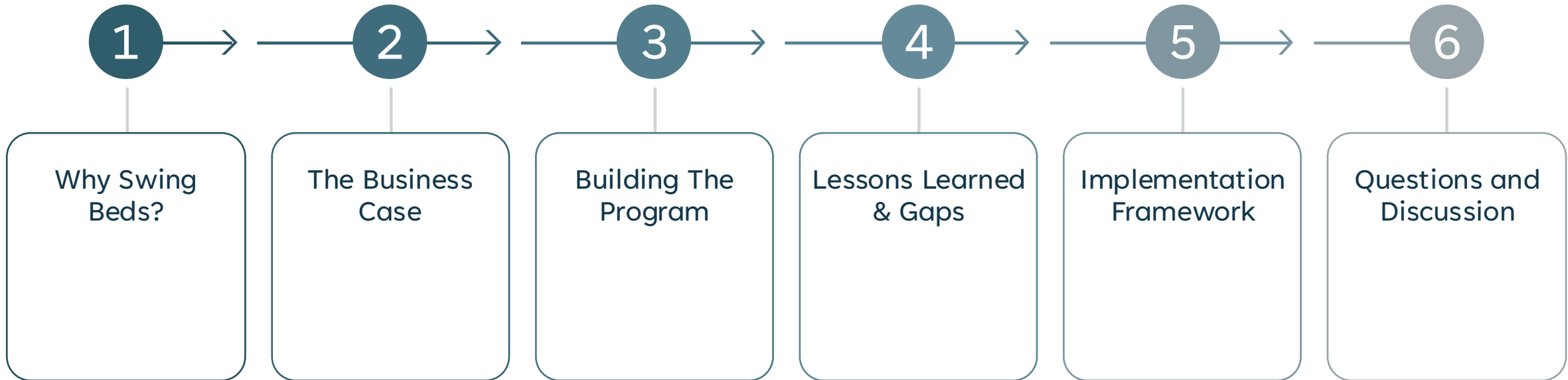




**FROM GAP TO GROWTH:
HOW ONE HOSPITAL BUILT A SWING BED
PROGRAM TO IMPROVE CARE DELIVERY**

June 10, 2026

SESSION AGENDA



ADVENTHEALTH MANCHESTER AT A GLANCE

- 49 licensed beds
- Rural – Clay County, KY
- PPS Short-Term Acute Care Hospital
- Only AdventHealth hospital in KY
- **Services:** Acute Care · ICU · Emergency Medicine · Obstetrics · Imaging · Laboratory · Rehabilitation · Home Health · Primary Care · Specialty Care
- **The challenge:** As the only hospital serving this rural community, AHM bears full responsibility for local care access, including the post-acute gap when patients need skilled care but can't access quality local SNF options



WHY SWING BEDS?



Capacity Constraints

Patients medically ready for post-acute care occupy acute beds, driving up costs and blocking capacity for new admissions

Patient Outmigration

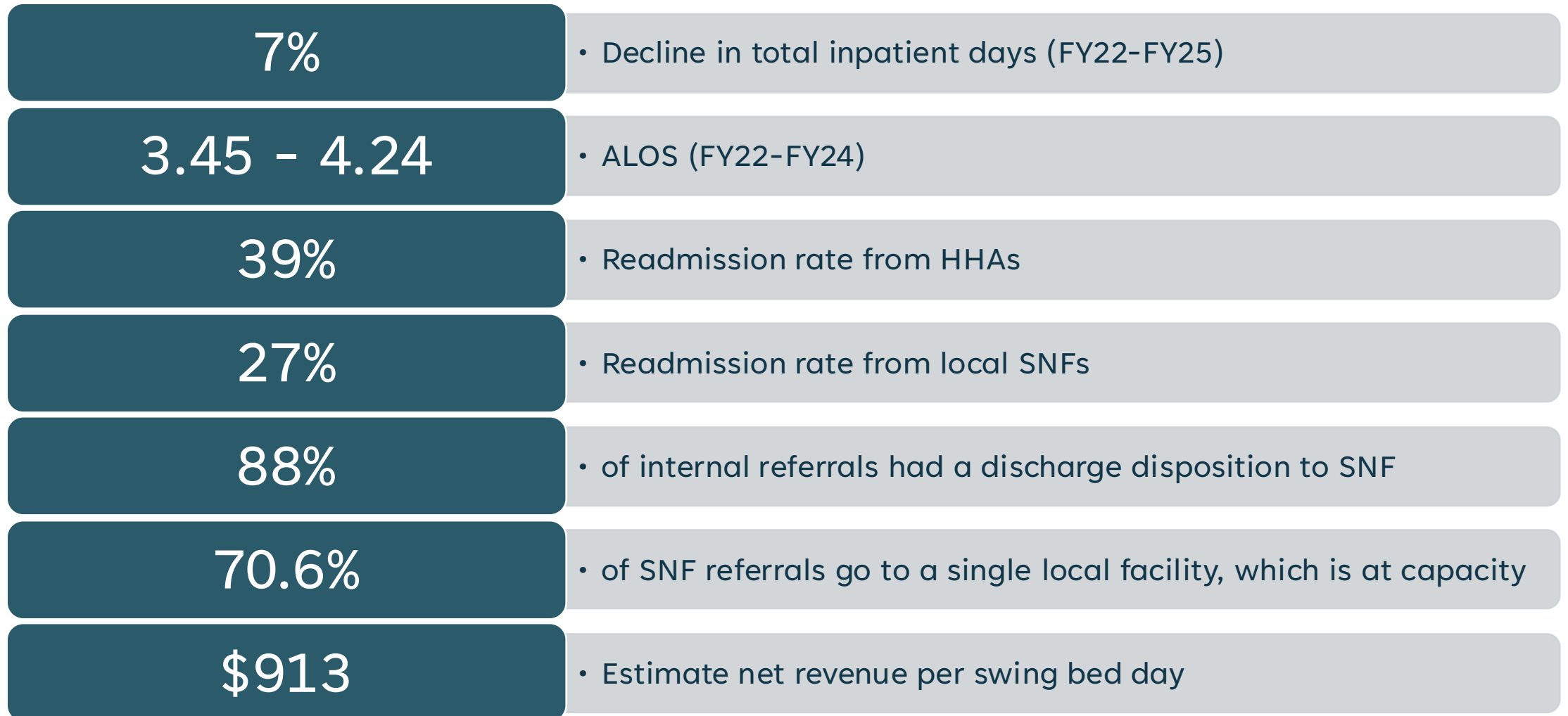
Families face long-distance travel. Patients are separated from support networks, leading to worse outcomes and lower satisfaction.

Revenue Leakage

Reimbursable SNF-level care days are transferred out of the hospital, losing both revenue and the care relationship



THE DATA BEHIND THE DECISION: KEY MARKET DRIVERS IDENTIFIED DURING AHM'S READINESS ASSESSMENT



THE LOCAL POST-ACUTE LANDSCAPE

Market Reality

Only 1 SNF in AHM's direct market area
34 SNFs within 50-mile radius - many at high occupancy (avg 85.6%)
Average SNF quality ratings vary widely - many low-scoring facilities show high occupancy
Families face significant travel barriers to accessing post-acute care
31.6% of referrals to local SNF were for Septicemia/Severe Sepsis—high-acuity patients needing continued skilled care

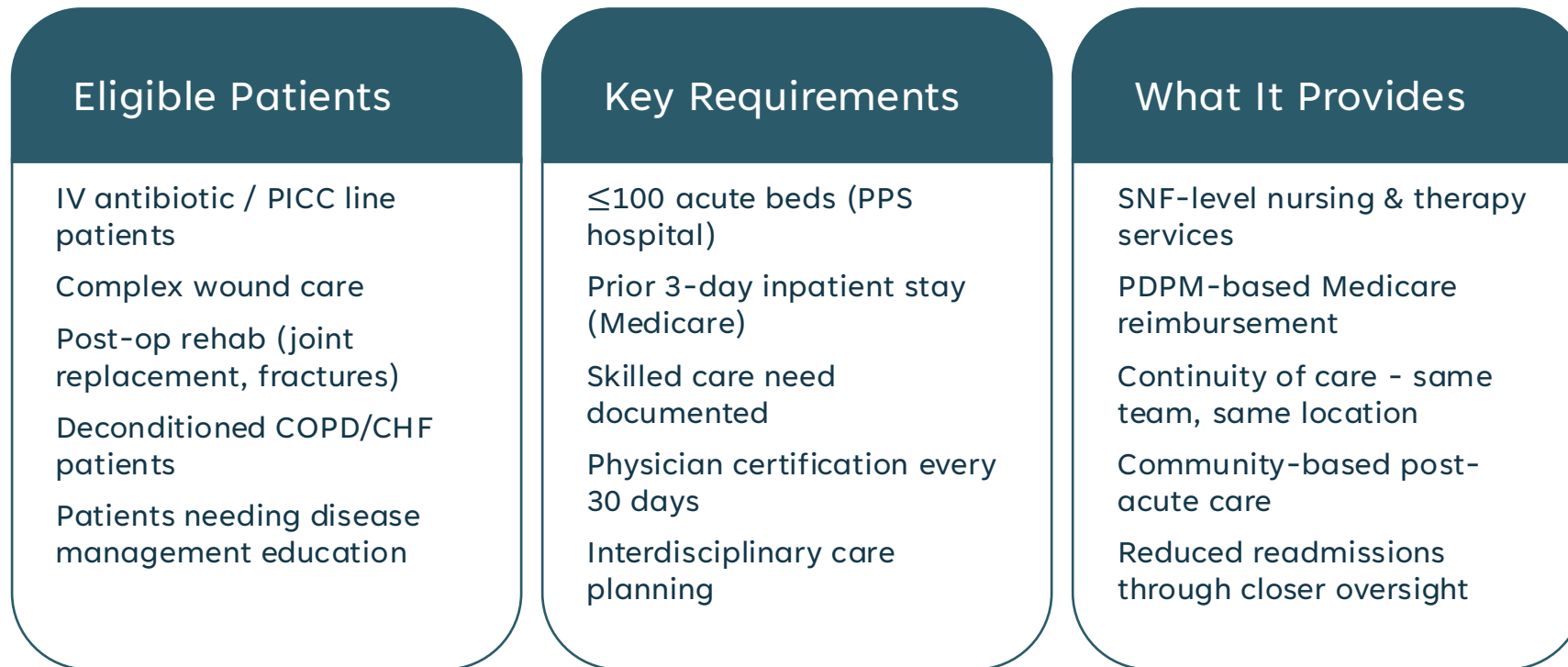
Strategic Opportunity

Keep patients in their community - improve family involvement & outcomes
Capture the percentage of current SNF referrals currently leaving AHM
July 2025: KY eliminated Certificate of Need for swing beds - green light to launch



WHAT EXACTLY IS A SWING BED PROGRAM?

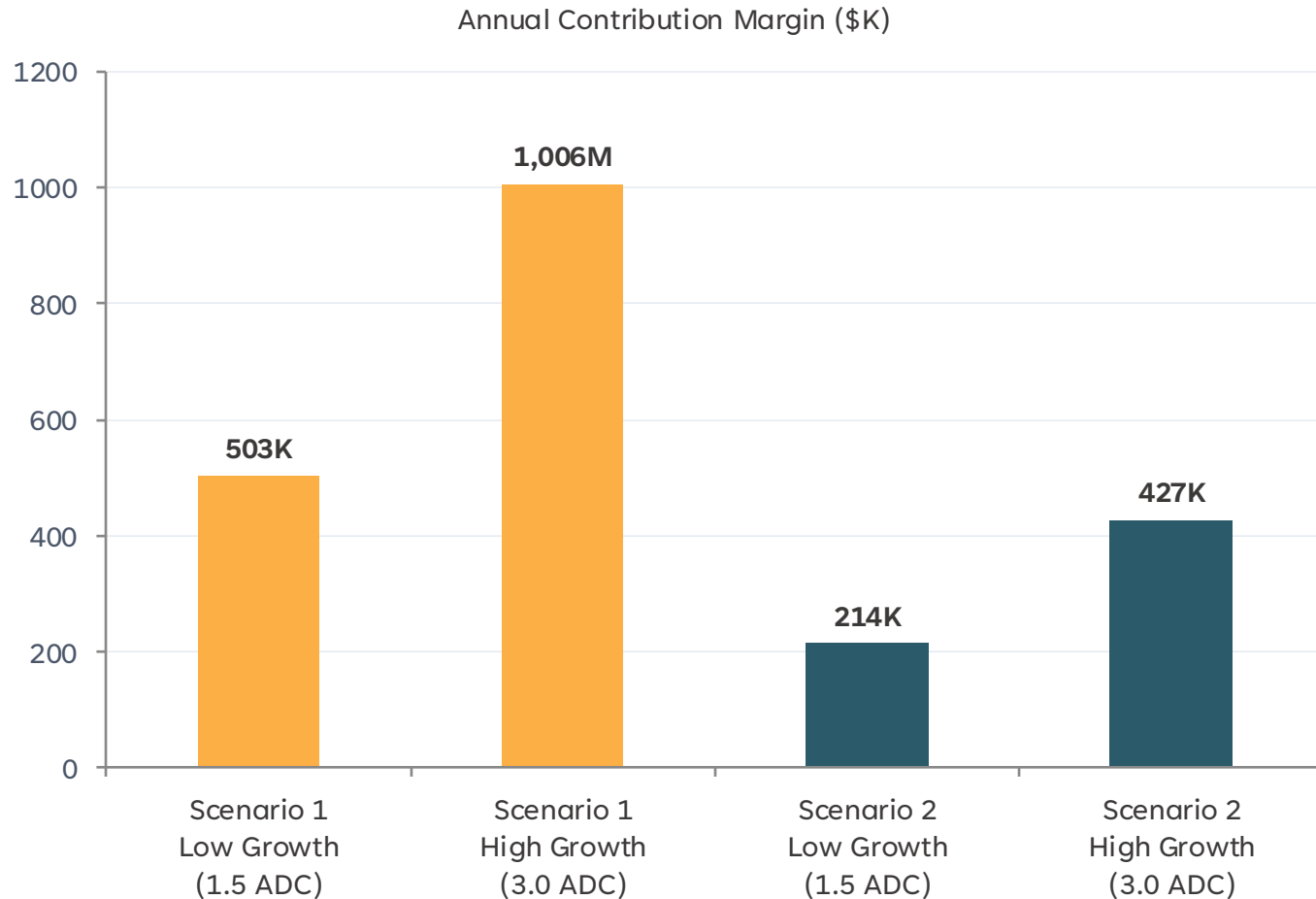
- A swing bed program allows an acute-care hospital to use the same physical bed for both acute inpatient care AND SNF-level skilled nursing care, i.e., "swinging" between levels of care based on the patient's clinical need





THE BUSINESS CASE

THE FINANCIAL OPPORTUNITY: TWO SCENARIOS MODELED FOR AHM BASED ON CONSERVATIVE AND AGGRESSIVE ASSUMPTIONS



Scenario 1 (AHM Proforma)

Revenue: \$1,500/day · Variable Cost: \$581/day

Low Growth: \$503K / High Growth: \$1.0M

Scenario 2 (MedPAC Conservative)

Revenue: \$540/day · Variable Cost: \$150/day

Low Growth: \$214K / High Growth: \$427K

* All figures represent annual contribution margin opportunity



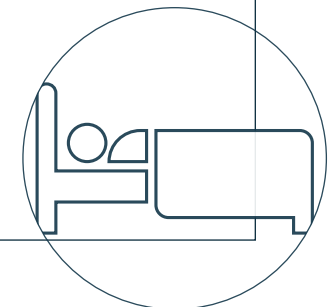
TEAM: AN ADDED STRATEGIC LAYER

What is TEAM?

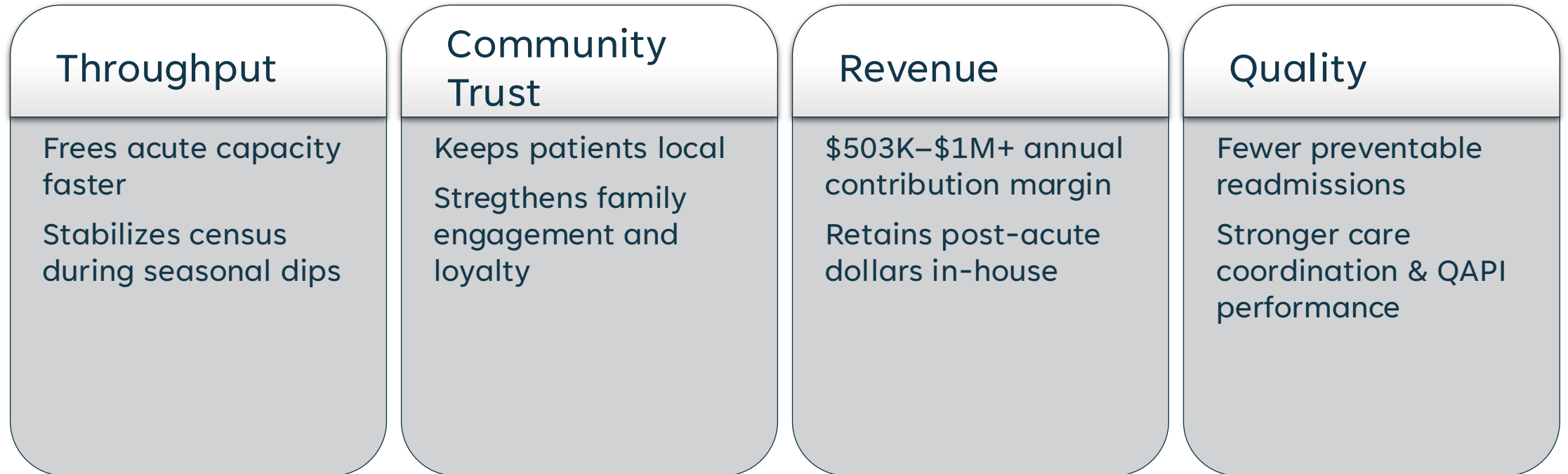
- **Transforming Episode Accountability Model — effective January 2026**
- CMS mandatory bundled payment program requiring AHM to manage cost and quality for 5 surgical episode categories:
 - Lower Extremity Joint Replacement (LEJR)
 - Surgical Hip Femur Fracture (SHFFT)
 - Coronary Artery Bypass Graft (CABG)
 - Spinal Fusion
 - Major Bowel Procedure

- Discharge qualifying beneficiaries directly to swing bed - 3-day requirement waived under TEAM
- Admission must occur within 30 days of OP/IP discharge
- Submit claim with TEAM demonstration code A9
- Track LOS + readmissions as key performance indicators under the model
- Low-volume policy protects smaller hospitals from downside risk in categories with <30 episodes

**Swing Bed
+ TEAM**



WHY SWING BED IS A STRATEGIC LEVER, NOT JUST A SERVICE LINE

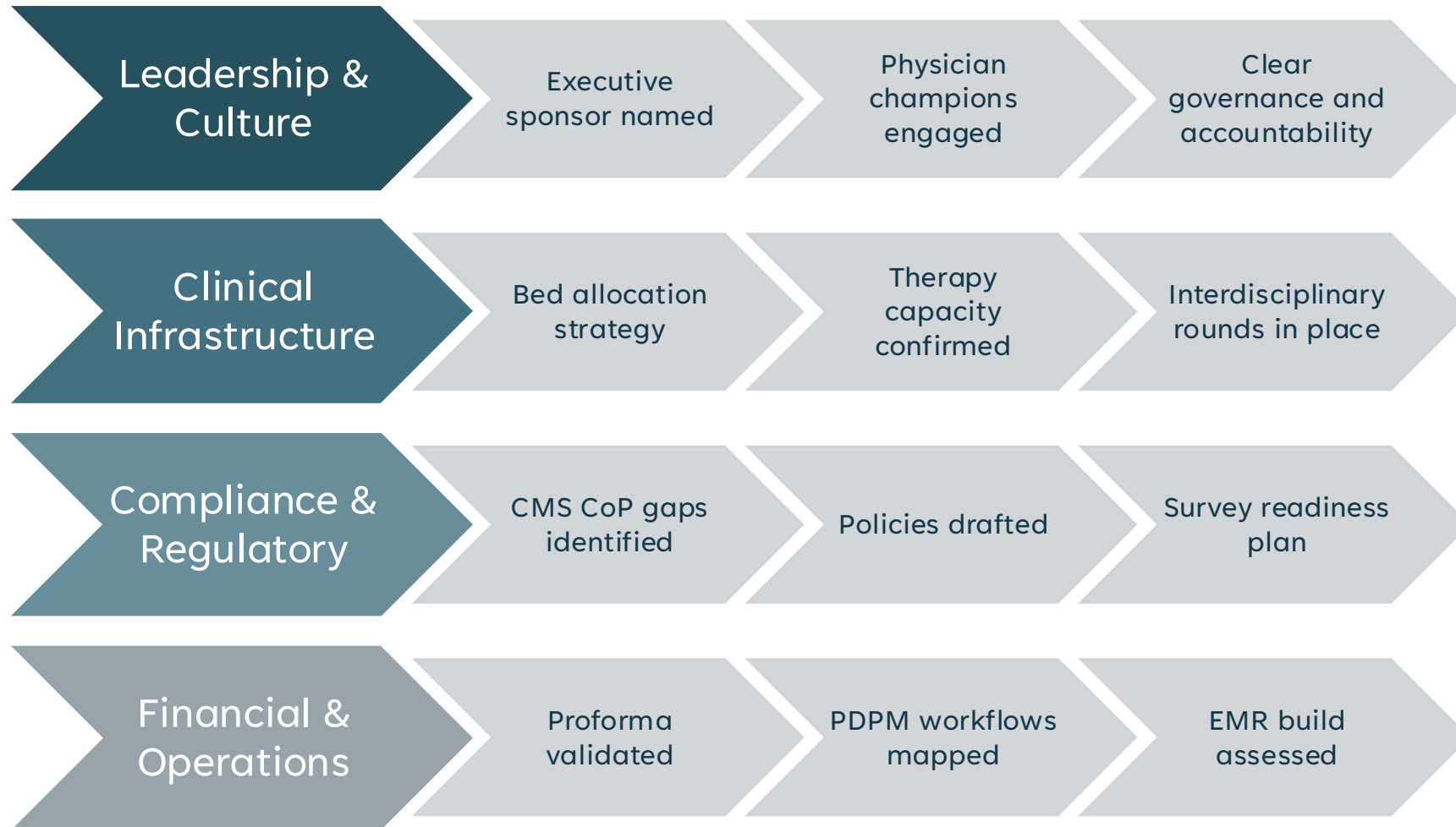




BUILDING THE PROGRAM

WHERE TO START: READINESS ASSESSMENT

- AHM completed a formal readiness assessment with Stroudwater Associates, using structured interviews across all four domains.



WHAT AHM HAD GOING FOR IT

Strengths identified during the readiness assessment: Every hospital has a foundation to build on

- ✓ **Strong Leadership** - Engaged executive team, physician champions, and clinical staff eager to support swing bed development
- ✓ **Quality Culture** - QAPI framework, daily huddles, and structured rounding reflect a culture of continuous improvement
- ✓ **Therapy Integration** - PT/OT well-integrated into care delivery and able to expand; OT added recently; ST available PRN
- ✓ **Available Capacity** - Med-surg (14–16 beds), PCU (22 beds), and ICU (6 beds) offer flexibility for swing-bed allocation
- ✓ **Case Management** - Structured discharge planning, early post-acute screening, and strong cross-team coordination already in place
- ✓ **Community Presence** - Strong marketing infrastructure (billboards, radio, health fairs, SEO) ready to support program launch



EVALUATING THE STRATEGIC AND FINANCIAL BUSINESS CASE

Business Case Dimension	Key Considerations	Impact of Swing Bed Program
STRATEGIC	Patient retention, community access, care continuity	Keeps patients local and strengthens community trust
OPERATIONAL	Length of stay, bed utilization, discharge delays	Reduces LOS variability and optimizes unused capacity
FINANCIAL	Reimbursement, staffing costs, contribution margin	Positive margin compared to extended acute stays
QUALITY	Readmissions, patient experience, outcomes	Improves oversight and continuity of post-acute care





LESSONS & GAPS

THE GAPS AHM HAD TO CLOSE

Policies & Compliance

- Swing bed-specific policies incomplete; CMS SNF-level CoP expectations not yet embedded in processes

Staff Education

- No competency checklist for SNF-level skills; hospitalists had no swing bed training; MDS coordinator not yet identified

Technology / Epic Build

- Epic swing bed structure exists but unvalidated; order sets, documentation templates, and MDS module not yet configured

Equipment & Environment

- No structured inventory vs. SNF-level Appendix PP requirements; therapy space unclear; fall/PI risk gaps identified

Program Design

- No finalized operating model, bed allocation strategy, formal governance, or clear program 'ownership'

Workflow Definition

- Inconsistent patient identification; no standardized admission workflow; discharge follow-up gaps

Financial Readiness

- Pro-forma assumptions incomplete; payer recognition not confirmed; PDPM and TEAM billing workflows not finalized

Marketing & Referrals

- No swing bed-specific marketing plan; no formal referral pathways with SNFs or regional hospitals

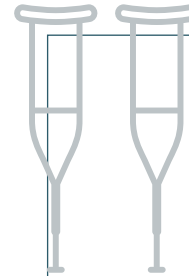


STAFFING: A COMMON CHALLENGE

Rural hospitals face unique staffing constraints. Here's what AHM found.



Nursing: Cross-training for swing bed workflows not established; documentation education needed for SNF-level specificity



Therapy: PT/PTA model in place; OT added recently; ST available PRN only — no backup plan if volume grows



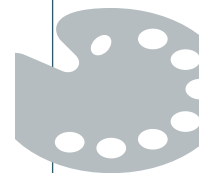
Case Management: Resource-constrained with manual workflows; limited social work coverage; CarePort → AIDIN transition ongoing



Hospitalist: "No education on swing bed" - certification, recertification, and documentation expectations all need training



Minimum Data Set (MDS) Coordinator: Not yet identified. Critical role for CMS compliance, data accuracy, and PDPM reimbursement accuracy.



Activities Staff: Activities professional or qualified designee needed for regulatory compliance



WHO BELONGS IN SWING BED?



Appropriate Candidates for AHM

- IV antibiotic / PICC line patients (31.6% of AHM SNF referrals = Sepsis)
- Complex wound care - pressure ulcers, post-surgical, dressing changes
- Post-op orthopedic / rehab patients - joints, fractures, spinal fusion
- Deconditioned COPD/CHF - disease management education, strengthening
- Dialysis patients – with proper capacity planning

Not Appropriate for AHM

- High-acuity patients requiring close medical monitoring
- Tracheostomy / ventilator-dependent patients
- Behavioral health / suicidal ideation

Best Practice

- Use a daily interdisciplinary eligibility checklist during rounds to proactively identify swing bed candidates before discharge becomes urgent
- Define exclusions in writing BEFORE launch, to protect quality and compliance



TOP RECOMMENDATIONS FROM THE EVALUATION

Governance First

Establish a formal steering committee with charter, defined roles, reporting to QAPI - before clinical workflows begin

Build Epic in Parallel

Don't wait until launch - engage IT/Informatics early to configure order sets, documentation, MDS module

Educate Every Role

Hospitalists, nurses, CMs, and therapy - all need targeted training specific to their swing bed responsibilities

Map Every Workflow

Define future-state:
screening →
admission →
care planning →
weekly IDT →
discharge →
follow-up

Validate the Proforma

Confirm PDPM assumptions, payer recognition, TEAM compliance, and staffing cost model before go-live

Mock Survey Early

Conduct simulation 60-90 days before go-live, identify deficiencies while there is still time to fix them



PHASED IMPLEMENTATION AND KEY TAKEAWAYS

Phased Roadmap Approach

Implementation used phased steps focusing on policy, education, validation, and readiness to balance speed and compliance

Pilot Launch and Testing

Pilot with internal referrals tested workflows and monitored quality and financial metrics before broader rollout

Key Lessons Learned

Success requires strategic focus, executive sponsorship, early education, clear workflows, and data transparency

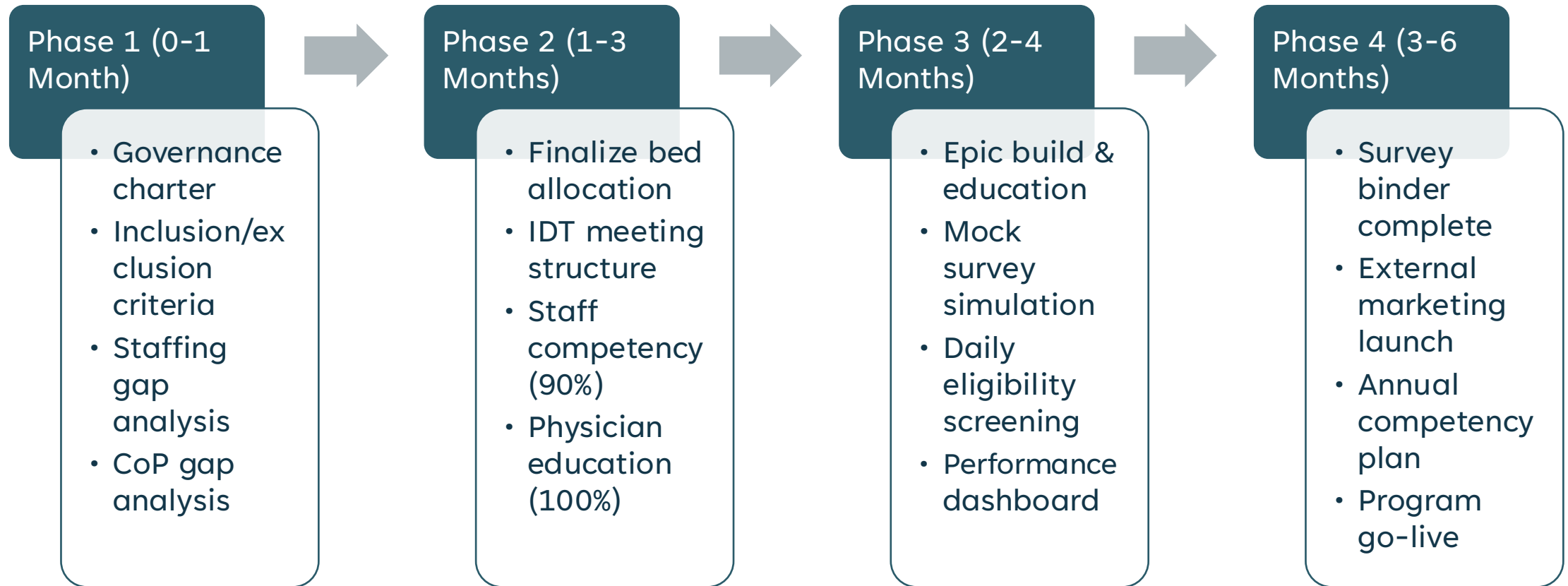
Framework for Growth

Clear business case, leadership alignment, compliance design, and data-driven growth guide long-term success



THE IMPLEMENTATION ROADMAP

Six interconnected workstreams across a 6-month launch horizon



MEASURING WHAT MATTERS FOR SWING BED SUCCESS

VOLUME & ACCESS

Average Daily Census (ADC)

- Target: 5-10 patients

Eligible patients screened/day

- Screening compliance >95%

Conversion rate: acute to swing

- Baseline in first 90 days

ED/Inpatient referrals

- Increase 20% post-launch

QUALITY & SAFETY

30-day readmission rate

- Track vs. SNF baseline (27%)

Length of Stay (swing bed)

- Trending toward discharge goals

Falls with injury rate

- Monitoring required; reduction goal

Pressure injury rate

- Stage 2+ monitoring per QAPI

FINANCIAL & OPERATIONAL

Net revenue per patient day

- Track vs. \$913 proforma target

Contribution margin

- Monthly vs. \$503K-\$1M annual goal

Therapy timeliness

- PT eval \leq 48h of swing admission

Patient satisfaction scores

- CAHPS/internal surveys trending \uparrow



IMPLEMENTATION FRAMEWORK

IS SWING BED RIGHT FOR YOUR ORGANIZATION?

Do you have available bed capacity?	You can flex existing beds without construction	Consider dedicated beds vs. open floor model
Is there unmet SNF demand in your market?	Clear patient pipeline from day one	Assess referral patterns – gaps may be hidden
Do you have therapy services?	PT/OT foundation exists – add ST coverage	Contract model is viable; plan before launch
Can case management absorb additional work?	You're ready to move fast	Add 0.5–1.0 FTE CM before go-live
Is your EMR configurable?	Engage IT 3–4 months pre-launch	Manual workflows possible but document clearly
Can leadership align around program?	Governance and accountability are established	Define 'owner' before writing one policy



PRACTICAL NEXT STEPS

Pull your SNF referral data

- How many patients are you discharging to SNFs? What are the primary diagnoses? What percentage stay local vs. transfer far?

Map your bed capacity

- Identify which beds/units could flex to swing. Dedicated vs. integrated model—which fits your census patterns?

Identify your champions

- Who are the physician, nursing, and case management leaders who will own this?

Run a quick pro-forma

- Use $\$900\text{--}\$1,500/\text{day}$ revenue assumption \times projected ADC \times 365 days. What does even 1.5 ADC mean for your bottom line?

Conduct a CoP gap self-assessment

- Understand your biggest compliance gaps



WHAT SUCCESS CAN LOOK LIKE AT 6 AND 12 MONTHS



At Launch	6 Months	12 Months
First swing bed patient admitted	5 - 10 patients consistently in program	Sustainable ADC of 3.0+ achieved
All staff trained and competency-verified	Monthly QAPI reporting in place	Survey-ready: mock survey passed
EHR build active and validated	Readmission rate trending down vs. SNF baseline	\$500K+ contribution margin on track
Governance meetings established	Community referral pathways active	Staff competencies validated annually

A swing bed program is not simply a regulatory designation—it is a strategic tool for improving patient flow, supporting local access to care, and enhancing financial performance. For many rural hospitals, the challenge is clear, but so is the opportunity.



QUESTIONS / DISCUSSION



COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



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