HealthTech

Pre-Admission – Admission - Continued Stay - Discharge 2:15 – 3:00

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Presenter

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Objectives

1. Objective 1: Attendees will describe at least two Medicare criteria for admission to Swing Bed, including when the time from hospital discharge to swing bed admission can exceed 30 days.

2. Objective 2: Attendees will identify continued stay criteria.

3. Objective 3: Attendees will explain discharge documentation requirements.

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Pre-Admission

Review of Potential Admissions

Different organizations have different systems for determining who must review a potential admission before the patient is accepted

Some organizations only require Case Management and a provider. Other organizations include nursing and rehab.

IMPORTANT TO ACCEPT THE PATIENT QUICKLY

Consider Developing Admission Criteria to Streamline Admission Process

Example of Hospital Swing Bed Admission Criteria	

Payor
Will consider all patients with Medicare, Medicare Advantage, Medicare / Medicaid, or other private payors.
 	
Patients with the following care needs can be accepted
• *Physical Therapy*
• *Occupational Therapy*
• *Speech Therapy*
• *IV Antibiotics*
• *Wound Care*
• *Education / Training*
  ○ *Diabetic teaching*
  ○ *Care of colostomy*
  ○ *Complex medication management*
  ○ *Monitoring signs & symptoms (weight, blood pressure, etc.)*
• *Management of Plan of Care / Skilled Observation*
• *Tube Feedings / PEG*
	Patients with the following diagnosis can be accepted
	• *Weakness / Failure to Thrive / Weight Loss*
	• *Orthopedics (Fractures, Post-Surgery)*
	• *Post-Stroke*
	• *CHF*
	• *Pneumonia*
	• *Covid-19*
	
	Patients with the following care needs will be reviewed on a case-by-case basis
	• *Dialysis (incidental to other reason for admissions) only if patient is sufficiently mobile to be transported by family in private car or by public transportation.*
	• *TPN – IF pre-made from manufacturer*
	
	Patients with the following care needs cannot be accepted
	• *Pediatrics*
	• *Severe or unmanaged mental illness*
	• *History of violent behavior*

Patient Choice Post-Acute Provider (Swing Bed, SNF, IRF)

C-1425 “The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.”

Source: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

Swing Bed quality and resource use data

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

Options

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

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

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

Providing potential patients with quality and resource use data

Identify facilities that provide skilled care in your geographic area:

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

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

Nursing Home Compare

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

The information is not organized as quality and resource use measures. However, resource use is typically defined as spending per beneficiary and preventable readmissions.

Quality measures are generally related to care processes and outcomes, including functional status, skin integrity, falls or injuries, cognitive function, and medication management.

It is important to note that out of the seventeen indicators listed on Nursing Home Compare, six of the seventeen or 35% are related to improvements in functional status.

Nursing Home Compare

Overall rating

Above average

The overall rating is based on a nursing home's performance on 3 sources: health inspections, staffing, and quality measures.

Learn how Medicare calculates this rating

Health inspections

Above average

View Inspection Results

Staffing

Above average

View Staffing Information

Quality measures

Above average

View Quality Measures

Example of quality & resource use data

Facility Name	Overall Star Rating	Health Inspections	Quality Data				Resource Use Data	
			Overall Quality Rating	Short-Stay Quality Rating	Nursing Hours Per Patient Day	# of Patients	Return to prior residence	Readmission < 30 days
Hospital Swing Bed Program	NA*	NA*	NA*	NA*	12.0	6	74%	10%
Facility 1	1	1	1	1	4.1	66	40%	23%
Facility 2	3	3	3	3	4.2	43	45%	28%
Facility 3	5	5	5	5	4.5	25	50%	15%
Facility 4	1	1	1	1	4.0	46	30%	28%
Facility 5	2	2	2	2	3.8	52	55%	26%

You can also use an I-pad to go to Nursing Home Compare. (Pre-load those in your area.) But if you do this make sure you document. Ensocare for example has this option.

If you develop a handout make sure you update whenever Nursing Home Compare data is updated.

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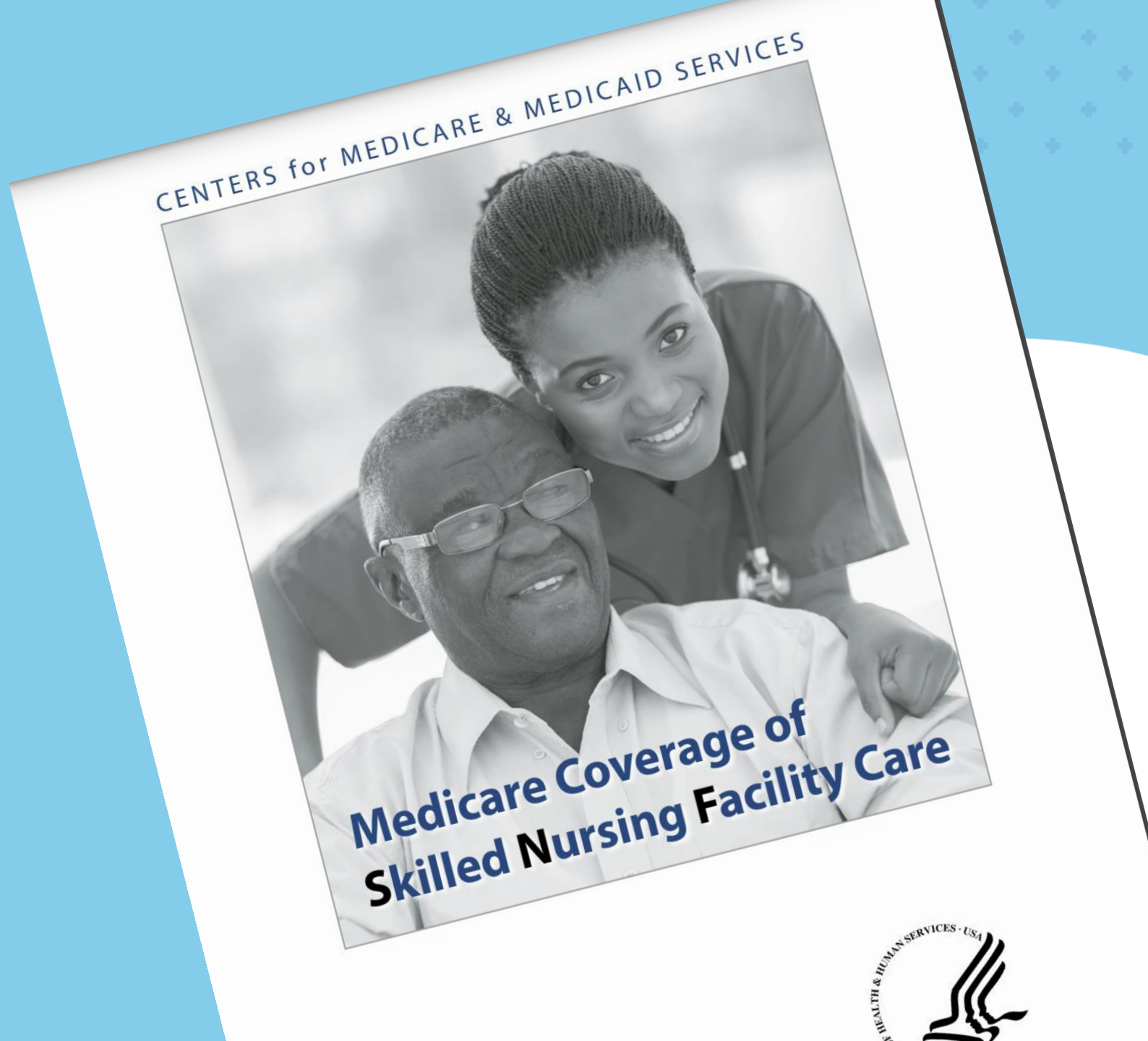
Admission Criteria



3-Days

Just because a patient has been in acute care for 3 days (96 hours) DOES NOT make them appropriate for Swing Bed if they still meet inpatient/acute criteria.

C-1026: Furthermore, for each Medicare beneficiary, the CAH is required in accordance with Medicare payment law and regulations to have the practitioner who admits the beneficiary as an inpatient certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. However, while it may be true that CAHs generally are not expected to handle patients requiring complex, specialized inpatient services, such as those services provided by trauma centers, or cardiac surgery centers, CAHs should be able to handle a range of patient needs requiring inpatient admission. CMS does not believe it is in the best interest of patients for them to routinely be transferred to a more distant hospital if instead their care can be provided locally without compromising quality or the length of stay requirements (78 FR 50749).

Swing Bed Admission Criteria

Medicare Benefits Manual Chapter 8 has information and examples for both admission and continued stay

The criteria for admission and continued stay is specific to patients with traditional Medicare


Medicare Benefit Policy Manual
Chapter 8 - Coverage of Extended Care (SNF) Services
Under Hospital Insurance

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(Rev. 12283; Issued: 10-05-23)

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Medicare Benefits Manual Chapter 8
Coverage of Extended Care (SNF) Services Under Hospital Insurance

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Other Payors – Their Rules

Other payors can admit a patient to swing bed from home or the emergency department without a 3-day qualifying stay --- which is required for patients with traditional Medicare

Swing Bed Medicare Criteria

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

Care in a SNF is covered if all of the following **four** factors are met.....

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

Swing Bed Medicare Criteria

#1. The patient requires skilled nursing services or skilled rehabilitation services,

- i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4)

- are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services

Swing Bed Medicare Criteria

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

Swing Bed Medicare Criteria

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

Swing Bed Medicare Criteria.

#4. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury,

- i.e., are consistent with the nature and severity of the individual's illness or injury,
- the individual's particular medical needs,
- and accepted standards of medical practice.

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

3-day Prior Hospitalization

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

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services (including services of an emergency hospital) or a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously hospitalized. In this context, the applicable hospital condition need not have been the principal diagnosis that actually precipitated the beneficiary's admission to the hospital.

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

3-day Prior Hospitalization

10.0 – General Requirements: The beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days.

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

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

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

3-day Prior Hospitalization

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

Time spent in observation 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. For purposes of the SNF benefit's qualifying hospital stay requirement, inpatient status commences with the calendar day of hospital admission.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Readmitted Within 30 days

20.2.3: If an individual who is receiving covered post-hospital extended care, leaves a SNF and is **readmitted to the same or any other participating SNF for further covered care within 30 days after the day of discharge, the 30-day transfer requirement is considered to be met.** The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days after the first day of noncoverage. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage. (See §§20.2.2 and 20.2.2.3 above for situations where a period of more than 30 days between SNF discharge and readmission, or more than 30 days of noncovered care in a SNF, is followed by later covered care.)

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More than 30-days After Hospital Stay

20.2.1: A Post-hospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are “post-hospital” if initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital services.

20.2.2: 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. The fact that a patient enters a SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Hospice / Palliative Care / Supportive Care

20.3.1 - Payment Bans on New Admissions

Hospices contract with SNFs for services related to the beneficiary's terminal condition. These bills are not processed by the A/B MAC (A) or (HHH).

However, there will be situations where a beneficiary is admitted as a hospice patient, but later **requires daily skilled care unrelated to the terminal condition**. If the beneficiary was initially admitted as a hospice patient prior to the date sanctions were imposed, and **meets the requirements for Part A coverage**; sanctions will not be applicable. **Benefits will be paid under SNF PPS from the first date the beneficiary qualifies for Medicare Part A for care unrelated to the terminal condition**. The facility must complete the Medicare-required assessments from the start of care for the unrelated condition.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Maintenance Therapy

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

Maintenance Therapy

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Daily Skilled Care

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

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

Skilled Restorative Nursing – Skilled Nursing

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

Skilled Rehabilitative Therapy

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

Skilled Nursing Examples

- Intravenous or intramuscular injections and intravenous feeding
- Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day
- Naso-pharyngeal and tracheotomy aspiration
- Insertion, sterile irrigation, and replacement of suprapubic catheters
- Application of dressings involving prescription medications and aseptic techniques (see §30.5 for exception)
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder (see §30.5 for exception)
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately (see §30.5 for exception)
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training program
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

Medicare Benefit Policy Manual Chapter 8 30.3

Non-Skilled Supportive or Personal Care

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

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

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

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Non-skilled Supportive or Personal Care Services Examples

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

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

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.2.3.1 Management and Evaluation of Plan of Care

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

However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment**. The sum total of nonskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention.**

30.2.3.1 Management and Evaluation of Plan of Care cont.

The patient's clinical record may not always specifically identify "skilled planning and management activities" as such. Therefore, in this limited context, if the documentation of the patient's overall condition substantiates a finding that the patient's medical needs and safety can be addressed only if the total care, skilled or not, is planned and managed by skilled nursing personnel**, it is appropriate to infer that skilled management is being provided, but only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management, as illustrated in the following……**

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.2.3.2 Observation and Assessment of Patient Condition

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

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

30.2.3 Teaching and Training

Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services.

Some examples are:
• Teaching self-administration of injectable medications or a complex range of medications;
• Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
• Teaching self-administration of medical gases to a patient;
• Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
• Teaching patients how to care for a recent colostomy or ileostomy;
• Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
• Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
• Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and
• Teaching patients the proper care of any specialized dressings or skin treatments.

Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

All of these examples can be used for both admission criteria and continued stay

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H&P Orders Certification

History and Physical
The rabbit hole.....

F-710
PA, NP, CNS employed or not employed by the facility **MAY NOT** perform the initial comprehensive visit.

F-712
The first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days after admission and then at 30-day intervals until 90 days after the admission date. After that, visits must be conducted at least once every 60 days thereafter.

However, this doesn't MEAN that the H&P and/or an assessment from a provider can wait 30 days to be done.

History and Physical
The rabbit hole.....

BUT.....the F tags, don't refer to H&P but rather the first comprehensive visit that must be completed within 30 days

C-1114
All or part of the history and physical exam (H & P) may be delegated to other practitioners in accordance with State law and CAH policy, but the MD/DO must sign the H & P and assume full responsibility for the H & P.

SO..... can a NP-PA complete the initial H&P? **Probably YES**.

History and Physical Question

Question: Does the provider REALLY need to complete a new H&P? Can they use the IP discharge summary with an addendum?

Answer: YES they need a new H&P

C-1102 §485.638(a)
When a patient reimbursement status changes from acute care services to swing bed services, a single medical record may be used for both stays as long as the record is sectioned separately.

Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.

Admission Orders
The rabbit hole (again)

F-710
PA, NP, CNS employed or not employed by the facility **MAY NOT write admission orders unless ….** physician personally approved in writing a recommendation for admission to the facility prior to the resident's admission.

C-0986 §485.631(b)(1)
The doctor of medicine or osteopathy-] (iv) Periodically reviews and **signs** the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

SO…… can a NP-PA write admission orders – **YES** if admission recommended by a physician.

Certification
The rabbit hole (one more time)

40 - Physician Certification and Recertification of Extended Care Services Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification, and where services are furnished over a period of time, the required recertification regarding the services furnished.

40.1 - Who May Sign the Certification or Recertification for Extended Care Services A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner (NP), a clinical nurse specialist (CNS) or, effective with items and services furnished on or after January 1, 2011, a physician assistant (PA)) **who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician**

Certification

SO..... can a NP or PA complete the certification?

YES - if NOT employed by the facility

NO - if employed by the facility

Certification Content

Note: Edited – not all text included

40 - Physician Certification and Recertification of Extended Care Services

There is no requirement for a specific procedure or form as long as the approach adopted by the facility permits verification that the certification and recertification requirement is met.

Certification or recertification statements may be entered on or included in forms, notes, or other records that would normally be signed in caring for a patient, or on a separate form. Except as otherwise specified, each certification and recertification is to be separately signed.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services Table of Contents

Certification Content cont.

Note: Edited – not all text included

40.2 - Certification for Extended Care Services

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a daily basis for an ongoing condition for which he/she was receiving inpatient hospital services prior to transfer to the SNF (or for a new condition that arose while in the SNF for treatment of that ongoing condition).

Certifications must be obtained **at the time of admission**, or as soon thereafter as is reasonable and practicable

The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services

Recertification

Note: Edited – not all text included

40.3 - **Recertifications for Extended Care Services**

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care.

The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress notes.

40.4 - Timing of Recertifications for Extended Care Services (Rev. 1, 09-11-02)

The first recertification must be made no later than the 14th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

Subsequent recertifications must be made at intervals not exceeding 30 days.

Source: Medicare General Information, Eligibility, and Entitlement Chapter 4 - Physician Certification and Recertification of Services

Initial Certification - Example

Patient Name: _____ **Admission Date:** _____ **Health Insurance:** _____

Reason for Admission:	
Goals for Admission:	Specific Form Not Required
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

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Patient Admission Notices & Disclosures

Patient Admission Notices / Disclosures

- ❑ Description of Swing Bed (Recommended)
- ❑ Patient Rights and Responsibilities (Required)
- ❑ Visitation Rights (May be part of Patient Rights document)
- ❑ Advance Directives (Required)
  - A description of hospital policies regarding advance directives
  - Information - If the patient does not have an Advance Directive
  - Copy of Advance Directive placed in the medical record if the patient has an advance directive

Patient Admission Notices / Disclosures

- ❑ Choice of physicians – and - Information on how to contact all providers including consultants (Required)
- ❑ Financial Obligations (Required)
- ❑ Transfer and discharge rights (Required – may be part of Patient Rights)
- ❑ Notice of privacy practices (Required – may be the same as provided to all patients)
- ❑ Hospital responsibility for preventing patient abuse – how to report abuse (Recommended)
- ❑ Information for reporting abuse and neglect (Required)
- ❑ Contact information for Hospital and State Agencies including State Ombudsman (Required)

Patient Admission Notices / Disclosures Example Signature Page

Signature Page

NAME OF HOSPITAL is required to provide you with certain information at the time you are admitted to a Swing Bed.

By signing this document, you acknowledge that ***Name of Hospital*** has gone over the documents listed below verbally in a language that you can understand and provide you with a written copy. ***Name of Hospital*** has given you the opportunity to ask any questions you may have. You may ask any questions you have at any time during your stay.

- ☐ Swing Bed General Information
- ☐ *Advance Directives
- ☐ Rights and Responsibilities
- ☐ *Choice of Physician
- ☐ Provider Contact Information
- ☐ Financial Obligations
- ☐ Privacy Practices
- ☐ Abuse and Neglect
- ☐ Transfer and Discharge
- ☐ Contact information for Hospital, QIO, and State Ombudsman

Patient Printed Name ---- Patient Signature ---- Date

Name and title of person who reviewed information with patient ---- **Date**

Patient Admission Notices / Disclosures Patient Rights

C-1608 §485.645(d) SNF Services.
The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) **Resident Rights** (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter).

F-941
Facilities must inform residents in a language they can understand of their total health status and to provide notice of rights and services both orally and in writing in a language the resident understands

See end of presentation for list of patient/resident rights

Important: Swing Bed Rights are NOT LTC Rights

Patient Admission Notices / Disclosures Financial Obligations

C-1608 §483.10(g)(17): The facility must—

(i) Inform each **Medicaid-eligible resident**, in writing, at the time of admission to the nursing facility and 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 Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

C-1608 §483.10(g)(18): 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/Medicaid** or by the facility's per diem rate.

Patient Admission Notices / Disclosures Financial Obligations

There are no length of stay restrictions for Swing Bed – as long as patient meets skilled criteria

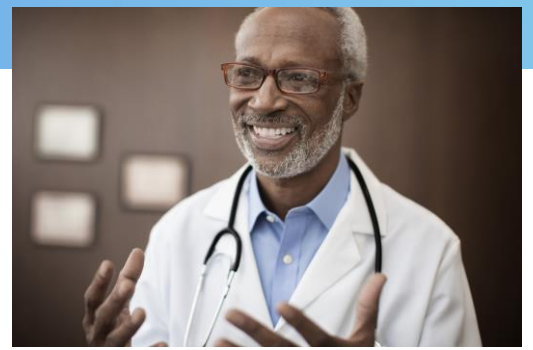
However, for Medicare patients, co-pay is required from Day 21 – 100 and after day 100, all costs

Skilled Nursing Facility (Swing Bed) stay In 2023, you pay

- $0 for the first 20 days of each benefit period
- $204 per day for days 21–100 of each benefit period (2024)
- All costs for each day after day 100 of the benefit period

Make sure you are providing both Medicare and Medicaid information – and update Medicare co-pay every year

Patient Admission Notices / Disclosures Choice of Providers



C-1608 §483.10(d) Choice of attending physician.
The resident has the right to choose his or her attending physician.
(1) 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.

(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.

Patient Admission Notices / Disclosures Provider Contact Information

C-1608 §483.10(d) Choice of attending physician.

(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.

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Comprehensive Assessment

Comprehensive Assessment Responsibility: Multi-disciplinary Team

C-1620 §485.645(d)(5): 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).

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 trauma**
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 of PASSAR – if one has been done

Trauma Informed Care Responsibility: Nursing or Case Management

C-1620 §483.21(b)
(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.**

Review your organization's policy

Appendix PP F-656 and PP F-699 Care Planning Cultural Preferences and Trauma

- For residents with a history of trauma, does the care plan describe **corresponding interventions for care that are 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?**

Culturally Competent Trauma Informed Care – Questions to Consider

1. Has there been anything within the last six months to a year that has caused you to be upset or very worried?

2. Have you experienced the loss of a close friend, relative or a pet that you loved recently?

3. Have you had any past trauma in your life that we should know about so we can better care for you?

4. If you have experienced some kind of trauma is there something that helps you feel better?

5. Is there anything we can do to help while you are in the hospital?

Comprehensive Assessment
Does NOT all have to be done by nursing

Assessment	Example of Assessment Questions	Primary	Secondary
Customary Routine	❑ Time wake up ❑ Time go to sleep ❑ Naps ❑ Time eat meals (Bkf / Lunch / Dinner ❑ Other	Activities Nursing	
Cognitive Patterns	❑ Cognition Measurement Tool at end	Provider	Nursing
Communication	❑ Ability to express ideas and wants, consider both verbal and non-verbal expression. ❑ Understood. ❑ Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. ❑ Sometimes understood - ability is limited to making concrete requests. ❑ Rarely/never understood.	Nursing	Provider
Vision	❑ Corrective Lenses ❑ Cataracts ❑ Blind	Nursing	

Comprehensive Assessment

Assessment	Example of Assessment Questions	Primary	Secondary
Mood	❑ Little interest or pleasure in doing things ❑ Feeling down, depressed or hopeless ❑ Trouble falling or staying asleep, or sleeping too much ❑ Feeling tired or having little energy ❑ Poor appetite or overeating ❑ Feeling bad about yourself – or that you are a failure or have let yourself or your family down ❑ Trouble concentrating on things such as reading the newspaper or watching television ❑ Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual ❑ Thoughts that you would be better off dead, or of hurting yourself in some way	Social Work or Nursing	
Behavior	❑ Hallucinations ❑ Delusions ❑ Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others) ❑ Verbal behavioral symptoms directed toward others (threatening, screaming, cursing) ❑ Other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste	Nursing	Provider

Comprehensive Assessment

Assessment	Example of Assessment Questions	Primary	Secondary
History of traumatic events	❑ Has there been anything within the last six months to a year that has caused you to be upset or very worried? ❑ Have you experienced the loss of a close friend, relative or a pet that you loved recently? ❑ Have you had any past trauma in your life that we should know about so we can better care for you? ❑ If you have experienced some kind of trauma is there something that helps you feel better? ❑ Is there anything we can do to help while you are in the hospital?	Social Work	Nursing
Culture	❑ Determine if there are any cultural beliefs / customs that will impact care.	Social Work	Nursing
PASARR	❑ IF patient has a PASRR (usually completed if patient was a resident of LTC) review PASRR	Social Work	Nursing
Physical functioning and structural problems	❑ Independent ❑ Setup or Clean-up Assistance ❑ Supervision or touching assistance ❑ Partial/moderate assistance ❑ Substantial/maximal assistance ❑ Dependent	PT	Nursing

Comprehensive Assessment

Assessment	Example of Assessment Questions	Primary	Secondary
Continence, bladder and bowel	☐ Urinary incontinence ☐ Bowel incontinence	Nursing	
Active diagnosis		Provider	
Health conditions		Provider	
Dental	❑ Dentures (fitting / loose) ❑ Broken Teeth ❑ Overall dentation	Nursing	Dietician
Swallowing	❑ Loss of liquids/solids from mouth when eating or drinking ❑ Holding food in mouth/cheeks or residual food in mouth after meals ❑ Coughing or choking during meals or when swallowing medications ❑ Complaints of difficulty or pain with swallowing	Nursing	Dietician
Nutrition	❑ Nutrition Risk Assessment ❑ Loss of 5% or more in the last month or loss of 10% or more within last 6 months	Nursing	
	❑ Dietician Nutrition Assessment	Dietician	
Skin condition	❑ Braden Scale ❑ If pressure ulcers or skin breakdown, describe in nursing notes	Nursing	

Comprehensive Assessment

Assessment	Examples of Assessment Questions	Primary	Secondary
Activity pursuit	What do you like to do? ❑ Reading – print or audio books ❑ Puzzles ❑ Word games ❑ Watching TV ❑ Knitting / Crocheting ❑ Visiting with friends ❑ Other **NOTE: Assessment by an Activities Professional or an Occupational is no longer required for CAH Swing Beds – But recommend assessment by Nursing**	Activities or Nursing	
Medications	❑ Medication Reconciliation	Nursing	Pharmacy
Special treatments and procedures and programs		Provider Orders	
Restraints and alarms		Nursing	

Multi-Disciplinary Plan of Care
Developed from the Comprehensive Assessment

C-1620 §485.645(d)(5) 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),

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17. Review of PASSAR – if one has been done

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Plan of Care

Multi-Disciplinary Plan of Care

C-1620 §483.21(b
(2) A comprehensive care plan must be—

(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.

Other Members of the Team

Case Manager / Discharge Planner
These individuals are almost always included! They are a critical part of the team.

Pharmacy
If there is a complicated medication regimen or the patient is receiving antibiotics or is receiving psychotropic drugs ---- include the pharmacist.

Cardiopulmonary
For patients who are on oxygen or have a respiratory-related diagnosis – include cardiopulmonary.

Nursing Manager
If at all possible include the nursing manager – they can support nursing staff and provide education as needed.

Business Office / Finance
Some organizations include a representative from finance to assist with financial questions.

Multi-Disciplinary Plan of Care

C-1620 §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).

(1) 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

Measurable Goals and Timelines

Every discipline must have goals that are:

- Measurable
- Include a time frame for achieving
- Related to swing bed stay

If nursing is supporting Rehab (i.e., walking the patient, helping the patient to get dressed, etc. ---- that is an appropriate nursing goal

Typical nursing care plan goals ARE NOT measurable or include time frames for achieving the goal.

Goals must address psychosocial needs not just physical needs

Measurable Goals and Timelines Antibiotic Therapy

Goal: You will receive antibiotic therapy as ordered by the provider

Timeframe: Antibiotic regimen will be completed within 10-days

Interventions:

1) IV site will be assessed daily for signs of infection

Measurable Goals and Timelines Teaching and Training

Goal: You will check your own blood sugars and administer the correct dose of insulin independently

Timeframe: You will be independent in administering insulin in five (5) days

Interventions

Day 1: Nurse or pharmacist will educate you verbally and with pictures about how to check blood sugar
Day 2: You will use appropriate technique to check blood sugar with nurse or pharmacist observing
Day 3: Nurse or pharmacist will instruct you on how to administer the correct dose of insulin based on blood sugar
Day 4: You will check blood sugar before meals and at bedtime independently. You will independently administer insulin using appropriate technique based on blood sugar reading

Measurable Goals and Timelines Rehabilitation

Physical Therapy
Goal: You will walk 60 feet with a front-wheel walker with stand-by assist

Timeframe: Within 7 days

Interventions
Therapy twice per day five days per week

Occupational Therapy
Goal: You will get dressed independently including putting on shoes

Timeframe: Within 7 days

Interventions
Therapy twice per day five days per week

Measurable Goals and Timelines Nutrition

Goal: You will increase weight by 5 pounds

Timeframe: Within 7 days

Interventions

1) Daily weights
2) Nutritional supplements three (3) times per day
3) Document percent of meals consumed
4) Provide culturally appropriate meals

Patient Goals

Part of the admission process is identifying the patient's

- goals for admission and desired outcomes
- preference and potential for future discharge

I want to go home
I want to be able to walk my dog

Post Plan of Care in Patient's Room And/Or Have Patient Sign Plan

F-553 §483.10(c)(2)

The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

Ideas about Care Plan Documentation

Use the Care Conference to summarize goals and time frames.

Make it personal/individualized:

Your Goal is to: Go home and live with my wife

Each discipline can document prior to the meeting – or – someone can document the discussion at the meeting.

IF disciplines document before the meeting it is important that they update any changes after the meeting!

Initial Care Plan Meeting Documentation

Initial Care Plan Meeting Date: Multidisciplinary Team Attending:

Your Goal is to: Return home and function independently

How We Can Help:
Rehab: Therapy five times per week until you can independently walk 100 feet with a front wheel walker. Estimated: Time frame 3 weeks.

Nutrition: Improve your nutritional status to increase your weight to at least 150 pounds. We will provide protein shakes three times per day. We will provide foods that you like for meals. Time frame 2 weeks

Nursing: We will administer IV Antibiotics, as ordered by the physician for ten (10) days. We will assess you each shift for any signs of infection at your IV site.
Nursing: We will provide wound care twice daily as ordered by the physician. We will notify the physician of any changes in the appearance of the wound.

Second Care Plan Meeting Documentation

Second Care Plan Meeting Date: Multidisciplinary Team Attending:

Your Goal is to: Return home and function independently.

How We Can Help:
Rehab: You are progressing on the goal of walking independently with a front wheel walker and are half-way to your goal of 100 feet. We will continue therapy five times per week until you can independently walk 100 feet with a front wheel walker. Estimated: Time frame to discharge 2 weeks.

Nutrition: Your weight is up to 140 pounds. The goal is 150. You are drinking the protein shakes and eating 80% of your meals. Time frame to meet goal 2 weeks.

Nursing: You have received 7 of the 10-day antibiotic therapy. There are no infections noted at the IV site.
Nursing: You continue to receive wound care twice daily. The wound is healing and the physician is recommending 10 more days of wound care until you can be discharged.

Put Subsequent Notes in Sequence

Oct 1: Rehab:
Therapy five times per week until you can independently walk 100 feet with a front wheel walker.
Estimated: Time frame 3 weeks.

Oct 7: Rehab
You are progressing on the goal of walking independently with a front wheel walker and are half-way to your goal of 100 feet. We will continue therapy five times per week until you can independently walk 100 feet with a front wheel walker. Nursing will get you up for meals three times / day.
Estimated: Time frame to discharge 2 weeks.

You may use progress notes or develop a separate template.
You don't have to duplicate everything in the individual disciplines plan of care.

Sounds simple…… so what's the problem??

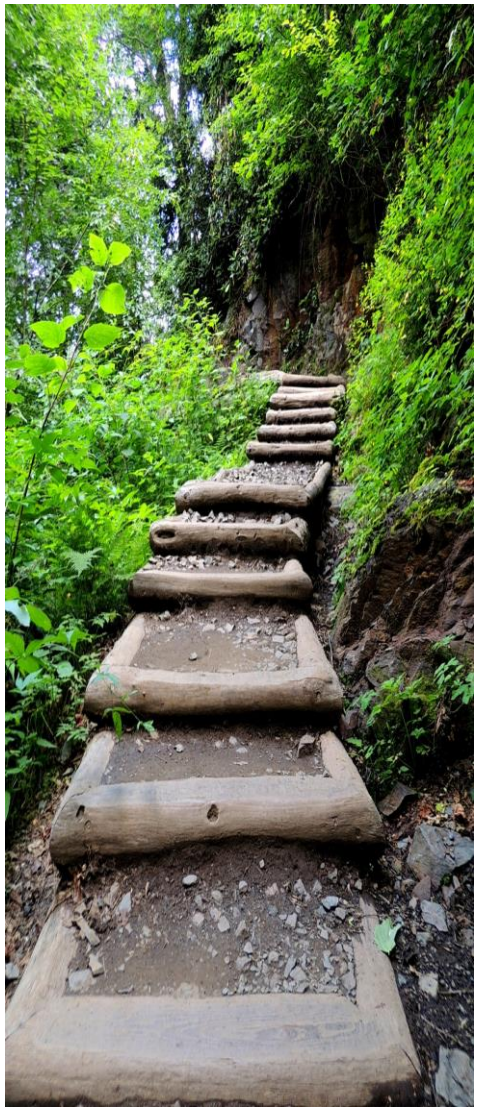
1. Most EMRs do not have multi-disciplinary documentation options

2. If each discipline documents its OWN goals, it's hard (impossible) to see collaboration/coordination

3. If each discipline documents its OWN goals, it's hard (impossible) to provide succinct/understandable goals for the patient that they can agree to --- or to post in the patient's room --- or provide the patient with a hard copy

ANYONE HAVE A GOOD SOLUTION?

Overview: Steps to Develop the Interdisciplinary Plan of Care



Step 1: Review the assessment

- The plan of care starts with the comprehensive assessment!
- Must include all elements
- Must include discussion with patient

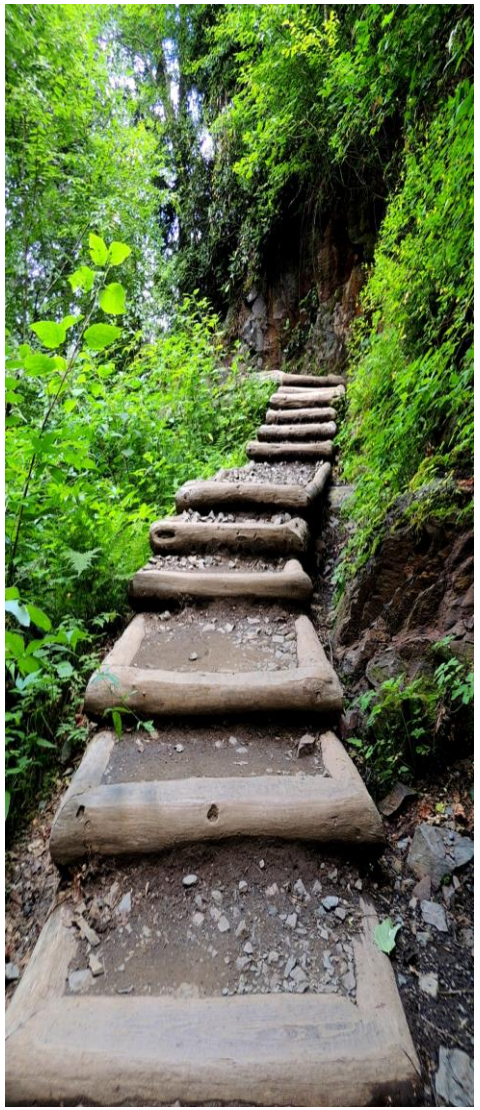
All members of the team should take the time to review the assessment of other disciplines

Step 2: Determine patient's goals

- Determine the patient's goals for admission and desired outcomes
- Determine the patient's preference and potential for future discharge
- Document as part of the comprehensive care plan

It's not the teams' goals – it's the patients goals
Decide who will gather this info – RN / Case Manager / Social Work

Overview: Steps to Develop the Interdisciplinary Plan of Care



Step 3: Schedule INITIAL multi-disciplinary team meeting

- Initial meeting usually takes 30 – 45 minutes
- Invite patient and/or family
- Attendees: Provider, RN caring for patient, CNA caring for patient, Representative from dietary, Others as appropriate (PT, OT, Speech, Pharmacy, etc.)

Step 4: Develop Plan of Care

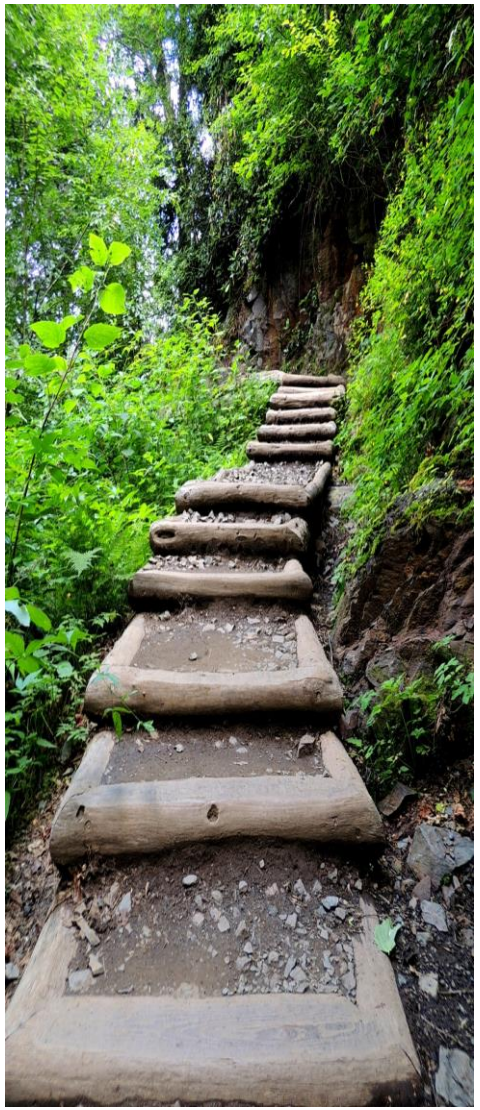
Review / Discuss

- Patient's goals for admission and desired outcomes
- Patient's preferences for discharge
- Each discipline's assessment (Focus on those areas specific to why the patient has been admitted to Swing Bed)

Develop Goals

- Long Term Goals (measurable objectives and timeframes
- Short Term / Intermediate Goals (measurable objectives and timeframes)
- Document patient's concurrence with goals

Overview: Steps to Develop the Interdisciplinary Plan of Care



Step 5: Document Plan of Care in Medical Record (This is not a nursing care plan)

Step 6: Post Plan of Care in Patient's Room
Include both Long Term Goal and Short Term Goals for day or week

Step 7: Schedule at least weekly multi-disciplinary meetings (better if twice per week)

- Review Long Term Goal(s)– has anything changed? – does the long term goal need to be modified?
- Review Short Term Goals – has anything changed? - do any goals need to be modified?
- Review with patient if not in attendance at meeting – ensure documentation of patient's concurrence with goals

Step 8: Discharge Plan of Care

- Review all goals
- Document if met or not met and if not met – why?
- Provide plan of care to next post-acute provider (Home Health, Long Term Care, etc.)

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Interdisciplinary Team Meetings

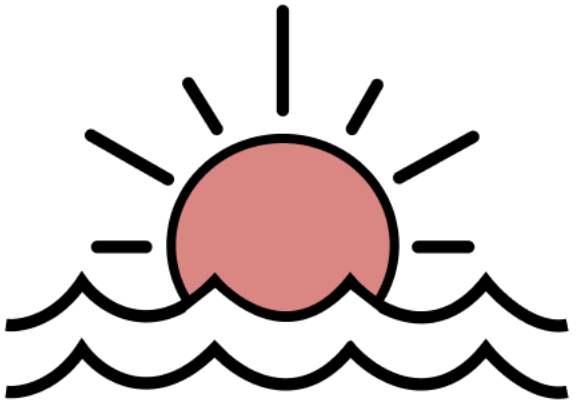
Effective IDT Meetings

Have a team discussion **BEFORE** the conference with the patient.

This allows ideas to be shared freely and a draft plan developed for discussion with the patient.

Effective IDT Meetings

Start on time

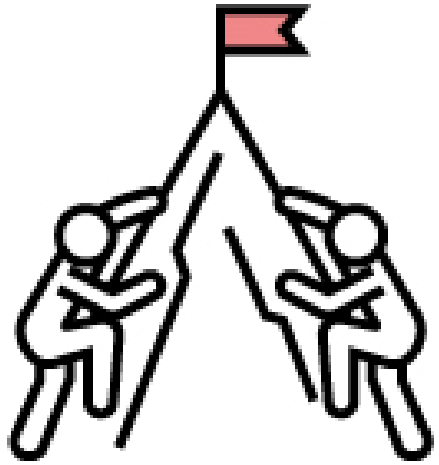


Effective IDT Meetings

Have an agenda

Effective IDT Meetings

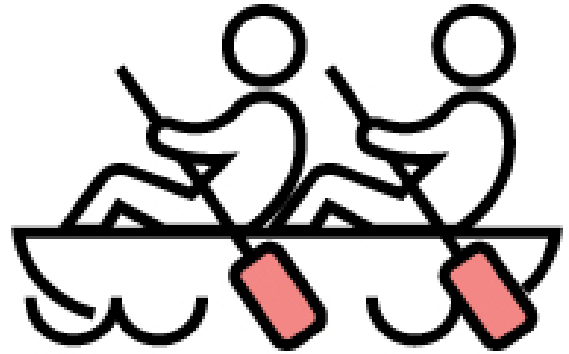
Everyone prepared



Effective IDT Meetings

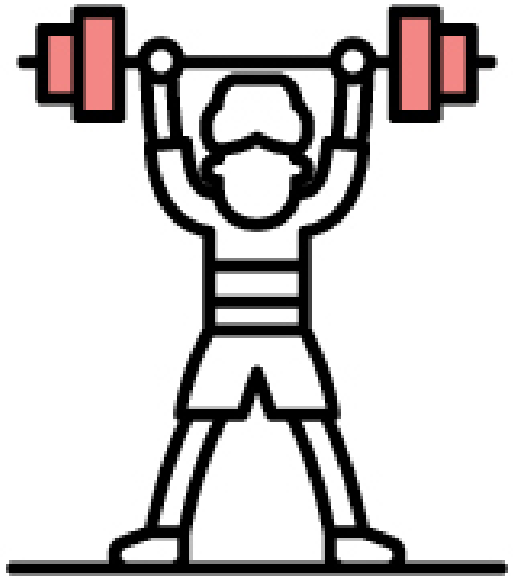
Everyone understands their role

Team members must understand the roles and contributions of each discipline on the team.



Effective IDT Meetings

Designated Facilator

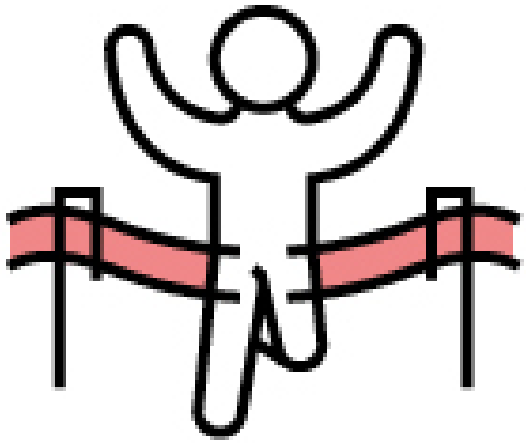


The Whole is Greater than the Sum of the Parts

Each discipline documenting separately **is not** a multi-disciplinary plan of care.

The intent of the IDT meeting is to share ideas and plans.

Team members **must integrate** their assessments and recommendations for intervention, which creates a comprehensive care plan.



Respectful Communication

Do not refer to "*the patient*" . Address the patient directly by name.

If others are attending (family, caregivers, etc.) ensure you still involve the patient.

Don't use medical jargon – use terms the patient can understand.

Take time to listen to the patient and what they have to say!

Remember -----
Patient Goals – Not Team Goals

- Focus on **WHY** the patient is in Swing Bed
- Patient's goals for admission
- Patient's goals for outcomes by end of stay
- Patient's preferences for discharge

Sample IDT Meeting Agenda

Discharge Plan

- Any update on discharge plans?
- Has anything changed?
- Does the discharge plan or timeline need to be modified?

Long Term Goals

- Review Long Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Can the patient sustain the goals if they are discharged today, or do they need additional time in the hospital to ensure there is a safe discharge?

Short Term Goals

- Review Short Term Goals
- Have the goals been met?
- Do the goals need to be modified?
- Are there any other goals that need to be added?
- If there are rehabilitation goals, how is nursing supporting the goals?

Nutrition and Hydration

- Has the patient experienced a weight loss or gain since the last meeting, and how much has the weight changed?
- If more than 5% has the dietician assessed the patient and what are the recommendations?
- Is there documentation in the medical record regarding nutrition and hydration?

Patient Input

- Does the patient agrees with the goals and plan?
- Ask the patient to discuss any issues or provide feedback for the team

Continued Stay

Nursing

Nursing spends more time with the patient than any other discipline.

Nursing's role is CRITICAL to help the patient meet their goals!!!!

Swing Bed patients **are not** acute patients and have different needs.

- Out of bed for meals and dressed
- Allow patient to do as much as they can independently even though it takes more time

Reassessment after Significant Change

C-1620; 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).

Frequently Missed ---- Discuss as part of IDT Meetings

Nutrition

C-1626 §483.25(g)
Based on a resident's comprehensive assessment, the facility must ensure that a resident—
(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health.

F692 §483.25(g)
(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet

Nutrition

F-692
INTENT §483.25(g)
The intent of this requirement is that the resident maintains, to the extent possible, acceptable parameters of nutritional and hydration status and that the facility:

- Provides nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment;

- Recognizes, evaluates, and addresses the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition and hydration; and

- Provides a therapeutic diet that takes into account the resident's clinical condition, and preferences, when there is a nutritional indication.

Nutrition

Even for patients that are found to not be at nutritional risk at the time of admission….. assessment of nutrition and hydration should be ongoing including dietician assessment

1) Document of oral intake (percent of meals consumed) for all patients
2) Weekly weights for all patients
3) Twice weekly weights if the patient is at nutritional risk
4) Assessment of hydration as part of nursing daily assessment (dry lips, skin, etc.)
5) Weekly dietician assessment
6) Adherence to dietician recommendations – and documentation that recommendations were followed

Dental

C-1624 §485.645(d)(7)

The facility must assist residents in obtaining routine and 24-hour emergency dental care.
(a) Skilled nursing facilities. A facility-

(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;
(4) Must if necessary or if requested, assist the resident—
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services location; and

(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

Medication Management

There are no specific requirements in Appendix W related to medication medication for Swing Bed patients.

However, all of the requirements for medication management in Appendix W would apply – as appropriate to the patient.

Medication Management Appendix PP

Appendix PP F-56 §483.45(c): Requires monthly Pharmacist Drug Regimen Review

F-758 §483.45(c)(3) Psychotropic Drugs

- Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

- Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

- PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

- PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Medication Management Appendix PP

INTENT: F-757 §483.45(d) Unnecessary drugs and F-758 §483.45(c)(3) Psychotropic Drugs

The intent of these requirements is that:

- each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being;

- the facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and

- PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited

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Continued Stay Criteria

WHEN is the patient ready for discharge?

WHEN is the patient ready for discharge?

- When they have met the goals established by the multi-disciplinary team
- When they can sustain the goals established by the multi-disciplinary team

Sounds easy……

What about…….
Patient refuses to participate in therapy

ASK WHY

1. Pain: Patient is not pre-medicated
2. Medical Issues: Diarrhea, UTI, etc.
3. OTHER:

Make sure the patient understands the consequences of refusing

What about…….
Rehab goals met

1. Does the patient need additional time to make sure they can sustain the goals?
2. Is additional time needed to ensure they can function in the home environment?
3. Are there other qualifying reasons for Swing Bed (i.e., nursing)?

What about…….
Patient refuses to leave

1. Ask WHY the patient is refusing to leave.
2. Deliver notice of discharge and NOMNC
3. Convert to private pay
4. Involve court system if necessary

Note: You cannot discharge a patient while an appeal is pending

HealthTech

Discharge

Choice of Post-Acute Providers

C-1425 (Rev.) (8) *"The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences."*

Federal Register: *"Finally, for CAHs, we proposed at § 485.642(c)(8) to require that CAHs assist patients, their families, or their caregiver's/support persons in selecting a PAC provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH, data on quality measures and data on resource use measures. We would expect that the CAH would be available to discuss and answer patients and their caregiver's questions about their post-discharge options and needs. We would also expect the CAH to document in the medical record that the PAC data on quality measures and resource use measures were shared with the patient and used to assist the patient during the discharge planning process."*

Source: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. Sept 2019

Discharge Rights

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

§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.

Required Discharge Information

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

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

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

Required Discharge Information

C-1620: §483.21(c)(2)

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

(NOTE – USUALLY IN DISCHARGE SUMMARY)

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

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

(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 Before Discharge

C-1610 §483.15(c)(5)
Revised Appendix PP F-623: Content of Discharge Notice

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

Notice Before Discharge Example
There is NO CMS form

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

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

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

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

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

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

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

Patient Signature / Date

Timing of Discharge Notice

There is not a specific time to deliver the notice if the patient has been in Swing Bed < 30 days

C-1610 §483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least **30 days** before the resident is transferred or discharged.
§483.15(c)(1) Transfer and discharge—(1) Facility requirements—

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

Notice of Medicare Non-Coverage

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

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

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

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

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

Notice of Medicare Non-Coverage

CMS Form Instructions for NOMNC

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

Note: The two day advance requirement is not a 48 hour requirement.

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

Appeal

C-1610 §483.15(c)(1)

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

Notify Ombudsman

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

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

Send the Discharge Notice you provide to patient

Appendix PP F-623 §483.15(c)(3)

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 transferred or 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. The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for ombudsman notification in their state

Questions?

THANK YOU

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HealthTech

Patient/Resident Rights

Swing Bed Patient Rights
NOT LTC Rights

1. If you are adjudged incompetent under the laws of a State by a court of competent jurisdiction, your rights will be exercised by the patient representative appointed under State law to act on your behalf. The court-appointed patient representative exercises your rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

2. Your wishes and preferences must be considered in the exercise of rights by the representative. To the extent practicable, you must be provided with opportunities to participate in the care planning process. In the case of a patient representative whose decision-making authority is limited by State law or court appointment, you retain the right to make decisions outside the representative's authority.

3. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

4. You have the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising your rights.

5. You have the right to be supported by the facility in the exercise of your rights.

6. You have the right to be informed of, and participate in, your treatment, including the right to be fully informed in a language that you can understand of your total health status, including but not limited to your medical condition.

7. You have the right to be informed, in advance, of changes to your plan of care.

Swing Bed Patient Rights
NOT LTC Rights

8. You have the right to request, refuse, and/or discontinue treatment.

9. You have the right to participate in or refuse to participate in experimental research

10. You have the right to formulate an advance directive

11. You have the right to choose an attending physician. You have the right to be informed if the physician you have chosen is unable or unwilling to be your attending physician, and to have alternative physicians discussed with you, and to honor your preferences, if any, in identifying options.

12. You have the right to be informed of the name, specialty, and way of contacting your physician and other primary care professionals responsible for your care.

13. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights of health and safety or other residents.

14. You have the right to share a room with your spouse when you and your spouse are in the same facility, and both you and your spouse consent to the arrangement.

15. You have the right to immediate access by immediate family and other relatives, subject to your right to deny or withdraw consent at any time.

Swing Bed Patient Rights
NOT LTC Rights

16. You have the right to secure and confidential personal and medical records.

17. You have the right to personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and patient groups, but this does not require the facility to provide a private room for each resident.

18. You have the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility, including those delivered through a means other than the postal service.

19. You have the right to be informed in writing, if you have Medicaid insurance, at the time of admission or when you become eligible for Medicaid of:
    - The items and services that are included in nursing facility services under the State plan and for which you may not be charged
    - Those other items and services that the Hospital offers and for which you may be charged, and the amount of charges for those services
    - Be informed when changes are made to items and services

16. You have the right to be informed before, or at the time of admission, and periodically during your stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per-diem rate.

17. You have the right to access stationery, postage, and writing implements at your own expense.

Swing Bed Patient Rights
NOT LTC Rights

22. You have the right to secure and confidential personal and medical records. You have the right to refuse the release of personal and medical records except as required or provided by federal or state laws. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine your medical, social, and administrative records in accordance with State law.

23. You have the right to contact the Office of the State Long-Term Care Ombudsman.

24. You have the right to remain in a swing bed and not be transferred or discharged unless:
    - The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility
    - The transfer or discharge is appropriate because your health has improved sufficiently so that you no longer need the services provided by the facility
    - The safety of individuals in the facility are endangered due to your clinical or behavioral status
    - The health of individuals in the facility would be endangered
    - You have 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 you do not submit the necessary paperwork for third-party payment or after the third party, including Medicare or Medicaid, denies the claims and you refuse to pay for your stay.
    - The facility ceases to operate

25. The facility may not transfer or discharge you while an appeal is pending unless the failure to discharge or transfer would endanger the health or safety of you or other individuals in the facility

26. You have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat your medical symptoms.