STROUDWATER

Critical Access Hospital Swing Bed Programs Outperform Skilled Nursing Facilities on Quality Performance

Results capture three years of quality data collected through the Stroudwater Associates Swing Bed Quality Reporting Tool.

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Executive Summary

In October 2018, Stroudwater Associates launched the first-ever swing bed quality reporting tool for Critical Access Hospitals (CAHs). This is the first program that CAHs have had available for tracking their swing bed quality measures. The goal was to help CAHs proactively enhance their role as providers of high-quality, community-centered care through quality reporting and the strategic use of data. These insights could help hospitals build high-quality swing bed programs vital for their patient populations. Stroudwater has tracked swing bed quality data for approximately 200 CAHs across 29 states.

Since Stroudwater developed the Swing Bed Quality Reporting Program utilizing CMS's Minimum Data Set (MDS) which is mandatory for Skilled Nursing Facilities (SNFs), CAHs can now compare their quality scores to their SNF competitors. To compare the CAH results to the SNFs, we compiled the CAH data utilizing the same reporting time frame that CMS reports on Nursing Home Compare, which is where the MDS data is reported for public consumption.

The data reveals that CAHs provide the best skilled-level care, performing better than programs at Skilled Nursing Facilities (SNFs) on three major measures:

- 73.6% of CAH swing bed patients were discharged to their community, significantly exceeding SNFs' rate of 49.7%, during the period 10/1/2020 through 9/30/2022.
- From 7/1/2022 through 6/30/2023, 8% of CAH swing bed patients experienced unplanned returns to acute care, compared to SNFs' 11.4%.
- 9.2% of CAH swing bed patients had returned to acute care within 30 days post-discharge from 10/1/2020 through 9/30/2022, whereas SNFs' rate stood at 10.5% for the same period.
- SNFs ranked slightly higher than CAHs in two categories: Risk-Adjusted performance improvement for mobility and self-care from 4/1/2022 through 3/31/2023.

By leveraging quality outcomes data, CAHs can better recognize and communicate the effectiveness of their swing bed services to referral partners and patients and understand how to improve their quality metrics continuously. Centering data allows CAHs to more effectively communicate to referring facilities how their swing bed program performs compared to other facilities and let potential patients know they are in good hands if they stay within the hospital.

In addition to keeping care within the community, the revenue derived from swing bed Medicare reimbursements has emerged as a significant financial lifeline for CAHs. This income source enables them to sustain the provision of essential medical services, particularly during periods of decreased cash flow from acute care sources.[1]

> "When hospitals can effectively market the success of their swing bed program, they are more likely to fill hospital beds that might otherwise remain vacant," said Lindsay Corcoran, MHA and Principal at Stroudwater Associates. "For a CAH that relies on cost-based reimbursement and has a very low acute daily census, an effective swing bed program is crucial to helping maintain a positive cash flow."

Background

The Medicare swing bed program offers vital flexibility for rural hospitals with fewer than 100 beds, allowing them to utilize their inpatient beds for either acute care or SNF-level swing bed care. While swing bed services in rural Prospective Payment System (PPS) hospitals are reimbursed under the SNF PPS, CAHs receive cost-based reimbursement for such services. The 2022 cost report data shows that 94% of CAHs had swing bed days compared to 21% of PPS hospitals with under 50 beds.[2]

While an effective swing bed program can provide a financial lifeline and accessible care for patients at any hospital, there are notable differences in data collection requirements between PPS hospitals and CAHs. PPS hospitals must submit patient data to the Centers for Medicare & Medicaid Services (CMS) using the swing bed Minimum Data Set (MDS), a standardized assessment tool for care management, but CAHs are exempt from this requirement.[3] This difference in reporting requirements and resulting lack of data left CAH swing bed programs without a means to track and measure their programs' quality or compare it to that of peer hospitals.

[1] https://huskiecommons.lib.niu.edu/cgi/viewcontent.cgi?article=1018&context=ctrgovernment-reports

[2] https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports/cost-reports-fiscal-year

[3] https://rhrc.umn.edu/wp-content/uploads/2019/10/UMRHRC_swing-bed-10.10.19.pdf

The lack of comparable swing bed quality measure data resulted in two issues. First, CAHs lack standardized data to demonstrate the quality of care for swing bed patients or to compare it against national standards. Second, the absence of quality metrics diminishes CAHs' participation in alternative payment models for post-acute care, as these models require outcome data for partner selection.

Swing bed quality of care has remained largely overlooked since a 1990 study comparing SNFs and swing beds. Recent research has predominantly focused on swing bed cost analysis and comparing patient characteristics and diagnoses between swing beds and SNFs. Moreover, swing beds have been excluded from recent national quality measurement initiatives. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) and the National Quality Forum (NQF) Measure Application Partnership project have both aimed at enhancing quality measures in post-acute care settings, but these efforts have primarily centered on SNFs, Home Health Agencies (HHAs), Long-Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), and hospices, without addressing swing beds.

To address this, in April 2018, the University of Minnesota Rural Health Research Center conducted a study, *Quality Measures for Critical Access Hospital Swing Bed Patients*[4], to assess the quality measures for CAH swing bed programs, focusing on outcome and functional status. This focus was chosen for two primary reasons: it aligned with the need that interview respondents (a mixture of CAH networks, CAHs, and consultant groups)[5] cited to assess quality in swing bed programs compared to SNFs, and it resonated with the priorities outlined in the IMPACT Act of 2014, which mandated the development of quality measures for post-acute care settings, including outcomes like discharge to the community, preventable hospital readmissions, and resource use across five quality domains.

The study revealed that CAHs are informally tracking the discharge disposition of swing bed patients, although definitions and data collection methods vary. Similarly, CAH leaders recognize the importance of reducing unplanned hospital readmissions, but there is a lack of uniformity in defining readmissions and conducting risk adjustment.

Respondents emphasized the significance of tracking discharge disposition and readmissions for CAH swing bed programs while also advocating for additional data on Emergency Department visits, observation stays, and nursing home admissions during a 30-day follow-up period.

Standardizing Quality Reporting for CAHs with Swing Bed Program

Recognizing the absence of swing bed quality data, Stroudwater Associates introduced the Swing Bed Quality Reporting Tool (SBQRT) in 2018 to standardize reporting and develop industry-wide benchmarks. The tool now has five years of data from approximately 200 CAHs in 29 states. As the only dedicated solution for CAH swing bed programs, it serves as the national platform for collecting data and benchmarking swing bed outcome measures. The Swing Bed Quality Reporting Tool integrates sections of the CMS Minimum Data Set (MDS), providing CAHs the opportunity to benchmark against their peers and SNF competitors.

[4] https://rhrc.umn.edu/wp-content/uploads/2019/10/UMRHRC_swing-bed-10.10.19.pdf

[5] https://rhrc.umn.edu/wp-content/uploads/2019/10/UMRHRC_swing-bed-10.10.19.pdf

The Swing Bed Quality Reporting Tool utilizes CMS's methodology to calculate results for the five Key Metrics as defined by CMS:

MEASURE 1: Return to Acute Care from Swing Bed (Unplanned)

» This measure scores the percentage of the hospital's swing bed patients who were re-hospitalized after a swing bed admission.

MEASURE 2: Return to Acute Post 30-day Discharge

» This measure scores the percentage of swing bed patients who were readmitted to the hospital's acute unit within 30 days from the swing bed discharge date.

MEASURE 3: Risk-Adjusted Performance Improvement in Mobility

» This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in mobility based on 17 measured activities.

MEASURE 4: Risk-Adjusted Performance Improvement in Self-Care

» This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in self-care based on 7 measured activities.

MEASURE 5: Discharge to Community

» This measure scores the percentage of the hospital's swing bed patients who were discharged to home/community (includes discharge to home, ID/DD, hospice and home with home health care).

"The 2018 study underscored the need for quality metrics to track and measure, so CAHs could reliably benchmark against other CAHs and continue to optimize their program and enhance quality outcomes," said Corcoran.

Core components of the tool include assisting CAHs with standardizing pre-admission and discharge processes. CAHs can manage, track, and benchmark their swing bed data across a multitude of measures that range from management reports to functional outcomes to discharge dates to other quality measures like fall rates and vaccines.

MEASURE 1: Return to Acute from Swing Bed (unplanned)

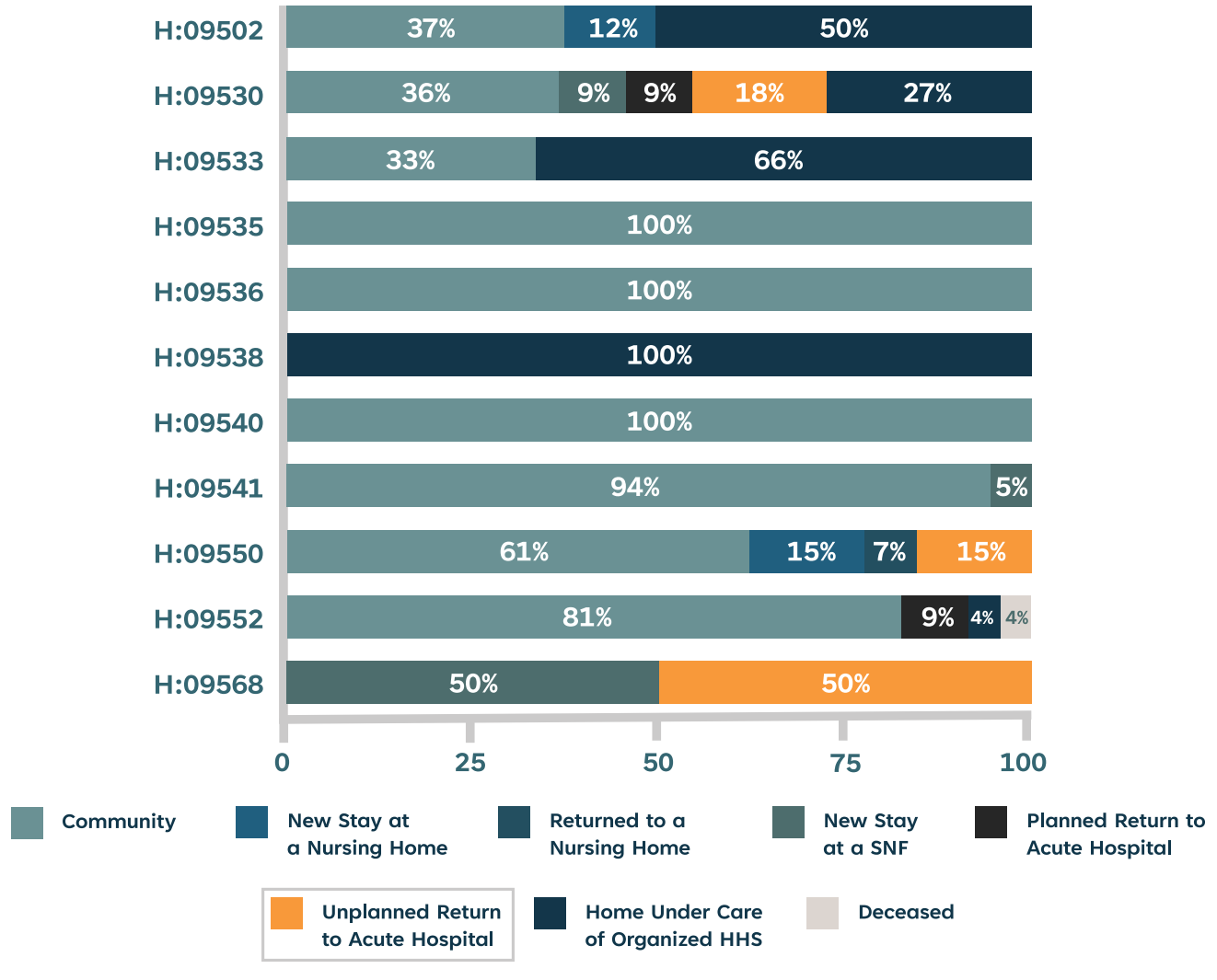
Lower is better.

Participation in SBQRT led to notable success for CAHs, with an 8% rate of patients returning to acute care, significantly lower than the 11.4% rate observed among patients in SNFs within the same timeframe.

"Understanding the potential repercussions of readmittance after a swing bed stay is essential for providers and staff," said Corcoran. "It's important that the hospital conduct a thorough review of all patients returning to acute care while they are still in the hospital as it allows healthcare teams to assess whether these returns could have been prevented."

Discharges by Discharge Diposition | Time period (2022Q2)

Percent of all discharges by disposition - **EXAMPLE ONLY**



MEASURE 2: Return to Acute Post 30-Day Discharge

Lower is better.

CAHs within SBQRT had a 9.2% readmission rate post-30-day discharge, compared to SNFs at 10.5%.

"Effective discharge planning is vital for ensuring patient satisfaction and providing quality care. For hospitals using the tool, they were able to track patient returns to acute care, visits to the emergency department, transfers to other facilities, and instances where patients were not readmitted to another facility," noted Corcoran.

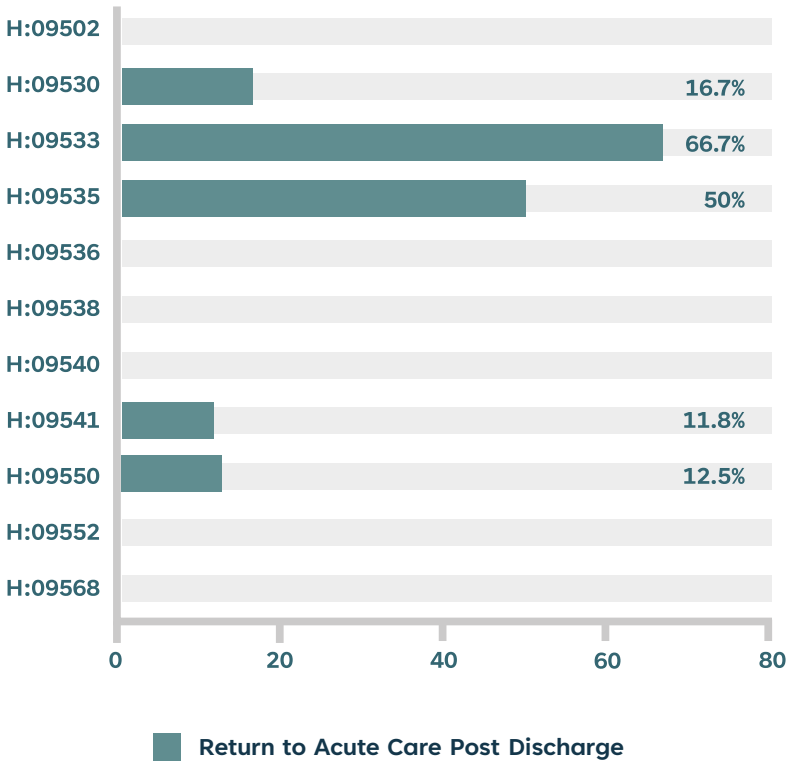
Implementing consistent processes and procedures around discharge planning ensures that patients receive comprehensive support for a successful transition post-discharge and helps decrease the likelihood of a patient returning to the swing bed or acute care.

The process should start with an early assessment that addresses the available support, transportation needs, pharmacy requirements, and financial considerations.

"We encourage the hospitals to provide clear and concise written discharge instructions, schedule timely follow-up visits with healthcare providers within a week or sooner, and conduct clinical follow-up calls within 24-72 hours post-discharge. These practices collectively contribute to seamless care transitions and improved patient experiences," noted Corcoran.

Return to Acute Care Post Discharge | Time period (2022Q2)

Percent of discharges returned to acute post discharge. This includes 05. Return to Acute (same condition) and 06. Return to Acute (new condition) for discharge disposition 01. Home/Community, 08. Intermediate Care Facility (ID/DD), 09. Hospice and 10. Home with Home Health Services. We eliminate any discharges where the 3-day follow up is 00. Not attempted, 01. Attempted 3 times, no response and 02. Readmission to another facility unknown. **EXAMPLE ONLY**

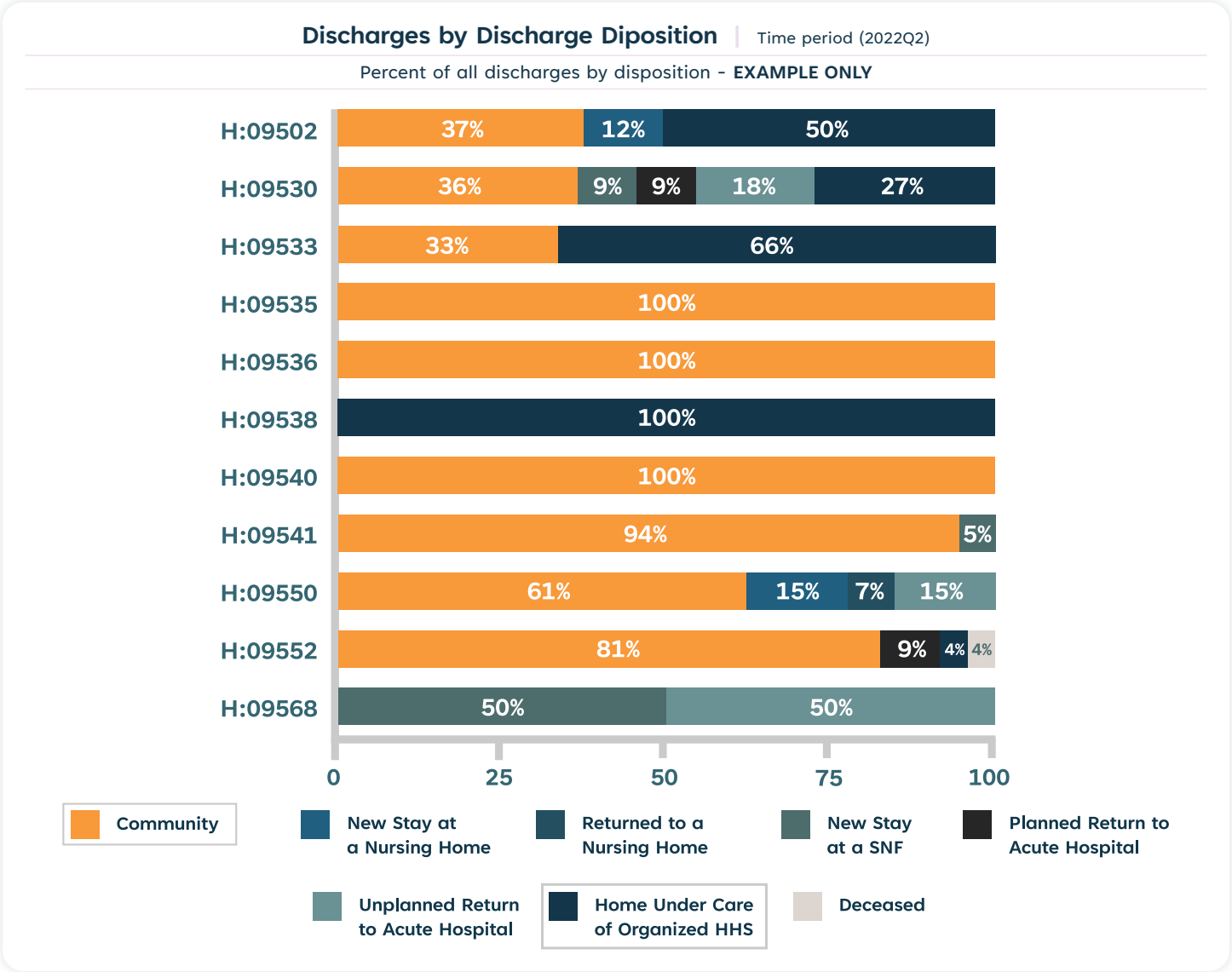


MEASURE 5: Discharge to Community

Higher is better.

The Discharge to Community metric reveals a significant variance in outcomes: CAHs within the program achieved a success rate of 73.6%, compared to SNFs at 49.7%.

Involving the patient's family or caregivers throughout the whole patient's stay is critically important. By engaging a patient's support system in discharge planning, interdisciplinary care plan meetings, and ongoing education and support, CAHs can anticipate a higher success rate.



MEASURE 3 & 4: Risk-Adjusted Improvement in Mobility and in Self Care

Higher is better.

> "While the hospitals using the tool had higher quality metrics than SNFs on three of the five measures, there are still two measures where they continue to work on improving their performance: improvement in mobility and self-care," said Corcoran.

Within the SBQRT, CAHs can evaluate improvements in mobility across 17 activities. The tool facilitates comparison between the CAHs' scores and the expected improvement scores, indicating the percentage of discharges meeting or exceeding expectations. For Measure 3: Risk-Adjusted Improvement in Mobility, CAHs in the program saw an average expected improvement in mobility of 37% compared to SNFs at 46.3%.

Similarly, for Measure 4: Risk-Adjusted Improvement in Self Care, while the variance between CAHs and SNFs was slightly lower than in mobility, there remains room for improvement in self-care metrics. CAHs in the program saw an average expected improvement in self-care of 47.7% compared to SNFs' average of 50.5%.

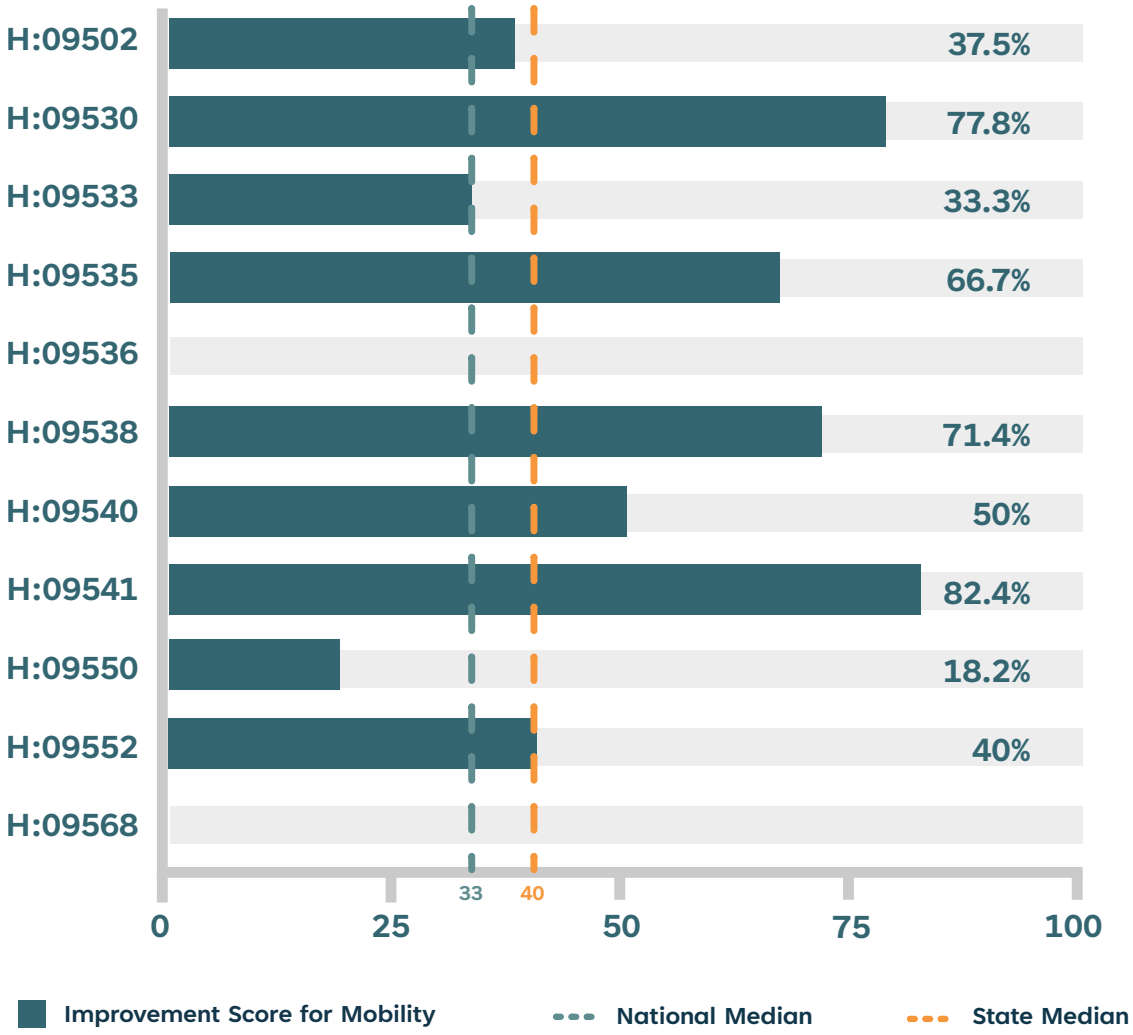
> "Despite the average metrics being a bit lower than SNFs when comparing the data, our team has worked very closely with several CAHs whose main objectives were to improve their mobility and self-care scores and did that by creating a performance improvement action plan. Our team supported the CAHs in establishing a desired goal, planned interventions, and expected outcomes, layering on accountability mechanisms of individual/team ownership and target dates. This allowed the CAHs to assess progress monthly and pivot interventions where needed," said Corcoran.

As the participating CAHs work towards improving patients' self-care and mobility outcomes, Stroudwater continues to emphasize the importance of fostering a rehab model of patient care and prioritizing discharge planning, including discharge disposition, level of assistance, and functional status. Encouraging independence and involving patients and families throughout the process are key.

See Mobility graph on the next page ⟶

Performance Improvement Score - Mobility (Risk-Adjusted) | Time period (2022Q2)

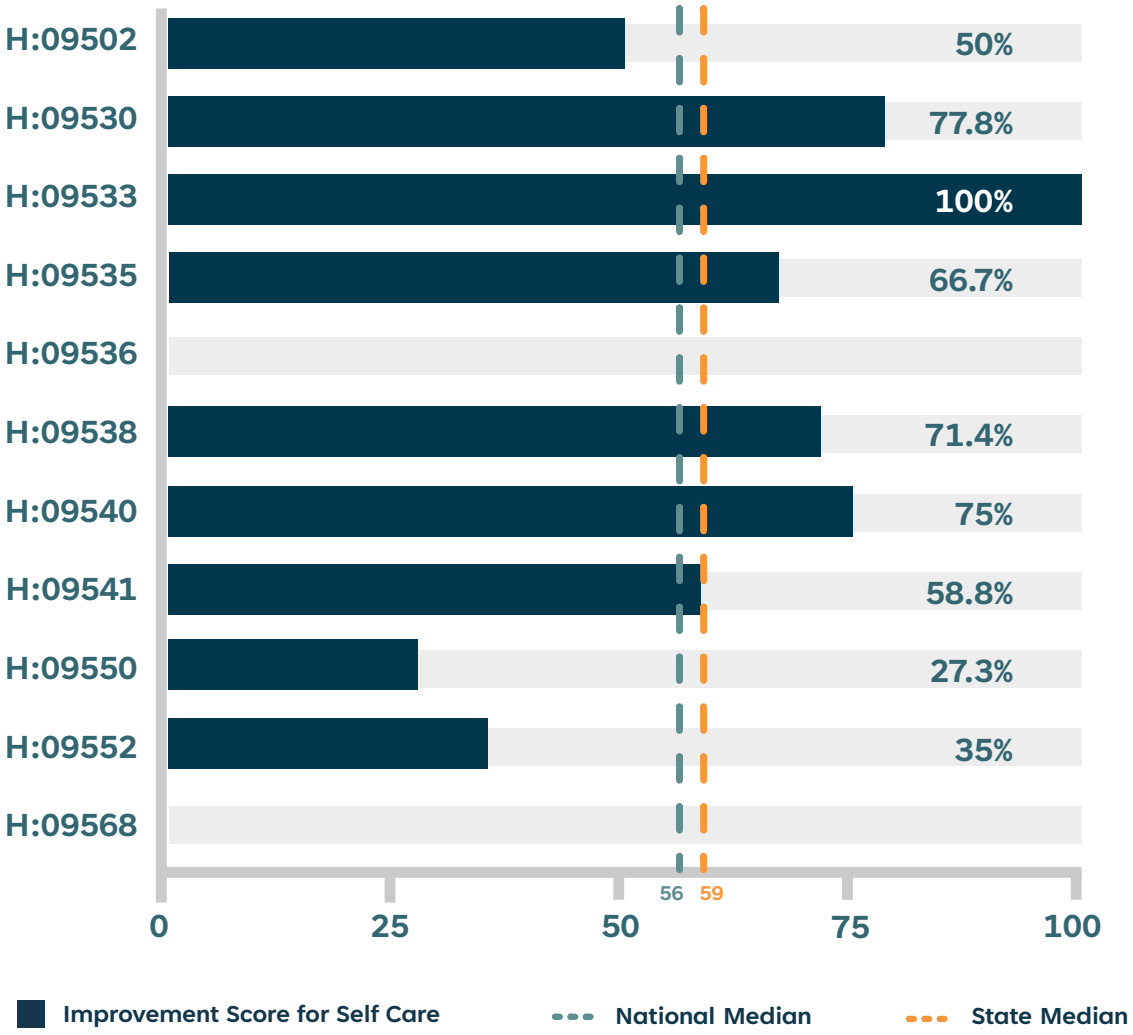
Risking adjusting the Mobility assessment produces an expected improvement score for Mobility. We compare your actual improvement score to the expected improvement score and return the percentage of discharges that met or exceeded the expected improvement score. **EXAMPLE ONLY**



See Self Care graph on the next page ⟶

Performance Improvement Score - Self Care (Risk-Adjusted) | Time period (2022Q2)

Risking adjusting the Self Care assessment produces an expected improvement score for Self Care. We compare your actual improvement score to the expected improvement score and return the percentage of discharges that met or exceeded the expected improvement score. **EXAMPLE ONLY**



Physical therapy and occupational therapy interventions should encompass diverse strategies, including simulation where possible. Examples include clear communication of discharge goals, consistent coding practices, and regular team meetings to assess progress and adjust care plans. By ensuring alignment between nursing and therapy, adequate staffing, and comprehensive training, CAHs can improve patient outcomes and strive for continuous quality improvement.

See Findings from the Field on the next page ⟶

Findings from the Field

Marshfield Medical Center – Park Falls (MMC-PF), a CAH in western Wisconsin, wanted to improve the facility's swing bed metrics. Swing bed patients needed to build greater mobility and reach self-care goals to heal and return home, yet there seemed to be confusion among rehabilitation staff, nursing, and the patient in knowing who was responsible for what. MMC-PF wanted nursing staff to be an integral part of the team helping swing bed patients improve their mobility and self-care goals.

Risk-Adjusted Performance Improvement in Mobility	Risk-Adjusted Performance Improvement in Self Care
» Q4 2021 – 7 discharges – 42.9%, which is better than the national median of 27%	» Q4 2021 – 7 discharges – 71.4%, which is better than the national median of 48%

Kearney County Health System (KCHS), , a CAH in southcentral Nebraska, needed to improve its swing bed patients' risk-adjusted mobility performance scores, and KCHS's rehabilitation staff and nursing staff needed to work as a team in motivating their swing bed patients to achieve their mobility goals, heal, and return home.

KCHS's action plan included getting patients in a chair for all meals unless medically contraindicated and setting a targeted number of times for patients to ambulate each day. The staff was provided monthly education on the importance of keeping patients moving multiple times a day as recommended by the therapy department. Along with staff education, patients' mobility goals were written on the whiteboard in the patient's room so that the staff, patient, and patient's family were aware of the goal. As the project progressed, rehabilitation staff added orders around mobility so nursing staff would be able to chart against the patient's activity throughout the day. KCHS now has electronic care boards where they post daily goals as well as reminders for patients and their families to continue to work on mobility.

Risk-Adjusted Performance Improvement in Mobility
» Baseline value: Q3 2021 – 15.4%
» Improvement was shown in Q1 2022 at 31.7% and again for Q2 2022 at 64%

"Our swing bed patients benefitted greatly from the swing bed quality improvement project we embarked on with Stroudwater Associates," said Kendra Brown, MSN, RN, PCCN and CNO at Kearney County Health Services. "Our improvement over the entire project was vastly better than we would have seen with any one intervention and encompassed many different departments throughout the facility. The project increased communication between the departments and allowed many employees who would not have normally played a part in a quality project to not only participate but also contribute to the interventions that we put into place. It was so much more successful than other quality projects that we've done, that we began using the model of intervention and re-assessment throughout the facility in all quality projects."

Wayne County Hospital (WCH), a CAH in southcentral Kentucky, sought to improve risk-adjusted mobility performance scores for its swing bed patients and create a team mentality among rehabilitation and nursing staff as they help swing bed patients achieve their mobility goals and support their return home.

WCH's action plan included implementing care team huddles to discuss new swing bed patients admitted after the weekly interdisciplinary team (IDT) meeting, making additional PRN rehab staff available to accommodate increases in patient loads (allowing for BID treatments as appropriate), and providing additional education to nursing and rehab staff to ensure more accurate coding. As the project progressed, the WCH administration made a strong push to restructure the review of incoming referrals, focusing on timeliness in responding to referring facilities.

Risk-Adjusted Performance Improvement in Mobility

- Baseline value: Q3 2022 – 14%
- Improvement shown in Q1 2023 at 16.7% and again for Q2 2023 at 24%

MARSHFIELD MEDICAL CENTER – PARK FALLS

KEARNEY COUNTY HEALTH SYSTEM

WAYNE COUNTY HOSPITAL

The Future of Quality Report for Swing Bed Programs for CAHs

With approximately 200 CAHs already utilizing the tool, Stroudwater hopes that more CAHs will join the program to strengthen reporting and benchmarking.

> "For many years, we theorized that swing bed programs put patients and communities at the forefront of the care and now we have actual data to support that," said Corcoran. "We're hopeful that more CAHs will utilize the tool, so they can not only compare and improve their quality in their swing bed programs, but we can create valuable benchmarks for CAHs to work toward."

Capturing, reporting, and benchmarking the data are significant steps toward increasing utilization in rural swing bed programs, but the next step is for organizations to use this data to market the success of their program to potential patients or referring providers.

> "It's critical that hospitals use this data to build community awareness of their swing bed programs to potential patients and referring providers, so they can continue to increase their volumes," said Corcoran.

With 220 closed or converted rural hospitals since 2005[6], many CAHs depend on the revenue derived from swing bed Medicare reimbursements to sustain the daily operations of their small, rural hospital.

> "For most of the CAHs we work with, their swing bed programs are not only keeping care within the community but are also acting as a financial resource to maintaining operating margins," said Corcoran. "We anticipate that as we continue to build on the data, more rural hospitals will be able to communicate the effectiveness of their programs and continue to increase their swing bed census."

Through proactive quality reporting and strategic use of data insights, CAHs can enhance their role as providers of high-quality, community-centered care.

[6] https://www.stroudwater.com/