Belle Fourche River To Gannett Peak:
Bottom to Top Regulatory Review
March 2023

BURROWS CONSULTING

Wyoming Office of Rural Health

Today's webinar is funded by the FLEX Grant through the Wyoming Office of Rural Health

Wyoming
Office of
Rural Health

Presenter Biography

Kerry Dunning, MHA, MSH, CAH-CBS, Lean Six Sigma Black Belt

Kerry has over 35 years in the health care industry, and over 30 specifically working in post-acute. She has been a COO and CMO in national rehabilitation chains and in hospital leadership positions. Kerry has experience with start-up units/facilities, programs beginning Medicare services, ongoing management of hospital business office operations, IRF units, skilled facility operations, and in 100-day turn around programs centered on cost reduction, cost avoidance and revenue enhancement. She is the primary swing bed trainer for multiple state/healthcare associations as well as continuing SNF/SWB onsite audits, training, and regulatory/compliance reviews.

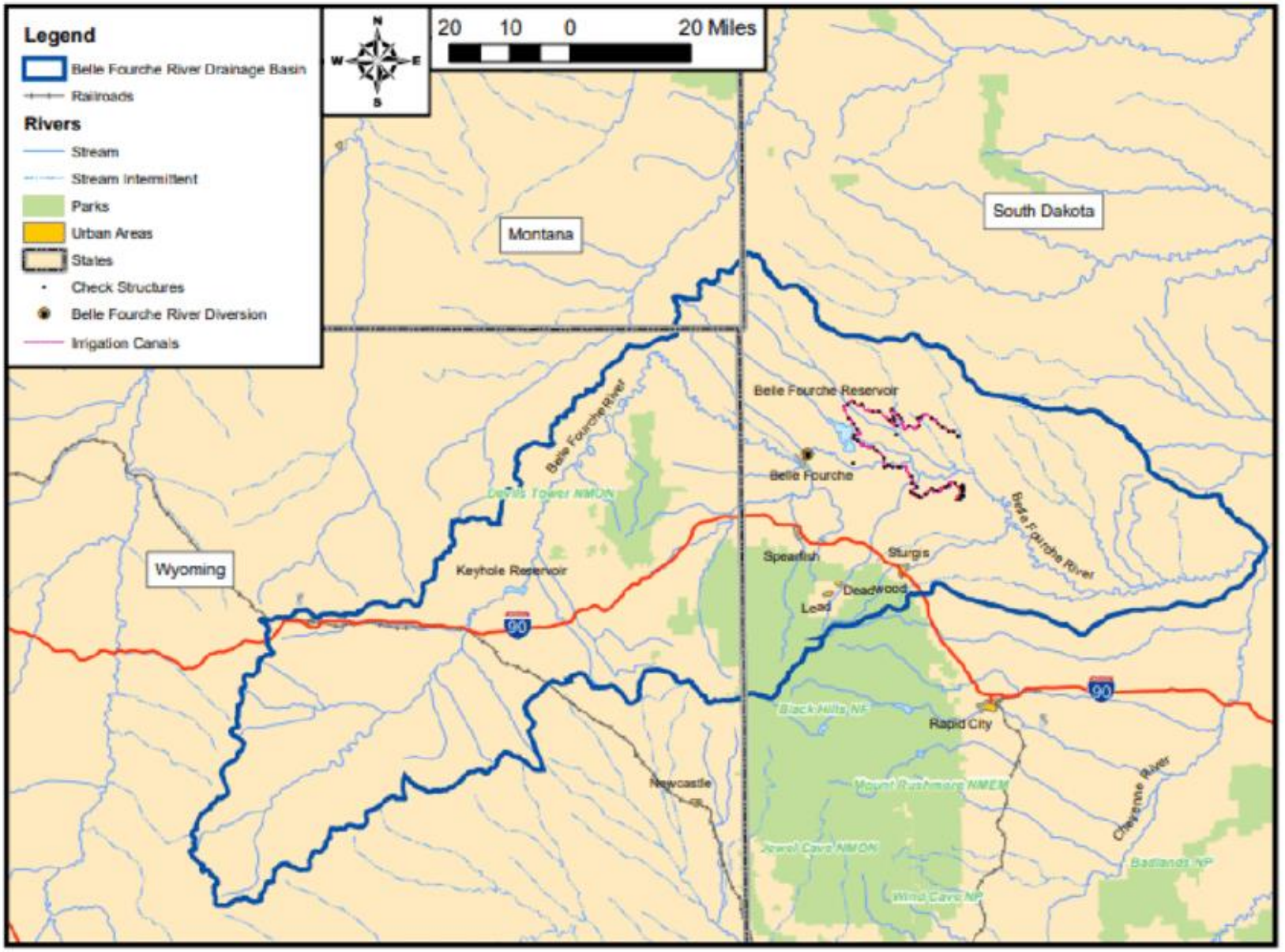
Her international work includes projects in Russia (training and starting the first nursing home services), China (teaching graduate students western post-acute services and western inpatient rehabilitation); volunteering with an orphanage clinic in Bolivia; teaching physicians outpatient surgery operations (National Health Services, England); training on Home Health (European Health Conference, Spain); presentations on Chinese Health in a Poster Session and a Free Theme Session at the 36th World Hospital Congress (Brazil); and study projects in Italy, Cuba, and Canada.

Resources

At the end of this presentation there will be more detailed information on some of the topics brought up during the presentation. Each might be a training session by itself, but this will provide baseline ideas.

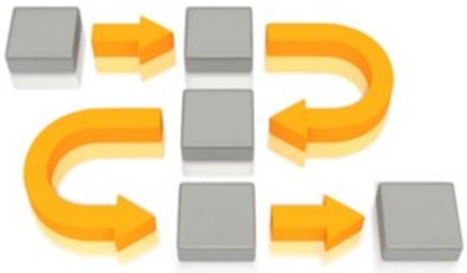
Learning Objectives

1. Initiate a review of SWB regulations including current survey requirements
2. Provide current sources for State and Federal surveys, including Federal laws, SOM Appendix PP and W, and Ombudsman requirements
3. Provide review materials for Swing Bed internal training opportunities


Legend
Belle Fourche River Drainage Basin
Railroads
Rivers
Stream
Stream Intermittent
Parks
Urban Areas
States
Check Structures
Belle Fourche River Diversion
Irrigation Canals
N
W
E
S
20 10 0 20 Miles
Montana
South Dakota
Wyoming
Belle Fourche Reservoir
Belle Fourche River
Belle Fourche
Devils Tower NMON
Keyhole Reservoir
Spearfish
Sturgis
Deadwood
Lead
Black Hills NF
Rapid City
Mount Rushmore NMEM
Jewel Cave NMON
Wind Cave NP
Badlands NP
Cheyenne River
Newcastle
90

The lowest point in Wyoming is 3,125 feet and is near the northeast corner where the Belle Fourche River crosses the state line from South Dakota

Identify the design of SWB Programs



- A swing bed is a physical hospital bed that can be used for two purposes – acute and post-acute care
  - The purpose is to provide quality post-acute care in rural communities
- Benefits
  - Fills empty rural acute beds
  - Provides new revenue opportunity
  - Reduces readmission rates
  - Allows time for the “next” services

Know Medicare Intent

CAH swing bed programs need to understand the reason behind the initiation of swing beds and the reliance on understanding skilled nursing regulations to operate and successfully financially manage the program

Swing Bed programs need to center around Medicare-required documentation and management decisions on programming: Long-COVID? CHF and COPD? Clinically Complex?

Review and Update

- 1350 CAHs and 88% with SWB
- CAHs do not complete MDS
- Reimbursed at a hospital per diem making it an important revenue source -- Not RUGs
- Who reviews SOM W? PP?
  - Transmittals for PP
  - Tag crosswalk 1600s
  - CMS policy and memos to state
  - March 2019 immediate jeopardy

Know Medicare Intent (PPS/SNF)

- Your planning (and ongoing evaluation) includes
  - Identifying the strengths of the current program
  - Understand future patient populations
  - Connecting multiple health services before, through, and beyond swing beds
- Planning should also be specific to key (and oft repeated) concerns of CMS
  - Understand skilled nursing and compliance – what are key elements that must be met in your swing bed program?
  - Example: Reducing unnecessary medications, scheduling gradual dose reductions, and working with hospitalists and PCPs to review meds

Your “Design”

- Basics
  - Provide opportunity to free up acute beds at your hospital
  - Build relationships with SNF/LTC – admissions criteria for patients they won’t/can’t take
  - Educate your physicians on benefits and opportunity for continued physician reimbursement
- Advanced
  - Determine specialty (COVID-19) – train staff, “market” skill sets, keep nursing (better nurse ratios)
  - Referrals from multi-counties, multi-states
  - Program: Cancer, Bariatric, Wound Care, etc.

Your “Patient Care”

- Specialists in town or by telehealth
- Certified (wound care, etc.) staff
- Data – outcomes, ICD-10 primary list, quality measures
- Special services: Med Rec
  - Pharmacy reviews total meds, alternative meds, cost savings to patient, reducing mistakes (Beers List)
  - Confirm medical necessity of a skilled stay/acuity
- Patient Choice
  - IDT, Family support, plans post SWB stay

Your "Uniqueness"

- Brookings, Brookings, SD
  - Services: Recovery from a stroke or accident; Pain management issues; Wounds that require special care; Physical, Occupational, and Speech therapy needs after a prolonged illness or major surgery
- Other Ideas:
  - Bariatric care – insurance will pay at contracted rate
  - Cardiac rehab – the program IN BETWEEN acute and outpatient cardiac rehab
  - Cancer care – Correlation between functional status and survival for cancer patients (limited mobility, extensive acute stays)

Your "Marketing"

- Truth is . . .
  - Rural areas have more chronic disease
  - Outmigration of younger Americans (Long-COVID)
  - Patient satisfaction is measurable
  - Tracking data should be required: ADC, ALOS by diagnosis, top 10 admitting diagnoses, readmission rates, discharge disposition

- "Patients stay in a private hospital room, wear their own clothing and are encouraged to participate in a variety of recreational and social activities." *Mariners Hospital, Tavernier, Fl*

Your “Market”

1. What makes you stand out?
2. Does it help recruiting nurses, therapists, RTs, physicians?
3. Routine vs. extraordinary
4. “Name” recognition

Your “Resources”

- Medicare Benefit Policy Manual
  - 3-Day Prior Hospitalization
  - 30-day Transfer
  - Medical Appropriateness Exception (Medical Predictability) – inappropriate for immediate care/needs care within “predeterminable” time period
  - Documentation to Support Skilled Care Determinations
  - Direct Skilled Nursing Services: *Nursing services are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse.*
  - Practical Matter
  - Physician Cert

Should Be Preaching to the Choir

- Are you reviewing documentation to support the need for 24-hour head in the bed care?
- Do you have a clear discharge plan?
- Does your IDT meet at least once every 7 days for each patient (and at least once before discharge)?
- Does your team do med recs? Understand the home situation?
- Self-audit BEFORE submitting a claim?

The highest point is Gannett Peak at 13,785 feet, which is part of the Wind River Range in the west-central portion of the state

Recognize ways to study the need for changing the program

- Is your swing bed program considered a service line?
- Do you review patient outcomes?
- Minimum number of admissions for a financially viable program?
- Geographic area of admissions base
- What percentage of discharges go to another “bed”? (SNF, LTC, Psych, IRF, LTAC)
- How do you evaluate success and program benefits?

Regulatory Changes

- November 2017 LTC Revisions/SOM Appendix PP
- October 2018 SWB Revisions/SOM Appendix W
- November 2019 SWB Revisions/Federal Register
- February 2020 SWB Revisions/SOM Appendix W
- February 2023 SWB Revisions/SOM Appendix PP

CAH SWB Requirements

- 2018 rewrote COP for CAHs
  - CMS changed regulations in Appendix W (in red)
  - Changed PP
    - Guidelines and survey procedure
    - Long Term are manual
    - SWB originally in LTC manual
- Survey TAGs: form 288

Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Regulations and Interpretive Guidelines for CAHs

§485.601 Basis and Scope
§485.603 Rural Health Network
§485.604 Personnel Qualifications
§485.606 Designation and Certification of CAHs
§485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations
§485.610 Condition of Participation: Status and Location
§485.612 Condition of Participation: Compliance With CAH Requirements at the Time of Application
§485.616 Condition of Participation: Agreements
§485.618 Condition of Participation: Emergency Services
§485.620 Condition of Participation: Number of Beds and Length of Stay
§485.623 Condition of Participation: Physical Plant and Environment
§485.625 Condition of Participation: Emergency Preparedness

Changes Nov 29, 2019

- Trauma Informed Care and Culturally Competent Care *(actually began in 2018 for Swing Beds and November for SNFs)*
- Dental Care – address emergent dental care under existing COPs and have P&P
- Activities – if patient stays a longer period of time expected but not required but "basics" for short stays
- Social Worker – section removed for licensed personnel, but services still needed
- Contact Ombudsman for discharges

CAH Swing Beds

42 CFR § 485.645 - Special requirements for CAH providers of long-term care services ("swing-beds")

- Conditions of Participation include:
  - Culturally-Competent and Trauma-Informed Plan of Care (C-0388): The CoPs require that residents who are trauma survivors must receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
  - The first step, of course, is to identify if trauma has occurred, which should be incorporated as part of the comprehensive assessment. The information from the assessment can then be utilized, in consultation with the resident, to develop an individualized plan of care.

- WHAT IS INCLUDED IN ASSESSMENTS? WHAT DOES YOUR POC COVER? IS YOUR STAFF TRAINED AND BEEN ASSISTED?

DATE	ADDITION/CHANGE/NEW	REGULATION
10/18	Clarified/New	Resident Choice of Physician / How to Contact Physicians / Providers
10/18	New	Timelines for Reporting Abuse
10/18	Clarified	Incorporate Pre-Admission Screening and Resident Review (PASRR) into POC/documenting rational for completion
10/18	Clarified/New	New/Changed Language added to POC regulatory requirements
10/18	New	Required Culturally Competent and Trauma Informed Care (TIC)
10/18	New	Medication Reconciliation at Discharge
10/18	New	Transfer and Discharge process/information at discharge provided to new post-acute care provider and Ombudsman
11/19 and 02/20	New	Choice of post-acute care provider and provision of resource and quality data
02/20	New	Routine and 24-hour dental care SWB/Hospital policy for loss or damage of dentures as facility responsibility

Pandemic waivers not on list but now reversed

Surveyor Exhibit 288 Crosswalk

GAPS: some things in the worksheet that were old SWB regs and some still being assessed and tag numbers that don't exist

SURVEYOR WORKSHEET FOR SWING-BEDS

Medicare Provider Number	Vendor Number	Facility Name and Address
		_____ _____ _____ _____ _____ STATE ZIP CODE
Survey Date (A1)		
Type of Survey (circle) /___/ Initial /___/ Complaint /___/ Recertification /___/ Sample Validation /___/ Follow-up /___/ Other		
Surveyor / Title		Surveyor / Title
Surveyor / Title		Surveyor / Title
Surveyor / Title		Surveyor / Title
Survey Team Composition (A2 Indicate the Number of Surveyors According to Discipline) /___/ A. Administrator /___/ B. Nurse /___/ C. Dietician /___/ D. Pharmacist /___/ E. Records Administrator /___/ F. Social Worker /___/ G. Qualified Mental Retardation Professional A3 Indicate the Total Number of Surveyors On-Site:_____		/___/ H. Life Safety Code Specialist /___/ I. Laboratorian /___/ J. Sanitarian /___/ K. Therapist /___/ L. Physician /___/ M. Psychologist /___/ N. Other

Survey Targets

- Trauma Informed Care
- Infection Control and Prevention
- Comprehensive Care Plans and IDT
- Emergency Preparedness *(specific to skilled)*
- Behavioral Health (COVID)

REVIEW and review again – policies, training (documented), chart audits, emergency readiness

Ombudsman

- A discharge notice must be in writing and in a language and manner you understand. It must include:
  - The reason for the discharge
  - The proposed effective date
  - The location to which you will be discharged
  - Information on your rights to appeal the discharge and have an administrative hearing,
  - Contact information for the Long-Term Care Ombudsman

IDT

- Required once every 7 days or at least once before D/C
- Team Membership: Care is planned by an interdisciplinary team representing all appropriate health care professionals.
- Core Members:
  - **Attending Physician**
  - **RN with responsibility for patient**
  - **CNA**
  - **Dietary**
  - **Resident/patient and/or Patient Representative**
  - Case Management
  - Therapy (PT, OT, ST)
  - Respiratory Therapy
  - Social Services/Discharge Planning
  - Pharmacy

MDS

Not required for CAH swing beds BUT the basis for State/Federal surveys – train SWB staff to key components

1. Last time the SWB had emergency preparedness training and testing?
2. Required training on TIC – and how often repeated?
3. IDT – is everyone IN THE ROOM?
4. Infection control/prevention – specific to SWB/Skilled?

MDS

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission

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 Conditions**
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**

I0020B. ICD Code

☐☐☐☐☐☐☐☐

Section I -- 13

— Code 01, Stroke, if the resident'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 resident'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 resident'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 resident'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.

Section I -- 13

— Code 04, Non-Traumatic Spinal Cord Dysfunction, if the resident'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 resident'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 resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

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

Section I -- 13

— Code 08, Amputation, if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.

— Code 09, Hip and Knee Replacement, if the resident'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 resident'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 resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

Section I -- 13

— Code 12, Debility, Cardiorespiratory Conditions, if the resident'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 resident'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.

Discharge Planning

- Discharge planning requirements include facilities assisting patients, their families, or the patient's representative in selecting a PAC service relevant to what the patient has stated as "goals of care"
- Requirement to send necessary medical information to the receiving facility or PAC setting INCLUDING to the physician responsible for the patient after discharged from Swing Bed
- Hospitals must ensure and support patients' rights to access their medical records in the form and format requested by the patient.
- Policy? Process? Outcomes?

If I Were to Ask You . . .

1. Where would you find your Admissions Criteria? When was the last time it was reviewed?
2. Where would you find a MSP? Why is it important?
3. Is the first Physician Cert in admission orders and the second one in the chart? If yes, who audits to make sure the second one signed and dated timely?
4. All signatures for IDT signed/dated at the end of the meeting? Is the patient/patient rep involved?

Additional Examples:

- When was your last financial audit?
- When was your last state survey? (can be completed by TJC)
- Therapy services most audited SNF/SWB service – team training on documentation specific to CAH swing beds? Discharging on the same "date"? Discharging to SNFs?
- Does your IDT meet WITH the physician present? Bedside so patient/patient family can be involved?
- Without the MDS, how are you measuring therapy goals at admission and at discharge? Is progress clearly defined? What were the patient goals – and are they "met"?

IDT is mandated in federal regulations, so reviews include medical necessity for this level of care, discharge planning from admission and involvement of the Ombudsman, compliance, education for patient/family, and constant review of clinical/financial program goals.

What do you need to audit?

1.
2.
3.
4.
5.

Team Coordination

From clinical documentation to coding (MDS!) to billing, how many ways can the claim not reflect the correct CAH payment?

1.

2.

3.

Review

- Rehab Services Requirements
  - Optional CAH services
  - Provided by staff qualified under state regulations AND consistent with requirements for therapy services (409.17)
  - Provided in accordance with national standards of practice (APTA, AOTA, American Speech-Language-Hearing Association)
  - MUST HAVE rehab P& on site consistent with state law
- Med Administration, Med Monitoring training, P&P

Survey Deficiencies

- Failure to inform patients of their rights orally and in writing
- Failure to inform non-English speaking patients of their rights in a language they can understand
- Failure to allow patients to get copies of their own medical records
- Failure to provide interpreters so a patient can understand their condition
- No policy to advise patient on difference between inpatient and observation status.
- Really no restraints although regulation says without an order and an assessment – failure to follow restraint policy (including siderails)
    - Restraint orders were written prn
    - Policy for restraint not appropriate and allow for a trial application (not permitted)
    - No monitoring of patients in restraints
    - Did not have a plan of care
- Nursing Staff unaware of specific rights for SWB patients
- Failure to provide medically appropriate social services
    - No documentation to show what social services should be provided
    - Person doing social services was not licensed and background not appropriate to do the job
- No comprehensive POC and physician not involved in process
    - No comprehensive assessment done
    - No information on smoking while a patient
- Failure to do a discharge summary

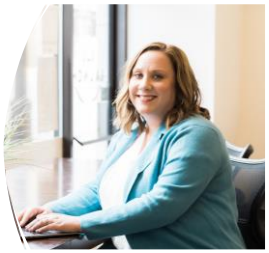
SWB Basics/Appendix W and PP

- Medicare patients need a qualifying IP stay of 3 days
- Patient must be admitted to a SWB within 30 days of discharge from the acute stay
- Patient must have Part A with benefit days
- Must be medially necessary/meet the criteria AND your Admissions Policy
- Timely POC (culturally competent and trauma informed plan of care with changes, clarifications, etc.)
- Dental care changes and clarification
- Nutrition needs clarified and documented

Information to Provide

- Choice of Physician
- List of attending physician who are treating the patient
- Rights and Responsibilities
- Contact info for ombudsman, etc.
- Description of SWB requirements
- Financial obligations
- HIPPAA notice of private practices
- Transfer Policy/Discharge Policy
- How to report abuse/neglect

Contact Information for the Burrows Consulting Team:



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Next Webinar

Thursday, April 27th at 1:00 p.m. MT

- **Snake River: Long Winding Road to Current Survey and Audit Issues**
  - State and Federal surveys are on the uptick timing with the ending of many COVID PHE regulations.
  - Topics Included: Trauma Informed Care, Cultural Competence, Staffing, Plan of Care, Physician Certification
    Audience: SWB leadership, Nursing, Therapy, Social Services, Key Nursing personnel, Compliance

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