CAH Swing Bed Management

Managing SB: From Admission to ~~Discharge~~

HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

Webinar Series – Part 5

January 6, 2021

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Objectives

The SB team will be able to:

1. Verbalize key responsibilities for team disciplines and more specifically the SB Coordinator tasks

2. Discuss best practice in day-to-day operations of a swing bed program

3. Identify at least one process in need of improvement at participating hospital SB program

4. Consider including this activity as part of SB PI Program and report on status of action plan with pros & cons until final process is adopted by all

Topics

- ❑ Preparing for Potential Upcoming Admission
- ❑ Staff Notification of Upcoming Admission
- ❑ Key Role & Responsibilities
- ❑ Tasks Associated with SB Coordinator Role
- ❑ Provider Role & Responsibilities
- ❑ Communication with Billers
- ❑ Best Practice for Rehab Model Interdisciplinary Processes
- ❑ Q&A
- ❑ Documentation Resources

Presenter's SB Program Training Goals

- That we offer skilled care not just for financial reasons, but we do it well while getting paid for it!
- Not just another inpatient day but we offer a "program" with measurable outcomes!
- To motivate the participants to develop a program where you would let your parents participate in even if you were away!
- To prevent denials due to poor documentation

Disclaimer

- **This information was prepared with the best of intention using CMS such as State Operations Manual, Claims Processing Manual, Medicare Benefit Policy Manual and other resources for regulations and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.**

- **This presentation includes best practice developed over time with years of experience working with both swing bed and acute rehab programs across the country. Recommendations are not necessarily based on the law but rather based on how to best meet CMS regulations within a hospital-based program vs SNF along with best practice in patient-centered care.**

Best practice discussion of processes

- Knowledge of Skilled Care Admission Criteria
  - Was reviewed in Part 1 of this CAH SB Training series
- Documentation
  - Multiple webinars on this subject in 2019-2020
  - More resources at the end of this set of slides
- Managing Utilization:
  - Internal & external identification of acute patients meeting SB admission criteria as well as pre-admission approval process
  - To be discussed in Part 6)

- **Today covers from:**
  - Staff notification of upcoming admission

    TO
  - Clinical post-discharge follow-up

Preparing for Potential Upcoming Admission

- ❑ Develop a pre-admission assessment tool (see sample with recommended P&Ps)
  - Will allow a shorter version of patient status and needs to discuss with admitting MD/DO, therapist and nursing as applicable for accepting or denial process
  - Ensure we carry the medication and equipment needed

- ❑ Discuss referral with the referring care manager/discharge planner
  - Diagnosis – date of admission to acute (not Observation)
  - Payor / need for pre-authorization
  - Purpose of the referral
  - Patient/family's goal(s)
  - Final discharge plan
  - Level of family involvement
  - Expected transfer date (to determine the legitimate 3 MN if applicable)
  - Other based on outcome of the above discussion

- ❑ Agree on the information you require from referral sources
  - Face sheet
  - H&P and physician progress notes
  - MAR
  - Surgical and special procedure report(s) if applicable
  - Consulting specialist report
  - Pertinent Lab & Radiology or other test reports
  - Therapy assessment(s) and progress notes if applicable
  - Vital Sign for at least the last 48 hrs.
  - I&O for the last few days if pertinent to the situation
  - Nursing system review and progress notes for past 48 hrs.
  - Will require a Discharge Summary and Medication Reconciliation report with the transfer

Staff Notification of Upcoming Admission

- Make a copy of the completed pre-admission assessment tool for the admitting physician, nursing and therapy
  - Agree on where it is to be kept for staff to refer to
- Agree on what to do with the referring hospital's medical records for your staff's review as needed
- Copy of face sheet for registration
- Some hospitals have a SB email group to notify them of an internal transfer from acute to SB or an external admission to SB (VP of Patient Care, DON, Patient Access Dir, Pharmacy Dir , Dietary Dir, BO Dir., Lab, Radiology and RT Dir….)
- Pending admission to be discussed at am stand-up IDT meeting including when he/she is expected to be transferred
  - If decision for admission is not final, still update the team on status
- Huddle with the nursing staff to discuss the incoming patient's skill and special needs
  - They are responsible to pass the info on to the next shifts
- Add name to the Patient Schedule Board (discussed later) with expected date and time of admission
- Admitting nurse to be assigned to the patient for when he/she arrives, prep the Patient Engagement Board and to welcome him/her when they arrive
- Agree who is to call the referring hospital floor nurse the day of the transfer to discuss the following:
  - Obtain an update on the patient's status including VS, Temp., I&O if applicable, pain level if applicable, new meds
  - Remind them of the need for Discharge Summary and Medication Reconciliation
  - Discuss when the patient can be expected

Key Role & Responsibilities

❑ Nursing Administration:

- Ensures sufficient staffing
- Ensures orientation to the program
- Staff orientation to SB P&Ps
- Shares expectations re: Rehab Model and documented Staff Competencies
- Ensures participation in huddles, IDT meetings, self-care and mobility assessments
- Oversees high clinical quality care and patient satisfaction
- Expects timely and updated care plans
- Expects medication reconciliations (admission and at discharge)
- Ensures patient education and provides tools for staff use (managing medical diagnosis, S&S to report, actions to take…)
- Clear discharge planning instructions
- Meaningful documentation to support IP skill needs attributed to nursing
- Works closely with the SB Coordinator, Pharmacists, Infection Preventionist and PI Dir.
- Supports increased SB program utilization to meet communities needs
- Maintains the program survey ready with assistance from PI Director and others based on the hospital expectation

❑ PI/QI and Infection Preventionist:

- Keeps abreast of CMS expectations re: performance improvement and infection prevention program expectations and documentation of such (as for all other services in the hospital)
- Are involved in the SB QAPI Project for CAHs by reviewing reports and discussing root-cause analysis and action plans as needed

Key Role & Responsibilities

❑ Therapy Director:

- Ensures that all disciplines work as a team and follow discipline and state regulations
- Participates (or assigns designee) in determining the physical skill needs during the pre-admission or admission process
- Therapy staff orientation to SB program expectations
- Develops functional rehab competency labs for nursing
- Staff orientation to SB P&Ps
- Ensures sufficient staff to meet the physical rehab skilled needs of the patients
- Ensures meaningful participation of self-care & mobility coding and all IDT meetings
- Ensures meaningful documentation to communicate with MD/DO and staff and prevent denials
- Participate in the PI program for SB including chart review
- Supports increased SB program utilization to meet communities needs

❑ Respiratory Therapy:

- Follows discipline specific regulations
- Participate in the IDT meetings as applicable
- Assessments and treatment documentation to support skill needs
- Orients nursing to treatment and documentation expectations when they are part of RT staff for 24 hr. coverage

Key Role & Responsibilities

- **Pharmacist:**
  - Documented medication review from physician orders to:
    - Decrease medication errors and adverse drug events;
    - Assure proper medication selection;
    - Monitor drug interactions, over-medication, and under-medication; and
    - Improve the documentation of medication administration
    - Medication review is on admission and with all new or changes in medication
  - Participate in the admission medication reconciliation
  - Discuss issues (if applicable) with the provider and document outcome
  - Come to the IDT meetings prepared to discuss findings and alert the team as to what they should be looking for (GI issues, balance, lab changes, confusion…)
  - Listen to reports/discussion in the IDT meeting to identify potential medication related S&S
  - Assists in creating patient/family medication education tools. Participates in medication education as needed and preferably prior to discharge
  - Ensure that orders are clearly written in the MAR for clarity to prevent errors
  - Other standards of care applicable in acute care and PI reviews for survey readiness

Key Role & Responsibilities (cont')

❑ SB Coordinator:

- Many rural hospitals combine the Acute Care Manager role and the SB Coordinator role. Others, the nurse manager is also the SB Coordinator – regardless of the staffing model, the SB Coordinator is responsible to ensure that the following takes place:

❑ Overall "big picture" responsibilities:

- The program is managed as planned within regulations,
- Responsible for pre-admission assessments,
- Acts as Care Manager, Discharge Planner and most often SW designee
- Is the liaison between the patient, family, providers and IDT members
- Manages the rehab model processes
- Assists in preventing denials (identified skill needs and on-going utilization review, provider and therapy medical necessity documentation and on-going documentation to support the skilled needs)
- Most frequently manages plan to increase utilization

❑ The following slides cover the tasks associated with the responsibilities

Tasks Associated with SB Coordinator Role

- Works with Acute D/C planner to determine appropriate patients for SB (may be the same person in small rural hospitals hence a moot point)
- Receives external referrals & data and responds back with an answer within 1 to 4 hours based on acuity regarding clinical acceptance or denial
- Ensures 3-day acute hospital stay related to the reason the Medicare patient is referred for and at least a 1-day acute stay for most other payors but still with related skill needs
- Ensures Medicare days available (# at full coverage and # with co-pay if applicable)
- Discusses with the hospitalist on duty or PCP if condition is questionable at the time of the referral and ensures that they have an opportunity to discuss the patient with the referring physician as needed
- Gathers information to complete a pre-admission assessment to determine if they meet criteria and what are the most likely skill needs
- Communicates with non-Medicare payors to determine benefits and pre-auth if applicable
- Shares information re: upcoming new admission with pertinent staff to include a huddle meeting with nursing to give them a report
- Works closely with each providers to ensure that the admitting H&P or progress note supports medical necessity for an IP skilled program (in CAHs, this serves as the certification of need)
- Ensures that there is a physician order for SB admission or skilled care IP admission
- Once admitted, completes an assessment within 24 hrs. of admission to include pre-hospitalization living status and functional capabilities, psychosocial and discharge planning needs
- Orients patients to SB (financial responsibility, rights and responsibilities, explains the rehab model as well as participation expectation etc)
- Ensures that the Advance Directive process is activated

Tasks Associated with SB Coordinator Role (cont')

- Schedules a stand-up meeting for nursing and therapy within 1 to 3 days of admission to complete the self-care and mobility admission assessment
- Facilitates the initial and weekly SB IDT meetings and ensure meaningful discussions
- Facilitates agreement on admission medical condition, skill needs, overall discharge goals
- Maintains the Patient Schedule Board re: admissions, planned discharges, IDT mtgs etc (recommend a patient schedule board for staff)
- Arranges or sees to it that all discharge needs are addressed re: DME, living arrangements, community needs etc…
- Attends acute Patient Care Conferences on a daily basis to help in identifying potential candidates for SB and hear if there are new issues with SB patients that cannot wait for regular SB IDT meetings
- Uses the daily unit patient care meetings to remind staff of planned discharges and share up-coming admissions and what she/he knows thus far
- Serves as the liaison between patient/family and the team including the physician (meets/call) before IDT to discuss needs, potential changes in D/C plan and after each IDT meetings to report on D/C goals, updated status etc…)
- Notes and reviews discharge goals on the Patient Engagement Board/White Board
- Purposely meets with SB patients' physicians on a at least a weekly basis before and after each IDT meetings to discuss the status and progress unless the physician attends all IDT meetings
- Gives notice of non-coverage 2 days prior to discharge of SB to every Medicare patients (generic Medicare and Medicare Advantage)
- Schedules a huddle meeting with nursing and therapists as close to discharge as possible to discuss the discharge self-care and mobility assessment and documents such

Tasks Associated with SB Coordinator Role (cont')

- Works with HIM Coders to ensure all in line with primary diagnosis as necessary and when looking at whether a readmission is related to the last admission or a new condition
- Communicates anything pertinent for business office such as not meeting skill criteria post admission, medical necessity delay in skill rehab, appeal request post Notice of Medicare Non-Coverage etc
- Works closely with the DON and Nurse Manager re: staff documentation, care planning and cost management
- Completes an additional assessment for readmission to attempt to determine what could be done differently for discharge planning
- Tracks and reports data on a monthly basis re: SB Admissions and discharges, SB Days, SB ADC, SB ALOS, % Medicare and non-Medicare, referral sources, acceptance to the program and refusal with reason, D/C destination, program goal outcomes etc…
- Completes a post-discharge clinical follow-up call
- Maintains well written processes as the coordinator for the above responsibilities to ensure that her/his back-up can function when primary coordinator is not available
- Ensures P&Ps are updated
- Participates in an on-going marketing plan (if applicable)

And if you find this is not enough, you could always wash the floors!!!

Provider Role & Responsibilities

- Involved in timely pre-admission process as needed
- Works closely with the SB Coordinator to discuss skilled needs, discharge plan etc.
- MD/DO to write admission orders
- MD/DO to complete admission H&P and treatment plan ensuring documentation to support certification for medical necessity as an IP program – certification may consist of a pre-typed statement, but the documentation must support it
- Signs therapy treatment plans or clarification orders
- All other visits in a SB may be completed by a NP
- Understands the rehab model vs medical model
- Understands direct admission to SB and Medical Appropriateness delays
- Examines the patient within 24 to 48 hrs. (mostly completed day of admission in SB due to availability of physician and higher acuity) and PRN thereafter but no less than weekly to ensure he/she is aware of the patient status and continues to support the skilled needs as demonstrated thru documentation
- Works closely with the SB coordinator to discuss team's discharge goals and status
- Has a good grasp of the PI/QI monitors
- Writes discharge orders based on patient meeting his/her discharge goals
- Participates in growing utilization
- Other ??

Communication with Billers

- The following needs to be shared with the billers in both CAHs and PPS for them to code UB-04 correctly:

  - 3-day qualifying stay
  - Skilled days used/available
  - Medical delay admissions and based on what 3-day qualifying stay
  - SB/SNF readmission within the 30 days post SB/SNF discharge
  - Overnight Leave of Absence (LOA) day(s)
  - Non-Medicare auth # for MAs and Commercial
  - Contract amount (if applicable)
  - Days not meeting skilled criteria
  - Other??

Best Practice for Rehab Model Interdisciplinary Processes

- Schedule the w/in 3-day self-care and functional admitting assessment nursing/therapy/SB Coordinator huddle (for SB QAPI Project)
- Schedule the 1st IDT meeting within 3 days to share all discipline assessments and agree on discharge goals (clinical, self-care & mobility) including where and ELOS

  Note: many complete the scoring huddle with nursing and therapy on day 1 or 2 and have the full IDT mtg on day 3 to report all assessments and agree on discharge goals
- Following IDT meeting is first within 1 wk. (7 days) of the initial and every 7 days where the status towards each goal is discussed and care plan is updated as necessary
- Patient Schedule Board
  - PT/OT/SLP, RT, Nursing skilled tasks, SW counseling (if applicable), dialysis etc…
  - Used to know who to:
    - prepare for therapy first
    - when not to add an activity/test etc due to therapy time
    - date of due IDT mtgs for each patient
    - Other….
- Patient Engagement Board (White Board)
  - IDT team members including provider
  - D/C goals (clinical, functional, education needs including medication…)
  - Daily activity/goals including if OT wants nursing to complete upper, lower or no extremity ADL, ambulation, other nursing rehab tasks (with boxes for frequency), equipment (cane, walker, w/c, commode, Reacher, transfer board etc…)
- Schedule discharge scoring of self-care and mobility assessment with nursing/therapy/SB Coordinator huddle (for SB QAPI Project in CAHs)
- Review QAPI outcome and discuss what works, what are the opportunities and develop root-cause analysis and action plans as needed

Documentation Resources

- Documentation Guidelines for Skilled Care (April 28, 2015)

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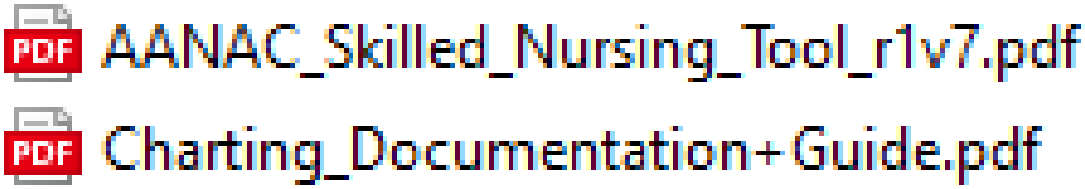
Good resource for staff training and chart review

- http://www.pacahpa.org/Education/DocumentationGuidelinesforSkilledCarePACAH.pdf

- See 2 handouts



- In case you have not downloaded the Medicare and You 2021
- https://www.medicare.gov/sites/default/files/2020-12/10050-Medicare-and-You_0.pdf

Final Questions Regarding Any Components

Did we cover what you were hoping to hear more about?

Next webinar (# 6) SB training is Wed. January 13 – 1*:00 PM ET*

Title: Developing a Plan to Increase SB Utilization

Stay tuned for copies of recommended sample updated P&P by Jan 25, 2021 or before:

1. To meet CoP
2. Explaining rehab model processes
3. Patient Orientation Packet