in resident's room.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review differences with resident between Acute and Swing bed stay.</td>
<td>Follow and document plan of care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete Swing Bed Admission Assessment. (New Assessment – not carry over from Acute)</td>
<td>Encourage resident to be up and dressed each day.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop nursing plan of care specific to Skilled Nursing Needs. (Note --- some facilities only require a multi-disciplinary plan of care and not a separate nursing plan of care).</td>
<td>Encourage resident to do as much as possible for themselves – based on plan of care.</td>
<td></td>
</tr>
</tbody>
</table>
**PHYSICAL THERAPY / OCCUPATIONAL THERAPY / SPEECH RESPONSIBILITIES**

<table>
<thead>
<tr>
<th>PRE-ADMISSION</th>
<th>ADMISSION</th>
<th>SWING BED STAY</th>
<th>DISCHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Review potential admission with Swing Bed Coordinator (Can care that is needed be provided? Are there any concerns?)</td>
<td>❑ Assess patient and document in the medical record.</td>
<td>❑ Provide therapy as ordered.</td>
<td>❑ Educate for Discharge. Provide discharge instructions / training / education as needed. This needs to be done WITH SUFFICIENT TIME PRIOR TO DISCHARGE TO ENSURE RESIDENT AND FAMILY ARE ADEQUATELY PREPARED.</td>
</tr>
<tr>
<td>❑ Complete an assessment of patients currently in the hospital – and/or – review record (if possible) of transfers.</td>
<td>❑ Request orders from physician for therapy if appropriate.</td>
<td>❑ Communicate to physician if changes are needed.</td>
<td>❑ Document education / training / discharge instructions.</td>
</tr>
<tr>
<td></td>
<td>❑ Develop plan of care specific to Rehab needs. (Note --- some facilities only require a multi-disciplinary plan of care)</td>
<td>❑ Attend and participate in multi-disciplinary care conferences and update plan of care as needed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ Assess patient and document in the medical record.</td>
<td>❑ Ensure plan of care and discharge plans are posted in resident’s room.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ Request orders from physician for therapy if appropriate.</td>
<td>❑ Encourage resident to be up and dressed each day.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ Develop plan of care specific to Rehab needs. (Note --- some facilities only require a multi-disciplinary plan of care)</td>
<td>❑ Encourage resident to do as much as possible for themselves – based on plan of care.</td>
<td></td>
</tr>
</tbody>
</table>
### Dietitian - Responsibilities

<table>
<thead>
<tr>
<th>Pre-Admission</th>
<th>Admission</th>
<th>Swing Bed Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ If appropriate ---- Review potential admission with Swing Bed Coordinator (Can care that is needed be provided? Are there any concerns?)</td>
<td>❑ Assess patients nutritional needs and document in the medical record.</td>
<td>❑ See / assess patient at least weekly or more often as needed.</td>
<td>❑ Educate for Discharge. Provide discharge instructions / training / education as needed. This needs to be done WITH SUFFICIENT TIME PRIOR TO DISCHARGE TO ENSURE RESIDENT AND FAMILY ARE ADEQUATELY PREPARED.</td>
</tr>
<tr>
<td></td>
<td>❑ Request orders from physician – and/or write orders to meet nutritional needs if allowed by State law.</td>
<td>❑ Update nutritional plans as needed – and ensure nutritional plan is being followed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>❑ Develop plan of care specific to Nutritional needs. (Note --- some facilities only require a multi-disciplinary plan of care).</td>
<td>❑ Attend and participate in multi-disciplinary care conferences and update plan of care as needed.</td>
<td>❑ Document education / training / discharge instructions.</td>
</tr>
</tbody>
</table>
## Activities Coordinator - Responsibilities

<table>
<thead>
<tr>
<th>Pre-Admission</th>
<th>Admission</th>
<th>Swing Bed Stay</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Assess patients preferences for activities and document in the medical record.</td>
<td>□ Provide activities – or – monitor to ensure activities are being provided and documented.</td>
<td>□ Review activities plan at least weekly and update if needed.</td>
</tr>
<tr>
<td></td>
<td>□ Develop specific plan for activities.</td>
<td>□ Attend and participate in multi-disciplinary care conferences.</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>□ Communicate plan to nursing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Post plan in resident room.</td>
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</tbody>
</table>

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REASON # 5: RESISTANCE
WHY DO I HAVE TO DO ALL THIS EXTRA STUFF?

Frequently staff (and providers) don’t understand the additional requirements for Swing Bed --- often what they perceive to be “busy work.” After all, it is the same patient that was in the same bed yesterday!

- Why do we have to discharge from Acute Care?
- WHY do I have to rewrite orders?
- WHY do we have to do a new assessment? We just did one.
- WHY do we have to do a multi-disciplinary care plan – we all have our own?

WHY? WHY? WHY? WHY?
SOLUTIONS FOR CONSIDERATION

1. Educate Staff and Providers ----- Explain

2. Lots and Lots and Lots of Feedback

3. Tell stories about WHY – and how it made a difference!
   Showcase a “resident of the month”. Showcase a “staff person of the month”.

Stories. Connect. People.
Most facilities have designated an individual to:

• Review admissions based on skilled criteria
• Coordinate swing bed admissions including required notices
• Plan and facilitate multi-disciplinary planning and documentation
• Provide discharge notices

However, when that person is gone (days off, weekends, vacation, holidays) – there is frequently no one who is knowledgeable and can step in.
SOLUTIONS FOR CONSIDERATION

1. Identify a back-up. Consider Charge Nurse / Shift Supervisor / Med-Surg Manager. Designate the person on the schedule.

2. Designate back-up to cover 24/7 or at least 7 days / week on Day shift.

3. Provide Easy to Read – Easy to Understand Resources.

4. Have designee coordinate even when primary person is working so they remain current and knowledgeable. Have them do it together.
SWING BED PROGRAM --- PROTECT IT

YOUR SWING BED PROGRAM

- IS A BENEFIT TO YOUR FACILITY
- IS A BENEFIT TO YOUR COMMUNITY
- IS A BENEFIT TO YOUR PATIENTS
If you would like to access the prior Swing Bed Webinar you may access the recording at:

https://attendee.gotowebinar.com/register/881296334679205635
Thank you!

Please contact me if you are interested in:

- A Review of your Swing Bed Program
- Education for Providers and Staff
- Assisting with Developing Admission Packets or other Patient Information
  - Assistance with Developing Policies & Procedures
  - Assistance with Developing Roles & Responsibilities

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Brentwood, TN 37027

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The CAH CoPs – Appendix W has some but not ALL of the regulatory requirements for Swing Bed

For example: Medicare Claims Processing Manual includes definitions of what constitutes skilled care

- **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
“SUBSTANTIAL” COMPLIANCE WITH…

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)
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))
RESIDENT RIGHTS

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))
**Resident Rights**

§483.10(b)

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))
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))
**RESIDENT RESPONSIBILITIES EXAMPLE**

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

2. To report unexpected changes in your condition to the Health Care Team.

3. To make it known whether you clearly understand your plan of care or need further explanation.

4. To actively participate in your plan of care. Refusal of treatments or therapies may result in discharge from Swing Bed.

5. To assure that the financial obligations of your health care are fulfilled as promptly as possible.

6. To follow hospital rules and regulations affecting your care and conduct.

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

8. To be respectful of the property of other persons and of the hospital.

9. To follow the Hospital's smoke free campus policy.
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*

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.

*Source: Consider Allen Cognitive Level Screen*
COMPREHENSIVE ASSESSMENT
C-0388 §483.20

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.
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.
DENTAL SERVICES §483.55(B)

(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.
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.
Thank you!
If you would like more information - or - have questions – or - would like to discuss a swing bed assessment at your facility please feel free to contact me.