CAH Swing Bed QAPI Project
What's New Effective 10/1/2020
(Webinar)

September 16, 2020

West Virginia
CRITICAL ACCESS HOSPITAL NETWORK
Association

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Agenda (1:00 PM to 2:30 PM)

- Project Name Change
- Why Update?
- Risk Adjusters - and their role
- Review updated Option 2 form and its coding
- Updated Self-Care & Mobility score measurement
- Train/Retrain/Update coding for Self-Care & Mobility section
- Tips on managing outcome
- Next step

Name Change

- To better mirror CMS's wording we are changing this project's name effective 10/01/2020 to

CAH Swing Bed QAPI Project

Why the Updates?

- Any good PI program continuously looks for improvement in their process both in what and how we measure to determine outcomes

- Measures assigned to a swing bed program should be no different than any other services the hospital offers such as Surgery, Lab, Radiology, Rehab, Dialysis etc…

- In 2019/2020 we used the Stroudwater Portal for
  - A breakdown on utilization to a certain level
  - Functional Self-Care & Mobility tracking
  - Discharge to Community
  - Readmits within 30 days

- At the request of some hospitals and in the spirit of developing a more robust QAPI program while respecting that some hospitals are not ready to have a more comprehensive program, we have opted to develop two options hence the birth of two levels of data abstraction
  - Option 1 - CAH SB QAPI Minimum Data Abstraction Form and
  - Option 2 – CAH SB QAPI Comprehensive Data Abstraction Form

- Option 1 (Update) basically remains the same as last year but with more specific Risk Adjusters (discussed later), minus the BIMS section and added the basics re: therapy utilization

- Option 2 (New) will give you not only what we just mentioned but also will allow you to benchmark the other quality measures you should be tracking such as: Falls, Medication Errors, Nosocomial Infections, Vaccination, Medication Reconciliation and 24-72 hr post-discharge Clinical Follow-up hence making this a comprehensive SB quality program

Why the Updates?

- Equally important, Option 2 will give you insight on how the patient is doing in regard to individual goals hence allowing you to take a deep dive in what you are good at and what are the opportunities for improvement regarding functional outcomes

- Option 2 will also allow you to better classify cases not only by admitting diagnosis/conditions using the CMS 1-13 list but also by the type of programs you offer in order to identify opportunities and use the data to promote your programs

- For hospitals choosing Option 2, Stroudwater will develop a quarterly QAPI report for you to share with your referring sources similar to what CMS posts for SNFs in NH Compare/Care Compare.
  - Referring hospitals including yours will be able to use this info in the “Patient Choice” letter

- Lastly, Stroudwater has a goal for 2021 to develop some type of SB Program Rating based on a CAH SB specific survey giving hospitals “bragging rights” about their SB program. Only those using Option 2 will be able to apply. More on this subject at a later date.

- I know many of you have already chosen Option 1 vs Option 2 but feel free to reconsider after today and let Dianna know ASAP - Option 2 shows a true interest in becoming the best of the best for a service that is so important to your hospital and community but we understand if you are not there yet

- Regardless of which option you choose, benchmarks data will be for all hospitals for the sections that are the same + other measures for those choosing Option 2

Risk Adjusters

- The following sections are measured and benchmarked similar to what CMS does for all other post-acute care programs (SNFs, PPS SB, IRFs, LTACH, HH)
  - Functional Self-Care & Mobility tracking
  - Discharge to Community
  - Readmits within 30 days

- In order to benchmark the above amongst your network and nationally (with CAHs participating in the Stroudwater's benchmarking project), and to be able to compare ourselves to SNFs and PPS SB programs it is imperative to risk-adjust the data. This allows for a closer apples-to-apples comparison of the programs

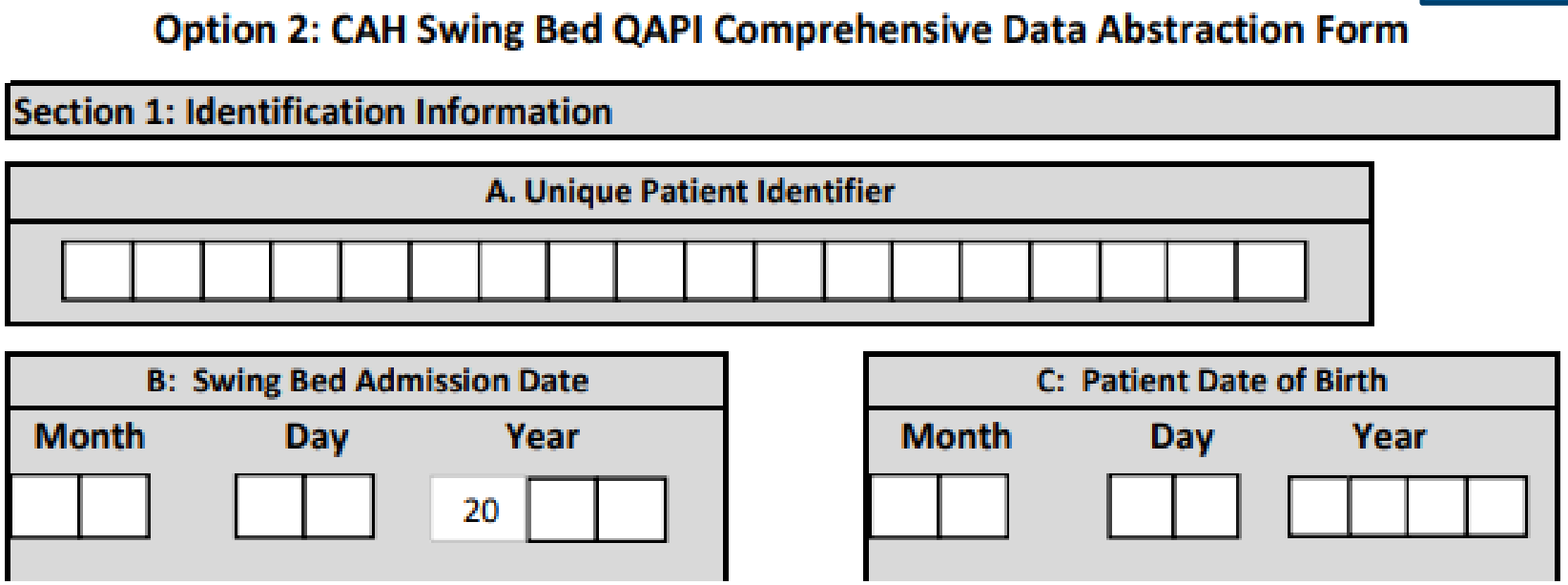
- To do so, both Options 1 & 2 asks for the same data as the MDS 1.17.2 (effective 10/1/2020) related to care planning and risk adjustment used to determine its impact on outcomes

- When Risk Adjusters exists but not identified or documented, one could unknowingly lower their PI scores

- Sections used to risk-adjust are worded exactly as the MDS in the following sections for Option 1 & 2:
  A: Primary Medical Condition Category
  B. Prior Surgery
  C. Prior Functioning
  D. Prior Device Use
  E. Bladder & Bowel Continence
  F. Unhealed Pressure Ulcers/Injuries at Swing Bed Admission
  G. Fall History on Admission
  H. Total Parenteral Nutrition & Tube Feeding while in Swing Bed
  I. Communication
  J. Comorbidities

- NOTE: CMS also uses BIMS to benchmark, but we found, based on the pilot project, that the risk adjuster for BIMs was not worth the effort and staff time to continue the BIMS assessment for CAH swing bed programs. You may feel free to continue the BIMS assessment in your programs, but it will not be entered in the portal

Review of the Data Abstraction Form – Option 1 & 2



A. **Unique Identifier #:** anything works as long as you remember the system you use so that you may be able to refer back to the medical record – Many choose to use the patient's account #. NEVER use the Patient's Medical Record #

B. **Admission Date**: please double-check that you entered the month and year correctly – we have records of patients discharged before they were admitted!!

C. **DOB**: again please double-check the year – based on wrong input, we have had records of young children and "ancient" patients!!

Option 1 & 2 – Admitted to SB From & Payor Source

D: Admitted to Swing Bed From:	
Choose one	
☐	**01. Home/Community** (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)
	02. Nursing home (long-term care facility)
	03. Skilled Nursing Facility (SNF, swing beds)
	04. Short-Term General Hospital (IPPS or CAH)
	05. Long Term Care Hospital (LTCH) (free standing or hospital-based unit)
	06. Inpatient Rehabilitation Facility (free standing or hospital-based unit)
	07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
	08. Intermediate Care Facility (ID/DD facility)
	09. Hospice (home or instutional facility)
	10. Home under care of organized home health service organization
	99. Not listed (ie: VA, prison, other)

D. Admitted From:

- This now asks where the patient was immediately before being admitted to SB to be in line with the MDS
- Should be self-explanatory

E. Expected primary payer source for swing bed stay	
Choose one	
☐	**01. Medicare**
	02. Medicare Advantage
	03. Medicaid
	04. Commercial Insurance (includes Blue Cross)
	05. Self-pay
	99. Other (ie, VA, prison)

E. Primary Payor Source:

- Should be self-explanatory – do not assume, should match what is reported on the claims form (UB-04)

Option 1 & 2 – Primary Medical Condition

Section 2: Risk Adjustment Elements

A (Part 1): Primary Medical Condition Category

Enter Code	Indicate the primary medical condition upon which the patient's skilled needs are based on
☐☐	01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Condition 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions

A. (Part 1) Primary Medical Condition Category:

- Used as a Risk Adjuster
- Code 01 to 13 is the category in which the primary admitting diagnosis resides

- See next 2 slides for the CMS description of each category
- The patient may have different issues that fall into more than 1 choice hence why you must concentrate on the primary admitting diagnosis with skilled care needs for which you are admitting the patient. For instance, a patient may be admitted for post-hip replacement and have COPD. This would be coded as (09) Hip & Knee Replacement and not (12) Debility, Cardiorespiratory Conditions
- This should be discussed with the PCP and the team during the initial IDT meeting at the time you are identifying the skilled needs
- Remember that the skilled needs should be shared with patient/family and all staff to improve communication and ensure pertinent documentation

Medical Condition/Reason for Admission - Definition

- **Code 01, Stroke** = if the patient's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

- **Code 02, Non - Traumatic Brain Dysfunction** = if the patient's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.

- **Code 03, Traumatic Brain Dysfunction** = if the patient's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

- **Code 04, Non - Traumatic Spinal Cord Dysfunction** = if the patient's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

- **Code 05, Traumatic Spinal Cord Dysfunction** = if the patient's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.

- **Code 06, Progressive Neurological Conditions** = if the patient's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

Medical Condition/Reason for Admission - Definition

- **Code 07, Other Neurological Conditions** = if the patient's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.

- **Code 08, Amputation** = if the patient's primary medical condition category is an amputation. An example is acquired absence of limb, toes

- **Code 09, Hip and Knee Replacement** = if the patient's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.

- **Code 10, Fractures and Other Multiple Trauma**, if the patient's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

- **Code 11, Other Orthopedic Conditions** = if the patient's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

- **Code 12, Debility, Cardiorespiratory Conditions** = if the patient's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.

- **Code 13, Medically Complex Conditions** = if the patient's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

Coding Examples – from the MDS Manual Chapter 3, Section I

Example #1: Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician.

- **Coding:** Section 2 A (part 1) would be coded 01, Stroke
- **Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission

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Example #2: Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

- **Coding:** Section 2 A (part 1) would be coded 10, Fractures and Other Multiple Trauma.
- **Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is 10, Fractures and Other Multiple Trauma.

Coding Examples – from the MDS Manual Chapter 3, Section I

Example #3: Mrs. H is a 78-year-old female with a history of hypertension and a hip replacement 2 years ago. She was admitted to an extended hospitalization for idiopathic pancreatitis. She had a central line placed during the hospitalization so she could receive TPN. She also received regular blood glucose monitoring and treatment with insulin when she became hyperglycemic. During her SNF stay, she is being transitioned from being NPO and receiving her nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into Mrs. H's SNF medical record.

- **Coding:** Section 2 A (part 1) would be coded 13, Medically Complex Conditions.

- **Rationale:** Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. All other items are treatments due to pancreatitis

Option 2 – SB Programming

A (Part 2): Swing Bed Programming	
Enter Code	**Indicate more specific medical/physical rehab program the patient was admitted for based on primary skilled needs (not comorbidities)** 01. Cardiac Rehabilitation (ie: post MI, CHF, Cardiac procedures/surgery, CABG) 02. Pulmonary Rehabilitation (ie: COPD, Emphysema, Chronic Bronchitis) 03. Post-Stroke Rehabilitation 04. Pneumonia Management and Rehabilitation 05. Short-Term Medical Management (a 2-4 day extension of acute care until treatment regimen is considered effective) 06. Wound Care Management 07. Long-term IV Management 08. Management of Newly Diagnosed Specific Conditions (ie: newly diagnosed diabetes or new ostomy) 09. Neuro-Muscular Disease Specific Rehabilitation (ie: Parkinson, Multiple Sclerosis) 10. Orthopedic Rehabilitation 11. Short-term New Tracheostomy Care 12. Short-term Ventilation Rehabilitation 13. Post Bariatric Surgery Rehabilitation 14. Short-term Nutritional Support (ie: J/G Tube, TPN) 15. Short-term Pain Management 16. General Malaise and/or Debility Rehabilitation 17. Post-acute Kidney Disease Management 18. Medically Complex/Multiple Trauma

A. (Part 2) SB Programming:

- This was added at the request of some hospitals who wanted more information about the different types of programs patients are being admitted to

- Serves to better delineate the services you offer
- Can be used to promote your services
- The choice of the programs is based on the major reason you are admitting the patient for – what are the treatments or skills needs related to?
- See next slides for examples based on concerns/feedback received from participants

- See attachment for updated descriptions of all 18 programs

Q: There may be times that multiple choices would be appropriate, and we would have to have some guidelines for consistent selection of a single program description versus an option to select multiple programs that could be running concurrently.

Example # 1: A patient was admitted to swing bed with a full thickness diabetic foot ulcer S/P resection of a metatarsal that required 6 weeks of IV antibiotics, wound care, and PT/OT for training for mobility and ADLs with non-weightbearing precautions to the extremity. Could it not be wound care, long-term IV antibiotics, and orthopedic?

A: The program would be # 10 “Ortho Rehabilitation”. In this case, the IV antibiotic and therapy are treatments related to his Orthopedic surgery

Example #2: A patient was admitted with an acute compression fracture and requiring short-term pain management while also requiring rehabilitation to learn strategies for spinal protection and/or use of a spinal orthotic while performing basic mobility and ADLs. Could it not be short term pain management and orthopedic rehabilitation?

A: The program would be # 10 “Orthopedic Rehab”. Again in this case, the therapy and pain management are treatments to deal with his acute compression fracture

Example #3: A patient was admitted with complicated GI condition, warranting TPN for several weeks while also requiring rehabilitation due to extended hospital course. Could it not be short-term nutritional support and general malaise and/or debility?

A: The program would be #14 “Short-Term Nutritional Support”. This is the primary reason he is admitted to SB. He is secondarily debilitated, and we are looking for the primary reason for SB.

Q: Can you please give examples of how Section 2 A (part 1) and (part 2) may differ

1) **Example #1**: Mrs. V was hospitalized for gram-negative pneumonia. Since this was her second episode of pneumonia in the past six months, a diagnostic bronchoscopy was performed while in the hospital. She also has Parkinson's disease and rheumatoid arthritis. She was discharged to a SNF for continuing care.

   - **Coding**: Section A (part 1) is coded as 13, Medically Complex Conditions
     (part 2) is coded as 04 – Pneumonia Management & Rehab

2) **Example #2:** Mrs. O, a diabetic, was hospitalized for sepsis from an infection that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. She was discharged to a SNF for continued antibiotic treatment and monitoring.

   - **Coding:** Section A (part 1) is coded as 13, Medically Complex Conditions
     (part 2) is coded as 07, Long-Term IV Antibiotic

3) **Example #3:** Mrs. H was hospitalized for severe back pain from a compression fracture of a lumbar vertebral body, which was caused by her age-related osteoporosis. She was treated with a kyphoplasty that relieved her pain. She was transferred to SB after discharge because of her mild dementia and need to regulate her anticoagulant treatment for atrial fibrillation.

   - **Coding:** Section A (part 1) is coded 10, Fractures and Other Multiple Trauma
     (part 2) is coded as 05, Short-term Medical Management

Option 1 & 2 – Past Surgery

B. Surgery	
Enter Code ☐	Did the patient have major surgery during the 100 days prior to admission? (general anesthesia and at least one overnight stay) 0. No 1. Yes 8. Unknown

- **B: Major Surgery within the last 100 days is also a Risk Adjustor**
- Major surgery may have occurred anytime in the past 100 days up until their admission to swing bed
- CMS has a very limited definition for major surgery:
  - Required at least 1 overnight stay in the hospital – one would assume that it could be as an IP or OP overnight stay since for example, hip surgeries are now frequently an overnight stay only yet has some degree of risk to the patient
  - The surgery carried some degree of risk to the patient's life or the potential for severe disability
- Recommend you discuss with the PCP and HIM Coder if you have difficulty deciding on whether a surgery is considered major or not

Option 1 & 2 – Prior Functioning

C. Prior Functioning

Prior Functioning: Everyday Activities. Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury

Coding:

3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper

2. Needed Some Help - Patient needed partial assistance from another person to complete any activities

1. Dependent - A helper completed all the activities for the patient

8. Unknown

9. Not Applicable

Enter Codes in Boxes

☐	A. **Self-Care**: Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury
☐	B. **Indoor Mobility (Ambulation)**: Code the patient's need for assistance with walking from room to room (with or without device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury
☐	C. **Stairs**: Code the patient's need for assistance with internal or external stairs (with or without a device such as a cane, crutch, or walker) prior to the current illness, exacerbation, or injury
☐	D. **Functional Cognition**: Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury

Ask the patient or his or her family and review the patient's medical records describing the patient's prior functioning with everyday activities.

- **C: Prior Functioning is a Risk Adjustor**

  (3) Independent – **NO Assistance** from a helper what-so-ever
  (2) Needed **some help** – in any amount - self-explanatory
  (1) Dependent – **a helper is a must**
  (8) Unknown – **only to be used if** the patient cannot say and there are no family/friends… who can inform us and the medical record does not have the information
  (9) Not applicable – one would expect that you would have a code 1, 2 or 3 for (A) self-care because that is a must but feasible that you would have N/A for ambulation and stairs if the patient does not do that. Same goes for functional cognition – so, If the patient was unable to do the everyday activity prior to admission to acute, code as 9, Not Applicable

Option 1 & 2 – Prior Device Use

D. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury	
Check all that apply	
☐	A. Manual wheelchair
☐	B. Motorized wheelchair and/or scooter
☐	C. Mechanical lift (i.e., hoyer, chair lift, stair lift)
☐	D. Walker
☐	E. Orthotics/Prosthetics
☐	Z. None of the above

Walker of any type – does not include canes

Ask the patient or his or her family and review the patient's medical records

- **D: Prior Devices**
- Does not apply to devices given to them during the acute hospitalization
- If patient was not using a device prior to acute hospitalization but was given a walker or w/c during the acute stay for his/her ambulation – the answer would be "Z" none of the above
- Ensure that the device is required for their mobility – for instance, if husband had a chair lift before passing and wife now uses it because its easier though not required to go from sit-to-stand, "C" Mechanical Lift would not be checked off
- If the patient was using a walking cane, then check "Z" – none of the above

Option 1 & 2 – Bowel/Bladder Continence & Pressure Ulcer

E. Bladder & Bowel Continence	
Urinary Continence	
Choose one	
☐	**0. Always Continent**
	1. Occasionally incontinent (less than daily incontinence)
	2. Frequently incontinent (may have daily incontinence but with also some episodes of continent voiding)
	3. Always incontinent (no episodes of continent voiding)
	9. Not rated (patient had a catheter [indwelling, condom], urinary ostomy, or no urine output for the entire stay)
Bowel Continence	
Choose one	
☐	**0. Always Continent**
	1. Occasionally incontinent (one episode of bowel incontinence)
	2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
	3. Always incontinent (no episodes of continent bowel movements)
	9. Not rated (patient had an ostomy or did not have a bowel movement for the entire stay)

F. Unhealed Pressure Ulcers/Injuries at Swing Bed Admission	
☐	0. No (Skip to next section)
	1. Yes (Answer question below)
↓	**Check all that apply**
☐	Stage 2 Pressure Ulcer
☐	Stage 3, 4, or Unstageable Pressure Ulcer

- **E: Bowel & Bladder Continence are** Risk Adjusters
- Self-explanatory but,
- Do read the definitions carefully in order to assign the proper code

- **F: Unhealed Ulcers/Injuries at the time of SB admission** is a Risk Adjusters
- CMS only uses these question to determine the risk factor hence why it is not more detailed then this

Option 1 & 2 – Fall History

G. Fall History on Admission	
Choose one	Did the patient have a fall any time in the last month prior to swing bed admission?
☐	0. No
	1. Yes
	9. Unable to determine

- **G: Fall History on Admission** is a Risk Adjuster
- Falls are a leading cause of injury, morbidity, and mortality in older adults
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling

DEFINITIONS for Falls

- **FALL** - Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat).
- The fall may be witnessed, reported by the patient or an observer or identified when a patient is found on the floor or ground.
- Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
- Falls are not a result of an overwhelming external force (e.g., a patient pushes another patient).
- An intercepted fall occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person –this is still considered a fall.
- Note: CMS understands that challenging a patient's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Fall Coding Examples

1. On admission interview, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.
   - **Coding**: Code 1, Yes.
   - **Rationale**: Falls caused by slipping meet the definition of falls.

2. On admission interview a patient denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.
   - **Coding**: Code 0, No
   - **Rationale**: If the individual is found on the floor, a fall is assumed to have occurred but, this was more than 1 month ago

3. On admission interview, Mr. M. and his family deny any history of falling. However, nursing notes in the transferring hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to the transfer to SB .
   - **Coding**: Coded 1, Yes
   - **Rationale**: Medical records from an outside facility document that Mr. M. was found on a mat on the floor. This is defined as a fall

Fall Coding Examples

4. Medical records note that Miss K. had hip surgery 5 months prior to admission to the nursing home and before being admitting to acute then SB. Miss K.'s daughter says the surgery was needed to fix a broken hip due to a fall.
   - **Coding:** Code 0, No
   - **Rationale:** Miss K. had a fall related fracture, but it was 5 months prior to admission (earlier that in the past month)

5. Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.
   - **Coding:** Coded 0, No
   - **Rationale:** The fractures were not related to a fall

6. Ms. P. has a history of a "Colles' fracture" of her left wrist about 3 weeks before the SB admission. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.
   - **Coding:** Code 1, yes
   - **Rationale:** Ms. P. had a fall-related fracture less than 1 month prior to entry.

Option 1 & 2 –TPN/Tube Feeding & Communication

H. Total Parenteral Nutrition & Tube Feeding while in Swing Bed			
Total Parenteral Nutrition		Tube Feeding	
Choose one		Choose one	
☐	1. Yes	☐	1. Yes
	0. No		0. No

- **H: TPN and J/G Tubes** are Risk Adjusters
- Do not count if they had such in acute but discontinued before being admitted to SB

I. Communication	
Makes self understood: Ability of patient to express ideas and wants, consider both verbal and non-verbal expression	
Choose one	
☐	0. Understood
	1. Usually understood - difficulty communicating some words or thoughts but is able if prompted or given time
	2. Sometimes understood - ability is limited to making concrete requests
	3. Rarely/never understood
Ability to understand others: Ability of patient in understanding verbal content	
Choose one	
☐	0. Understands
	1. Usually understands - misses some part/intent of message but comprehends most
	2. Sometimes understands - responds adequately to simple, direct communication only
	3. Rarely/never understands

- **I: Communication is a** Risk Adjusters
- Makes Self-Understood and
- Ability to Understand Others
- Consider discussing as a team to determent what best fits the patient
- Documentation should support findings

- **MAKES SELF UNDERSTOOD** - Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing

- Problems making self understood can be very frustrating for the patient and can contribute to social isolation and mood and behavior disorders.

- Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.

Steps for Assessment

1. Assess using the patient's preferred language or method of communication.

2. Interact with the patient. Be sure he or she can hear you or have access to his or her preferred method for communication. If the patient seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.

3. Observe his or her interactions with others in different settings and circumstances.

4. Consult with the primary nursing staff (over all shifts) and the patient's family and speech-language pathologist if involved

- **ABILITY TO UNDERSTAND OTHERS** - Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the patient's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.
- Inability to understand direct person-to-person communication
  - Can severely limit association with others
  - Can inhibit the individual's ability to follow instructions that can affect health and safety

Steps for Assessment

1. Assess in the patient's preferred language or preferred method of communication
2. If the patient uses a hearing aid, hearing device or other communications enhancement device, the patient should use that device during the evaluation of the patient's understanding of person-to-person communication.
3. Interact with the patient and observe his or her understanding of other's communication.
4. Consult with direct care staff over all shifts, if possible, the patient's family, and speech-language pathologist (if involved in care).
5. Review the medical record for indications of how well the patient understands others.

Option 1 & 2 - Comorbidities

J. Comorbidities: Indicate the patient's active comorbidities impacting skilled needs (must be included in provider's documentation)	
Check all that apply	
☐	**Major infections:** Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock; and Other Infectious Diseases
☐	**Metastatic Cancer** and **Acute Leukemia**
☐	**Diabetes:** Diabetes with Chronic Complications; Diabetes without Complications; Type I Diabetes Mellitus
☐	**Other Significant Endocrine and Metabolic Disorders**
☐	**Delirium and Encephalopathy**
☐	**Dementia:** Dementia with Complications; Dementia without Complications
☐	**Tetraplegia** (excluding complete tetraplegia) and **Paraplegia**
☐	**Multiple Sclerosis**
☐	**Parkinson's** and **Huntington's Diseases**
☐	**Angina Pectoris**
☐	**Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease**
☐	**Hemiplegia, Other Late Effects of Cerebrovascular Accident:** Hemiplegia/Hemiparesis; Late Effects of Cerebrovascular Disease, Except Paralysis
☐	**Dialysis Status and Chronic Kidney Disease - Stage 5**
☐	**Urinary Obstruction and Retention**
☐	**Amputations:** Traumatic Amputations and Complications; Amputation Status, Lower Limb/Amputation Complications; Amputation Status, Upper Limb
☐	**Cental Nevous System Infections:** Bacterial, Fungal, and Parasitic Central Nervous System Infections, Viral and Late Effects Centeral Nervous Systm Infections
☐	**Lymphoma and Other Cancers**
☐	**Other Major Cancers:** Colorectal, Bladder, and Other Cancers, Other Respiratory and Heart Neoplasms, Other Digestive and Urinay Neoplasms, Other Neoplasms
☐	**Mental Health Disorders:** Schizophrenia; Major Depressive, Bipolar and Paranoid Disorders; Reactive and Unspecified Psychosis; Personality Disorders
☐	**Aspirations, Bacterial and Other Pneumonias:** Apiration and Specified Bacterial Pneumonias; Pneumococcal Pneumonia, Empyema, Lung Abscess
☐	**Legally blind**
☐	**Chronic Kidney Disease**: Stages 1-4, Unspecified: Chronic Kidney Disease, Severe (stage 4), Chronic Kidney Disease, Moderate (stage 3), Chronic Kidney Disease, Mild or Unspecified (stages 1, 2 or unspecified)
☐	**Major Fracture**, except of skill, vertebrae or hip

- **J: Active Comorbidities** are Risk Adjusters
- This list is based on what CMS considers potentially impacting outcomes hence why they are used as risk adjusters (longer list than in the first version). It does not contain all possible comorbidities – only those proven to impact outcomes
- ***ACTIVE*** diagnosis/comorbidity = Physician-documented diagnoses that have a direct relationship to the patient's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during their stay
- Must be supported in the providers documentation along with what makes them "Active" in H&P, progress notes, orders etc…
- Consists of diagnosis remaining active in SB since admission
- Essential that diagnoses communicated verbally are documented in the medical record by the physician to ensure follow-up

- Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up and must be active during the SB stay to be checked of
- DO NOT code from symptoms listed in licensed nursing notes
- DO NOT code diagnoses added by therapists unless signed by the physician
- DO NOT guess/assume or estimate what you think the physician meant without asking the physician for clarification
- As for all diagnosis, the HIM coder should be able to assist as needed
- Diagnosis are made by Physicians (Attending physician, covering physicians, Radiologists, Specialists, etc.) • Nurse Practitioners • Clinical Nurse Specialists • Physician Assistants
- Diagnosis may be found in
    - History and Physicals (hospitals and SB)
    - ER records and other hospital records such as Observation prior to admission
    - Discharge summaries
    - X-ray and Lab reports
    - Surgical reports
    - Physician progress notes
    - Transfer records

Option 1 & 2 – Therapy Utilization

Section 3: Therapy Utilization	
Did patient receive any therapy while in Swing Bed?	
Choose one	
☐	0. No
	1. Yes
If yes, which discipline was provided?	
Check all that apply	
☐	1. Physical Therapy
☐	2. Occupational Therapy
☐	3. Speech Therapy

- This section was added to help management understand therapy utilization at a basic level
- Only intended for patients receiving multiple days of therapy
- When looking at individual cases, you would be able to quickly see if they had therapy or not and if so, which disciplines were involved
- Could look at self-care & mobility outcome status based on therapy disciplines involved
- Will allow benchmarking for therapy utilization with other network and project participants

- **Section 3: Therapy Utilization**
- **Check "yes" if** the decision to treat was made based on an assessment
- **Check "no" if** only included a one time visit for evaluation and development of a nursing management plan when skilled rehab interventions are not necessarily warranted

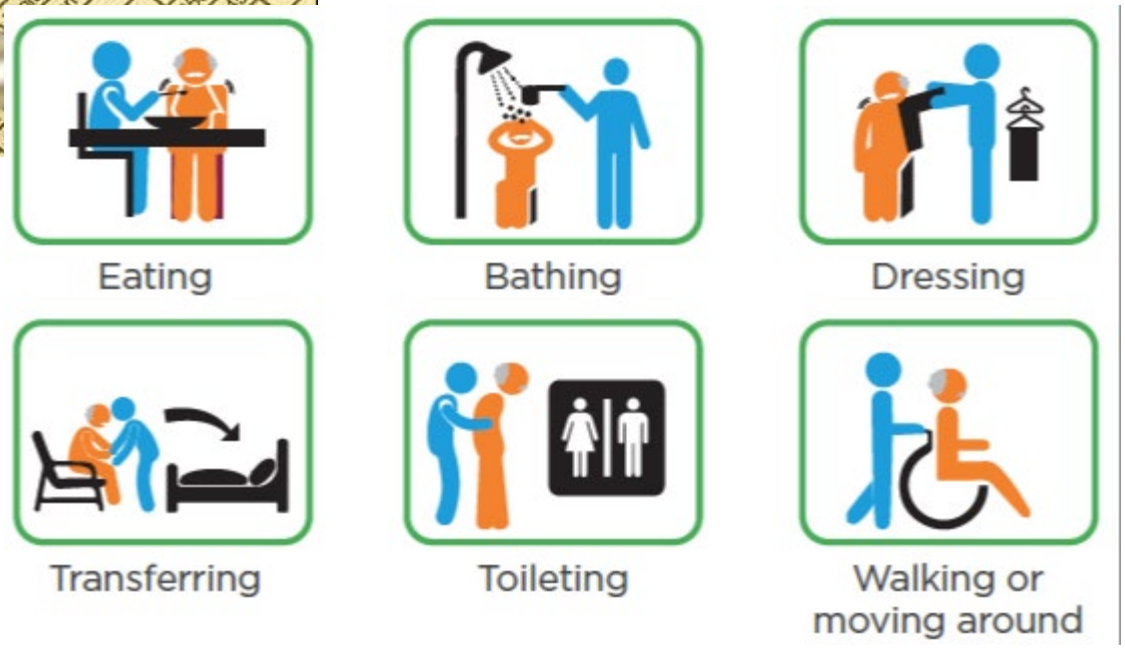
Option 1 & 2 - Exclusions

Section 4. Exclusions	
If any of the following apply, skip to Discharge and 30-day Follow-Up	
Choose One	
☐	Died while in Swing Bed
☐	Left the swing bed program against medical advice
☐	Discharged to hospice care
☐	Unexpectedly discharged to a short-stay acute hospital/CAH
☐	Planned Short Medical Management for Less than 3 days (3 midnights)
☐	Independent with all mobility activities at the time of admission (all 15 mobility items are coded 06)
☐	Patient with any of the following medical conditions: coma/persistent vegetative state; complete tetraplegia; locked-in syndrome; severe anoxic brain damage, cerebral edema, or compression of brain
☐	Younger than 21 years old
☐	Not receiving Physical Therapy or Occupational Therapy (including those only receiving PT for wound care)
If None of the exclusions above apply complete the Functional Abilities sections	

- We often find discrepancies between this section and the Discharge Disposition section. Numbers don't always add up
  - For instance, you have a patient receiving therapy and at the end of the stay, patient/family/PCP agree that he should be discharged to hospice.
  - Remember to come back and check the "hospice" exclusion and the ADLs scores will be ignored by the Stroudwater program

- **Section 4: Exclusions**
- Important to understand that if a patient meets any one of these exclusions, they will not be included in the Self-Care & Mobility PI data
- If a patient meets an exclusion, you are to skip the self-care & mobility section and move on to Section 7

Coding Section 5 – Functional Abilities (Option 1 & 2)



Basic Guidelines in Coding Section 5

- Admission assessment must be completed within 3 calendar days of admission (including the day of admission)
- Coding on admission should reflect the person's baseline admission functional status and is based on clinical assessment
- The admission functional assessment, when possible, should be conducted prior to the person benefiting from treatment interventions in order to determine a true baseline
- Not all items have to be assessed in one sitting – some you may have to delay due to the patient's condition and/or weather… hence the 3 days
- Treatment should not be withheld in order to conduct the functional assessment
- Activities may be completed with (if they usually use a device or safer attempted with a device or without assistive device(s)). Coding is not based on devices
- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling). These are at the very lease not independent – will be coded a 5 (supervision/set up) or lower

- If the patient performs the activity more than once during the assessment period and the patient's performance varies, coding should be based on the patient's "usual performance," which is identified as the patient's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period

- The team may need to use the entire 3-day assessment period to obtain the patient's usual performance for all measures ie: patient too tired to complete the assessment on day 1 or weather is bad, and you do not have a car simulator…

- Assess the patient's self-care status based on:
  - direct observation,
  - the patient's self-report,
  - family reports, and
  - direct care staff reports documented in the patient's medical record during the assessment period

- CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the patient during the three-day assessment period
  - CMS defines "Qualified Clinician" as Healthcare professionals practicing within their scope of practice and consistent with Federal, State, local law and regulations"
  - So, a PTA or COTA may not assess but can contribute their observation etc same as a NA would

- This should not be a therapy only assessment – should be what the patient's usual performance is since admission on all shifts – not just what they did with therapy

- Ideally this is a stand-up meeting the day after all admission assessments have been completed - with SB Coordinator, nursing and therapy rep that know the patients at which time each item is discussed, and levels agreed to. Night shift should include patient's functional status at the morning report to get the full picture

- Read the description of the items to be coded very carefully – do not read into it more than its asking (see later examples) – Must be able to perform all aspects of the described items to be considered Independent

- Carefully read the coding key descriptions and choose what best fits the patient – always look at the descriptions before and after the one you think it is to make sure you have the correct one

- All assessment items must be attempted to be coded – otherwise a reason for no attempt must be coded (see slides on "Exceptions") – we will also be talking about the impact of using "exceptions"

- See attachments for Coding Examples, Probing Question Examples etc… This should be used when helping nursing to determine the level

Function Levels

- When coding the patient's usual performance, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

- 06 - Independent - Patient completes the activity by him/herself with no assistance from a helper

- 05 - Setup or clean-up assistance - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity

- 04 - Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently

- 03 - Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort

- 02 - Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort

- 01 - Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

Exception Codes

- **All functions must be attempted unless there is a reason why not as follows**:
  Note: It is expected that the documentation in the chart supports reasons for not assessing all items. So, when using any of these exception codes, there should be documentation to back up the reason for not assessing

  - **07 - Patient refused** – do all possible to convince them to participate and you cannot infer thru clinical data and observation/interviews. **Note:** If the patient is refusing because he/she is afraid or doubting their ability, they should be scored as Dependent

  - **09 - Not applicable - Not attempted** and **the patient did not perform this activity prior to the current illness**, exacerbation, or injury – for instance, if patient was not doing stairs before such as bed/chair ridden at home then its NA If patient does not ambulate or uses w/c in community then the walking scores are NA etc… Should only be used if the patient will not ever attempt this activity ever again (now or in the future).

  - This should not be used because it was not attempted or because its not directly part of the plan of care. Do not code 09 as N/A if the patient is not walking now, but therapy and nursing have goals for the patient to walk prior to discharge. Instead code it as 88 (not attempted due to medical condition or safety concerns)

  - **10 - Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) – for example, there are no 12-step stairs in the hospital (gym or stairs between hospital floors etc… Remember that if the weather is not good to test outdoors on day 1, do not use "not attempted due to environmental limitations" unless the weather does not change for all 3 days

  - **88 - Not attempted due to medical condition or safety concerns –** for instance you may not be able to assess stairs within the 1st 3 days for post stroke, or maybe their medical issues are still not sufficiently stable to attempt some of the testing such as a patient w/DVT to LLE on bedrest and unable to safely attempt transfer and ambulation

Self-Care Items

☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist, including fasteners, if applicable
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable

❑ EATING:

- Assess eating and drinking by mouth only
- Assistance with tube feedings or TPN is not considered when coding Eating
- If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN because of a new (recent-onset) medical condition but with plans to discontinue at some point, code as 88, Not attempted due to medical condition or safety concerns
- If the patient did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code eating as 09, Not applicable
- For patients who have a combination of oral and tube feeding, eating should be coded on the amount of assistance the patient requires to eat and drink by mouth
- If the patient eats finger foods with his or her hands, code based upon the amount of assistance provided

❑ TOILETING HYGIENE:

- This item pertains to both voiding and/or having a bowel movement
- Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement
- Hygiene tasks can take place before and after use of the toilet, commode, bedpan, or urinal
- If the patient does not usually use undergarments, then assess the patient's need for assistance to manage lower-body clothing and perineal hygiene
- If the patient has indwelling catheter or does not urinate due to dialysis and has bowel movements, code the toileting hygiene based on the assistance needed by the patient when moving his or her bowels
- If the patient completes a bladder or bowel in bed, code Toileting hygiene based on the patient's need for assistance in managing clothing and perineal cleansing

❑ SHOWER / BATH:

- Assessment can take place in a shower or bath, at a sink, or at the bedside (i.e., full body sponge bath)
- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the patient's back or hair.
- Shower/bathe self does not include transferring in/out of a tub/shower.
- If the patient bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.
- If the patient cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity

❑ UPPER & LOWER BODY DRESSING:

- The following items are considered a piece of clothing when coding the dressing items:
  - **Other upper body dressing examples**: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - **Other lower body dressing examples**: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis. o Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- For both upper & lower - If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the patient is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the patient needs when coding the dressing item

❑ UPPER BODY DRESSING:

- Includes bra, undershirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown **(NOT hospital gown),** and pajama top
- If the patient dresses himself or herself and a helper retrieves or puts away the patient's clothing, then code 05, Setup or clean-up assistance.
- Helper assistance with buttons and/or fasteners is considered touching assistance = 04

❑ LOWER BODY DRESSING:

- Helper assistance with buttons and/or fasteners, buckling the belt, attaching the suspenders to the pants are all considered touching assistance = 04
  - Includes underwear, incontinence brief, slacks, short, capri pants, pajama bottoms, and skirts
  - Other examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis

❑ PUTTING ON / TAKING OFF FOOTWEAR:

- Includes socks, shoes, boots, and running shoes
  - Other examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking shoes, compression stocking (on and off over foot)

- **For patients with bilateral lower extremity amputations** with or without use of prostheses, the activity of putting on/taking off footwear may not occur.

- For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg
  - If the patient performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.

  - If the patient did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the patient had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable

Mobility Items

Admission Performance Enter Codes in Boxes	
	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed
	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support
	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair)
	F. Toilet transfer: The ability to get on and off a toilet or commode
	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt
	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space

Lying flat on bed at level normal for that pt.

Flat on floor or on stool if bed cannot be adjusted

ROLLING LEFT TO RIGHT:

- Patient demonstrates being able to lie on back and turn left, return to back and turn to right then return to the back – must be able to do both w/out assistance – if he can do 1 side but not the other, level at how much assistance did you have to give for the other side
- If can go one side but not the other due to pain or tubes etc then put 88

SITTING TO LYING FLAT:

- Lying Flat = to what is usual for that patient – if they need bed up at 30 % due to breathing issues then that is “their flat”

LYING TO SITTING ON SIDE OF BED

- Lying to sitting on side of bed, indicates that the patient transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support.
- The clinician is to assess the patient’s ability to perform each of the tasks within this activity and determine how much support the patient requires to complete the activity.
- Clinical judgment should be used to determine what is considered a “lying” position for that patient.
- If the patient’s feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool.
- Back support refers to an object or person providing support of the patient’s back.

❑ CHAIR / BED-TO-CHAIR:

- Chair/bed-to-chair transfer, begins with the patient sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.

- The activities of "Sit to lying" and "Lying to sitting" on the side of the bed are two separate activities that are not assessed as part of "Chair/Bed-to-Chair"

- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and two helpers are needed to assist with a mechanical lift transfer, then Code 01 - Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer by holding the railing etc….

❑ CAR TRANSFERS

- The Car transfer item includes the patient's ability to transfer in and out of the passenger seat of a car or car simulator
- For item regarding car transfer, use of an indoor car can be used to simulate outdoor car transfers.
- These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.
- The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt
- In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations
- If at the time of the assessment the patient is unable to attempt car transfers and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.
    - But, if the patient could get in and out of a car prior to the hospitalization but unsafe to try now due to mobility limitation, then cade "88" - unsafe

❑ WALKING:

- Walking activities do not need to occur during one session

- Allowing a patient to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities
- When coding walking items, do not consider the patient's mobility performance when using parallel bars
  - Parallel bars are not a portable assistive device

- If safe, assess and code walking using a portable walking device when needed

- The turns are 90-degree turns.
  - The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right).
  - The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).

❑ WALKING 10 FEET :

- Once standing, the ability to walk at least **10 feet in a room, corridor, or similar space**
- **Note:** Does the patient walk? Mr. Z currently does not walk, but a walking goal is clinically indicated.
- Coding: 88 due to clinically unsafe on admission
- But it would be 09 N/A if he did not walk prior to his acute admission stay. Same goes to walking 50 ft and 150 ft.

❑ WALKING 50 FEET W/2 TURNS:

- Once standing, the ability to walk a total of at least 50 feet (1 way or go and return) and make two turns (left and right or 2 lefts and 2 rights)

❑ WALKING 150 FEET

- Once standing, the ability to walk at least 150 feet in a corridor or similar space (again 1 way or go 75 FT and return)

☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor **Also applies to picking up from a wheelchair**
☐	**P1. Does the patient use a wheelchair and/or scooter?** **0. No ⟶ Skip rest of questions** **1. Yes ⟶ Continue to Wheel 50 feet with two turns**
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns
☐	**RR1. Indicate the type of wheelchair or scooter used** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space
☐	**SS1. Indicate the type of wheelchair or scooter used** 1. **Manual** 2. **Motorized**

- **WALKING 10 FEET ON UNEVEN SURFACES:**
  - The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel

- **1 STEP CURB:**
  - The ability to go up and down a curb and/or up and down one step

- **4 STEPS:**
  - The ability to go up and down four steps with or without a rail

- **12 STEPS:**
  - The ability to go up and down 12 steps with or without a rail – can be in the gym or hospital staircase or in the community if you are taking the patient out

- **PICKING UP AN OBJECT:**
  - The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor – may be picking object from a W/C if the patient is W/C bound – remember that it is ok if they need a reacher to pick up the object – we are not measuring the need for device or not

- **WHEEL 50 FEET W/2 TURNS:**
  - Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns (see description of 90 degree turn on previous slide)

- **WHEEL 150 FEET**
  - Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space

Intention of the Wheelchair Item

- It is to assess the patient's use of a wheelchair for self-mobilization at admission and discharge when appropriate.

- The clinician uses clinical judgment to determine if the patient's use of a wheelchair is appropriate for self-mobilization due to the patient's medical condition or safety.

- If the patient walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair/scooter gateway items at admission and/or discharge items as follows: Does the patient use a wheelchair/scooter = 0 for No.
  - Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions.

- Otherwise said, only code wheelchair mobility based on an assessment of the patient's need and ability to mobilize in the wheelchair.

- Remember that it is very possible that the patient starts with a wheelchair but no longer is the case on discharge – only walking will apply at discharge.

Impact of Section 5 on Quality Outcomes (Option 2)

Great outcomes do not happen by chance

It requires processes and a team on board

Setting Goals

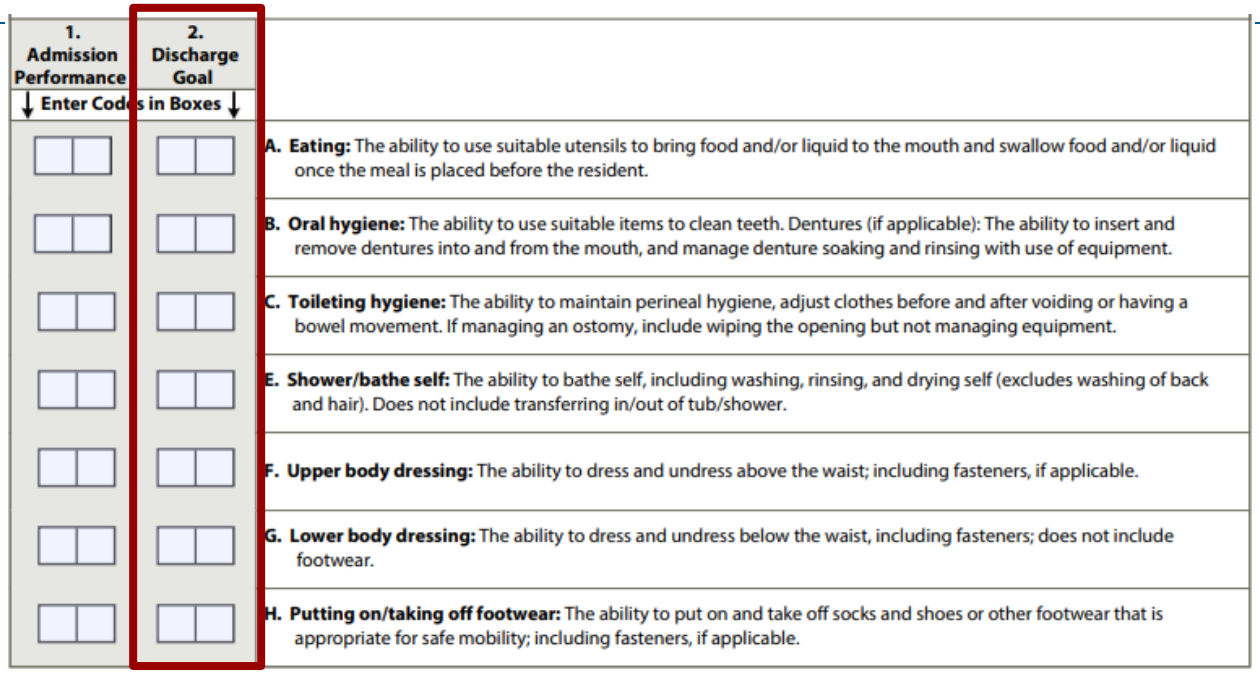
- Section GG is one of the MDS items from where functional outcomes are reported nationally
  - Some call it a Therapy Report Card
  - Section GG is what Stroudwater is replicating for CAHs in Section 5

- The focus of this quality measure is functional improvement for patients admitted to SB with an expectation of functional improvement due to skilled services, including physical and occupational therapy.

- Some skilled patients may receive skilled care, but not physical or occupational therapy services, and these patients are excluded in the QRP measure calculation as they are in QAPI.

- Setting realistic and aggressive discharge goals and tracking how we are doing on a daily/weekly basis to achieve the established care-planned Section 5 goals is the road to success

- The improvement scores are the difference between the admission assessment scores and the discharge assessment scores
  - The change in function score for Self-Care is the difference between the discharge self-care score (7-42) and the admission self-care score (7-42)
  - Change in Mobility function score is the difference between the discharge self-care score (15-90) and the admission self-care score (15-90)



1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
		A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
		B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
		C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
		G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
		H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

- Not all items require a goal – CMS states that at least 1 item must have a discharge goal otherwise subject to a penalty – we are following CMS's direction
  - Only stands to reason that most patients in skilled care should have at least 1 self-care or mobility items to improve and usually at least a handful of items or more are applicable
  - CMS does allow using a goal score the same as on admission because all you plan to do is maintain them at that level
  - CMS goes on to say that at times, its even feasible that the goal would be lower than baseline because you expect the patient to become more dependent as time goes on – especially with worsening medical issues
  - Exception scores can also be used when appropriate
  - A dash is even acceptable if its not part of the treatment plan

- Goals do not impact the outcome measurement methodology – it serves as a tool to have everyone on board as to what we are working on functionally for each individual patient
  - Should improve direction and communication between all parties including the patient/family and staff
  - Should improve nursing documentation by increasing observation, assessments and reporting on how the patients are doing towards those goals
  - Shift reports should elude to not only clinical update, but also functional update based on goals

- Goals should be set by day 3 which should coincide with your first IDT meeting
  - Understandably, there will be other goals than function goals such as medical management of their condition

- Treatment plan and all goals should be shared with the patient/family, all members of the IDT and bedside nursing staff

The only way to determine how you are doing with outcomes is to pull your outcomes, review the trends and discuss results openly and collaboratively

Section GG Self-Care Items	Admit Score	Goal Score	D/C Score	Change Score	Goal Met (Y/N)
Eating					
Oral Hygiene					
ETC					
Totals					

Create the same for Mobility

Discharge Functional Assessment (Option 1 & 2)

- Same items will be assessed on **discharge except no goal setting**
- Must be completed within 3 calendar days of discharge including the day of discharge
- For the Discharge assessment, code the patient's discharge functional status, based on a clinical assessment of the patient's performance that occurs as close to the time of the patient's discharge as possible to capture all areas of improvement possible
- Usually done the day prior or day of the discharge at a stand-up mtg
- Same coding principles apply to discharge assessments
- Again, all assessment items must be attempted to be coded – otherwise a reason for no attempt must be coded using the exception code list
- Patients should be allowed to perform activities as independently as possible for both admission and discharge, as long as they are safe for both admission & discharge assessments.
- Remember that even if the patient was coded on admission as 07 (refused) or 10 (environmental issue) does not mean it is automatically the same at discharge
- Exclusion codes are the same for the discharge as they were for admission

Measuring PI for Self-Care & Mobility (Option 1 & 2)

- Risk Adjusters are incorporated in the measurement
- Scores are not lowered for QAPI as we were led to believe

Discharge Self-Care & Mobility Coding	QRP Score
06	06
05	05
04	04
03	03
02	02
01, 07, 09, 10, 88, missing	01

- Note that "dependent" and exclusion scores are all = 01
  - This has a potential of impacting your total improvement score
    - Too many of these on admission may give you a false high improvement score
    - Too many of these on discharge will also give you a false low improvement score

Analyzing Outcomes

- First look at the scores themselves to identify potential process improvement
  - **Are the baseline admission scores too high? Potential reasons:**
    - Are we only admitting high functioning patients? One would assume not.
    - Is Section 5 derived solely by rehab?
    - Has our staff (therapy & nursing) been trained using CMS's expectation on how to measure such as we did today?
    - Do the staff understand the language or continue using how we were trained before SB?
    - Are we basing our scores on only one component of the measure vs scoring on the most affected item
    - Are we assuming vs truly assessing specific items like eating, oral hygiene and rolling right and left etc
  - **Do the discharge performance scores seem too low, it might be due to:**
    - Do we take the time to set goals at the IDT meeting and share with all staff?
    - Are Section 5 items addressed and discussed routinely during weekly rehab and IDT meetings?
    - Is Section 5 performance a focus of the team – do we treat using the rehab model?
    - Are Section 5 items not assessed at discharge yielding a score of 1 for all unassessed items
    - Are there too many items using the Exception scores – again assigning a score of 1
    - Is Section 5 being written solely by nursing?

- **What is the % of goals met or exceeded? Do we have too many unmet goals?**
  - Too many goals selected upon admission
  - Select any goal related to patient's individual needs, characteristics, and discharge plan
  - Goal levels set upon admission reflect potential for improvement in general vs. actual anticipated improvement specific to the patient
  - Are the goals posted for staff to refer to?
  - Are functional status discussed at change of shift
  - Are patients & family involved in goal setting and tracking their own successes?
  - Are we communicating the functional scores via Patient Communication Board?
  - Are the IDT meetings based on the patient's goal status vs simply an around the room discipline report
  - Are nurses expected to report on how they are doing regarding their goals during all shifts vs just a clinical report

Option 1 & 2 – Discharge Information

Section 7: Discharge Information

A. Swing Bed Discharge Date

Month	Day	Year
		20

B. Discharge Disposition

Enter Code		
	01. Home/Community (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)	
	02. Nursing home (long-term care facility)	
	Pick One	**a. New Stay at a Nursing Home**
		b. Returned to a Nursing Home
	03. Skilled Nursing Facility (SNF)	
	Pick One	**a. New Stay at a Skilled Nursing Facility**
		b. Returned to a Skilled Nursing Facility
	04. Short-Term Acute Hospital (CAH or IPPS)	
	Pick One	**a. Planned Return to Acute Hospital**
		b. Unplanned Return to Acute Hospital
	05. Long Term Care Hospital (LTCH) (free standing hospital or hospital-based unit)	
	06. Inpatient Rehabilitation Facility (free standing hospital or hospital-based unit)	
	07. Inpatient Psychiatric Facility (psychiatric hospital or unit)	
	08. Intermediate Care Facility (ID/DD facility)	
	09. Hospice (home or institutional facility)	
	10. Home under care of organized home health service organization	
	11. Deceased	
	99. Not listed (ie, VA, prison)	

- **Section 7: Discharge Information**
- Please double check that you have the date correct – we have seen discharges before being admitted and others looked like they were in SB forever!
- We have broken down new and return to NH and SNF
- We broke down planned and unplanned return to acute directly from the SB stay
- Please remember to go back and check your exclusion list when completing the discharge disposition section – Return to acute, Discharged to Hospice and Deceased should be marked on the exclusion list as such to exclude those patients from the Functional measures PI determination

Option 2 – Clinical Post-Discharge Follow-Up

C. Clinical Post-Discharge Follow-up	
	A post-discharge follow-up call was made within 24-72 hrs. (and documented) with patient/family to determine their knowledge of S&Ss to report (if applicable), check on medication reconciliation (all names, dosages and times taken), status of follow-up appointments, HH activated (if applicable), DME delivery (if applicable), issues with transportation, access to medication, assistance at home… (minimum but not necessarily comprehensive list based on the patient and services in the area)
☐	0. No
☐	1. Yes

- **Section 7 C: Clinical Post-Discharge Follow-up**
- Post-discharge follow-up calls for patients returned to the community has shown to prevent readmissions

- Ideally, the last IDT meeting includes a discussion as to when we should schedule a follow-up call (24-72 hrs based on condition, discharge disposition support available, concerns you may have etc…)
- Hospitals should have a set of questions including comments as in the box above
- The caller should be trained in conducting these interviews
- The patient should be notified at discharge to expect this call and the purpose – discuss a time better than others they can expect you – allows them to have meds in reach as well as instructions you provided
- We should track outcome of the calls to look for opportunity for improvement on our side and refer back to when analyzing readmissions
- ?? A topic of discussion this coming year along with tool development

Option 1 & 2 – Post-Discharge 30-Day Follow-Up

C. Post Swing Bed 30-day Discharge Follow-up	
Enter choice of 00 thru 02, if applicable ☐	00. No Attempt to Contact Patient/Family
	01. Contact with Patient/Family Attempted 3 times, no Response
	02. Patient Reached but Readmission/ Observation to Another Facility Unknown
Enter choice of 03 thru 06, if applicable ☐	03. Patient not Readmitted to any Facility
	04. Planned Return to Acute or SB/SNF
	05. Return to Acute (same condition)
	06. Return to Acute (new condition)
Enter choice of 07 or 08, if applicable ☐	07. Visit to ED/Observation (same condition)
	08. Visit to ED/Observation (new condition)
☐	09. Deceased

- **Section 7 D: 30-day Post-Discharge Follow-up**
- As you can see, we have streamlined the choices to decrease confusion
- Patients should be told to expect this call – ask for a best # to call – any time of the day or day to not call…
- Note the “if applicable”

- **Planned return to acute** would be for instance – surgery scheduled in 3 weeks post discharge
- **Planned return to SB** could be the post hip surgery who came to SB for non-weight bearing transfer training etc.. Then discharged to home with a planned return to complete therapy when surgeon allows to be weight bearing
- **Return to acute: same or new condition**. CMS obtains this information for SNFs based on hospital claims. It is assumed that it is based on the primary diagnosis the patient had on the first admission compared to the primary diagnosis upon their return within 30 days – so, base your answer on what the patient/chart tells you compared to the primary diagnosis of the acute admission before they came to SB

- **Visit to ED/Observation (same or new condition)** – Apply the same logic as above but based on the reason the patient was admitted to SB

    - **Example 1**: a patient was hospitalized for a hip fracture and developed fluid overload post-operatively with exacerbation of CHF. The patient is then transferred to swing bed for orthopedic rehab after compensating/stabilizing the CHF, and this remained stable throughout the swing bed stay. Two weeks following discharge from swing bed, the patient is evaluated in the emergency department for CHF. Would this count as a "same condition" since CHF would be considered a secondary condition in this example?
    - **A**: Until further clarification, we would say "New" condition since his primary diagnosis was related to his hip and not his CHF

    - **Example 2**: patient was admitted for surgery, tolerated well – would not have had the need to be transferred to SB except he had exacerbation of his CHF a few days before discharge and now was transferred to SB for CHF management. After 5 days, the patient is discharged home but returns to ED for CHF within 2-3 weeks
    - **A**: Since the patient was admitted to SB for CHF, this would be coded as "same" condition

- **Note**: If the patient went to ED then admitted, do not check ED/Observation. Check the box for 04-05 or 06 – this will prevent double counting patients

Option 2 – Other Quality Measures

Section 8: Other Quality Measures

A. Did the patient develop a new pressure ulcer/injury during the Swing Bed stay?	
Choose one	
☐	0. No
	1. Yes

Only looking at new pressure ulcer/injury

B. Fall during the Swing Bed stay		
	Enter Codes in Boxes	
Coding: 0. None 1. One 2. Two or more	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major Injury** - bone fractures, join dislocations, closed head injuries with altered consciousness, subdural hematoma

Every box needs to have a "0", "1" or "2"

C. Did the patient develop a nosocomial infection during the Swing Bed stay?	
Choose one	
☐	0. No
	1. Yes

Nosocomial infection determination is based on the hospital's P&Ps

DEFINITIONS

- **FALL** – see definition of Falls on slide 23

Option 2 – Influenza Vaccines

D. Vaccines

Influenza Vaccine

Enter Code ☐

A. Did the patient receive the influenza vaccine during this Swing Bed stay for this year's influenza vaccination season? ➞

- **0. No** ➞ Skip to C., If influenza vaccine not received, state reason
- **1. Yes** Continue to B, date influenza vaccine received

B. Date influenza vaccine received ➞ Complete date and skip to Pneumococcal section Question A

Month	Day	Year
☐☐	☐☐	20☐☐

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Patient was not a Swing Bed patient** during this year's influenza vaccination season
2. **Received outside of this Swing Bed stay** (including during acute stay)
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

A full 8-character date is required.

If the date is unknown or not available, a single dash needs to be entered in the first box.

- Influenza can occur at any time, but most influenza occurs from October through May. However, patients should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area
- Regardless of whether the patient was transferred from your own CAH or another hospital, it is important to check on the status of the patient's vaccination

Influenza Vaccine Coding Tips and Special Populations

- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza:
  - http://www.cdc.gov/flu/weekly/fluactivitysurv.htm
  - http://www.cdc.gov/flu/weekly/usmap.htm
- Facilities can also contact their local health department website for local influenza
- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, patients should still be vaccinated once the facility receives the influenza vaccine while the patient is still there – ideally, the PCP's office would be notified that the vaccine was not available
- A "high dose" inactivated influenza vaccine is available for people 65 years of age and older. Consult with the patient's primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the patient.

Steps for Vaccination Assessment

- Review the patient's medical record to determine whether an influenza vaccine was received while in the acute stay for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
- Ask the patient if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. – Recommend this being a question asked when transferring a patient to SB from another facility during the flu season – ask for copy of the record
- If vaccination status is still unknown, proceed to the next step.
- If the patient is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
- If influenza vaccination status cannot be determined, administer the influenza vaccine to the patient according to standards of clinical practice. - Do check with the provider and hospital's policy
- Note: Code 3, Not eligible—medical contraindication: if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a patient with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.

Option 2 – Pneumococcal Vaccines

Pneumococcal Vaccine	
Enter Code ☐	**A. Is the patient's Pneumococcal vaccination up to date?** 0. **No** ⟹ Continue to B, if Pneumococcal vaccine not received, state reason 1. **Yes** ⟹ Stop
Enter Code ☐	**B. If Pneumococcal vaccine not received, state reason:** **1. Not eligible** - medical contraindication **2. Offered and declined** **5. Not offered**

- If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the patient, according to the standards of clinical practice
  - If the patient has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
  - If the patient has a moderate to severe acute illness, the vaccine should be administered after the illness.
  - If the patient has a minor illness (e.g., a cold) check with the patient's physician before administering the vaccine

Coding Tips

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at
  - https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at —
  - https://www.cdc.gov/vaccines/schedules/hcp/index.html
  - http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
  - https://www.cdc.gov/pneumococcal/vaccination.html
- If a patient has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the patient's pneumococcal vaccination is up to date.

Examples for Pneumococcal Vaccination

- **Example #1**: Mr. L., who is 72 years old, received the PCV13 pneumococcal vaccine at his physician's office last year. He had previously been vaccinated with PPSV23 at age 66.
  - **Coding**: code 1, yes;
  - **Rationale**: Mr. L, who is over 65 years old has received the recommended PCV13 and PPSV23 vaccines.

- **Example #2**: Mrs. B, who is 95 years old, has never received a pneumococcal vaccine. Her physician has an order stating that she is NOT to be immunized.
  - **Coding:** code A - 0, no; and B would be coded 1, not eligible.
  - **Rationale:** Mrs. B. has never received the pneumococcal vaccine; therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.

Examples for Pneumococcal Vaccination

- **Example #3**: Mrs. A, who has congestive heart failure, received PPSV23 vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 years old and was admitted to SB one week ago for rehabilitation. She was offered and given PCV13 on admission.
  - **Coding:** code A as 1, yes ; skip to next section
  - **Rationale:** Mrs. A received PPSV23 before age 65 years because she has a chronic heart disease and received PCV13 at the Assisted Living she resides at because she is age 65 years or older. She should receive another dose of PPSV23 at least 1 year after PCV13 and 5 years after the last PPSV23 dose (i.e., Mrs. A should receive 1 dose of PPSV23 at age 79 years but is currently up to date because she must wait at least 1 year since she received PCV13).

- **Example #4:** Mr. T., who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 64 years old and is being admitted to SB for chemotherapy and strengthening. He has not been offered any additional pneumococcal vaccines.
  - **Coding:** Code A as 0, no ; and B would be coded 3, Not offered .
  - **Rationale:** Mr. T received 1 dose of PPSV23 vaccine prior to 65 years of age because he is a smoker. Because Mr. T is now immunocompromised, he should receive PCV13 for this indication. He will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after his last dose of PPSV23 (i.e., Mr. T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).

Option 2 – Medication Reconciliation

E. Medication Reconciliation	
Medication Reconciliation on Admission to Swing Bed	
Enter Code ☐	**At the time of admission to Swing Bed did the staff complete medication reconciliation to include home medications and new medications from previous setting?** 0. **No** - Medication reconciliation was not initiated or was incomplete 1. **Yes** - There is documentation of a completed admission medication reconciliation in chart
Medication Reconciliation on Discharge from Swing Bed	
Enter Code ☐	**At the time of discharge from Swing Bed did the staff complete medication reconciliation?** 0. **No** - No documentation of reconciled medication list provided to subsequent provider and/or patient/family 1. **Yes** - There is documentation in chart that medication reconciliation was provided to subsequent provider and/or patient/family

Thorough Drug Regimen Review including Medication Reconciliation along with patient/family education and provision of tools for home administration could go a long way in preventing side effects and ED visit or readmissions due to issues caused by duplication or missed doses

- A **Medication Reconciliation** is a component of the DRUG REGIMEN REVIEW
- Drug Regimen Review Definition - A drug regimen review includes medication reconciliation, a review of all medications a patient is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences. The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.
  - Hopefully your pharmacist is completing and documenting the drug regimen review
  - If nursing is completing the medication reconciliation component, this is shared with the pharmacist and confirmed, updated if necessary
- Best practice dictates that a comprehensive medication reconciliation is completed and documented as well as passed on to the patient and next provider – this too should be documented

Option 2 – SB Program PI Plan

- The only other documentation for your SB program PI that is recommended but not part of this project are your internal analysis of the following:
  - Reviews of LAMA and unexpected deaths during the program or w/in 30 days post discharge,
  - Outcome of the 24-72 hr. follow-up,
  - Reviews of return to acute during the program or within 30 days post discharge, and
  - Reviews of visits to ED/Observation within 30 days post SB discharge
- Adding the above to your PI plan would render a comprehensive program
- PI Minutes would include:
  - QAPI reports from the portal,
  - Outcome from the above reviews if applicable
  - Analysis, plan and outcome of components in need of process improvement as applicable for:
    - Goal setting
    - Self-Care & Mobility Functional outcome
    - Others as applicable (falls, decubitus ulcer/injury, nosocomial infection, vaccination,
    -

Next Step

1) Recommit to using this project as a tool to compare your programs to others and determine opportunities for improvement

2) Meet with you team and re-discuss Option 1 & 2 – Notify Dianna if you have changed your mind on which options you plan to choose no later than Monday 9/21/2020
   - Seriously consider Option 2 for a comprehensive PI program for the SB services
   - It is not that much more data and all something you should be doing regardless
   - Will allow you access to QAPI report for your referring hospitals and community

3) Make plans to train/retrain your staff ASAP on Section 5 and updates for new items effective 10/1/2020

4) Score to the best of your ability using this training and tools provided

5) Use the new form for any discharges from SB on or after 10/1/2020
   - The present version will not be accessible after Sept 30
   - So, use the new version (paper form) for any patient you believe will not be discharged by Oct. 1

6) PLEASE reach out to me if you have any question when you review these slides closer

7) You will be given until October 8 to complete all your discharges for Q3, 2020

8) Our next quarterly benchmarking webinar is scheduled for Nov 4, 2020 at 1:00 PM
   - Remember that this will be based on the data from the first version of the data collection

9) I will let Paula know which options you have chosen to have those ready to access via portal on 10/1/2020

10) Print new version of the data collection form Option 1 or 2 (based on your choice of Options) to start collecting the data for any admissions that you believe will still be in the program on Oct. 1


Q&A

STAY SAFE & HEALTHY