STROUDWATER

3RD ANNUAL SWING BED BOOTCAMP

FROM PATIENT IDENTIFICATION TO PROGRAM PERFORMANCE

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YOUR SPEAKERS



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WHY ARE WE HERE TODAY?

How many patients left your community last year for skilled care they could have received close to home?

Close to home

Keep patients near family and community

One patient

Mrs. Eleanor Smith, from acute care to program performance

Real findings

From Stroudwater swing bed program evaluations

First, a poll: what is your biggest swing bed challenge today?

POLL: YOUR BIGGEST CHALLENGE

What is your program's biggest swing bed challenge today?

- **A** Finding and identifying the right patients
- **B** Referrals and admissions
- **C** Documentation and compliance
- **D** Length of stay and discharge
- **E** Financial performance



AGENDA

- Swing Bed Overview and Regulatory Requirements
- Meet Mrs. Smith: Identifying the Right Patient
- Referral, Screening, and Admission
- Mrs. Smith’s Swing Bed Stay: Care, Documentation, and Length of Stay
- Discharge, Growth, and Program Performance

WHAT YOU WILL TAKE AWAY

Identify

- Match eligibility, skilled need, and capability

Admit

- Reliable referral and admission with clear roles

Document

- Medical necessity, compliance, reimbursement

Coordinate

- IDT care, length of stay, discharge planning

Stay ready

- Survey readiness in daily operations

Grow

- Internal capture and referral relationships

Measure

- Clinical, operational, quality, financial

Act

- Choose 2–3 priorities for Monday



SWING BED OVERVIEW AND REGULATORY REQUIREMENTS

WHAT IS A SWING BED PROGRAM?

What it is

Inpatient beds used for post-acute skilled nursing and rehab, close to home

3

target ADC per 10,000 population

Who qualifies

Qualifying 3-day inpatient stay

Daily skilled nursing or rehab

Related to the hospitalization

The rules

CAH: 42 CFR 485.645

PPS: 42 CFR 482.58

Eligibility and clinical appropriateness are separate decisions

SWING BED AS A SERVICE LINE

Manage swing bed as a service line: volume, quality, compliance, and margin.

WHY PROGRAMS ARE UNDERUTILIZED

No screening

Skilled patients leave without evaluation

Unclear admissions

Roles and after-hours coverage undefined

No care spectrum

Referrals declined or sent out

No tracking

Leaders cannot see what is lost

Why it matters: close to home • quality • access • sustainability

PATIENT RIGHTS: WHAT STAFF MUST KNOW

Core rights

Dignity, self-determination, informed choice, privacy, and required notices

Advance directives

Written policy; status documented at admission

Abuse prevention

Free from abuse, neglect, and unneeded restraints; report serious injury within 2 hours

Discharge summary

Post-discharge plan, specific needs, caregiver education complete first

THE 5 CATEGORIES OF SKILLED CARE

Skilled care is too complex to be done safely by a non-professional.

1

Observation & Assessment

Spot the need for treatment changes

2

Management & Evaluation

Skilled planning and oversight of total care

3

Teaching & Training

Educate the patient or caregiver

4

Rehabilitation Therapy

PT, OT, or SLP at least 5 days a week

5

Respiratory Therapy

7 days a week with a physician order

If a non-professional could safely provide the care, it is NOT skilled.



WHAT THE RECORD MUST SHOW

Category	The record must show
Observation & Assessment	Abnormal findings and the risk of complication without skilled oversight
Management & Evaluation	Total care needs skilled planning; risk of serious complications
Teaching & Training	Education given, return demonstration, teach-back, barriers
Rehabilitation Therapy	ROM, strength, balance, ADLs; supervised exercise and gait training
Respiratory Therapy	7 days a week; physician order with modality and frequency

A terminally ill patient may still qualify — improvement can occur even with progressive diagnoses.



MEET MRS. SMITH: IDENTIFYING THE RIGHT PATIENT

MEET MRS. ELEANOR SMITH

Who she is	What she needs	The goal
• 76 years old • Admitted 4 days ago: CHF exacerbation • Type 2 diabetes, mild dementia • Lives alone; daughter nearby works full time	• Gait and balance work: deconditioned, unsafe with transfers • Daily weights and medication titration • Leg edema; blood sugars poorly controlled	• Home with daughter and home health • Caregiver education before discharge

Is Mrs. Smith an appropriate candidate? What else do we need to know?



POLL: DOES MRS. SMITH QUALIFY?

Which category covers her CHF monitoring and medication titration?

- **A** Observation & Assessment
- **B** Management & Evaluation
- **C** Teaching & Training
- **D** Rehabilitation Therapy
- **E** Respiratory Therapy

RECOGNIZING THE OPPORTUNITY

Nursing	Therapy	Case management	Provider	IDT
Notes functional limits each day	Documents rehab needs and frequency	Reviews post-acute options with family	Confirms skilled need; places orders	Confirms fit; accepts or declines

Screen every acute patient for post-acute skilled need before discharge planning begins.

Track every patient who leaves for a SNF. Review monthly.

COULD THIS PATIENT BE SWING BED?

Check first: qualifying 3-day inpatient stay (observation days do not count) • daily skilled need • can we meet it?

Common candidate	Likely skilled category
Heart failure or COPD with deconditioning	Observation & Assessment; Teaching & Training
Pneumonia with continued oxygen needs	Respiratory Therapy; Observation & Assessment
Joint replacement or fracture	Rehabilitation Therapy
Stroke recovery	Rehabilitation Therapy; Management & Evaluation
Wound care or IV antibiotics after acute illness	Management & Evaluation

Internal candidates come from your acute census; external candidates from tertiary and regional hospitals.

QUESTIONS TO ANSWER BEFORE ADMISSION

1. Qualifying 3-day inpatient stay?
2. Daily skilled nursing or rehab needed?
3. Does documentation support medical necessity?
4. Is the condition within our care spectrum?
5. Are the clinical resources available?

For Mrs. Smith: 3-day stay, skilled need, documentation, and scope are confirmed. Confirm therapy availability.



REFERRAL, SCREENING, AND ADMISSION

Mrs. Smith has been accepted

CAN WE MEET MRS. SMITH'S NEEDS?

Nursing

Competencies and staffing levels

Therapy

Frequency and weekend coverage

Provider, pharmacy & dietary

Coverage, medication, and nutrition needs

Equipment

IV pumps, wound care, fall prevention

Length of stay

Anticipated stay and resource alignment

For Mrs. Smith

Daily PT/OT, CHF monitoring, diabetes management. Is rehab available 5 days/wk? Is nursing on the weekend prepped for CHF edema monitoring?

Write your care spectrum. Review declined and transferred referrals monthly.

ADMISSION DAY: WHAT MUST HAPPEN?

Orders & certification

Services, frequency, duration; timely

Clinical assessments

Functional, nutritional, psychosocial

Coverage verified

Medicare eligibility and skilled need

Rights, notices & directives

Informed in writing; notices given; advance directive documented

Day 1 discharge goal

Anticipated date and goal set

Response time & after-hours

Response-time standard; named owner for weekend acceptance

One checklist. Assigned roles. Sign-offs for every discipline.

POLL: WEEKEND ADMISSIONS

A swing bed referral arrives Saturday at 2 pm. What happens at your hospital?

- **A** A named person accepts and admits
- **B** Whoever is on call decides
- **C** It waits until Monday
- **D** We have no defined process



MRS. SMITH’S SWING BED STAY

Care delivery, documentation, survey readiness, length of stay

DAY 1: MRS. SMITH BEGINS HER STAY

Mrs. Smith's Day 10 goal

150 ft

independent with a walker

Stable weight, edema controlled, daughter educated before discharge

1. **Assess**
   Functional, nutritional, and psychosocial
2. **Set goals**
   Individualized, measurable, time-bound
3. **Involve family**
   Mrs. Smith and her daughter from Day 1
4. **Set the date**
   Anticipated discharge date and the plan to meet it



HER INDIVIDUALIZED CARE PLAN

GENERIC

~~**Patient will improve mobility**~~

SPECIFIC

Patient will ambulate 150 feet with a rolling walker independently by Day 10

LINK EVERY GOAL TO A SKILLED CATEGORY

PT/OT goals

Rehabilitation Therapy

Daily CHF monitoring

Observation & Assessment

Daughter's medication teaching

Teaching & Training

Multi-system coordination

Management & Evaluation

Swing bed shifts care from acute treatment to function, mobility, and independence. Review goals at every IDT round; audit care plans monthly for generic language.

DOES THE RECORD TELL THE STORY?

1. Why skilled services remain necessary
2. Skilled interventions and by whom
3. Measurable patient response
4. Functional progress or limits
5. Changes in condition or plan
6. Progress toward discharge

Not skilled language:

- "Tolerated treatment well"
- "Continue current plan"
- "No acute changes"

PROVIDER ROLE AND SKILLED CARE

THE PROVIDER ESTABLISHES MEDICAL NECESSITY

- Orders and certification at admission
- Admission note: why skilled care now
- Progress notes: continued skilled need
- Documented response to changes
- Discharge order and plan

ACUTE CARE

Diagnose, stabilize, and treat the active illness

SWING BED

Daily skilled care to restore function and get home

SURVEY READINESS EVERY DAY

Surveyors look for	Make it routine
• Certification, orders, timely assessments • Patient rights, notices, and directives • Individualized, measurable care plans • Skilled need and physician communication • Discharge plan; Swing Bed in QAPI	• Checklists are part of the record • Monthly chart audits with feedback • Review in IDT rounds and QAPI

Survey-ready every day, not just before a survey



DAY 5: IS MRS. SMITH ON TRACK?

5 QUESTIONS FOR EVERY IDT ROUND

- Progress toward functional goals?
- Are skilled services still necessary?
- Are goals on schedule?
- What barriers delay discharge?
- Are patient and family prepared?

Mrs. Smith at Day 5

PT: 80 ft with walker — on track

Nursing: edema 1+, weight stable

Social work: DME found, home health started

Barrier: daughter needs insulin teaching



DAY 8: CHANGE IN CONDITION

310

blood sugar, 2 days in a row

Which of the 5 categories applies to her blood sugar management?

What does skilled documentation look like for the near-fall?

Near-fall

during morning PT

What should the family hear, and from whom?

What order changes are needed and documented?

Think it through, then vote in the poll that follows.



LENGTH OF STAY AND SKILLED NEED

1

Day 1

Set ELOS and discharge date

5

Day 5

On track: 80 ft, edema improving

8

Day 8

Change in condition: plan reset – new goal

14

Day 14

Home, goals met

Reassess skilled need at every IDT round

Reset the plan and discharge date when condition changes

POLL: DAY 8 DECISION

Blood sugar is 310 two days in a row, plus a near-fall. What happens to her discharge date?

- **A** Reassess with the provider, update orders and plan, tell the family
- **B** Keep the date and adjust later
- **C** Transfer her back to acute care
- **D** Wait for the next IDT round

THERAPY AND STAFFING

5 days/week
minimum when rehab is the primary skilled need

Weekends & holidays
coverage confirmed before admission

Full sessions
not shortened by staffing constraints

Nursing mobility
support between sessions, documented as skilled

Align admission decisions with available therapy and staffing.



DISCHARGE, GROWTH, AND PROGRAM PERFORMANCE

Getting Mrs. Smith Home Safely – and Measuring Program Results

DISCHARGE PLANNING STARTS ON DAY 1

Date set Day 1

Reviewed at every IDT round

Caregiver ready

Training needs assessed early

Home & DME

Safety needs and equipment identified

Home health

Referral started early, not in the last 2 days

Follow-up booked

Appointments scheduled before discharge

Education complete

Teach-back done before the date is final

Discharge checklist signed by nursing, therapy, social work, and provider.

DAY 14: IS MRS. SMITH READY TO GO HOME?

14 days

Home. Goals met.

- ✓ 150 ft with walker (goal reset after Day 8)
- ✓ Weight stable, edema trace
- ✓ Insulin teach-back documented
- ✓ DME in place, home health confirmed
- ✓ Physician discharge order and plan
- ✓ Cardiology and endocrine follow-up set

Mrs. Smith is home. Next: where would YOUR program struggle?

POLL: WHERE WOULD YOU STRUGGLE?

Where in Mrs. Smith's journey would YOUR program struggle most?

- **A** Identifying her as a candidate
- **B** Accepting and admitting her quickly
- **C** Documenting skilled need
- **D** Managing length of stay and discharge
- **E** Measuring program results



SWING BED VS. SNF 45 MILES AWAY

	Swing bed at our hospital	SNF 45 miles away
Patient and family	Daughter, who works full time, can visit and attend teaching	Daughter's visits and caregiver education are harder to schedule
Continuity of care	Local providers know her history; planned handoff to home health	New team and records; follow-up with local providers is less certain
Outcomes	Day 5 and Day 8 changes caught by a team that knows her	Goals, discharge date, and readmission risk are harder for us to see
Hospital	Swing bed days, revenue, and quality data stay in the program	Revenue and the chance to show results go to another provider
Community	Care stays close to home	Patients leave the community for skilled care

REFERRAL DEVELOPMENT AND REPATRIATION

Growth starts with knowing who is leaving.

Track referrals

Acute census, ED, orthopedics, tertiary hospitals

Review monthly

Accepted, declined, and missed

Find who leaves

Patients going elsewhere for skilled care

Market to partners

Hospitalists, case managers, PCPs, ED

Bring patients home

Build relationships with regional hospitals • Clear transfer-center path: contact, response time, care spectrum

Where is your hospital losing appropriate swing bed opportunities?

POLL: TRACKING PATIENTS LOST

Does your hospital track patients who leave for a SNF?

- **A** Yes, and we review it monthly
- **B** Yes, but we do not review it
- **C** Occasionally
- **D** No

GROWING VOLUME AND CONVERSION

Understand leakage	Improve conversion	Build relationships
• Track SNF discharges by diagnosis and destination • Compare with your care spectrum	• Record why referrals are declined • Commit to response times, weekends too	• Visit regional case managers • Market outcomes; be easy to choose

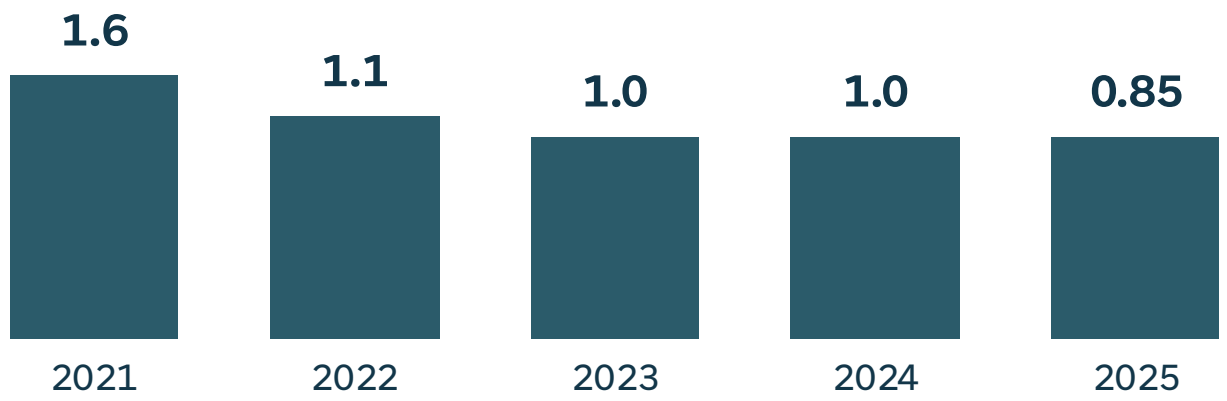
Referred → **Screened** → **Accepted** → **Admitted**

Track every step of the funnel.

EXAMPLE REGION: CENSUS IS FALLING

AVERAGE SWING BED ADC, EXAMPLE RURAL REGION

Target: 3 ADC



601 → 312
swing bed days per hospital, 2021–2025 (≈1.6 → 0.85 ADC)

2.2 → 0.7
ADC at the region's one PPS hospital only

15 hospitals
with swing beds compete with 28 skilled nursing facilities

Example rural region (anonymized). Source: HCRIS; Stroudwater analysis.

POLL: WHERE IS YOUR ADC?

What is your hospital's average swing bed ADC?

- A Under 1
- B 1 to 2
- C 2 to 3
- D 3 or more
- E We do not track it

EXAMPLE REGION: WHERE PATIENTS GO

$5M
in Medicare SNF payments for one hospital's patients in a single year

33.7%
of area SNF discharges are Medicare short-stay: potential swing bed candidates

68%
of SNF-to-hospital referrals come from just two SNFs

Top reasons for SNF care

Orthopedic aftercare, including joint replacement, COPD, pneumonia, and respiratory failure

What it means

Build relationships with area SNFs and referral hospitals

Match your care spectrum to these diagnoses

Where do YOUR discharges go? Pull your own claims and SNF data.

Example rural region (anonymized), 2024. Source: Medicare claims (Definitive Healthcare); CMS SNF data; Stroudwater analysis.

BILLING AND FINANCIAL IMPACT

Reimbursement basics

- CAH: cost-based payment
- PPS hospital: SNF PPS
- Part A: days 1–20 in full; coinsurance days 21–100

Where revenue is lost

- Patients never evaluated or sent out
- Documentation that does not support skilled need
- Delays in admission, therapy, or discharge

What drives the claim

- Eligibility verified before admission
- Orders and certification on time
- Daily skilled need documented

A claim is only as strong as the record behind it.

MARGIN PER DAY AT A CAH

Revenue per day
Cost pool ÷ total days, from your cost report

−

Variable cost per day
Added nursing, dietary, pharmacy, supplies, therapy

=

Margin per day
Before the per diem effect

THEN RECALCULATE WITH THE ADDED DAYS

- More days spread fixed costs further
- Cost per day falls for every Medicare day
- Only variable cost is added
- Gain is less than days × average margin

One CAH example: ADC 1.6 to 4.0 added about $441K in net margin a year

Illustrative, CAH Medicare SNF days only. Use your own cost report.

SAMPLE SWING BED DASHBOARD

Domain	Measures	Reviewed
Capture	Referrals received, accepted, and declined with reasons; patients leaving for post-acute care	Monthly
Operations	ADC (target at least 3), admissions, ALOS vs. ELOS, therapy utilization	Monthly
Clinical	Functional improvement, discharge disposition, falls, readmissions, ED visits after discharge	Quarterly
Quality	Documentation audit results, checklist completion, post-discharge follow-up, patient and family experience	Quarterly, in QAPI
Financial	Payer mix, net revenue, contribution margin	Quarterly, with finance

- Turn Data Into Action:
  - Report through QAPI at least quarterly and assign a program champion
  - Set annual targets for ADC, admissions, and payer mix; choose one or two focus actions

POLL: YOUR MEASURES

Which do you report at least quarterly? (select all that apply)

- A ADC and admissions
- B Referrals and acceptance rate
- C Length of stay and discharge disposition
- D Functional improvement and readmissions
- E Net revenue and contribution margin

SWING BED'S ROLE IN HOSPITAL STRATEGY

Community access

Patients get skilled care close to family; returning them to your hospital keeps them local

Acute capacity

Earlier acute discharges free beds and reduce avoidable days

Financial sustainability

Margin from a well-run program supports the hospital as a whole

Partnerships

Tertiary hospitals, SNFs, home health, and PCPs work with a clear program

Swing bed is part of how the hospital serves its community.

FOUR QUESTIONS EVERY PROGRAM ASKS

Are we capturing the opportunity?	Are we operating the program well?	Are we compliant and delivering quality?	Is our program creating value?
• Identification, referral tracking, patients leaving	• Admissions, IDT care, length of stay, discharge	• Eligibility, documentation, regulations, outcomes, QAPI	• Financial performance, capacity, access, mission

If any answer is uncertain, that is your next priority.

POLL: YOUR BIGGEST GAP

Which of the four questions is your biggest gap?

- **A** Are we capturing the opportunity?
- **B** Are we operating the program well?
- **C** Are we compliant and delivering quality?
- **D** Is our program creating value?

TURNING LESSONS LEARNED INTO ACTION

30 Days

Evaluate Current Practices

- Review identification and referral processes.
- Assess admission and documentation workflows.
- Identify care planning and discharge gaps

60 Days

Implement Improvements

- Standardize workflows and responsibilities.
- Provide targeted staff education.
- Strengthen interdisciplinary care planning.

90 Days

Monitor Progress

- Review utilization and outcomes.
- Evaluate referral and staffing performance.
- Monitor improvements through QAPI.

WHAT WILL YOU DO THIS WEEK?

One thing I will

START

_____

_____

_____

One thing I will

IMPROVE or STANDARDIZE

_____

_____

_____

One thing I will

BRING BACK to my team

_____

_____

_____

Thank you!

STROUDWATER

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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REFERENCES

- 42 CFR 485.645: CAH Swing Bed Requirements
- 42 CFR 482.58: PPS Hospital Swing Bed Requirements
- 42 CFR Part 483: Applicable Long-Term Care Requirements
- 42 CFR 409.30–409.31: Medicare SNF Coverage Requirements
- 42 CFR 485.641: CAH QAPI
- 42 CFR 482.21: Hospital QAPI
- Medicare Benefit Policy Manual, Chapter 8

