Ensign Affiliates **SKILL IN PLACE TOOL KIT**

In this kit:

- Guidance on applying the QHS Waiver
- Guidance on applying the Spell of Illness Waiver
- A "Skill in Place Decision" guide
- A Skill In Place Workflow
- A guide to the COVID19 Demographics area in PCC
- Instructions on using the pre-scripted COVID19 Admit to Skilled Care order
- Guidance for Skill in Place for COVID19 Patients
- A respiratory assessment documentation guide

Qualifying Hospital Stay Waiver Info:

Criteria	How it Applies	Examples
Purposefully avoiding a hospital stay to ensure bed access in the community or avoid exposure to the virus.	• **Shortened Stay**: An inpatient admission of less than 3 days. *We do not require any specific documentation from the acute explaining the decision to transfer quickly to support application of the waiver.* • **Route from ER/Observation Stay**: Hospital access but not admitted as an inpatient before transferring to a SNF environment. *We do not require any specific documentation from the acute explaining the decision to transfer quickly to support application of the waiver*. • **Skill in Place:** LTC patient converted to Part A based on the decision of the IDT and Physician that a higher level of care is appropriate as an alternative to a hospital admission, or a LTC patient converted to Part A after an ER or observation stay at the acute hospital. Strong support in the record is essential in this instance. • **Skill from Home/Community**: When a patient is admitted to a SNF for a skilled level of care from the community or an unskilled stay at a different SNF.	• **Skill form home scenario**: A patient at home has several falls and stops eating/drinking. The home health team and community MD arrange an admission to your facility for labs, medication management, PT/OT/ST and nutritional oversight. • **Skill in place scenario**: A patient develops a fever, becomes lethargic, becomes significantly more dependent with ADLs and mobility. The MD elects to do multiple labs while at the SNF, makes multiple order changes, schedules follow up labs, and orders PT and OT. Additional MD visits are scheduled via telehealth and daily nursing updates.
Directly Impacted by the Emergency	• A patient who has or is suspected of having Covid19 • A patient who requires isolation/droplet precaution status, elevated monitoring and daily (or more frequent) assessment of respiratory status due to close personal exposure to an individual with Covid19 or a presumptive positive Covid19 individual. • A patient who has a *catastrophic* response to the environmental restrictions imposed by CMS	• A patient begins to show complications in multiple areas due to the prolonged facility restrictions and limited contact with family. Sx include weight loss, fatigue, resistance to care, decline in independence. The MD orders labs, aggressive nutritional support, PT and OT, a special activities care plan and close monitoring. • A patient's roommate tests positive for COVID19. The patient's roommate is moved to a new room, and the patient themselves is placed on isolation/droplet precautions and close monitoring and assessment.
Displacement/ Relocation	• A patient who has had a catastrophic response to a room/facility transfer necessitated by the emergency • A patient who gets admitted to a skilled nursing facility because their community care/services broke down due to illness or quarantine related to Covid10	• A LTC patient gets moved into a different room when the facility develops a quarantine wing. Over the next week the patient becomes progressively more confused, agitated, complains of pain more often and has multiple falls. The MD orders PT and OT, and a remote psychosocial assessment.

Note 1: A DAILY NEED for a service that can ONLY BE PERFORMED BY A LICENSED NURSE OR THERAPST must also be present for a patient to be placed/maintained on Part A status.

Note: Patients who are in any isolation status due to COVID19 or COVID19 exposure who are **asymptomatic** *must still have* detailed, daily respiratory assessments to manage their risk and demonstrate that a daily skilled need was present.

Spell of Illness Period Waiver

Criteria	How it Applies	Examples
Directly Impacted by the Emergency	• A patient who has or is suspected of having Covid19 • A patient who requires isolation/droplet precaution status, elevated monitoring and daily (or more frequent) assessment of respiratory status due to close personal exposure to an individual with Covid19 or a presumptive positive Covid19 individual. • A patient who has a *catastrophic* response to the environmental restrictions imposed by CMS and needs a daily skilled service to remediate them	• Example 1 - A SNF resident was at day 90 of the Medicare stay and was placed on observation/isolation due to Covid19+ positive roommate for a 14-day period before being cleared to be discharged home on day 105 of the SNF stay. It appears that the §1135 waiver will cover days 101-104. • Example 2 - A beneficiary was admitted to a SNF for skilled rehabilitation and on day 70 was became ill with Covid19 and could only tolerate skilled maintenance therapy. Due to the interruption, the goals for home discharge were not reached until day 110 of the stay and the beneficiary was discharged to home on day 111. It appears that the §1135 will cover days 101-110. • A patient begins to show complications in multiple areas due to the prolonged facility restrictions and limited contact with family. Sx include weight loss, fatigue, resistance to care, decline in independence. The MD orders labs, aggressive nutritional support, PT and OT, a special activities care plan and close monitoring. • A patient's roommate tests positive for COVID19. The patient's roommate is moved to a new room, and the patient themselves is placed on isolation/droplet precautions and close monitoring and assessment.
Displacement / Relocation	• A patient who has had a catastrophic response to a room/facility transfer necessitated by the emergency • A patient who gets admitted to a skilled nursing facility because their community care/services broke down due to illness or quarantine related to Covid10	• A LTC patient gets moved into a different room when the facility develops a quarantine wing. Over the next week the patient becomes progressively more confused, agitated, complains of pain more often and has multiple falls. The MD orders PT and OT, and a remote psychosocial assessment.

Notes: The CMS language is explicit that a new benefit period is made available **when the emergency** is disrupting a patient's benefit renewal period. This means that individuals who never entered a benefit renewal period because of a long term skilled need (ie, a PEG, vent, wound care, etc) **will not be eligible for the waiver even if the patient develops Covid19** because it wasn't the emergency that them from accessing a new benefit period.

However: When the disruption to a benefit renewal period is *simultaneously* impacted by an ongoing skilled need and the emergency (ie: a new PEG tube concurrent with Covid19 management that exceeds the 100 day benefit period) we believe the waiver will apply for the additional *emergency related* days and end as soon as the emergency related condition has resolved.

To Initiate a New 100 Day Benefit Period for a patient who exhausts their days and immediately converts to waiver status:

- Complete a DC from PPS MDS in PCC
- Start a new certification document
- Complete a new 5 day MDS
- Restart section GG charting, plan out BIMS/PHQ9
- A new therapy track starts (this is to align with the MDS calendar per normal practice)
- Create a new claim starting on the new day 1 with the DR occurrence code

Skill in place Decision Guide

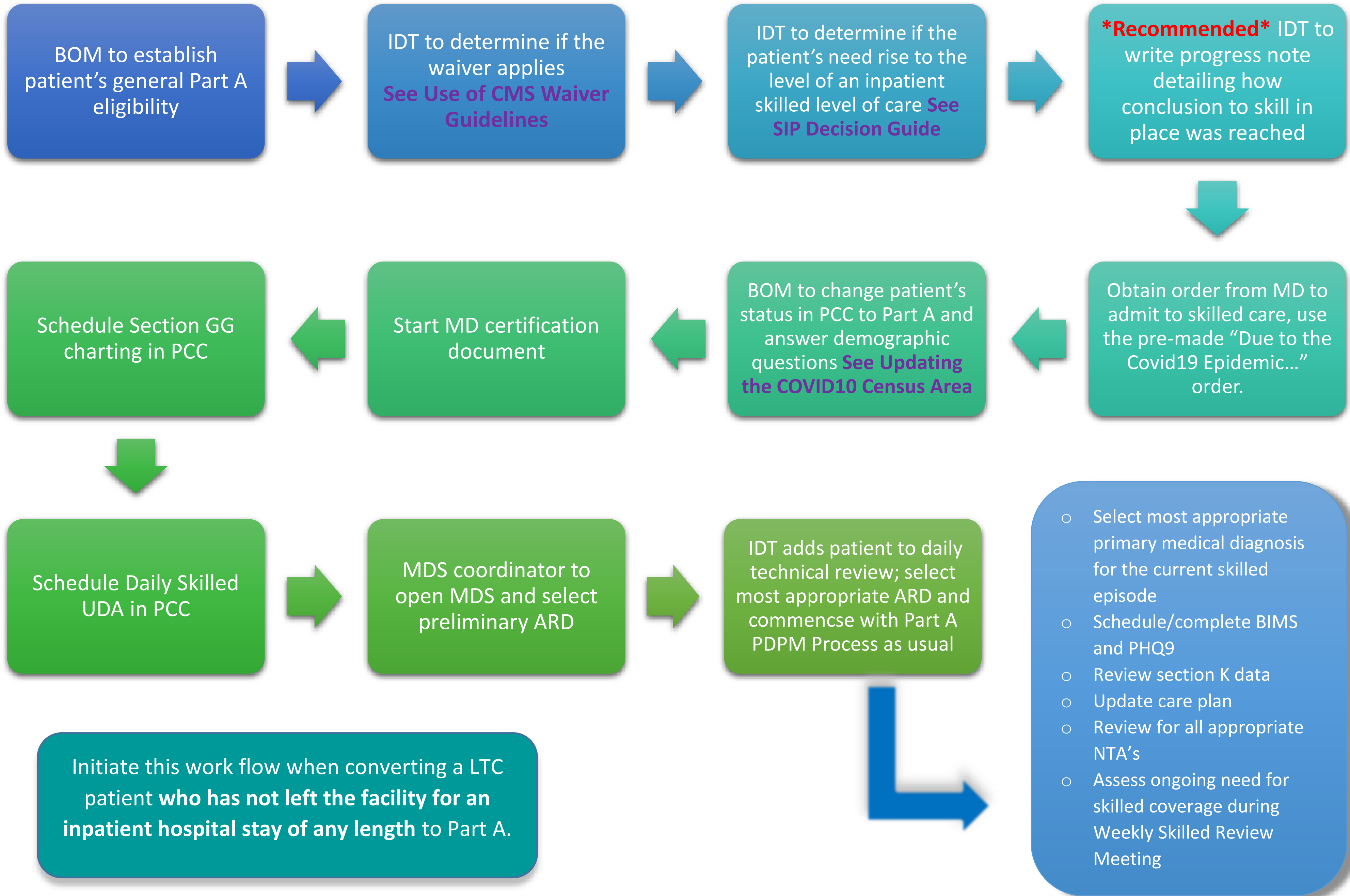
FIRST ENSURE YOU HAVE:
1- Documentation that Clearly relates the skilled need is RELATED to the emergency.
See "Applying the CMS Waivers Guidance"

2- Documentation that shows that the resident requires a higher level of care than Routine custodial care or incidental Part B services *

<table>
<tr><th>Routine Custodial or LTC SNF services- NOT Acceptable for skill in place</th><th>The Grey area- SOME RISK if skilling in place: May rise to level of Skilled level of care based on comorbidities, likelihood of complications/medical risk</th><th>High acuity Inpatient SNF services- LOW RISK for skill in place</th></tr>
<tr><td>Not Complex, easily managed in a short amount of time, STABLE
(Think ALF care)</td><td>IDT Assessment required. Consider the likely plan if the patient visited a community doctor: single visit with new meds to manage at home (is not a skilled level of care)? Or orders for diagnostic investigations, multiple therapy/specialist services and immediate plan for f/u visit with MD (is a skilled level of care).</td><td>Complex/Multiple Medical Needs, Likelihood of change in patient's condition, Risk for further COC, decompensation, UNSTABLE.
Think Hospitalization/Skilled Post-Acute SNF care</td></tr>
<tr><td>• Periodic labs for routine monitoring, Intermittent labs
• Intermittent orders/med changes to manage minor changes
• Responding to normal variations of chronic conditions that are easily managed with short-term/intermittent i nterventIons and do not require a lot of follow up.
• Therapy responding to expected progression of impairments
• Monitoring/Care planning as part of routine care</td><td>• Non-critical changes in condition
• New Illness of moderate complexity
• Exacerbation of chronic Illness
• Multiple therapies to manage a moderate decline
• Moderate frequency order changes/New medications
• Monitoring/Care planning to address change
• Changes in one or more of the following: Vitals, weight, assessment indicators (Edema, wound), mood, behaviors.</td><td>• Initiation of IV Medications
• Daily Labs, Multiple order changes new Meds
• Multiple therapies required 5x/week
• Daily complex nursing/IDT assessments for medical instability.
• Constant daily monitoring/careplan changes to address need
• Significant Complex Combination of multiple needs/changes that occur daily: Vitals, weight, abnormal labs, assessment indicators (Edema, wound), mood, behaviors, Education.
• Significant Catastrophic changes that need daily skilled attention: Change requires daily enteral feeding >26% &501cc fluid, New/worsening stage III PU or greater with daily dressing changes.</td></tr>
<tr><td>What Might this look like? Examples:
• Labs Q 3 months,
• New pain order with no other needs/ monitoring, Contacting MD for Medication needs with no
• further needs/follow up,
• Decline in ADLS easily managed with RNA, or increase in activities/Part B therapy.
• Part B Therapy for decline of resident with chronic conditions (ie: Parkinson's, MS, etc),
• Monthly, daily weekly, quarterly monitoring/charting that we do anyways.
• Single care-plan updates or single UDA assessments</td><td>Consider how many of the following are present to make a determination about a skilled level of care:
• Functional retraining (PT and/or OT)
• Cognitive retraining Speech/language retraining/Swallow therapy
• Nutritional Supplementation
• Caloric monitoring/ I/O monitoring
• Investigatory labs/imaging
• Follow up labs/imaging
• Psychosocial interventions
• Activity regimen management
• Care plan revisions
• Medication changes
• Treatment changes</td><td>What Might this look like? Examples:
• Severe infection requiring IV meds
• Complicated infection requiring: labs, order changes, monitoring
• Significant functional decline requiring multiple therapies 5x/wk.
• Complicated mood/behavior changes impacting health
• Emergence of new high acuity medical conditions ie: edema, wounds, cardiac/respiratory system changes
• Complex clinical changes including Weight loss, Frequent labs, Order changes and Need for increased communication with MD multiple times to manage.</td></tr>
</table>

Reminder: Skilling In Place must ALSO have a relation to the Emergency

Skill In Place Process Flow Chart



Updating the COVID-19 Census Area in PCC

<table>
<tr><th>Covid19 Testing Question</th><th>QHS Waiver Questions</th></tr>
<tr><td>Use for ALL PATIENTS who undergo testing regardless of payer status (Part A, Managed Care, Medicaid, Private Pay, etc):
Use for both POSITIVE and NEGATIVE tested patients.
Select Not Tested if no testing has occurred but you are answering other COVID19 census questions.
REMINDER: You may need to update this question if the initial results were still pending when you first updated the census OR a patient who was not tested when the COVID19 census area was first updated gets tested at a later time.</td><td>Use for identifying any traditional Medicare patient who did not have a 3 day qualifying hospital stay.
If a patient had an inpatient admission of less than three days, select Shortened Hospital Stay/ER Transfer
If a patient had an ER or observation stay, select Shortened Hospital Stay/ER Transfer.
If a patient who was yours previously is placed on Part A without any access to an acute hospital, select Skilled in Place.
If a patient is coming to you from any community setting or another skilled nursing facility, select Skilled from Community.
Select NA if:
The patient is skilled through a managed care payer.
The patient is not being skilled but you are answering other COVID19 census questions.
The patient had a 3day QHS and you are answering other COVID19 census questions.</td></tr>
<tr><th>Pre-Auth Waiver Question</th><th>Spell of Illness Waiver Question</th></tr>
<tr><td>Answer this question for any Managed Care plan when the patient was admitted without a pre-auth.
This includes patients that transfer from the hospital and patients who have a skill-in-place stay started.
Answer N/A for all traditional Medicare beneficiaries.</td><td>Used for identifying any traditional Medicare beneficiary who is receiving a new 100 day episode due to the emergency.
If a patient has exhausted their 100 days and the emergency is allowing us to bill a second 100 day episode select YES.
If a patient is in a Medicare Part A stay but does not have need of a new benefit period, select NO.
If a patient is not being placed into a part A stay, select NA.
REMINDER: You may need to update this question if the patient became eligible for the waiver after the initial data was entered into PCC.</td></tr>
</table>

When to use the pre-scripted COVID-19 Admit to Skilled Care order:

- When a long-term care patient is being converted to Part A without any kind of hospital access.
- When a long-term care patient is being converted to Part A after an ER visit or Observations Status hospital stay.
- When a patient is being placed on Part A from the community of from another SNF without any kind of hospital stay.

Do NOT use the order:

- When a patient has had a 3 day qualifying stay
- When a patient who was not yours previously admits after any kind of hospital access.

Skilling for Severe Respiratory Illness and Observation for Covid Exposure

Definitions:

- Confirmed Case: Individual with positive Covid19 test or confirmed dx by provider.
- Suspected for Symptoms: Individual placed in isolation or cohorted due to active respiratory symptoms and other respiratory diagnoses
- Observation for Exposure: Patient placed in isolation with close respiratory assessment due to close exposure to suspected or positive Covid19+ individual.

1. Initiate Admission to Skilled Care
   - A. 3 day Waiver Considerations
     - i. If patient has <3 day stay, but is coming from the acute, CMS QHS Waiver applies and no specific language for admission is required.
     - ii. For skill in place or skill from home patients, admit to skilled care with the "Due to Covid19 Outbreak…" order template in PCC.
     - iii. For skill in place or skill from home patients, identify the first date a daily skilled service was delivered as this is the first date of Part A episode (this will typically be the first date of isolation status for Observation for Exposure patients)
   - B. Clarify/request all necessary treatment orders for assessment, monitoring, therapy, treatments and medications
   - C. Initiate order for Isolation, specify nature of precautions (droplet, contact isolation, etc) and reason for isolation status
   - D. Initiate appropriate care plan(s), including:
     - i. COVID specific care plan available, customize to the patient's specific situation;
     - ii. Respiratory assessment care plan required, customize to patient patient's specific situation

2. Activate MDS Process
   - A. Start daily skilled documentation (activate the scheduler)
   - B. Start GG observations (activate the scheduler)
   - C. Plan out the ARD for and open MDS
   - D. Organize all technical components of covering patient for skilled services (certs, daily tech review, IDT meetings, Interview windows)
   - E. When patient is skilled for Observation for Exposure identify who will monitor daily documentation to ensure that a skilled level of assessment is being documented

3. Diagnosis Selection **Reminder that all diagnoses must confirmed with attending medical provider.**
   - **A. For CoViD19 positive cases**, **either from testing or MD confirmed diagnosis**:
     - i. For confirmed cases with ARD's **AFTER 4/1/20 code U07.1, Covid-19** in question I0020B.
     - ii. Code all additional respiratory diseases subsequently. Note that *acute* respiratory disease does not trigger the NTA for Chronic respiratory diseases.
   - B. **For suspected cases due to symptoms** or confirmed cases with ARDs prior to 4/1/20:
     - i. Code the active respiratory disease as the primary condition (I0020B):
       1. For Pneumonia as primary presentation: J12.89, Other viral pneumonia
       2. For Acute Respiratory Disease Syndrome (ARDS), code J80, Acute respiratory distress syndrome
       3. For Acute Bronchitis as primary presentation: J20.8, Acute bronchitis due to other specified organisms

4. For non-specified Bronchitis as primary presentation: J40, Bronchitis, not specified as acute or chronic
5. For unspecified respiratory infection as the primary presentation: J98.8, Other specified respiratory disorders

ii. If exposure to confirmed/suspected cases also occurred:
   1. Add Z20.828, Contact with and (suspected) exposure to other viral communicable diseases <u>if exposure **source** ultimately tests positive</u>
   2. Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out, <u>if exposure **source** ultimately tests negative</u>.

iii. If Covid+ but ARD is prior to 4/1: Code B97.29, Other coronavirus as the cause of diseases classified elsewhere

iv. **If patient eventually has a positive test or MD confirmed diagnosis, update the coding per the guidelines in section A**.

C. <u>For Isolation and Observation for Exposure</u> patients, the following coding sequence is recommended:
   i. R09.89: Other specified symptoms and signs involving the circulatory and respiratory systems (I0020B) followed by Z20.828, Contact with and (suspected) exposure to other viral communicable diseases
   ii. Ensure that any other clinical conditions that are present that are contributing to the patient's risk profile or that may have exacerbated due to the impact of isolation status are included in the diagnosis array

   Note that maintaining a skilled level of care for a patient who is generally asymptomatic but has had exposure is <u>wholly dependent</u> on the quality of the daily charting of respiratory assessments and maintenance of the isolation status.

4. <u>Concluding skilled Episode:</u>
   A. For patients with positive Covid19 test or with active respiratory illness:
      i. Conclude skilled episode when daily skilled needs have concluded, or when patient and care regimen becomes fully stable and predictable.
      ii. Issue NOMNC/SNFABN as soon as last covered day can be identified, complying with 48 hour notice for NOMNC.
   B. For Observation for Exposure patients who never become symptomatic:
      i. Conclude skilled episode once negative test is received or quarantine period is over per physician.
      ii. Issue NOMNC/SNFABN with LCD of last date of quarantine or earliest date when lab results are expected, as 48 hour NOMNC notice requirement remains. Adjust date out if lab results are delayed.

<u>Tips for Coding Isolation to the MDS:</u>

Reminder that the RAI manual has very strict coding requirements for coding isolation, including conformation of the infectious organism. Patients placed in isolation for infection control purposes due to symptoms or exposure meet the requirements for a *skilled episode,* but can only have isolation coded on the MDS if they then test positive for an infectious organism, including Covid19 or Influenza.

When placing a patient in isolation, ensure the following:

1. An MD order for the specific precautions and diagnosis have been obtained.
2. A MAR/TAR item is created for q shift confirmation that isolation is being maintained
3. The patient is in private room (or semi- private without roommate and that this is documented)
4. A care plan for the management of isolation, including plan for therapy, activities, dietary, ADL care, etc, has been developed.
5. Daily nursing UDA includes content regarding the isolation, consider adding ISOLATION to the PCC "special Instructions" area.
6. Include details of patient's condition, treatment plan, testing, and management of isolation care in the weekly IDT skilled progress notes
7. Ensure all disciplines are providing treatment and care in the room and are <u>documenting</u> the delivery of that in their assessments or notes
8. Ensure dx for the isolation is in the dx profile/ on the MDS in Section I (example CDiff)
9. Inactivate the CNA tasks for out of room activities until the precautions are DC- make sure reactivated once resident is no longer on precautions

Documenting Assessment and Monitoring for resident with
Active Respiratory Disease/Suspected Covid/Observation for Exposure:

<table>
<tr><td colspan="2">Ensure respiratory symptom/exposure to respiratory disease care plan has been developed.</td></tr>
<tr><td colspan="2">Documentation areas:</td></tr>
<tr><td colspan="2">General:</td></tr>
<tr><td>• Status of existing chronic respiratory disease or respiratory treatments
• Testing Status: +/-, testing pending, no testing indicated</td><td>• Maintenance of isolation status, precautions, procedures – develop routine mechanism for checking them (MAR/TAR recommended)
• Vital Signs: SP02%, Respiratory Rate, Blood Pressure, Temperature (with evaluation of trends from baseline)</td></tr>
<tr><td colspan="2">Psychosocial Factors:</td></tr>
<tr><td colspan="2">•General Mood
•Activities</td></tr>
<tr><td colspan="2">Appearance:</td></tr>
<tr><td>• Mental status/LOC
• Cyanosis</td><td>• Labored/Unlabored Breathing
• Fluid status (edema present?)</td></tr>
<tr><td colspan="2">Cough:</td></tr>
<tr><td>• Duration and timing (at night/During the day/ how many days?)
• Productive or non-productive
• Sputum consistency, color, odor, amount</td><td>• Description: hacking, dry, barking, hoarse, congestion, Bubbling.
• Irritants, What helps?
• Cough efficiency</td></tr>
<tr><td colspan="2">Dyspnea/SOB:</td></tr>
<tr><td colspan="2">• Severity
• Timing/Positioning
• Associated/Hx with night sweats, pollen, dust, animals, season, environment</td></tr>
<tr><td colspan="2">Pain:</td></tr>
<tr><td>Chest Discomfort:
• Initial Start/timing
• Description: (Burning, stabbing)
• Prerequisites to pain (infection, exercise, fever, illness)
• Associated meds/treatment</td><td>Sore throat</td></tr>
<tr><td colspan="2">Breathing/Respiratory status:</td></tr>
<tr><td>• Pursed-lip
• Skin color and nail beds (Free from cyanosis or pallor)
• Accessory muscles or retractions
• Irregular breathing
• Redness around the eyes</td><td>• Bilateral chest expansion
• Cough effort (Strong/Weak)
• Ability to speak: volume, vocal quality, length of utterances
• Ability to eat: presence of fatigue with eating/drinking, cough with eating/drinking</td></tr>
<tr><td colspan="2">Auscultation:</td></tr>
<tr><td colspan="2">• Clear, Equal (left to right, in all lung fields), Decreased
• Wheezing, Rhonchi, Crackles, Stridor
• Identify if sound is on inspiration or expiration or both</td></tr>
<tr><td colspan="2">Other System Changes:</td></tr>
<tr><td>• GI: Diarrhea, GI upset, Nausea
• General weakness/Fatigue, Headaches, Body Aches</td><td>• Loss of sense of smell or taste</td></tr>
<tr><td colspan="2">Physician Communication:</td></tr>
<tr><td colspan="2">• Immediate notification to MD of change of condition
• Establish communication expectations with MD for routine updates</td></tr>
</table>