Swing Bed Series Part 1
Improve Your Swing Bed Program One Step At A Time

April 5, 2019
Currently provides hospital management, consulting services and technology to:

- Serving community, district, non-profit and critical access hospitals
- Example managed hospital client includes Barrett Hospital and Healthcare in Dillon, MT. Ranked as a Top 100 Critical Access Hospital for 8 years in a row
- Example technology and AR services client includes two-hospital NFP system in southeast GA with numerous associated physician practices

Preferred vendor to:

- California Critical Access Hospital Network
- Western Healthcare Alliance
- Partner with Illinois Critical Access Hospital Network
- Vizient Group Purchasing Organization
# Areas of Expertise

**Governance & Strategy**
- Executive management & leadership development
- Community health needs assessment
- Lean culture

**Finance**
- Performance optimization & margin improvement
- Revenue cycle & business office improvement
- AR outsourcing

**Recruitment**
- Executive and interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

**Clinical Care & Operations**
- Continuous survey readiness
- Care coordination
- Swing bed consulting
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 also has extensive experience in working with rural hospitals to both develop and strengthen Swing Bed programs.

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360-584-9868
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.
Critical Access Hospitals Regulatory Requirements: Anything New for 2019?
Host: Carolyn St.Charles, RN, BSN, MBA - Chief Regional Clinical Officer, HealthTechS3
January 11, 2019 at 12:00 pm CT
https://bit.ly/2Q5OmCU

What’s New in the 2019: Physician Fee Schedule that may Impact your Care Coordination Program
Host: Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
January 17, 2019 at 12:00 pm CT

Strategies for Growing Your Swing Bed Program
Host: Carolyn St.Charles, RN, BSN, MBA - Chief Regional Clinical Officer, HealthTechS3
February 8, 2019 at 12pm CT
https://bit.ly/2AMVoWw

Interim Leadership: CNO Stories from the Front Line
Host: Jennifer LeMieux - Chief Operating Officer, HealthTechS3
February 20, 2019 at 12:00 pm CT

Treating Opioid Use Disorder Requires a Team Approach
Host: Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
February 21, 2019 at 12:00 pm CT

Becoming a Highly Reliable Organization – What is your Journey?
Host: Carolyn St.Charles, RN, BSN, MBA - Chief Regional Clinical Officer, HealthTechS3
March 8, 2019 at 12pm CT

How to Prepare for a Stand-out Interview!
Host: Peter Goodspeed - VP of Executive Search, HTS3 Executive Recruiting
March 15, 2019 at 12pm CT

Creating a Lean Culture in Healthcare
Host: Faith M Jones, MSN, RN, NEA-BC - Director of Care Coordination and Lean Consulting, HealthTechS3
March 21, 2019 at 12pm CT

Interim Leadership: CEO Stories from the Front Line
Host: Jennifer LeMieux, Chief Operating Officer, HealthTechS3
March 27, 2019 at 12:00 pm CT
https://bit.ly/2KWIWs1

All Webinars are recorded and available for download

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<td>April 10</td>
<td>Interim Leadership: CEO Stories From The Front Line</td>
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<td>April 11</td>
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AGENDA

1. Regulatory Changes – Briefly

2. Pre-Admission

3. Admission and Continued Stay

4. Transfer and Discharge

Note: We will review the requirements for Swing Beds in a Critical Access Hospital. Almost all of the requirements apply to Swing Beds in a non-CAH Rural Hospital. The primary different is that non-CAH Rural Hospital Swing Beds must complete a MDS and use the MDS to develop the plan of care.
July 27, 2018
1,348 CAHs
1,183 provide Swing Bed services
REGULATORY RESOURCES


- State Operations Manual – Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals – (Rev. 183, 10-12-18)

- State Operations Manual - Appendix PP: Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17)

- State Operations Manual Appendix T - DELETED
  – Regulations and Interpretive Guidelines for Swing Beds in Hospitals (paid under PPS)

- Medicare Claims Processing Manual, Chapter 4 (Rev. 3941, 12-22-17)

- Medicare Claims Processing Manual, Chapter 6 (Rev. 4077, 06-26-18)

- Medicare Benefit Policy Manual Chapter 8 (Rev. 242, 03-16-18)
# Regulatory Changes

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Nov 22, 2017</td>
<td>New requirements for LTC facilities</td>
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<td>State Operations Manual</td>
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<td>Appendix PP</td>
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<td>October 12, 2018</td>
<td>Swing Bed Revisions</td>
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<td>State Operations Manual</td>
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<td>Appendix A</td>
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<td>October 12, 2018</td>
<td>Swing Bed Revisions</td>
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<td>State Operations Manual</td>
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<td>Appendix W</td>
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REGULATORY CHANGES

1. Resident Choice of Physician - **Clarification**
2. Timelines for Reporting Abuse - **New**
3. PASARR – **Clarification**
4. Plan of Care – **Additional language** and **Clarification**
5. Provide Culturally-Competent and Trauma Informed Care – **New**
6. Reconciliation of Pre-Discharge Medications with Post-Discharge Medications – **New**
7. Dental Care – **Clarification** of Timelines
8. Transfer & Discharge – Information at Discharge and Ombudsman Notification - **New**
WHAT STAKEHOLDERS WANT

Resident
- Satisfied with care
  - Respectful care
  - Informed care
  - Compassionate care
- Get better

Hospital
- Satisfied patients
- Program meets regulatory requirements
- Resident meets criteria and/or there is insurance approval prior to admission (No denials)
- Documentation supports stay in swing bed (no denials)
- Revenue stream

Care Team
- Satisfied patients
- Understanding of regulatory requirements
- Clear processes and systems
- Mutual respect of each other’s unique roles
- Easy documentation

Providers
- Satisfied patients
- Easy documentation
# Assessment

<table>
<thead>
<tr>
<th></th>
<th>A (5) Excellent</th>
<th>B (4) Good</th>
<th>C (3) OK</th>
<th>D (2) Needs a lot of work</th>
<th>F (1) It’s pretty bad</th>
<th>Total Score</th>
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<tr>
<td>Pre-Admission</td>
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<td>Admission</td>
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<td>Continued Stay</td>
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<td>Discharge</td>
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**YOUR TOTAL SCORE**
PRE-ADMISSION CHECKLIST

- 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 potential admission with other disciplines to ensure that patient needs can be met: Nursing – Rehab – Pharmacy – Dietitian – Other

- 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.
ADMISSION CRITERIA

Private Insurance – Their Rules

Medicaid – Different by State – Their Rules

Medicare
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 (observation doesn’t count)
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
Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
(Rev. 242, 03-16-18)

Great Examples of “skilled care”
PHYSICIAN ADMISSION - CHECKLIST

- Order to admit to Swing Bed
- Orders for Swing Bed stay
- New or updated H&P
- Initial certification or documentation of NEED for Swing Bed stay, expected length of stay and statement that care can only be reasonably provided on an inpatient basis
RESIDENT INFORMATION - CHECKLIST

Information provided 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.

- Description of Swing Bed
- Resident Rights and Responsibilities
- A description of Hospital’s policies regarding advance directives
- A list of attending physicians who treat patients
- Resident Choice of physicians
- Information on how to contact providers (ALL)
- Financial Obligations
- Transfer and Discharge policies
- Notice of privacy practices
- How to file grievance or complaint
- Hospital responsibility for preventing patient abuse
- Information for reporting Abuse and Neglect
- Contact information for Hospital and State Agencies including State Ombudsman
(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.

Medicare

• $0 for the first 20 days of each benefit period

• $170.50 per day for days 21–100 of each benefit period (2019) **ASSIGN SOMEONE TO UPDATE EACH YEAR!**

• All costs for each day 101 and beyond
C-0361 §483.10(d): Choice of attending physician. The resident has the right to choose his or her attending physician. The physician must be licensed to practice, and

(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.

(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident’s preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.
C-0381 §483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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

3. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

4. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
COMPREHENSIVE ASSESSMENT

C-0388 §485.645(d)(6): Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) 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.

PASARR NOTE: 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. Also, note that CAHs are not required to complete the PASARR.

However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.
§483.20(b): Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

1. Identification and demographic information
2. Customary routine
3. Cognitive patterns
4. Communication
5. Vision
6. Mood and behavior patterns
7. Psychosocial well-being – HISTORY of traumatic events (October 2018)
8. Physical functioning and structural problems
9. Continence
10. Disease diagnoses and health conditions
11. Dental and nutritional status
12. Skin condition
13. Activity pursuit
14. Medications
15. Special treatments and procedures
16. (Discharge potential)

17. REVIEW PASSAR – if one has been done

......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.
COMPREHENSIVE ASSESSMENT - CHECKLIST

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood and behavior patterns
- Psychosocial well-being – HISTORY of traumatic events (October 2018)
- Physical functioning and structural problems
- Continence
- Disease diagnoses and health conditions
- Dental and nutritional status
- Skin condition
- Activity pursuit
- Medications
- Special treatments and procedures
- Discharge potential
- Review of PASARR (if one has been done)

Assign specific responsibility for each assessment element
The new CoPs eliminate the requirement for specific timelines for Swing Beds in a CAH (7 day and 14 day timelines are not applicable).

However, timelines must be congruent with your Length of Stay. For example:

- Nursing within 24 hours
- Rehab within 48 hours
- Dietary within 48 hours
- Activities within 48 hours
- Social Services / Discharge Planning within 48 hours
- Pharmacy, if appropriate, within 48 hours
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).
§483.21(b) Comprehensive care plans.

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The comprehensive 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 §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(i) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(ii) In consultation with the resident and the resident’s representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
COMPREHENSIVE CARE PLAN

C-0388 §485.645(d)(6):
(ii) Prepared by an interdisciplinary team, that includes but is not limited to—
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident’s medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—
(i) Meet professional standards of quality.
(ii) Be provided by qualified persons in accordance with each resident's written plan of care.
(iii) Be culturally-competent and trauma-informed
Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

http://traumainformedcareproject.org/index.php
## Goal Examples

### Measurable Objectives and Timelines

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<tr>
<th>Goal: Mrs. Jones will be independent in medication management within 10 days of admission to swing bed</th>
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<tbody>
<tr>
<td><strong>Intermediate Goal:</strong> Mrs. Jones will correctly identify each medication and why it has been prescribed within 3 days of admission</td>
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</tbody>
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<tr>
<th>Goal: Mr. Smith will dress himself, including shoes, without assistance each morning by 8:00 AM within 5 days of admission</th>
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<tbody>
<tr>
<td><strong>Intermediate Goal:</strong> 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>
COMPREHENSIVE CARE PLAN - CHECKLIST

Prepared by interdisciplinary team:

- The attending physician.
- A registered nurse with responsibility for the resident.
- A nurse aide with responsibility for the resident.
- A member of food and nutrition services staff.
- To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
- Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

Content

- Services to attain or maintain highest practicable physical, mental and psychosocial well being
- Specialized services or specialized rehab services provided as a result of PASARR recommendations
- Culturally Informed and Trauma Informed Care
- Resident’s goals for admission and desired outcome
- Resident’s preference for discharge including where the resident desires to return

Format

- Measurable
- Time oriented
- Responsible Discipline

Frequency

- Updated after every care conference (minimum of weekly)
- Updated if change in condition

Document who attends IDT Meeting
If not able to attend, document input
OTHER DOCUMENTATION - CHECKLIST

Activities
- Activities Assessment
- Activities Plan
- Activities Documented (daily)

Nutrition and Hydration
- Nutrition Assessment
- Nutrition recommendations implemented
- Documentation of hydration status (IMPORTANT!)
C-0373 §483.15(c)(1): Transfer and discharge—(1) Facility requirements—
   (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

   (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
   
   (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
   
   (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
   
   (D) The health of individuals in the facility would otherwise be endangered;
   
   (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
   
   (F) The facility ceases to operate.
C-0373 §483.15(c)(2): Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
TRANSFER AND DISCHARGE

C-0373 §483.15(c)(2)
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information.
(C) Advance Directive information.
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals.
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
NOTICE BEFORE DISCHARGE

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

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

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

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

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.
§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.
NOTICE TO OMBUDSMAN

C-0373 §483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

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

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

Appendix PP §483.15(c)(3)-(6)

Guidance - Notice of Transfer or Discharge and Ombudsman Notification

For facility-initiated transfer or discharge of a resident, the facility must notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman.

The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. **Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. The medical record must contain evidence that the notice was sent to the Ombudsman.** While Ombudsman Programs vary from state to state, facilities must know the process for ombudsman notification in their state.
C-0388 §483.21(c)(2): Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

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

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

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

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
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.
TRANSFER AND DISCHARGE - CHECKLIST

- Physician order for discharge
- Discharge plan with involvement of resident
- Discharge Documentation
  - Recapitulation of resident’s stay
  - Final summary of resident status (elements in comprehensive assessment)
  - Where resident will reside
  - Arrangement for follow-up care
  - Post-discharge medical and non-medical services

- Notice of Discharge provided to Resident (as soon as discharge is known)

- Notice of Medicare Non-Coverage (Medicare), if applicable

- Notice sent to Ombudsman

- Information provided to the receiving provider
  - Contact information of the practitioner responsible for the care of the resident
  - Resident representative information including contact information
  - Advance Directive information
  - All special instructions or precautions for ongoing care, as appropriate
  - Comprehensive care plan goals
  - All other necessary information, including a copy of the resident’s discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care
QUESTIONS
SWING BED CONSULTING PACKAGE

1. Growth Strategies
2. Skilled Criteria
3. Policy and Procedures
4. Patient Admission Packet
5. Staff Education
6. Provider Education
7. Multi-disciplinary Assessment / Care Planning Tools
8. Annual Survey on-site
9. Quarterly reviews off-site
10. Unlimited telephone and e-mail support

Let me know if you would like a proposal, or would like to talk about our consulting services.

Stay Tune for a New Swing Bed Collaborative Opportunity Coming Soon!
I hope the information has been helpful

Please contact me if you would like to schedule a review of your Swing Bed Program or have questions about the presentation

Swing Bed Webinar – Part 2
Implementing Trauma-Informed Care
May 3

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