STROUDWATER

2ND ANNUAL SWING BED BOOTCAMP

Thursday, October 16, 2025

OUR SPEAKERS TODAY

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OUR TIME TOGETHER

Ask the Experts!

Deeper Dive

- Marketing for Growth
- Program Design
- Quality / Outcomes

Key Takeaways / Discussion

HOUSEKEEPING

All participants are muted during the webinar

Please place any comments or questions into the Q/A feature

The recording and slide deck will be sent out following the webinar

All questions in the Q/A will be answered in a follow-up document after the webinar

We thank you for spending time with us and we hope the information is valuable!

DISCLAIMER

This information was prepared with the best of intention using CMS such as State Operations Manual, Claims Processing Manual, Medicare Benefit Policy Manual and other resources for regulations and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage participants to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

This presentation includes best practice developed over time with years of experience working with both CAH and PPS swing bed programs across the country. Recommendations are not necessarily based on the law but rather based on how to best meet CMS regulations within a hospital-based program vs SNF along with best practice in patient-centered care.

ASK THE EXPERTS!

GENERAL

PPS HOSPITAL SWING BED ELIGIBILITY

Question: How do you know if you are an eligible PPS?

Answer:

Eligibility Requirements (PPS Hospitals)

- **Be in a rural area**, including all areas not defined as urban by the most recently published U.S. Census Bureau data (we don't include an urban cluster area)
- Have **less than 100 beds**, excluding beds for ICUs and newborns
- Have a **Medicare hospital provider agreement**
- **Not have had its swing bed approval terminated** within 2 years before application resubmission
- **Not have a 24-hour nursing waiver** granted under 42 CFR 488.54(c)
- **Comply with these SNF participation requirements** under 42 CFR 482.58(b)(1–7):
  - Residents' rights
  - Admission, transfer, and discharge rights
  - Freedom from abuse, neglect, and exploitation
  - Social services
  - Discharge summary
  - Specialized rehabilitative services
  - Dental services

https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

SOCIAL SERVICES

Question: Do we have to have a licensed social worker on staff, or can it be an RN or an LPC?

Answer: **§483.40(d)** All facilities are required to provide medically-related social services for each resident. Facilities must identify the need for medically-related social services and ensure that these services are provided. It is not required that a qualified social worker necessarily provide all of these services, except as required by State law.

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

DOCUMENTATION

COMPREHENSIVE ASSESSMENT

Question: Does the **comprehensive assessment** have to in one document or can you have different assessments from the different disciplines, ex: PT/OT, nursing, nutrition etc.? (See Appendix for additional detail on the comprehensive assessment)

Answer: Ideally, our EHR allows for all elements of the comprehensive assessment to be in one place regardless of which discipline contributes to that assessment (PT/OT/Nursing etc.). However, in our experience we are finding that is just not realistic in many cases. That said, it is recommended that you review all components of the comprehensive assessment and verify that your medical record contains all the individual elements. For audit and survey purposes, it may be beneficial for you to create a document outlining where these elements are located within the medical record if they are not all located in one area. It is also important that all staff who will care for your Swing Bed patients, have access to all the elements of the comprehensive assessment.

§485.645(d)(5) **Comprehensive assessment**, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), **OR** to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).

COMPREHENSIVE CARE PLAN

Question: What is a comprehensive care plan?

Answer: A comprehensive care plan is an interdisciplinary care plan based on the needs identified in the comprehensive assessment.

§483.21(b) Comprehensive care plans.

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that **includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.**

The comprehensive care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (1) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (2) In consultation with the resident and the resident's representative(s)—(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

COMPREHENSIVE CARE PLAN (CONT.)

Question: What is the best way to document the comprehensive care plan? (See Appendix for procedure)

Answer: The unit must develop and implement a comprehensive person-centered care plan for each patient, consistent with the patient's rights that **includes measurable objectives and timeframes to meet a patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.** The comprehensive care plan must describe the following:

- The **services that are to be furnished** to attain or maintain the patient's highest practicable physical, mental, and psychosocial well-being and,
- **Any services that would otherwise be required but are not provided** due to the patient's exercise of rights including the right to refuse treatment.
- **Any specialized services or specialized rehabilitative services provided because of PASRR recommendations**. If there is disagreement with the findings of the PASRR, the rationale must be included in the patient's medical record.
- **Inclusion of actions or interventions for patients who are trauma survivors** in accordance with professional standards of practice and accounting for patients' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.

- The services provided or arranged by the program, as outlined by the comprehensive care plan, must:
  - Meet professional standards of quality.
  - Be provided by qualified persons in accordance with each resident's written plan of care.
  - Be culturally competent and trauma informed.
- In consultation with the patient and/or the patient's representative(s):
  - The patient's goals and desired outcomes that includes measurable objectives and timetables to meet the patient's medical, nursing, rehabilitation, and psychosocial needs.
  - The patient's preference and potential for future discharge, including whether the patient's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose

COMPREHENSIVE CARE PLAN (CONT.)

Question: More specifics on daily documentation requirements from nursing, rehab, RT, etc. standpoint. (See Appendix for additional details)

Answer:

- Documentation requirements are specific to hospital policy, but recommendations are that clinical documentation include:
  - System reviews each shift or every 24 hrs. and focus, problem-oriented on off shifts
  - Day-to-day documentation each shift, each X hrs., PRN
- Documentation must include clinical findings, treatments, observation regarding skilled needs, functional status if pertinent to the skilled needs including the activity, tolerance, level of initiation, level of assistance or supervision required, etc.
- Ensure all documentation "paints the picture" of why the patient is in skilled care, what is being done as a skilled service and what the outcome is. Therapy documentation should include time treated am/pm as per treatment plan, modalities used (at a minimum)- status and tolerance recommended

COMPLIANCE

DNV SURVEY

Question: We are a Critical Access Hospital (CAH) and I believe the guidelines change and our surveys are done by DNV?

Answer:

- As a Critical Access Hospital (CAH) accredited by DNV, your surveys follow CMS Conditions of Participation (42 CFR §485) but are conducted under DNV's NIAHO® accreditation program, which includes ISO 9001 quality standards.
- This means: DNV surveys use the same federal requirements but focus more on process improvement and quality systems than checklist compliance. Surveys occur annually instead of every three years.

BED ALARMS IN SWING BED / SNF CARE

Question: Can bed alarms be used on swing bed patients?

Answer: Bed alarms may be used for Swing Bed / SNF patients, but they must be treated cautiously — they cannot serve as a substitute for proper supervision or individualized care planning, and in certain cases may be considered a restraint under CMS guidelines.

- Key points from Appendix PP and CMS guidance:
  - Under F-Tag F604 (“Right to be free from physical restraints”), bed or chair alarms (also called “position change alarms”) may be interpreted as restraints if they restrict movement, are not removable by the patient, or inhibit voluntary movement.
  - If an alarm is used, it must be justified in an individualized care plan, documented, and reassessed over time to confirm it remains the least restrictive intervention.
  - Use of alarms does not eliminate the requirement for staff supervision or other fall prevention strategies.
  - The facility must monitor the alarm’s effectiveness and any adverse effects (e.g. fear, alarm fatigue, reduced mobility) and make adjustments accordingly.

FREQUENTLY SEEN CITATIONS

Care Planning (42 CFR 483.21)

- No timely or individualized care plan developed within 7 days of admission
- Care plans missing required interdisciplinary input (nursing, therapy, physician, social services).
- Care plans not updated with changes in condition or after readmission

Best Practice: Hold a weekly interdisciplinary team (IDT) meeting; document attendance, goals, progress, and updates

Therapy Services (42 CFR 483.65)

- Missing or outdated therapy evaluations and treatment plans
- Lack of coordination between nursing and therapy in care plan and discharge notes

Best Practice: Therapists should document daily progress and participate in care planning and discharge planning.

FREQUENTLY SEEN CITATIONS (CONT.)

Discharge Planning (42 CFR 483.21(c))

- No evidence of planned discharge summary or coordination with post-discharge providers
- Missing patient/family education on discharge instructions and follow-up appointments

Best Practice: Use a standard discharge checklist signed by the nurse and reviewed by the patient or family

Quality Assurance / QAPI (42 CFR 483.75)

- Swing Bed program not included in QAPI reporting or data tracking
- No documentation of performance improvement activities specific to Swing Bed outcomes (e.g., readmissions, falls)

Best Practice: Add a Swing Bed dashboard to the hospital's QAPI plan (LOS, discharges, falls, rehospitalizations, satisfaction)

BILLING

VA COVERAGE

Question: Is the VA contracted for swing bed?

Answer: Yes, the VA may cover swing bed services when a veteran meets specific medical criteria and the facility is approved for swing bed services. This coverage falls under the VA's Community Care Program.

https://vacommunitycare.com/doc/ccnBenefits/ccnSkilledNursingFacility

3-MIDNIGHT RULE

Question: The 3-midnight rule is changing?

Answer: The 3-midnight rule is not changing; Medicare requires a 3-consecutive-day inpatient hospital stay (excluding the discharge day, time in the ED or observation) to qualify for skilled nursing facility or swing bed coverage under Part A

Transforming Episode Accountability Model (TEAM) running from January 1, 2026 – December 31, 2030, **SNF 3-Day Waiver Rule**

- CMS will allow acute care hospitals who participate in the model to discharge patients without a 3-day hospital stay to a qualified SNF or swing bed provider, including a CAH
- The patient must meet the eligibility criteria for TEAM and have a qualifying outpatient procedure or hospital inpatient stay prior to admission to the SNF
- The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient
- Medicare will pay for services when the SNF claim meets certain payment criteria, including submitting the claim with the required TEAM demonstration code A9

https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

SWING BED ELIGIBILITY, COVERAGE

Question: Can we address critical access hospitals with limited beds, how patients are qualified for swing beds, insurance coverage and reimbursement?

Answer:

- To charge Medicare for a swing bed patient, the following criteria must be met:
  - The patient must be a **Medicare Part A enrollee and have benefit days available**;
  - There must be a **three-day qualifying stay**;
  - **Medicare age or disability/disease eligibility** requirements must be met;
  - The patient's **swing bed admission condition is the same as the qualifying stay** condition;
  - The patient is being **admitted to swing bed within thirty days of discharge**; and
  - The patient's condition **meets the criteria for daily inpatient skilled nursing, rehabilitation, or a combination of these services**.
- Care in a SNF is covered if all the following four factors are met:
  - The patient requires skilled nursing services or skilled rehabilitation services, i.e., **services that must be performed by or under the supervision of professional or technical personnel**
  - The **patient requires these skilled services on a daily basis**;
  - As a practical matter, considering economy and efficiency, **the daily skilled services can be provided only on an inpatient basis in a SNF**.
  - The **services delivered are reasonable and necessary for the treatment of a patient's illness or injury**, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- Medicare reimburses CAHs at 101% of reasonable costs

SWING BED PAYMENTS

Question: What are hospitals financially responsible for when accepting swing beds (ie dental work, medication cost, etc.)

Answer (CAH):

- A swing bed is not considered hospital-level care. It is defined in the payment regulations as SNF level.
- Not subject to SNF Prospective Payment System (PPS) or Consolidated Billing (CB) rules
- Non-professional services provided to a CAH swing-bed patient must be included on the CAH's swing-bed bill
  - Bed and board, nursing, and other related services
  - Use of CAH facilities
  - Medical social services
  - Drugs and biologicals
  - Supplies, appliances, and equipment for inpatient hospital care and treatment and diagnostic or therapeutic items or services they, or others, provide under arrangement
- Medicare pays Part B inpatient services when the beneficiary is not entitled to benefits under Part A
- Professional services are billed separately

Answer (PPS):

- Billed following Skilled Nursing Facility (SNF) Prospective Payment System (PPS) rules and Consolidated Billing (CB) rules
- Medicare beneficiaries in a Part A covered SNF stay
  - Services include ancillary medical services as well as room and board
  - Limited number of services specifically excluded from consolidated billing and separately payable
    - Physician's professional services
    - Certain dialysis-related services
    - Certain ambulance services
    - Erythropoietin for certain dialysis patients
    - Certain chemotherapy drugs
    - Certain chemotherapy administration services
    - Radioisotope services
    - Customized prosthetic devices
- Medicare beneficiaries whose Part A benefits have exhausted or no longer require a skilled level of care and remain in a swing bed
  - Certain medical services are covered under Medicare Part B (room and board is not covered)
  - Claims are submitted on Type of Bill 12X and paid under the Outpatient Prospective Payment System (OPPS) to hospitals subject to OPPS

https://www.cms.gov/files/document/mln006951-swing-bed-services.pdf

DENTAL SERVICES

Hospitals and CAHs are required to provide care in accordance with the needs of the patient that have been identified in such patients' plans of care; this includes 24-hour emergency dental care and non-emergency dental care

The expectation is that hospital swing-bed providers are currently addressing the emergent dental care needs of their patients under the existing hospital CoP at § 482.12(f)(2), which requires that hospitals have written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate

Similarly, we expect that CAH swing-bed providers are currently addressing the emergent dental care needs of their patients under the existing emergency services CoP at § 485.618, which requires CAHs to provide emergency care necessary to meet the needs of its inpatients and outpatients

SKILLED NURSING

Question: How can we maximize swing bed stays using nursing services as justification outside of therapy needs?

Answer: While therapy (PT/OT/ST) is a common qualifying need for swing bed admission, skilled nursing services alone can also justify a swing bed stay when the patient requires a daily skilled level of care that cannot be safely or effectively provided in another setting.

- A swing bed admission can be appropriate without active therapy when nursing care involves:
  - Complex wound care requiring skilled assessment and sterile technique.
  - IV therapy or injectable medications that demand skilled observation or administration.
  - Pain management necessitating frequent assessment or titration of medications.
  - New or unstable medical conditions requiring ongoing monitoring or teaching (e.g., diabetes management, post-stroke care, CHF, COPD, or oxygen weaning).
  - Patient or caregiver teaching for self-care, medication management, or use of new medical equipment prior to discharge.
  - Enteral or parenteral nutrition requiring skilled nursing supervision.
  - Each of these must be supported by documentation showing that the skilled service is reasonable and necessary, and that only licensed nursing personnel can safely perform or supervise the care.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf

LEAVE OF ABSENCE

Question: How do CAH process swing bed patient records and accounts when there is a Leave of Absence for the patient? For example, patient has a surgical procedure in the same facility during the Swing Bed stay. Is a new account issued, and a new record created or is it all under one Swing Bed account?

Answer:

- 40.3.5.2 - Leave of Absence (Rev. 4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18) **A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or nonparticipating portion of the same institution.**
  - If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.
  - Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at §30.1.1.1.
  - Occurrence span code 74 is used to report the LOA from and through dates. Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

https://med.noridianmedicare.com/web/jfa/provider-types/cah/cah-swing-bed-billing-chart
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

TRANSFER / DISCHARGE

Question: What are the documentation requirements for a transferred Swing patient who is sent to another facilities ED department for evaluation and then returned to CAH or admitted at the other facility?

Should this be a transfer or discharge disposition; and what transfer documentation should be included in the record? Or should this be determined once it is known the status of the patient at the other facility (sent back to CAH or admitted there)?

Answer:

- A ***transfer*** is generally considered when a patient either moves from one location to another within the same level of care/reimbursement such as from a swing bed to distinct part SNF or a nursing home SNF.
- A ***discharge*** is generally considered when a patient moves from one level of care/reimbursement to another as noted by a facility or program/unit to acute care, acute rehabilitation, psychiatric care, long term acute care, or is formally released from the hospital to home/community; OR patient expires on the unit.
- **§483.15(c)(3): Notice before transfer**. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

TRANSFER / DISCHARGE (CONT.)

Answer:

- Facility-Initiated Transfers and Discharges
  - In situations where the **facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman**.
- Emergency Transfers
  - When a **resident is temporarily transferred on an emergency basis to an acute care facility, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer**, according to 42 CFR §483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices at §483.15(c)(5).
- §483.15(c)(7) Orientation for transfer or discharge.
  - The immediate orientation and preparation necessary for a facility- initiated transfer, such as to a hospital emergency room or therapeutic leave where discharge planning is not required because the resident will return, or for an emergent or immediate facility-initiated discharge where a complete discharge planning process is not practicable.
  - Sufficient preparation and orientation means the facility informs the resident where he or she is going, and takes steps under its control to minimize anxiety

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

TRANSFER / DISCHARGE (CONT.)

Answer:

- Content of Discharge Notice
  - Discharge notice must include all of the following
  - The specific reason for the transfer or discharge
  - The effective date of the transfer or discharge;
  - The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged;
  - An explanation of the right to appeal the transfer or discharge to the State;
  - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests;
  - Information on how to obtain an appeal form;
  - Information on obtaining assistance in completing and submitting the appeal hearing request; and
  - The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman

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PRE-ADMISSION / ADMISSION

ACUTE TO SWING BED

Question:

- Are swing beds required to complete a new initial interview by nursing staff and discharge planning when they are changed from inpatient acute to swing bed?
- Are providers required to complete a discharge summary from acute inpatients status and a new H/P when a patient is changed from acute care to swing bed?

Answer: Yes, an admission assessment, including discharge planning by be initiated by nursing.

- §485.638(a) The CAH must maintain a medical record for each inpatient and outpatient evaluated or treated in any part or location of the CAH. A unit record for both inpatients and outpatients may be used; however, when two different systems are used they must be appropriately cross referenced. When a patient reimbursement status changes from acute care services to swing bed services, a single medical record may be used for both stays as long as the record is sectioned separately**. Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries**. The medical record must be properly filed and retained.

PATIENT CHOICE

Question: Specifically, in regard to patient choice about providers (we have hospitalists that rotate and cover the swing bed patients - do we have patients sign an agreement to the group of providers when they choose to come to our hospital)?

Answer: Yes, If you have other physicians on your medical staff, you must include them as part of the choice (although other physicians aren't required to accept). It is OK to disclose the names and contact info of physicians who DO provide care for Swing Bed patients and ask for the patient's concurrence. Make sure you document that a choice was given.

§483.10(d) Choice of attending physician.

- The resident has the right to choose his or her attending physician. (1) The physician must be licensed to practice, and (2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. (4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. (5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASARR)

Question

- We were trained to not do PASARR if placing patient in swing bed, when is a PASARR required and not required?
- Does a PASARR need to be completed when patient is transferring from one hospital to another for swing bed?

Answer

- A PASARR is not required for a swing bed admission but if the patient does have a PASARR it must be reviewed and included as part of the comprehensive care plan
- §483.21(b) Comprehensive care plans - (1) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

SKILLED CRITERIA

Question: A patient is wanting HH, but we live in a rural area and the patient doesn't have a HH with OT/Lymph wraps to come out 3x a week and we've exhausted all options, and patient can't drive and is homebound?

Answer: The patient could be a swing bed patient if they meet the four factors for skilled criteria – the important one here is daily skilled care:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., **services that must be performed by or under the supervision of professional or technical personnel**
- The **patient requires these skilled services on a daily basis**;
- As a practical matter, considering economy and efficiency, **the daily skilled services can be provided only on an inpatient basis in a SNF**.
- The **services delivered are reasonable and necessary for the treatment of a patient's illness or injury**, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf

SKILLED CRITERIA (CONT.)

Question: If a wound vac dressing is only changed every 72 hours, is this still considered a daily skilled need? Is there any guideline on how long this would be considered skilled since wound vacs can sometimes remain in place for longer periods of time for wound healing?

Answer: Since the skilled service is not completed daily it would not meet the “daily” requirement, which is 7 days. If there was more information about the patient there may be an indirect skilled need (observation/assessment, teaching/training, etc.) such as a patient with multiple comorbidities that may need skilled nursing to be managed to promote recovery for example.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf

PATIENT CONDITION

Question: What are types of conditions you would not keep in Swing bed?

Answer: Each facility should determine what type of patients can be cared for in the Swing Bed program based on skill set of staff and capabilities of facility. This is what was described during the webinar as determining your “Care Spectrum”. The facility interdisciplinary team works together to review current capabilities, potential capabilities and gaps identified to determine if there are possibly education needs or other needs that may be addressed to grow the capabilities of the Swing Bed program.

Non-skilled services:

- Routine or maintenance medication administration
- Long-term tube feedings once regimen stabilized
- Basic ADL assistance (bathing, dressing, toileting)
- Maintenance therapy after goals achieved
- Custodial or placement needs without a skilled component
- **CMS rule of thumb: if a non-clinical caregiver could safely perform the task at home, it is not skilled.**

ADVANCED CARE NEEDS IN SWING BED PROGRAM

Question: What amount of care/CT/telemetry etc. is appropriate for someone in swing bed that will not get us in trouble with Medicare vs going back to acute care if they are significantly declining?

Answer: Some Swing Bed programs allow for patients with advanced care needs and utilize ancillary services when needed. However, if the patient has had a significant change in condition that cannot be managed with an adapted plan of care and the patient meets medical necessity for observation or acute IP care, then moving to another level of care may be appropriate. Also, it may depend on why the physician wants to continue monitoring with telemetry.

PALLIATIVE CARE

Question: Is palliative care skillable?

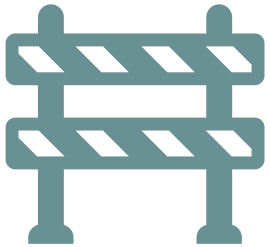
Answer: Maybe, when there is a skilled need and the patient is not in hospice. Rehab therapy may be needed, and improvement in a patient's condition may occur, even when a chronic, progressive, degenerative, or terminal condition exists. For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition or to maximize his/her functional abilities. The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by nonskilled personnel.

DEEPER DIVE

Marketing for Growth, Program Design, Quality/Outcomes

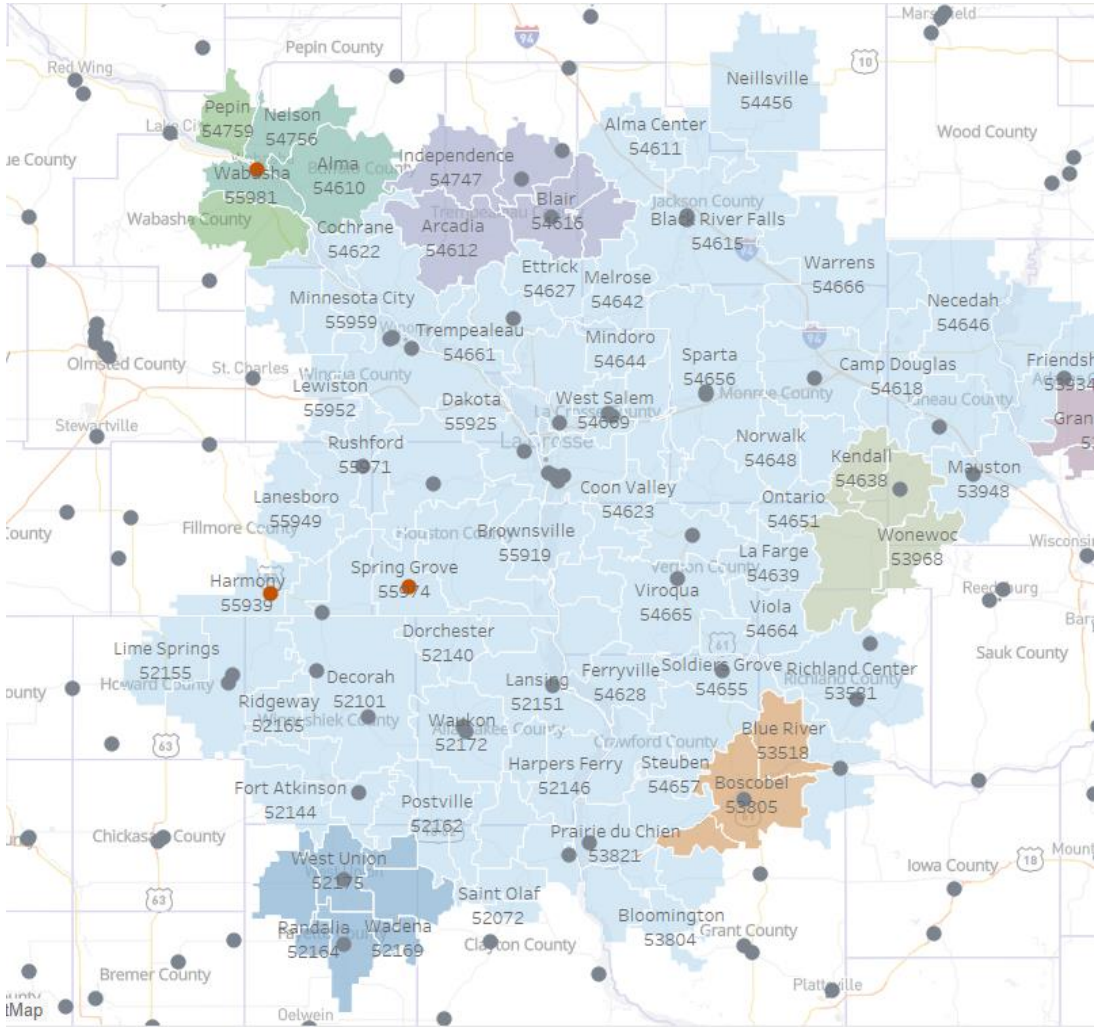
MARKETING FOR GROWTH

KEY QUESTIONS TO ASK

						
Why should a hospital refer a swing bed patient to your facility?	What makes our swing bed program stand out?	Does our community understand what a swing bed is?	Are there opportunities to expand our swing bed capabilities / services?	Are there gaps / barriers to obtaining swing bed referrals (internal / external)?	How will we measure success?	Goal to be the provider of choice

MARKET ANALYSIS

- Do we have a relationship with any other hospitals?
- Has there been a market analysis completed?
- What is your competition for Swing Bed?
- Any SNF programs? What do they offer? What don't they offer?
- Do we have IP Rehab Facilities (IRF) around for acute rehab? Where are they and what do they offer?
- What about Home Health programs?



SELF ASSESSMENT

- What services does your hospital offer?
- What services do you offer in swing bed?
- What is your hospital's reputation?
  - HCAHPS results?
  - Do we offer true patient-centered care?
  - Community hear-say?
  - Reported complaints?
  - How are you reported on Care Compare?

Stroudwater Hospital

Branded Sample Hospital Swing Bed Program Name

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Information	Referral Process	Specialists
PORTLAND, ME CUMBERLAND **COUNTIES SERVED:** County 1, County 2, County 3 **Swing Bed Contact** Blake Harris, BSN test@test.com (211) 221-2121 Ext. 11 (office) (212) 212-1212 (fax)	**Referrals Accepted:** Monday - Friday; 08:00 to 16:00 Saturday and Sunday; 08:00 to 16:00 **Preapproved Admissions:** Monday - Friday; 12:45 to 16:00 Saturday and Sunday; 08:00 to 16:00 **Medical Oversight:** Hospitalist and Primary Care Physician **Clinical Approval:** Within same day **Payors Accepted** **Medicare Advantage:** Yes **Commercial:** Yes **Worker's Comp:** Yes **Veterans Admin:** Yes **Prison:** Yes **Medicaid:** Yes	• Internal Medicine • Cardiologist • Pulmonologist • Orthopedist • Urologist • Neurologist • Podiatrist • General Surgeon • Physiatrist (Rehab Medicine) • Psychologist • Psychiatrist

Swing Bed Services/Patients Served

- Physical Therapy
- Occupational Therapy
- Speech/Language Pathology
- Respiratory Therapy
- In-House Registered Dietitian
- In-House Pharmacist
- Therapy Gym
- Tilt Table for Therapy
- Orthopedic Traction
- Bariatric Equipment (<400 lbs)
- Isolation Room (Negative Air Pressure)
- Tracheostomy Care
- BiPAP & CPAP Management
- Chest Tube Management
- Short Term Ventilator Mgmt & Weaning
- Ventilator Mgmt Training for Home Vents
- New Ostomy Training
- New Diabetic Training/Management
- Access to OP Dialysis in Close Proximity
- Peritoneal Dialysis (Short Term)
- Short-Term Palliative Care with Skilled Needs
- IV Therapy
- Anti-infective Treatment
- PICC Line Insertion & Maintenance
- Blood Transfusion
- Nasogastric Feeding Tubes (NG Tube)
- Paracentesis/Chest Tube Catheter Mgmt
- Telemetry
- Complex Wound Mgmt including Wound Vac
- Telehealth

Rehabilitation Programs

- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Post-Stroke Rehabilitation
- Pneumonia Management
- Short-term Medical Management
- Wound Care Management
- Long-term IV Management
- Newly Diagnosed Specific Conditions
- Neuro-Muscular Disease
- Orthopedic Rehabilitation
- Short-term New Tracheostomy Care
- Short-term Ventilation Rehabilitation
- Post Bariatric Surgery Rehabilitation
- Short-term Nutritional Support
- Short-term Pain Management
- General Malaise and/or Debility
- Post-acute Kidney Disease
- Medically Complex/Multiple Trauma

INTERNAL PROCESS CHECK

Determine where your swing bed patients are referred from

- Determine who should meet with referring hospitals

Have you met with the local physicians to determine which hospital do they refer to when not your CAH and for what purpose?

Have you met with Care Management/Discharge Planning for the community & tertiary hospitals (2x/yr) applicable to you service area to:

- Determine their skill needs – what type of patients do they tend to refer for skill rehab?
- What is their process to make referral?
- What do they like to happen when making referrals?
- Where do they tend to refer in your service area – any specific reason?
- What are the patient's they have the most difficulty discharging to skill care – any services you can offer to meet those needs?
- Any services you could add
- **Ask to see their Choice Letter to make sure your program is on the list and correctly**
- What has been their experience with your hospital?
- Do they have data regarding referrals to SNF/swing bed in general
- How do they share QAPI data with patients/family for referrals
- Do they allow for presentation regarding how you can help them manage their referrals and if so, what is the process to get on the list

MARKETING AND PROMOTION IDEAS

- Marketing material i.e. brochure
  - Monthly or every-other-month mailers (post card)
  - Local newspaper featuring services, patient testimonial, follow-up outcome, quality data
- Hospital website / social media
- Health fairs at the hospital, in the community, at senior centers, employers
- Chamber of Commerce and other businesses to pull a Welcome packet for new people in your service area
  - Consider a give-away with hospital name and logo or magnet for fridge with hospital name
  - Invite them to meet the CEO and a free service

MARKETING AND PROMOTION IDEAS (CONT.)

- Promote through community education:
  - Promote services through education on a particular health issue which you can relate swing bed, HH, OP therapy, Imaging etc… promote the idea that people have choices
  - Offer to participate in Speaker's Bureau for all clubs, associations such as AARP luncheons, Eldercare meetings, community outreach program, women's society, Red Hat Society
- Brown Bag Lunch – educational presentations
  - "Preparing for Your Hip Surgery," etc. (swing bed, OP Therapy)
  - "Stroke Prevention and Rehab Needs Post Stroke" (swing bed, HH, OP Therapy)
  - "Making the Home Safe for the Elderly" (swing bed, HH)
  - Living With Back Pain" - "Back Pain Prevention" (OP Therapy)
  - "No Longer Need Acute Care But Not Ready For Home – What Are My Options?" (swing bed, HH, OP Therapy)
  - "Caring for the Care Giver – Know the Community's Support Option"

“OUT OF THE BOX” IDEAS

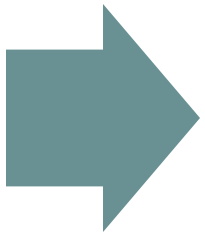
- Art of Healing” Exhibit
  - Display artwork or crafts made by Swing Bed patients during therapy
  - Host an annual exhibit night to celebrate recovery milestones
- “Talk Rehab” Podcast or Radio Series
  - Short 10-minute segments featuring PTs, nurses, or former patients sharing success tips on recovery and independence
- “Snack & Learn” Sessions at Senior Centers, etc.
  - Host informal coffee-and-cookie sessions with short Swing Bed overviews and Q&A
  - Bring along therapy tools for demonstrations

PROGRAM IMPROVEMENT OPPORTUNITIES

- Ask the patient/family at the time of the admission assessment to swing bed how they heard of your swing bed program
  - Track findings to inform the marketing team
- Ensure strong internal program processes
  - Clinical team to set discharge goals and assess patient status compared to goals on a daily/weekly basis to optimize outcome
  - Swing bed team to work closely in the monthly and quarterly review and discuss opportunities for improvement
  - Ensure a strong post-discharge clinical follow-up within 24 to 72 hrs:
    - Demonstrates a level of patient-centered care – speaks well for the hospital and the swing bed program
    - Allows you to identify patient's status and cause for alarm if pertinent
    - Continued follow-up as needed
    - Need for referral to PCP, community resources
    - Prevent readmission within the first 30-days post discharge
- Develop (if not already in place) a specific re-admission assessment to assist in determining what if anything could have been done differently to prevent ED visits or acute readmissions for the same reason

PROGRAM DESIGN

Staff notification of upcoming admission



Clinical post-discharge follow-up

PREPARING FOR ADMISSION

- **Develop a pre-admission assessment tool**
  - Summarizes patient status and needs for MD/DO, therapy, and nursing to support acceptance/denial decisions
  - Confirms availability of required medications and equipment
- **Review referral with care manager/discharge planner, covering:**
  - Primary diagnosis and acute admission date (not Observation)
  - Payor and pre-authorization requirements
  - Reason for referral
  - Patient and family goals
  - Anticipated discharge plan
  - Family involvement level
  - Expected transfer date (for 3-MN requirement, if applicable)
  - Other considerations identified during discussion

- **Information Required from Referral Sources**
  - Face sheet
  - History & Physical (H&P) and recent physician progress note
  - Medication Administration Record (MAR)
  - Surgical or special procedure reports (if applicable)
  - Consulting specialist reports
  - Pertinent labs, radiology, or other test results
  - Therapy assessments and progress notes (if applicable)
  - Vital signs for the last 48 hours
  - Intake & Output records for recent days (if relevant)
  - Nursing systems review and progress notes (last 48 hours)
  - Discharge Summary and Medication Reconciliation at transfer

ADMISSION CHECKLIST

PATIENT INFORMATION

If possible request the entire medical record and not just the H&P or discharge summary for any external refer

Name and Age

Attending physician

Date of admission and reason for admission to acute care

Anticipated discharge date from acute care

Stated reason for admission to swing bed

Acute Care Stay

- ☐ Surgical procedures
- ☐ Major complications or adverse events that occurred during the hospital stay
- ☐ Medications including IVs
- ☐ Nutritional status
- ☐ Functional status
- ☐ Continence
- ☐ Skin (including any skin breakdown)
- ☐ Wounds
- ☐ Mental status / Cognition
- ☐ Behavior
- ☐ Fall risk
- ☐ Ventilator weaning record (if applicable)
- ☐ Restraints during any point in hospital stay

Swing Bed Care Needs

- ☐ IV Therapy
- ☐ Simple Wound Care
- ☐ Complex Wound Care
- ☐ Ventilator Weaning
- ☐ Teaching / Training
- ☐ Nutrition Deficit
- ☐ PT/OT to increase ADLs / Functional status
- ☐ Speech Therapy thru-out swing bed stay
- ☐ Swallow exam(s)
- ☐ Special Equipment (i.e., specialty bed, wound vac, etc.)
- ☐ Non-formulary medications
- ☐ Other (i.e., dialysis, etc.)

Prior Living Arrangements	Anticipated Living Arrangements
☐ Home	☐ Home
☐ Assisted Living	☐ Assisted Living
☐ Group Home	☐ Group Home
☐ Long Term Care	☐ Long Term Care
☐ Homeless	☐ No clear plan
☐ Other	☐ Other

Family support structure and willingness to accept Swing Bed admission

Payor authorization obtained if needed. If traditional Medicare, benefit days are available.

MEDICARE CRITERIA

The patient requires skilled nursing or skilled rehabilitation services

There is a physician order for skilled services

Services are for a condition for which the patient received inpatient hospital services or for a condition that arose while receivi a condition for which he received inpatient hospital services

Services are required at least 7 days per week for skilled nursing

Rehab if required, is available at least 5 days per week

If Physical Therapy is required, it is available at the frequency and duration required by the patient

If Occupational Therapy is required, it is available at the frequency and duration required by the patient

If Speech Therapy is required, it is available at the frequency and duration required by the patient

As a practical matter, the daily skilled care can only be provided on an inpatient basis

The services are reasonable and necessary for treatment of the patient's illness or injury

3-Day inpatient qualifying stay within the last 30 days.

PREPARING **STAFF** FOR UPCOMING ADMISSION

- Provide copies of the completed pre-admission assessment tool to the admitting physician, nursing, and therapy staff
  - Decide where the tool will be stored for staff reference
- Determine how referring hospital medical records will be shared for staff review
- Send a copy of the face sheet to registration
- Use a swing bed email group (if available) to notify leadership and departments of internal or external transfers
- Discuss pending admissions during the morning stand-up IDT meeting, including expected transfer time
- If admission decision is not final, update the team on current status
- Conduct a nursing huddle to review patient's skills and special needs
  - Nursing staff responsible for passing updates to the next shifts
- Add patient's name, expected date, and time of admission to the Patient Schedule Board
- Assign admitting nurse to:
  - Prepare the Patient Engagement Board
  - Welcome the patient upon arrival
- Designate staff to call the referring hospital nurse on transfer day to:
  - Obtain patient status update (VS, temp, I&O, pain level, new meds)
  - Confirm receipt of Discharge Summary and Medication Reconciliation
  - Clarify expected transfer time

ROLES AND RESPONSIBILITIES: NURSING ADMIN

Ensure adequate staffing levels	Provide orientation to the Swing Bed (swing bed) program and P&Ps	Communicate expectations for Rehab Model and documented staff competencies	Support staff participation in huddles, IDT meetings, and mobility/self-care assessments
Oversee quality of clinical care and patient satisfaction	Require timely and updated care plans	Ensure admission and discharge medication reconciliations are completed	Provide patient education and tools for staff to use (diagnosis management, symptoms to report, actions to take)Set clear discharge planning instructions
Require meaningful documentation to support skilled nursing needs	Collaborate with swing bed Coordinator, Pharmacy, Infection Prevention, and PI Director	Promote program utilization to meet community needs	Maintain survey readiness with PI Director and others as needed

ROLES AND RESPONSIBILITIES: PI/QI & INFECTION PREVENTIONIST

- Stay current with CMS requirements for performance improvement and infection prevention
- Document compliance as required for all hospital services
- Participate in the swing bed quality by reviewing reports, conducting root-cause analysis, and developing action plans

ROLES AND RESPONSIBILITIES: THERAPY DIRECTOR

- Ensure interdisciplinary teamwork and compliance with state regulations
- Participate (or assign staff) in pre-admission/admission skill needs assessment
- Orient therapy staff to swing bed program expectations
- Develop functional rehab competency labs for nursing staff
- Ensure therapy staff orientation to swing bed P&Ps
- Provide sufficient staffing to meet patients' rehab needs
- Lead participation in self-care and mobility coding, as well as IDT meetings
- Ensure thorough documentation to support communication and prevent denials
- Participate in PI program including chart review
- Support program utilization to meet community needs

ROLES AND RESPONSIBILITIES: RESPIRATORY THERAPY

- Follow discipline-specific regulations
- Participate in IDT meetings as appropriate
- Complete assessments and documentation to support skilled needs
- Train nursing staff in treatment and documentation expectations when RT is providing 24-hour coverage

ROLES AND RESPONSIBILITIES: PHARMACIST

Perform documented medication reviews from physician orders to:

- Reduce medication errors and adverse events
- Ensure appropriate drug selection
- Monitor for interactions, over/under-medication
- Strengthen documentation of administration

Conduct medication reviews on admission and whenever changes occur

Participate in admission medication reconciliation

Discuss medication-related concerns with providers and document outcomes

Attend IDT meetings to present findings and highlight risks (GI issues, balance, labs, confusion, etc.)

Identify potential medication-related signs and symptoms during IDT discussions

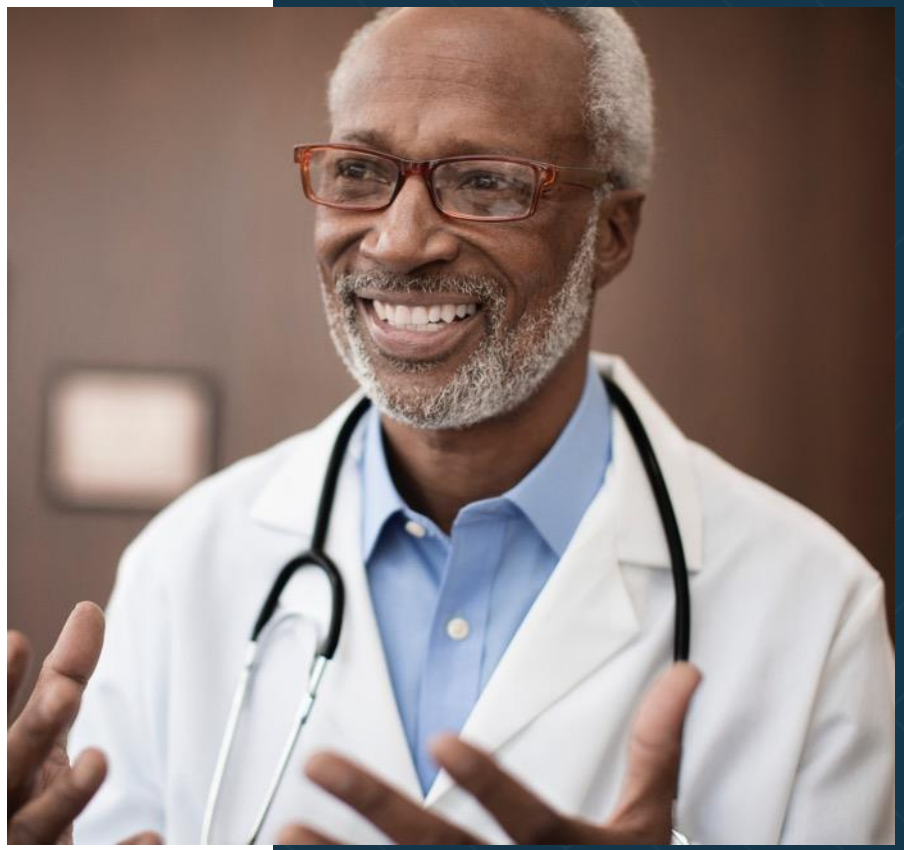
Develop patient/family medication education tools and provide education (ideally before discharge)

Verify MAR orders are clearly written to prevent errors

Meet other standards of care relevant to acute care and PI reviews for survey readiness

ROLES AND RESPONSIBILITIES: PROVIDER

- Participate in the pre-admission process when needed
- Collaborate closely with the swing bed Coordinator to review skilled needs and discharge planning
- Write admission orders (MD/DO responsibility)
- Complete admission H&P and treatment plan, with documentation that supports medical necessity certification for inpatient care
    - Certification may include a pre-typed statement but must be backed by clinical documentation
- Review and sign therapy treatment plans or clarification orders
- Allow NPs to conduct all other routine visits in swing bed
- Understand the differences between the rehab model and the medical model
- Understand direct admission to swing bed and medical appropriateness delays
    - Examine the patient within 24–48 hours of admission (often same-day in swing bed due to acuity) and PRN thereafter, but at least weekly
- Ensures ongoing awareness of patient status and documentation supporting skilled needs
- Work with swing bed Coordinator to align on discharge goals and progress
- Maintain awareness of PI/QI monitors
- Write discharge orders once discharge goals are achieved
- Support program growth and utilization



ROLES AND RESPONSIBILITIES: SWING BED COORD.

In some rural hospitals, this role is combined with Acute Care Manager or Nurse Manager

Overall Responsibilities:

- Manage the program in compliance with regulations
- Complete pre-admission assessments
- Act as Care Manager, Discharge Planner, and often Social Work designee
- Serve as liaison between patient, family, provider, and IDT members
- Direct rehab model processes
- Help prevent denials by ensuring skilled needs, utilization reviews, and strong documentation
- Oversee plans to increase program utilization

KEY DUTIES OF THE SWING BED COORDINATOR: **PRE-ADMISSION**

- Collaborates with the Acute Discharge Planner to identify appropriate Swing Bed candidates
  - In small rural hospitals, this may be the same person
- Reviews external referrals and responds within 1–4 hours based on acuity with acceptance or denial
- Confirms qualifying acute stay:
  - 3-day stay for Medicare patients (related to referral reason)
  - At least 1-day acute stay for most other payors with skilled needs
- Verifies Medicare days available (full coverage vs. co-pay)
- Consults with hospitalist or PCP when referral conditions are questionable, and facilitates discussion with the referring physician if needed
- Completes pre-admission assessment to confirm criteria and identify likely skilled needs
- Contacts non-Medicare payors to verify benefits and obtain pre-authorization (if required)Communicates details of upcoming admissions to staff, including a nursing huddle to provide report
- Works with providers to ensure H&P or progress note supports medical necessity for inpatient skilled care (serves as certification of need in CAHs)Confirms physician order for swing bed or skilled inpatient admission is in place
- Within 24 hours of admission, completes assessment including:
  - Pre-hospitalization living status and functional abilities
  - Psychosocial needs
  - Discharge planning needs

KEY DUTIES OF THE SWING BED COORDINATOR: **DURING SWING BED STAY**

- Orients patients to the Swing Bed program:
  - Financial responsibility, rights/responsibilities
  - Rehab model and participation expectations
- Activates the Advance Directive process
- Collaborates with HIM Coders to:
  - Align documentation with primary diagnosis
  - Review readmissions to determine if related to prior stay or a new condition
- Communicates important updates to the Business Office, including:
  - Patients not meeting skilled criteria post-admission
  - Delays in medical necessity for skilled rehab
  - Appeals after a Notice of Medicare Non-Coverage (NOMNC)Works with the DON and Nurse Manager on staff documentation, care planning, and cost management
- Completes additional assessments for readmissions to improve discharge planning practices

KEY DUTIES OF THE SWING BED COORDINATOR: **SWING BED DISCHARGE**

- Tracks and reports monthly data, including:
  - Admissions and discharges
  - swing bed days, ADC, and ALOS
  - Medicare vs. non-Medicare percentages
  - Referral sources, acceptance/refusal reasons, discharge destinations, and program outcomes
- Conducts post-discharge clinical follow-up calls
- Maintains clear written processes so back-up staff can manage responsibilities when coordinator is unavailable
- Ensures policies and procedures (P&Ps) are updated
- Participates in ongoing marketing efforts (as applicable)

COMMUNICATION WITH REVENUE CYCLE TEAM

To ensure accurate coding, provide billers with:

- Verification of 3-day qualifying stay
- Number of skilled days used and remaining
- Details of medical delay admissions and associated 3-day qualifying stay
- Any swing bed/SNF readmissions occurring within 30 days of discharge
- Documentation of overnight Leave of Absence (LOA) days
- Authorization numbers for Medicare Advantage or commercial payors
- Contracted reimbursement amount (if applicable)Identification of days not meeting skilled criteria
- Any other relevant billing information

QUALITY / OUTCOMES

SWING BED QUALITY OF CARE: GAPS IN MEASUREMENT

- Quality of swing bed care has been largely unexamined since a 1990 study comparing them to Skilled Nursing Facilities (SNFs)
- Recent research has focused more on **cost comparisons** and **patient characteristics** than care quality
- Swing beds are notably **excluded from national quality measurement initiatives**
- Major efforts like the **IMPACT Act (2014)** and **NQF Measure Application Partnership** have emphasized:
  - SNFs
  - Home Health Agencies (HHAs)
  - Long-Term Care Hospitals (LTCHs)
  - Inpatient Rehabilitation Facilities (IRFs)
  - Hospices
- **Swing beds remain unaddressed** in these quality improvement initiatives

CHALLENGES IN DEMONSTRATING SWING BED QUALITY IN CAHS

Swing-bed programs in rural Prospective Payment System hospitals and Skilled Nursing Facilities must submit Minimum Data Set patient data to CMS. CAHs are exempt.

CAHs are not uniformly demonstrating the quality of care provided to their swing-bed patients

Inability to demonstrate swing bed quality potentially limits CAHs' ability to participate in alternative payment models

CLOSING THE CAH PERFORMANCE GAPS IN MEASUREMENT

CMS Final Rule (Sept. 30, 2019) created an opportunity to develop a performance measurement system for CAHs

- **CMS Discharge Planning Rule**: *Must assist the patient (and/or the patient's representative) in selecting a post-acute provider/service by using and sharing data that includes, but is not limited to, SNF, HHA, IRF, or LTCH data on **quality measures** and resource use measures that are relevant and applicable to the patient's care goals and treatment preferences*

Referring facilities must give Medicare beneficiaries a list of qualifying post-acute providers with quality and resource use data

PPS providers likely to use CMS Star Ratings to meet this requirement

CAHs lack an equivalent rating system due to exemption from public reporting

New metrics are needed to showcase CAH performance and enable fair comparison

THE WHY TO ASSESS CAH SWING BED QUALITY

Assess whether patients are getting appropriate care; help them return home as quickly as possible; prevent hospital readmissions

CAHs desire to increase patient volume in swing-bed programs, compare swing bed care to SNFs

Ensure compliance with CMS requirements/intent regarding swing bed care

CAH SWING BED NATIONAL STUDY - 2019

- CAH swing beds have very positive outcomes for patients as evidenced by:
  - A 30-day risk-adjusted hospital readmission rate of 13.6% that is **significantly less** than the 30-day risk-adjusted hospital readmission rate for rural SNFs in the U.S. of 21.1%
  - **Approximately 3/4** of patients returned to their prior living situation or a more independent level of care after their swing bed stay
  - **Substantial average improvement** in patient functional status as measured by change in self-care and mobility scores

POLICY BRIEF
October 2019

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

Quality Measures for Critical Access Hospital Swing-Bed Patients

Michelle Casey, MS
Ira Moscovice, PhD
Henry Stabler, MPH

Key Findings:

Quality measures relevant for CAH swing-bed patients include:

- Two outcome measures (discharge status of swing-bed patients and 30-day follow-up status after a swing-bed stay)
- Two functional status measures (risk-adjusted change in self-care and mobility scores between admission and discharge for CAH swing-bed patients)

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Background

The Medicare swing-bed program allows rural hospitals with fewer than 100 beds to use their inpatient beds either for acute care or skilled nursing facility (SNF)-level swing-bed care.[1] Swing-bed services provided in rural Prospective Payment System (PPS) hospitals are paid for under the SNF PPS, while Critical Access Hospitals (CAHs) receive cost-based reimbursement for swing-bed services. Currently, approximately 90% of CAHs and 60% of rural PPS hospitals nationally provide swing-bed services.[2,3]

PPS hospitals are required to collect patient data and provide it to the Centers for Medicare & Medicaid Services (CMS) using the swing-bed Minimum Data Set (MDS), a tool for implementing standardized assessment and facilitating care management, which is a subset of the MDS used in SNFs. However, CAHs are exempt from this requirement. The lack of nationally comparable swing-bed quality measure data for CAHs creates two problems. First, CAHs are not uniformly able to demonstrate the quality of care provided to their swing-bed patients or compare it to national benchmarks. Second, the lack of quality data for their swing-bed services limits the ability of CAHs to participate in alternative payment models involving post-acute care, since organizations need outcome data to select appropriate partners.

Swing-bed quality of care has received little attention since a 1990 study compared the quality of care in SNFs and swing-beds.[4] Recent studies have focused on the cost of swing-bed care[5,6] and on comparing swing-bed and SNF patient characteristics and diagnoses.[7] Swing-beds also have not been included in recent national quality measurement efforts. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requires post-acute providers, including Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs), to submit standardized and interoperable patient assessment data that will facilitate coordinated care, improved outcomes, and overall quality comparisons, but does not include CAH swing-beds. Similarly, the National Quality Forum (NQF) Measure Application Partnership project to select post-acute and long-term care quality measures focused on SNFs, HHA, hospice, IRFs, and LTCHs, but did not address swing-beds.[8]

SWING BED QUALITY METRICS

Return to Acute Care	% of all patients who were re-hospitalized after a swing bed admission
Return to Acute Care Post Discharge	% of all readmissions to acute within 30 days from swing bed discharge date
Mobility	% of risk-adjusted patients who made above-average improvement in mobility based on 17 measured items
Self-Care	% of risk-adjusted patients who made above-average improvement in self-care based on 7 measured items
Discharge to Community	% of swing bed patients who were discharged to community

KEY RESULTS: FOUR-YEAR TREND (CY)

- **Unplanned Return to Acute Care** has increased since 2021. CAHs attribute this increase to the pre-admission process and a higher-acuity swing bed patient.
- **Return to Acute Care Within 30-Days** has increased in 2024, CAHs attribute this increase to a higher-acuity swing bed patient, and potentially discharging patients too soon due to capacity factors
- **Self-Care and Mobility Improvement – Risk-adjusted** performance have both improved since 2022, largely due to strong IDT, discipline communication, and discharge planning
- **Discharge to Community** has increased since 2021. CAHs attribute this to improved discharge planning, patient/family involvement, and education.

5 Key Swing Bed Metrics	2021	2022	2023	2024	
Return to Acute (Unplanned Returns)	7.3%	7.2%	8.8%	9.0%	
Return to Acute Post 30-Day Discharge	8.6%	9.6%	8.7%	10.0%	
Self-Care Improvement - Risk Adjusted	47.6%	47.3%	49.6%	52.4%	
Mobility Improvement - Risk Adjusted	36.9%	35.4%	42.5%	50.9%	
Discharge to Community	74.3%	73.7%	75.1%	76.0%	

CAH SWING BED PROGRAMS OUTPERFORM SNFs ON QUALITY PERFORMANCE

- 74.2% of CAH swing bed patients were **discharged to their community**, significantly exceeding SNFs' rate of 49.9% (10/1/21 through 9/30/23)
- 8.8% of CAH swing bed patients experienced **unplanned returns to acute care**, compared to SNFs' 25% (10/1/2023 through 9/30/2024)
- 9% of CAH swing bed patients had **returned to acute care within 30 days post-discharge**, whereas SNFs' rate stood at 10.5% (10/1/21 through 9/30/23)
- SNFs ranked slightly higher than CAHs in two categories: Risk-adjusted performance **improvement for mobility and self-care** (7/1/2023 through 6/30/2024)

Area	Year	Mobility Risk Adjusted Higher is better	Self-Care Risk Adjusted Higher is better	Return to Acute (Unplanned) Lower is better	Return to Acute 30-Day Post Discharge Lower is better	Discharge to Community Higher is better
All 29 states	Oct 20 through Jun 23	37.2%	47.8%	7.6%	9.0%	74.0%
All	Oct-Dec 2020	34.0%	46.2%	8.0%	9.5%	73.2%
All	Jan-Dec 2021	36.8%	47.5%	7.3%	8.6%	74.3%
All	Jan-Dec 2022	35.5%	47.3%	6.0%	9.6%	73.7%
All	Jan-Dec 2023	42.2%	48.8%	8.8%	9.3%	75.1%
All	Jan-Dec 2024	50.9%	52.4%	9.0%	10.0%	76.0%
SNF Data from National Nursing Home Compare		50.2%	52.7%	25.0%	10.5%	49.9%
Data date from NH Compare		07/01/2023 - 06/30/2024	07/01/2023 - 06/30/2024	10/01/2023 - 09/30/2024	10/01/2021 - 09/30/2023	10/01/2021 - 09/30/2023
National CAH for same date range as NH Compare		45.6%	50.4%	8.8%	9.0%	74.2%

CAH SWING BED PROGRAMS OUTPERFORM SNFs ON QUALITY PERFORMANCE – ADDITIONAL MEASURES

- 79.8% of CAH swing bed patients needed and got the **influenza vaccine**, compared to the SNFs' rate of 79% (10/1/21 through 9/30/23)
- 1.7% of CAH swing bed patients experienced **a new or worsened pressure ulcer/injury**, compared to SNFs' 2.4% (7/1/2023 through 6/30/2024)
- 0.2% of CAH swing-bed patients had **a fall with injury**, whereas SNFs' rate was 0.8% (7/1/23 through 6/30/24)
- SNFs ranked slightly higher than CAHs performance in patients who needed and got a **pneumococcal vaccine** rate (10/1/2023 through 12/31/2024)

Measure	CAHs	Nursing Home Compare	Date Range
Influenza Vaccine	79.8%	79.0%	07/01/2023 - 06/30/2024
Pneumococcal Vaccine	75.4%	81.6%	10/01/2023 - 12/31/2024
Pressue Ulcers/Injuries	1.7%	2.4%	07/01/2023 - 06/30/2024
Falls with Major Injury	0.2%	0.8%	07/01/2023 - 06/30/2024

BENEFITS OF THE SWING BED QUALITY REPORTING PROGRAM

NOW CAN EASILY TRACK AND TREND SWING BED QUALITY DATA

OPPORTUNITY FOR GOAL SETTING AND PERFORMANCE IMPROVEMENT FOR THE CARE TEAM

ABILITY TO BENCHMARK AND COMPARE TO PEER CAHS, STATE AND NATIONAL AVERAGES

IMPROVED COMMUNICATION ACROSS ALL DISCIPLINES (NURSING, REHAB, CASE MANAGEMENT, ETC.)

ABILITY TO SHARE PERFORMANCE REPORTS WITH KEY LEADERS

KEY TAKEAWAYS / DISCUSSION

KEY TAKEAWAYS

Swing Bed Success Starts with Strong Foundations

- Clear eligibility, documentation, and compliance build confidence and consistency.
- Align every process from admission to discharge with CMS intent and patient-centered care.

Documentation Drives Outcomes

- “If it’s not documented, it didn’t happen.”
- Daily notes must clearly show why care is skilled, how progress is measured, and what outcomes are achieved.

Interdisciplinary Teamwork is Non-Negotiable

- Effective communication across nursing, therapy, providers, and care management ensures smooth transitions.
- Weekly IDT meetings sustain alignment and quality.

Let Data Tell Your Story

- Track outcomes that matter; readmissions, LOS, functional gains, and satisfaction.
- Use data not just for reporting, but for learning and celebrating improvement.

Growth Comes from Visibility and Value

- Promote your program internally and externally, staff engagement and community awareness matter.
- Celebrate patient outcomes and success stories to strengthen reputation and referrals.

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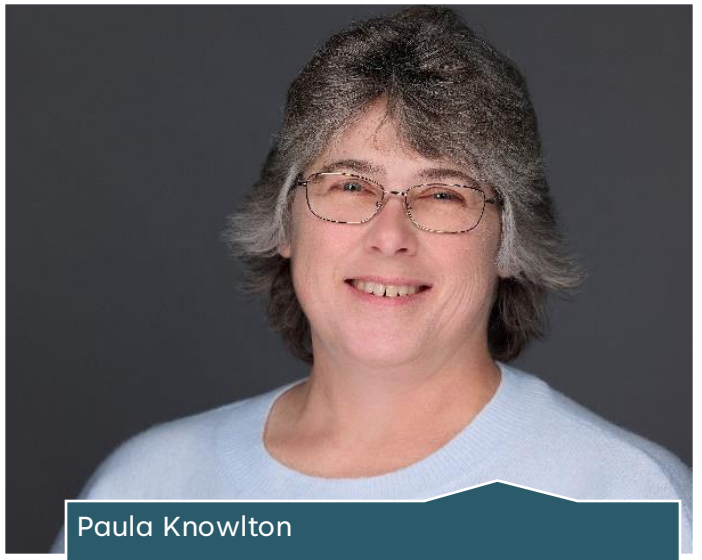

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APPENDIX

COMPREHENSIVE ASSESSMENT

- A comprehensive nursing assessment is completed within the shift of admission to include the following:
  - Patient interview (demographics, preferences, etc.)
  - Comprehensive system review
  - Pain assessment [add form if not included in your admitting assessment]
  - Fall assessment [add form if not included in your admitting assessment]
  - Skin assessment for pressure wound predictor [add form if not included in admitting assessment]
  - Mental Status Assessment [add form if used or remove if not used]

COMPREHENSIVE ASSESSMENT (CONT.)

- §483.20(b) A facility must complete a comprehensive assessment of a patient's needs, strengths, goals, life history, and preferences. The assessment must include at least the following:
  - Identification and demographic information
  - Cognitive patterns
  - Communication
  - Vision
  - Mood and behavior patterns
  - Psychosocial well-being
  - Physical functioning and structural problems
  - Continence
  - Disease diagnoses and health conditions
  - Dental and nutritional status
  - Skin condition
  - Activity pursuit
- Medications
- Special treatments and procedures
- Discharge planning
- Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts
- REVIEW PASRR – if one has been done
  - Recommendations from the PASRR should be included in the CAH's comprehensive treatment plan for the patient
- Assign responsibility for each assessment component.
- Timelines need to be congruent with your length of stay

COMPREHENSIVE CARE PLAN

A care plan will be initiated by the RN staff on the shift of admission and added to as needed when new potential or actual problems are identified.

- Each discipline will review the completed pre-admission data as part of their comprehensive assessment and will determine their action plan based on:
  - anticipated discharge destination
  - previous functional abilities
  - current medical and function condition
  - current support system available
  - anticipated discharge functional status
  - anticipate length of stay.
- The PT, OT, SLP, RT, Dietician, will develop discipline specific plan and add treatment plan to the initial nursing care plan as appropriate once they have completed their comprehensive assessments.
  - For instance, the frequency of each therapy discipline treating the patient will be added to the interdisciplinary care plan as well as what if anything should the nursing staff participate in, special equipment(s) to be used etc. but the full treatment plan will be documented on each discipline specific assessment.
  - Dietary and RT (if pertinent) will add any special instructions to nursing on the care plan.
- Patient discharge goals will be determined during the initial interdisciplinary team meeting and the care plan will be reviewed at this time and weekly thereafter to ensure that all identified issues are documented, and care planned.
- Nursing staff will document to the care plan problems, skills, and discharge goals daily as appropriate.
- Upon discharge, nursing will document the status of each problems identified during the stay as to whether they were resolved and if not, what is the plan post-discharge.

DAILY DOCUMENTATION

- Nursing will complete a system's review assessment [each shift or each 24 hrs. (note which shift), (choose what you will require)], document and report any changes in condition. [attach form of assessments required on a daily or weekly basis].
- [If the system review is only completed x 1/24 hrs., add the following – otherwise erase # 5]: The "off shift" will complete and document a focus clinical assessment based on care plan issues and report such as appropriate.
- Every nursing shift will include documentation of the patients' daily activities to include patients' status and progress regarding but not limited to the following items:
  - Nutrition
  - Skin /wound care
  - Functional activities
  - Mood & Behavior (if applicable)
  - Social activities (if applicable)
  - Elimination
  - Position change
  - Safety
  - Balance
  - Range of motion.