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CLINICAL CONNECTION NEWSLETTER
APRIL 2019

TEN THINGS TO KNOW ABOUT THE NEW SWING BED REGULATIONS

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As of July 27, 2018, there are 1,348 critical access hospitals (CAHs) in the US, and 1,183 (88%) provide swing bed services. Swing beds provide an opportunity for CAHs to increase or stabilize census, and to provide the community with care closer to home. Medicare swing bed is reimbursed at the same per-diem rate as Medicare acute care, making swing bed, for most CAHs, an important revenue source.

The Center for Medicare and Medicaid Services (CMS) issued substantial revisions to the swing bed regulatory requirements on October 12, 2018. The revisions were published in the *State Operations Manual, Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs.* Many of the revisions are similar to those in the Long-Term Care Facilities Conditions of Participation, Appendix PP, published in November of 2017. And, in fact, many of the new CAH swing bed regulations refer to Appendix PP Interpretative Guidelines.

Many hospitals have not implemented all of the new requirements. Below is an overview of the new requirements, clarification of some old ones, and some **Tips** for implementation. You will likely need to revise existing policies and educate staff to ensure compliance with the new standards.

1. Choice of Physician **(C-0361)**: Residents have always had the right to choose an attending physician. CMS has reaffirmed that the resident choice of physicians remains a requirement.

   Tip: *Provide residents with a list of physicians on your medical staff. If the resident chooses a physician that does not "typically" follow swing bed patients, you must still ask them if they will follow the resident. If you have a group (hospitalists for example), provide the name of the group as well as the names of individual providers.*

2. Contacting Providers **(C-0361)**: The resident must be provided with the name, specialty, and a way of contacting the attending physician and other primary care professionals responsible for their care.

   Tip: *Provide residents with a written list of names and contact details. Consider preparing a list of all providers in advance, and then highlighting those that are providing care to the resident. Instructions to "contact nursing – who will then contact the physician" are not adequate.*

3. Timelines for Reporting Abuse **(C-0381)**: Definitions and timelines for reporting abuse have been revised. There is a requirement to notify the administrator within two hours if the event involves abuse or results in serious bodily injury – or – within 24 hours if allegations do not involve abuse or result in serious bodily injury. Reports must also be made to other officials in accordance with state law.

   All alleged violations must be thoroughly investigated, and results of the investigation made within five working days of the incident, and if the violation is verified, appropriate corrective action taken. The investigation report must be made to the administrator or his/her designated representative and to other officials in accordance with state law, including to the State Survey Agency.

   Tip: *Review state guidelines for reporting requirements. Ensure the administrative staff, managers, and shift supervisors are aware of the changes for reporting.*

4. Comprehensive Assessment **(C-0388)**: The required elements of the assessment have not changed. CMS has clarified that CAHs are <u>not required</u> to use the Resident Assessment Instrument (RAI) or to comply with the requirements for frequency, scope, and number of assessments.

   Tip: *Ensure the timelines you have established are appropriate for your length of stay.*

5. Comprehensive Care Plans **(C-0388)**: The requirement for development of a comprehensive care plan has always been in the conditions of participation (CoPs). What's new is the requirement for who must participate in the development of the plan. Participants now include:
    - The attending physician
    - A registered nurse with responsibility for the resident
    - A nurse aide with responsibility for the resident
    - A member of the food and nutrition staff
    - To the extent practicable, participation by the resident and the resident's representative
    - Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident

    There's also a requirement to include, in consultation with the resident, the resident's goals for admission, desired outcomes, and preferences for future discharge.

    Tip: *Schedule meetings at a convenient time for the team and the resident. Consider bed-side conferences / rounding. If someone on the team can't attend the conference, make sure their input is considered and documented.*

6. Culturally-Competent and Trauma-Informed Plan of Care **(C-0388)**: The CoPs require that residents who are trauma survivors must receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

   The first step, of course, is to identify if trauma has occurred, which should be incorporated as part of the comprehensive assessment. The information from the assessment can then be utilized, in consultation with the resident, to develop an individualized plan of care.

   Tip: *Revise your assessment to include an assessment of trauma. Educate staff and providers about trauma-informed care including both how to identify trauma and how to prevent re-traumatization.*

7. Pre Admission Screening and Annual Resident Review (PASARR) - **(C-0388)**: There has never been a requirement to complete a PASARR – and there still isn't. However, if the resident has a PASARR already in place, the recommendations from the PASARR must be incorporated into the plan of care, or there must be documentation as to why the facility disagrees with the PASARR.

   Tip: *Residents who have been in a long term care facility will typically have had a PASARR completed. If it is not in the medical record request the PASARR from the long-term care facility. Include a review of the PASARR as part of the admission assessment – and the initial care planning meeting.*

8. Transfer and Discharge – **(C-0373)** & **(C-0388)**: The basic requirements to notify residents of discharge or transfer have not changed. However, there are quite a few new requirements including the requirement to provide a copy of the notice provided to the resident at the time of transfer or discharge to the Office of the State Long-Term Care Ombudsman.

   C-0373 requires that the physician document and that the information is communicated to the receiving health care institution or provider:
   - The basis for the transfer or discharge
   - If needs cannot be met – documentation of the specific needs that cannot be met, facility attempts to meet the needs, and the service available at the receiving facility to meet the need(s)

Other information provided to the receiving provider must include:

- The contact information of the practitioner responsible for the care of the resident
- Resident representative information
- Advance directive information
- Special instructions or precautions for ongoing care
- Comprehensive care plan goals
- Discharge Summary

C-0388 has similar requirements – but a few additions as well, including:

- Recapitulation of the resident's stay
- Final summary of the resident's status (The final summary must include all of the elements required as part of the initial assessment). IMPORTANT: This must be available at the time of discharge for release to authorized persons and agencies, with the consent of the resident or resident's representative.
- Reconciliation of all pre-discharge medications with the resident's post-discharge medications
- Post-discharge plan of care developed with the participation of the resident, and, with the resident's consent, the resident representative(s). The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

Tip: *Create a checklist. Assign responsibility for discharge documentation by discipline. Send a copy of the notice of transfer or discharge to the State Ombudsman.*

9. Dental **(C-0404)**: There are new requirements requiring that residents with lost or damaged dentures are referred within three days for dental services. There is also a requirement to ensure that the resident is eating and drinking adequately to maintain nutritional status if there is a delay in service.

   Tip: *Document referrals, and how you have maintained nutrition while you are waiting for an appointment, or dentures are being replaced or repaired.*

10. Nutrition **(C-0410)**: The information about how to assess nutritional status is removed - replaced with a statement that the resident must maintain acceptable parameters of nutritional status. What's new, is a statement that the resident must be offered sufficient fluid intake to maintain proper hydration and health.

    Tip: *Consider adding hydration to the daily nursing assessment.*

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