Senior Whole Health
BY MOLINA HEALTHCARE

# NURSING FACILITY
## REQUEST FOR SWH REVIEW/NOTIFICATION

Facility Name:_____ SWH Nurse Care Manager:_____

Member ID:_____ Last Name:_____ First Name_____

Member Room #:_____ Facility Representative:_____

| ENHANCED LEVEL OF CARE REVIEW | OTHER REQUESTS/NOTIFICATIONS |
|---|---|
| Please complete the following form and provide all listed supporting documentation to SWH for approval of Enhanced Levels of Care. The form and documentation can be faxed or e-faxed to SWH at:<br>**Fax: (844) 834-2152** | **BED HOLD**<br>☐ Medical<br>☐ Social |
| **Event Date:**___ _____ _____<br>**Check Incident Type:**<br>☐ **Fall with witnessed head injury requiring physician notification and scheduled neuro check**<br>☐ **Suspected infectious process requiring physician notification and physician orders**<br>☐ **Changes in respiratory status requiring physician notification and physician orders**<br>☐ **Outpatient surgery requiring anesthesia**<br>☐ **Blood transfusion**<br>☐ **Other Describe**_____ | **TRANSFERS**<br>☐ Transfer to ER<br>☐ Section 12 transfer<br>**ADMISSIONS/READMISSIONS**<br>☐ Readmission from hospital<br>☐ Admission from community<br>☐ Admission to hospice<br>**DISCHARGES**<br>☐ To alternate facility<br>☐ To community<br>☐ Death<br>**Other**_____ |
| ***Please fax ALL of the following documents to ensure reimbursement for Enhanced Level Of Care.***<br>☐ *Copy of 3 days of daily nursing documentation indicating the need for skilled monitoring related to the event*<br>☐ *Copy of physician orders,* when appropriate, including diagnostic testing, antibiotic therapy, and treatments indicated for a change in respiratory status, etc.<br>☐ *Copy of related lab results*<br>☐ *Information for dates* of Enhanced Level of Care | **PLEASE REPORT ALL INCIDENTS TO SWH IMMEDIATELY.**<br>✦ **Please report all state reportable events immediately.**<br>☐ **Information requested by SWH Quality for reportable event is attached.** |

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## WHAT IS ENHANCED LEVEL OF CARE?

The purpose of "enhanced levels of care" is to reimburse nursing facilities for "treatment in place" for SWH members, when appropriate, in order to avoid unnecessary hospital admissions. In order to receive reimbursement for enhanced levels of care, the facility MUST notify SWH of the reason for treatment in place and provide all documentation to ensure that the condition is appropriate for treatment in place and that the necessary diagnostic and treatment regimens were performed. All required documentation is listed on the "SWH REQUEST AND NOTIFICATION FORM." SWH will only reimburse for enhanced levels of care back to the first of the PRIOR month in which we receive the request.

Your assigned SWH Nurse Care Manager will conduct periodic onsite chart audits. Please contact your SWH Nurse Care Manager if you have any questions.

**SUGGESTED DOCUMENTATION GUIDELINES FOR ENHANCED LEVEL OF CARE**

| CARDIOVASCULAR/CHF | PNEUMONIA | GI BLEED |
|---|---|---|
| ■ VS qs<br>■ Pulse Ox monitoring<br>■ Edema: location/severity<br>■ Nutritional status<br>■ Pain: type/severity<br>■ I&O<br>■ Labs/x-rays<br>■ Physician visit/order changes | ■ VS qs<br>■ Lung assessment: note wheezes, crackles, rhonchi<br>■ Oxygen use: constant or prn<br>■ Inhalation treatments and response<br>■ Ability to cough and deep breathe<br>■ Cyanosis or pallor<br>■ I&O for hydration status<br>■ Endurance level<br>■ Labs<br>■ Physician visit/order changes | ■ VS qs<br>■ I&O<br>■ Labs<br>■ Signs of obvious bleeding; frank blood in stool, vomit<br>■ C/O abdominal pain<br>■ Changes in mentation<br>■ Medication administered/ and resident response<br>■ Nutritional status<br>■ Physician visit/order changes |

| SEIZURE DISORDER | FRACTURE/CAST CARE | INFECTION/IV THERAPY | UTI |
|---|---|---|---|
| ■ Type of seizure activity<br>■ Time and duration of seizure activity<br>■ Neuro signs<br>■ Medications: routine and prn<br>■ Use/need for oxygen<br>■ Post seizure status<br>■ VS post seizure<br>■ Physician visit/order changes | ■ Location/type of fracture or cast<br>■ Mobility restrictions<br>■ CSM<br>■ Pain and response to treatment<br>■ Skin condition<br>■ Therapy involvement<br>■ VS daily<br>■ Safety issues<br>■ Physician visit/order changes | ■ Type and location of IV<br>■ Solution type and flow rate<br>■ Appearance of IV site<br>■ Resident response to therapy<br>■ I&O<br>■ IV medications administered<br>■ Labs<br>■ Pain and response to treatment<br>■ Nutritional status<br>■ Physician visit/order changes | ■ Voiding frequency, burning, urgency<br>■ Nausea, vomiting<br>■ I&O qs<br>■ Pain<br>■ Labs/hydration status<br>■ Medications administered/response<br>■ VS qs<br>■ Physician visit/order changes |