SKILLED NURSING FACILITY

DO THIS DON'T DO THAT

Jessica Wright, PA-C

OHSU Inpatient Geriatrics Consult Service

17th Annual NW Regional Hospitalist Medicine Conference

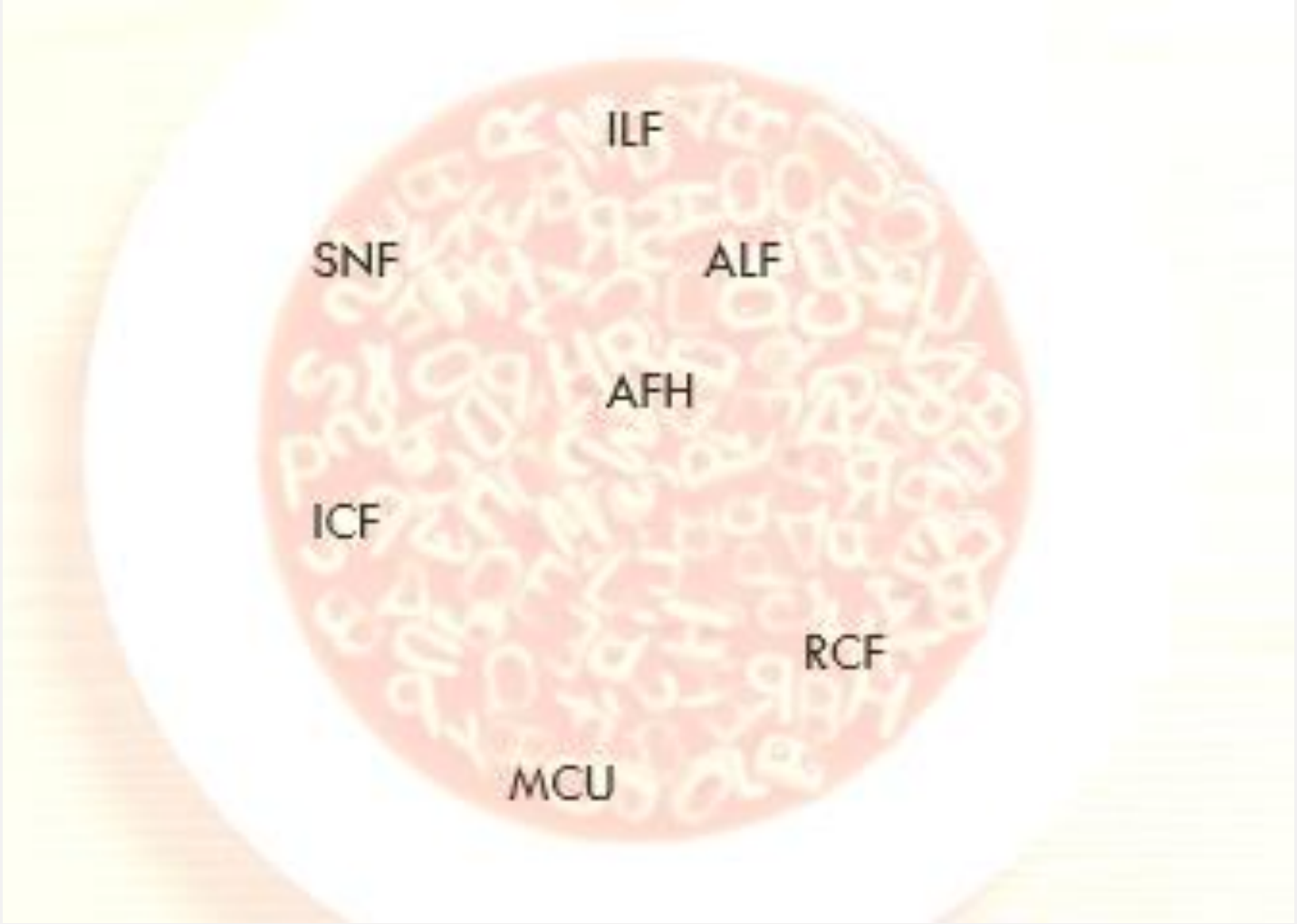
Disclosures

- No conflicts to disclose
- Images are for educational purposes only

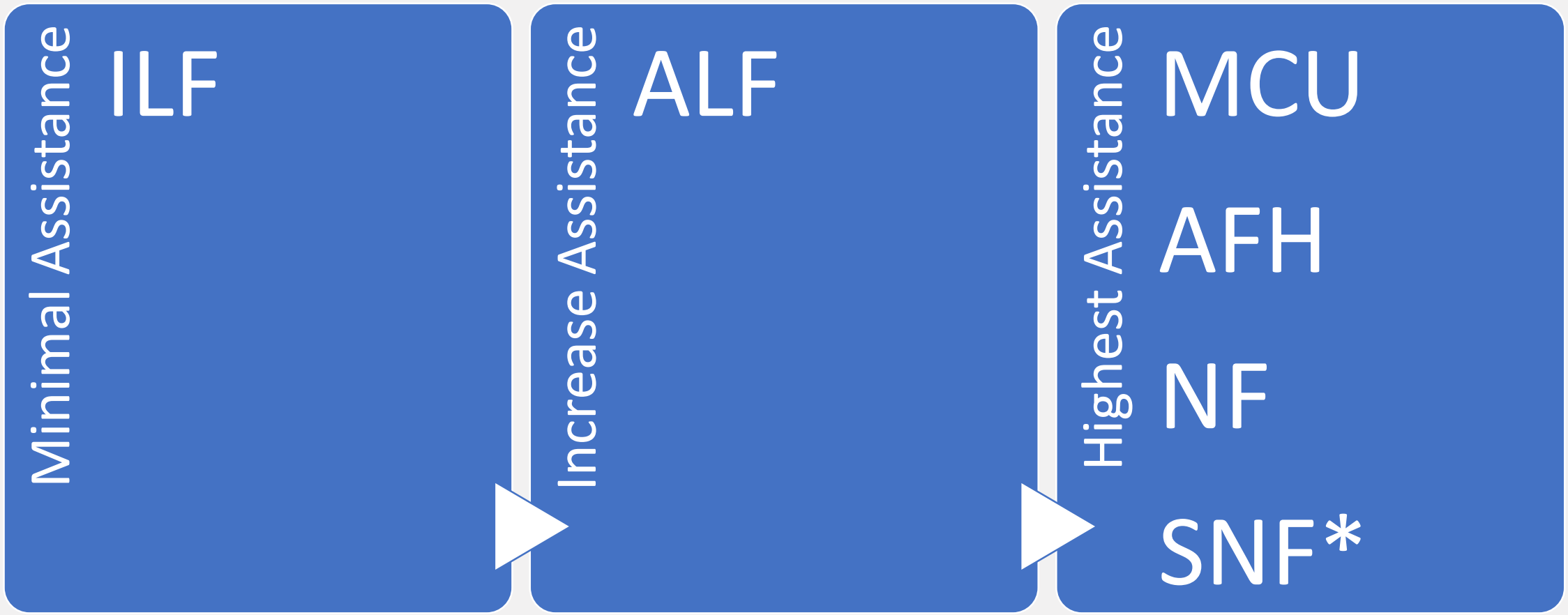
OBJECTIVES

- Review various levels of care
- Discuss criteria for SNF stay and Medicare coverage
- Understand staffing constraints and regulations affecting skilled nursing facilities
- Discuss who may or may not be an ideal SNF candidate
- Discuss some insider DO THIS and DON'T DO THATs to make SNF transitions more successful

ALF-A-BET SOUP



Levels of Care



How often and where?

Chart 6-18. Discharge destination of Medicare fee-for-service beneficiaries served in acute care hospitals, 2006–2015

Destination	2006	2014	2015	Percentage Point change 2006–2015
Home self-care	52.3%	46.0%	45.5%	–6.8
Skilled nursing or swing bed	18.8	21.0	21.2	2.4
Home with organized home health care	13.8	16.8	16.9	3.1
Inpatient rehabilitation facility	3.4	3.8	3.9	0.5
Died in hospital	3.8	3.3	3.3	–0.5
Hospice	1.6	2.9	3.0	1.4
Transferred to other acute care hospital	2.5	2.2	2.1	–0.4
Other setting (e.g., ICF, nursing facility)	2.0	1.6	1.6	–0.4
Long-term care hospital	0.9	1.2	1.2	0.3
Left against medical advice	0.6	0.8	0.8	0.2
Inpatient psychiatric facility	0.4	0.5	0.4	0.0

What Qualifies as SNF Level of Care

- Management and Evaluation of a care plan
- Observation and Assessment of a condition(s)
- Teaching and Training
- Direct skilled nursing services
- Direct skilled therapy services (PT, OT, or SLP)

Medicare Coverage

- When and how long does Medicare cover care in a skilled nursing facility?
  - Up to 100 days per benefit period
  - Benefit period ‘resets’ after 60 days out of SNF and hospital
- How much is covered by the Original Medicare Plan?

For Days	Medicare Pays For Covered Services	You Pay For Covered Services
1–20	Full Cost	Nothing
21–100	All but a daily copayment*	A daily copayment*
Beyond 100	Nothing	Full Cost

Daily Copayment: $194.50

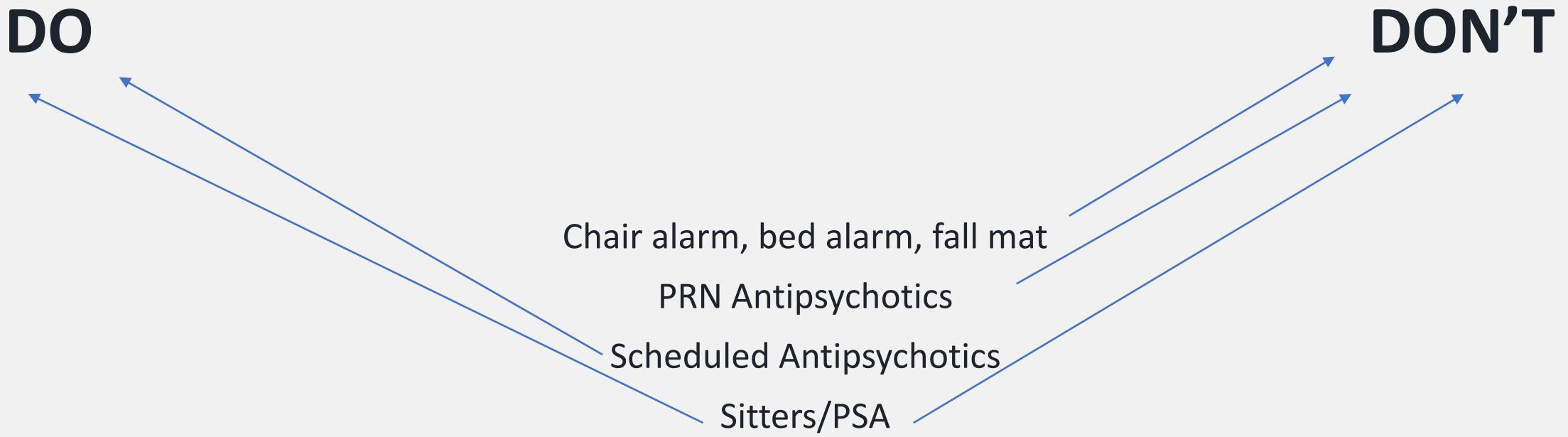
SNF Staffing

DO

- Be aware that the only requirement for nursing is to have **8 hours of RN coverage in every 24 hour period** for each patient
- Know that most of the direct nursing care is done by LPNs
- Know that most of the direct nursing care is spent in med pass
- Know that **CNA ratios** are set by the State. In Oregon it is **7:1** on day shift, **9.5:1** on eves, and **17:1** on night shift

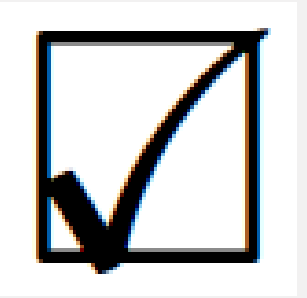
DON'T

Regulatory Considerations



In general, SNFs cannot do physical restraints (even chair/bed alarm, fall matts, bed rails) or chemical restraints. Antipsychotics can be used for mood disorders or psychiatric conditions and cannot be used PRN. Patients have to be off of IV antipsychotics and PSA/video monitor prior to discharge.

House Provider to Follow



- For a census of 75 patients, the Medical Director (aka house provider) might be following about 75% (55 patients)
- A physician is required to see a patient **within 30 days of admit to a SNF**
- Variable on site coverage
- A typical rounds list for the Medical Director can be from 12 to 20 patients. So not every patient is seen each time the MD is in the building.
- After initial visit has occurred they may be put on the rounds list to be seen by the nursing staff, by patient or family request, or by the provider's request as a follow-up. Medicare requires that they be seen by a medical provider once every 30 days during SNF admission

House Provider to Follow

- DON’T assume that a tenuously stable condition will automatically get close monitoring
- DO set up the house provider for success by writing predictive orders at discharge
  - Scheduled lab draws
  - Stop dates
  - Weight-triggered PRN dosing for Lasix
  - Voiding trial orders
  - Medication taper schedule

- DO Consider a patient’s mobility for outpatient follow-up
  - Cost of transportation
  - Activity tolerance
- DO pick up the telephone to provide a warm hand off

Regulatory Considerations for Orders

Stumptown Skilled Nursing Facility

Your patient Duchess Moe has not had a bowel movement in 3 days, would you like to order house bowel protocol?

Yes ☐ No ☐

Regulatory Considerations for Orders

DON'T

- Orders cannot be written in a range
- Medication orders that are incomplete cannot be followed

DO

- Can use a pain scale to write for a range
  - Oxycodone 2.5 mg every four hours as needed for pain scale of 1-4. Oxycodone 5 mg every four hours as needed for pain scale of 5-10.
- Order needs med, dosage, route of administration otherwise it will not get administered. Technically also need an indication for the medication

Regulatory Considerations for Orders

DON'T

- Schedule II medications cannot be dispensed with incomplete information or without a hard copy prescription
- PRN pain medications cannot be offered by offered by SNF nursing staff
- Gabapentin and Pregabalin. Don't try to make sense out of the fact that some SNFs require paper Rx.

DO

- Remember to include DEA #, quantity and indication on your prescription. Cannot include refills so consider dispensing a sufficient quantity
- Unlike the hospital, PRN pain medications cannot be offered to patients. If you have a patient that is unlikely to advocate for themselves, consider writing for scheduled medications
- Err on the side of caution and write a hard copy prescription for questionable pain medications

SNifF Potpourri

CPAP	DO: Skilled nursing facilities do allow CPAP/BiPAP
	DON'T: SNFs do not allow auto-titrate settings. Need to specify home settings on discharge orders.
Oxygen	DO: SNFs do have oxygen concentrators
	DON'T: SNFs do not automatically titrate oxygen. Consider writing titration orders for oxygen or putting in custom oxygen goals for COPD patients
Imaging	DO: SNFs do have EKG and mobile imaging available
	DON'T: SNFs don't usually have echo and obtaining U/S to rule out DVT can sometimes be a struggle
Labs	DO: SNFs do have lab capability
	DON'T: SNFs don't usually have lab processing more than once daily

SNifF Potpourri

Medication Reconciliation	DO: SNFs do provide medication reconciliation and education to patients regarding new medications
	DON'T: SNFs don't always make an effort to resume home medications at discharge. Consider writing for home DM medications, inhalers, etc at hospital discharge rather than assuming the SNF will resume them at discharge
Medical Records	DO: SNFs usually have read only access for EPIC
	DON'T: House Providers don't always have Epic access. It is sometimes accessed by an admit nurse and they deem what info is critical for the house provider to know.

Ideal SNF Candidate?

Sharon P

- 83 y.o. female, lives in private home with 14 stairs leading into the house. Independent with ADLs and iADLs. Maintains frequent contact with her children who live outside of the area.
- Admitted to hospital after a ground level fall resulting in a small SAH. Non-displaced left humerus fracture and left 8th and 9th rib fractures
- Hospital course complicated by difficulties with pain control and delirium
- All medical issues stabilized, including delirium but she is now requiring a walker for ambulation.

Ideal SNF Candidate?

Norma J

- 88 yo female who lives at a local memory care unit. Her only medical issues are moderate to severe dementia, osteoporosis and essential hypertension.
- Norma was sent to the hospital for worsening confusion and was found to have a UTI.
- Hospitalization was prolonged due to struggles with anxiety and restlessness. Had a VMT for a good portion of her stay due to impulsivity with mobility. Transitioned to a bed alarm.
- Worked with PT and felt to be below her baseline and at risk for falls. They are recommending SNF.

Ideal SNF Candidate?

Frank M

- 87 y.o. male, lives in ALF. Cognitively is sharp but needs assistance with medication management and ADLs.
- Has had a difficult last 12 months with 3 hospitalizations for CHF, Acute encephalopathy secondary to acute dehydration, and now a pelvic fracture secondary to a ground level fall.
- His family is asking you about the process of applying for Medicaid as he is reaching the end of his savings.
- Joe’s medical issues have stabilized and we are able to control his pain with scheduled pain medications, however, he is now ambulating with a walker and is a one person assist.

Ideal SNF Candidate?

PERSPECTIVE

REHABBED TO DEATH

Rehabbed to Death

Lynn A. Flint, M.D., Daniel J. David, R.N., Ph.D., and Alexander K. Smith, M.D., M.P.H.

Flint, et al. n engl j med 380;5 nejm.org January 31, 2019

Goals of Care

DO ask yourself, “do I think this person is nearing end of life?” and consider if SNF is in this person’s best interest.

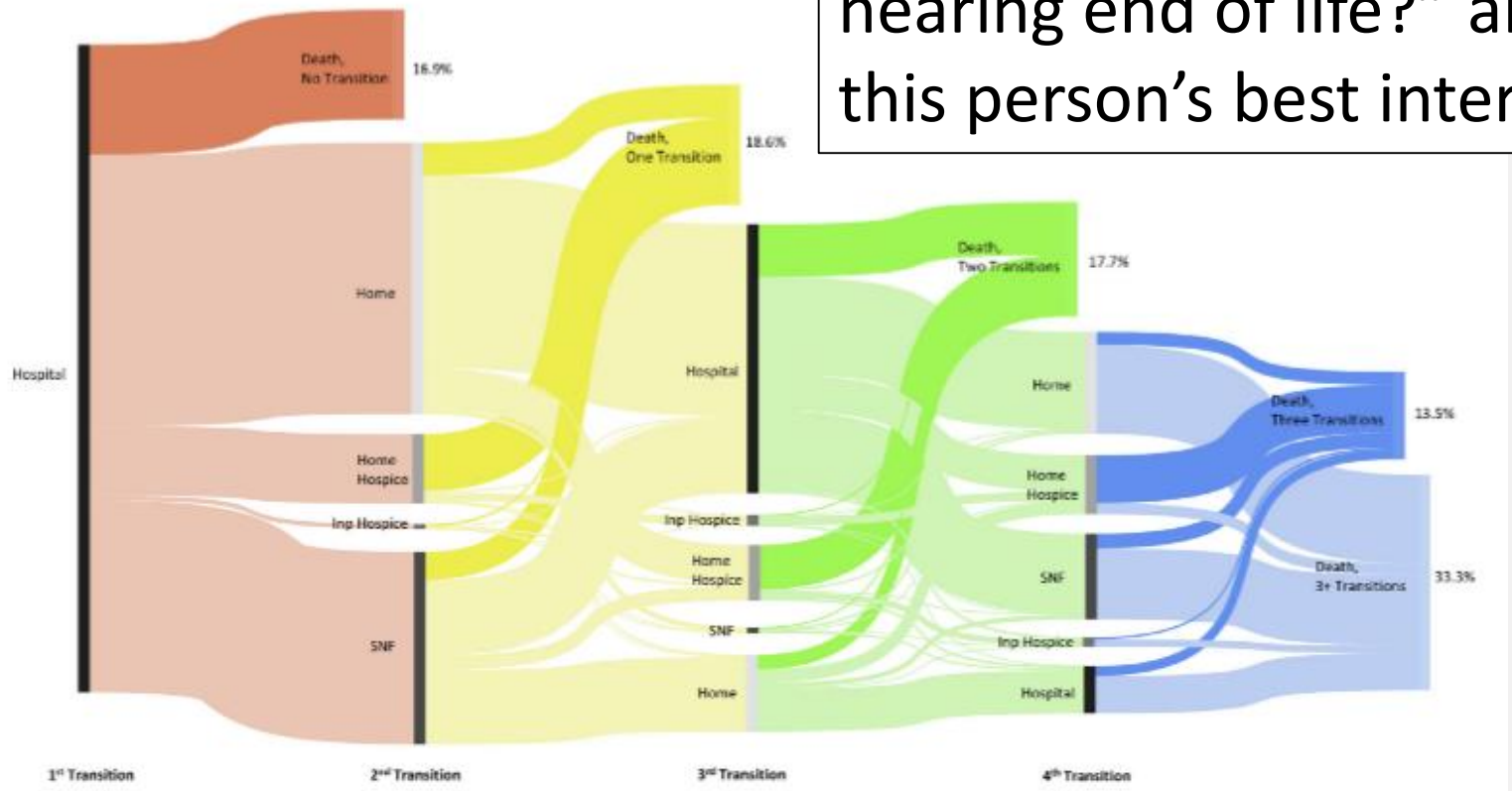
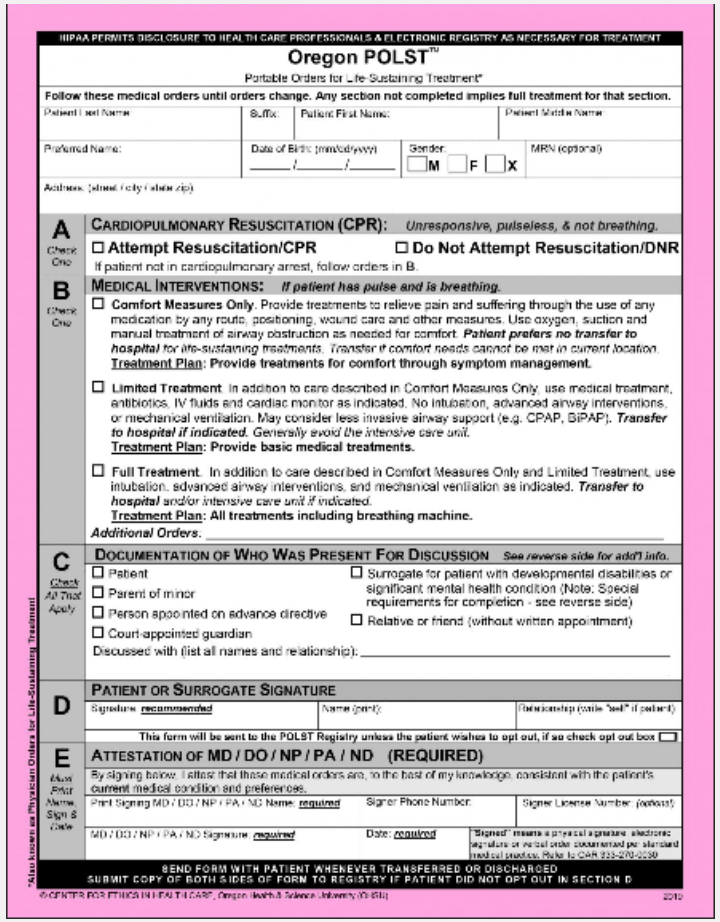


Figure 1. Sequence of care transitions after first hospitalization in the last 6 months of life as seen in Medicare claims in the United States. This figure does not include 19.5% of Medicare decedents who do not have a hospitalization in their last 6 months of life. Inp, inpatient; SNF, skilled nursing facility.

Tools for Transition-Goals of Care Discussions



HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Oregon POLST™

Portable Orders for Life-Sustaining Treatment*

Follow these medical orders until orders change. Any section not completed implies full treatment for that section.

Patient Last Name | Suffix | Patient First Name | Patient Middle Name

Preferred Name | Date of Birth (mm/dd/yyyy) ____/____/____ | Gender: ☐M ☐F ☐X | MRN (optional)

Address (street / city / state / zip)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

If patient not in cardiopulmonary arrest, follow orders in B.

B Check One — **MEDICAL INTERVENTIONS:** *If patient has pulse and is breathing.*

☐ **Comfort Measures Only.** Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: Provide treatments for comfort through symptom management.

☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.*** *Generally avoid the intensive care unit.*
Treatment Plan: Provide basic medical treatments.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.*
Treatment Plan: All treatments including breathing machine.

Additional Orders: _____

C Check All That Apply — **DOCUMENTATION OF WHO WAS PRESENT FOR DISCUSSION** *See reverse side for add'l info.*

☐ Patient
☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion - see reverse side)
☐ Relative or friend (without written appointment)

Discussed with (list all names and relationship): _____

D — **PATIENT OR SURROGATE SIGNATURE**

Signature: **recommended** | Name (print): | Relationship (write "self" if patient)

This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐

E Print, Sign & Date — **ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)**

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

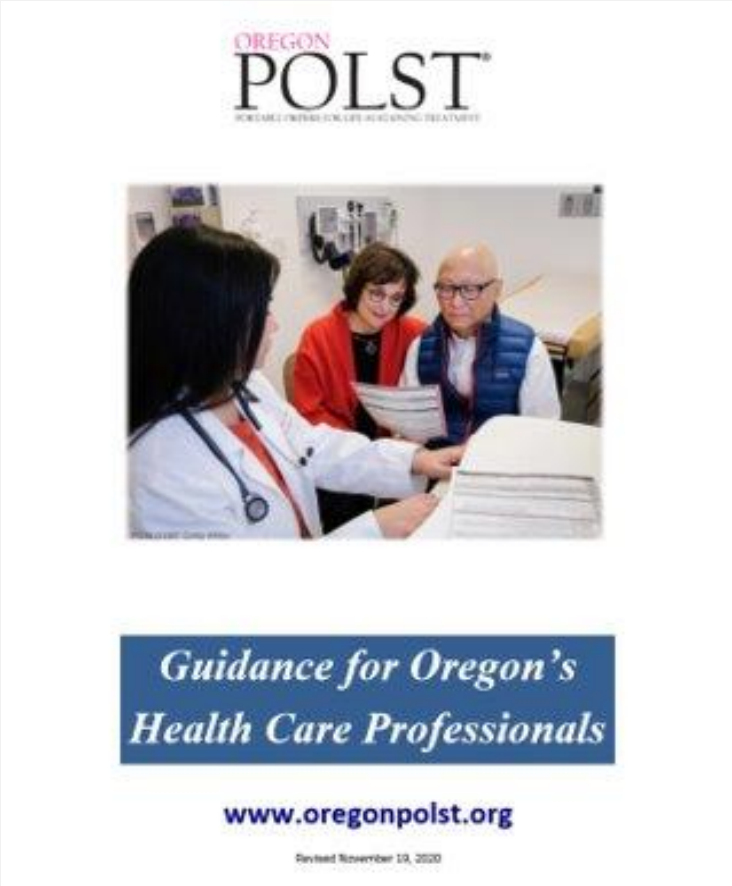
Print Signing MD / DO / NP / PA / ND Name: **required** | Signer Phone Number: | Signer License Number: (optional)

MD / DO / NP / PA / ND Signature: **required** | Date: **required** | "Signed" means a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0230

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED
SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D

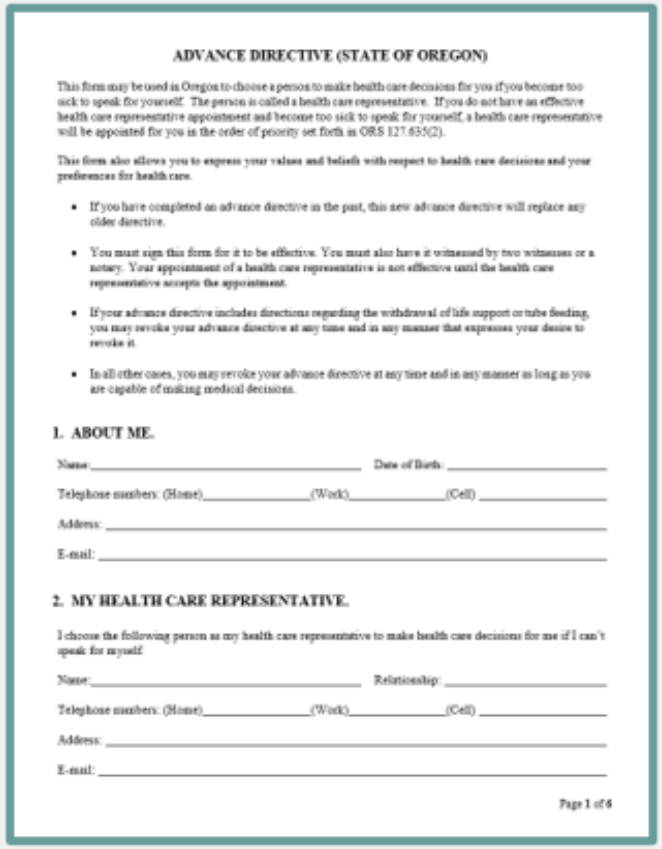
*Also known as Physician Orders for Life-Sustaining Treatment

 2019



https://oregonpolst.org/health-professionals/

Tools for Transition-Goals of Care Discussions



ADVANCE DIRECTIVE (STATE OF OREGON)

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative. If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an advance directive in the past, this new advance directive will replace any older directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.
- In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME.

Name:_____ Date of Birth: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail: _____

2. MY HEALTH CARE REPRESENTATIVE.

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name:_____ Relationship: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail: _____

Page 1 of 6

https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf

What is the difference between an Advance Directive and a POLST?

Advance Directive: a legal form	POLST: a medical order
For healthy people 18 and older.	For people with serious illness or who are older and frail and may or may not want all treatment.
It is **not** a **medical order** and it cannot be followed in an emergency.	This is a **medical order** decided by you and signed by your doctor.*
You give basic instructions about the care you would like in the future. You choose someone to make medical decisions for you, if you are not able to speak for yourself.	You state what treatments you want and do not want. Emergency and other medical staff must follow these instructions.
You can fill it out on your own.	You fill it out with your doctor or nurse practitioner.
You can change it at any time on your own.	You and your doctor can change your POLST at any time.
It is up to you to have a copy added to your medical record.	If you choose, it may be registered with the Oregon POLST Registry. This means medical staff can quickly access your POLST order in an emergency.

*Doctor or Nurse Practitioner or Physician Assistant.

https://oregonpolst.org/advance-directives

Tools for Transition-Goals of Care Discussions

Do	Don't
• Listen and let the patient do most of the talking	• Wait until death is imminent
• Break information into small chunks	• Qualify treatment as
• Check frequently for understanding	• Ask patients if they want
• Provide empathy and support	• Tell patients there is
• Emphasize what can be done	• Focus solely on preferences for procedures
• Offer your recommendation(s) based on their goals and values	• Exclude surrogate decision-makers from the discussion

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4592692/

- https://www.ariadnelabs.org/serious-illness-care/
- https://washingtonacp.org/goals-of-care-discussions-for-the-hospitalist-workshop/
- https://www.uptodate.com/contents/discussing-goals-of-care
- https://www.vitaltalk.org/clinicians/

Hospital Discharge Considerations

DO THIS

- Consider what services a patient has at baseline and what may be the best setting for your patient
- Keep in mind that SNFs are highly regulated and have strict criteria for orders
- Consider writing for scheduled pain medications for patients who may not be able to advocate for themselves
- Set your patient and house provider up for success by writing predictive orders and giving a warm hand off.
- Complete a POLST if discussions have been had about limiting care

DON'T DO THAT

- Discharge to rehab just because they qualify
- Leave out route of administration, dose and indication for medications in your orders
- Assume that a PRN medication will be administered because it is on the MAR
- Assume that a patient will be seen right away or have close monitoring for disease stability
- Leave it for the a potentially less experienced or involved person to complete it

Contact Info

- DO THIS
  - Contact me if you have any questions about SNF

Jessica Wright PA-C
Wrighjes@ohsu.edu
(503) 494-6433

Thank you to the NW Regional Hospital Medicine conference committee for inviting me to speak on this important topic.

References

- http://www.medpac.gov/docs/default-source/data-book/jun18_databookentirereport_sec.pdf
- https://www.medicare.gov/basics/costs/medicare-costs
- https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=280568
- https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=91092
- Flint, et al. n engl j med 380;5. January 2019. https://www.nejm.org/doi/full/10.1056/NEJMp1809354
- Flint, et al. JAGS, 67;11. November 2019. **https://doi.org/10.1111/jgs.16128**
- https://oregonpolst.org/health-professionals/
- https://www.oregon.gov/oha/PH/ABOUT/Pages/ADAC-Forms.aspx
- https://oregonpolst.org/advance-directives