STROUDWATER

Kentucky Swing Bed Quality Reporting Program

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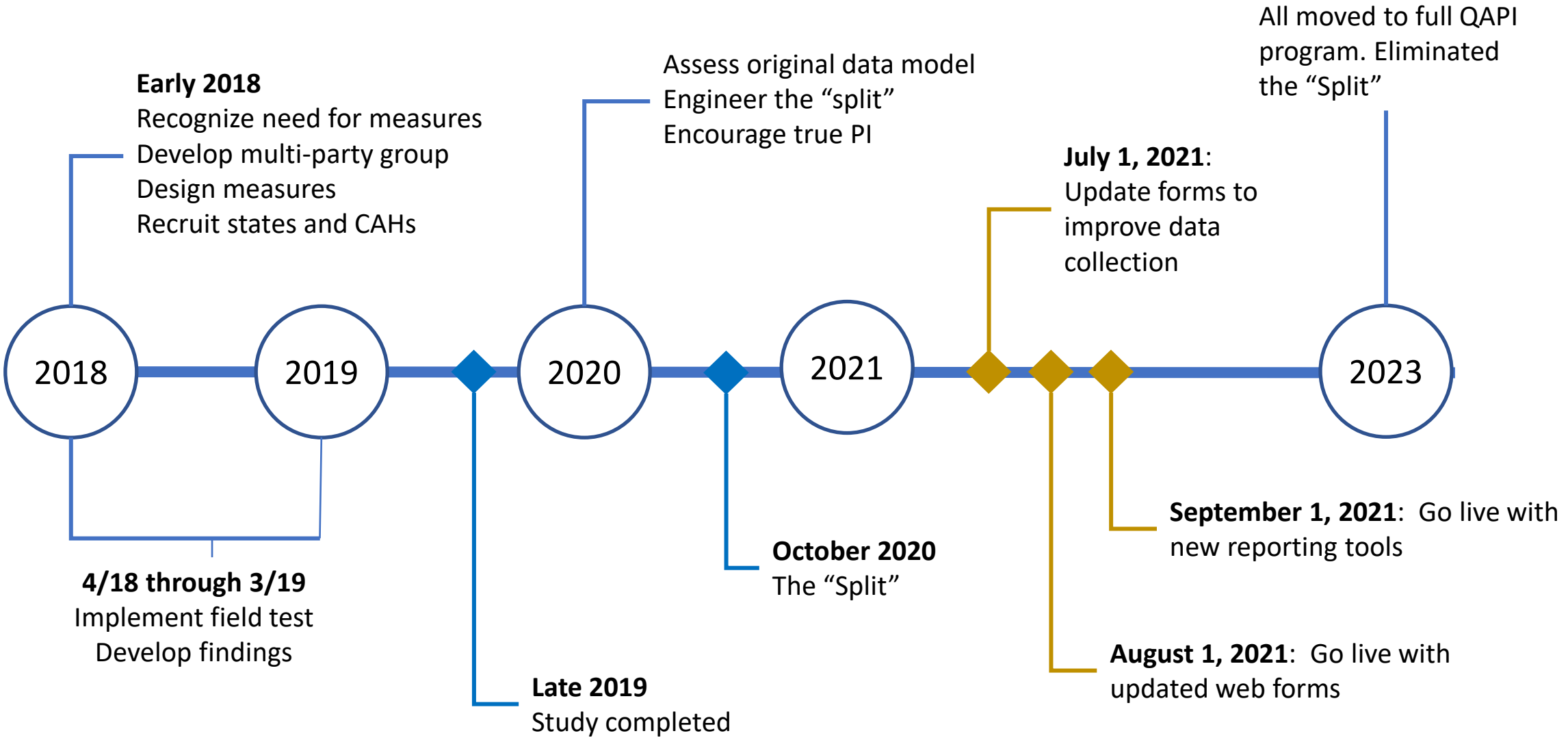
Swing Bed Quality Reporting Program

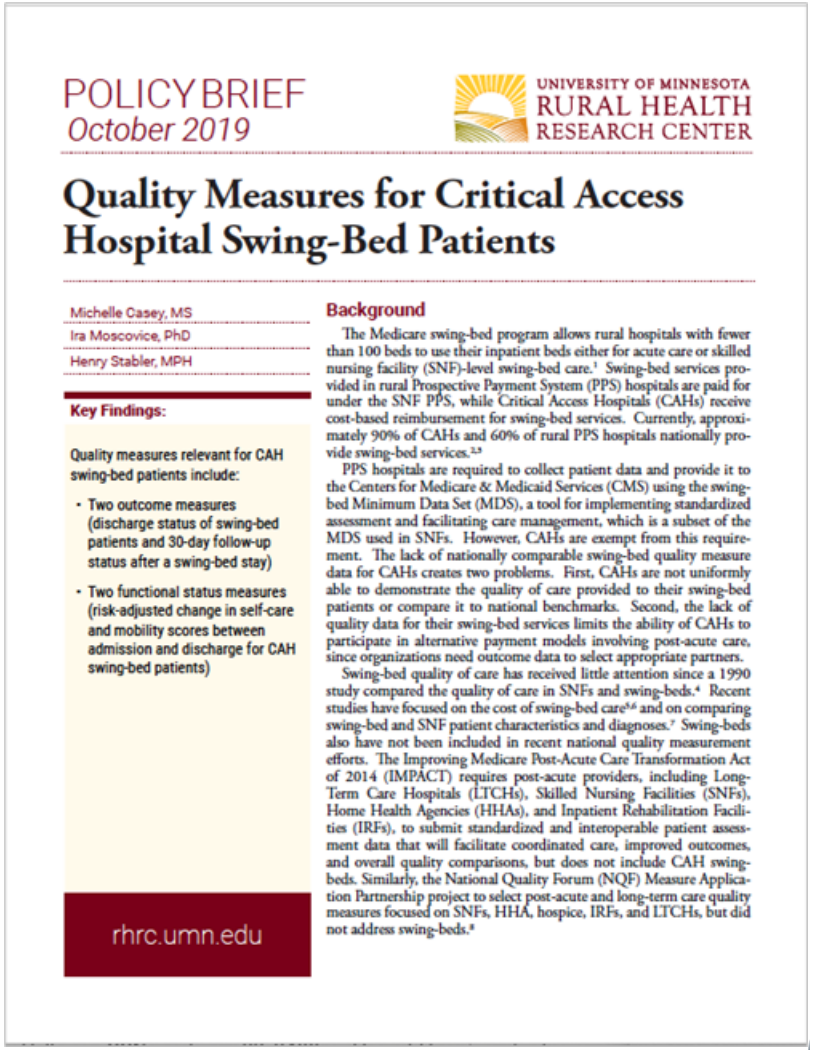


CAH SWING BED NATIONAL STUDY

Conclusion: 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

You can find the complete study on our website



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)

rhrc.umn.edu

Background

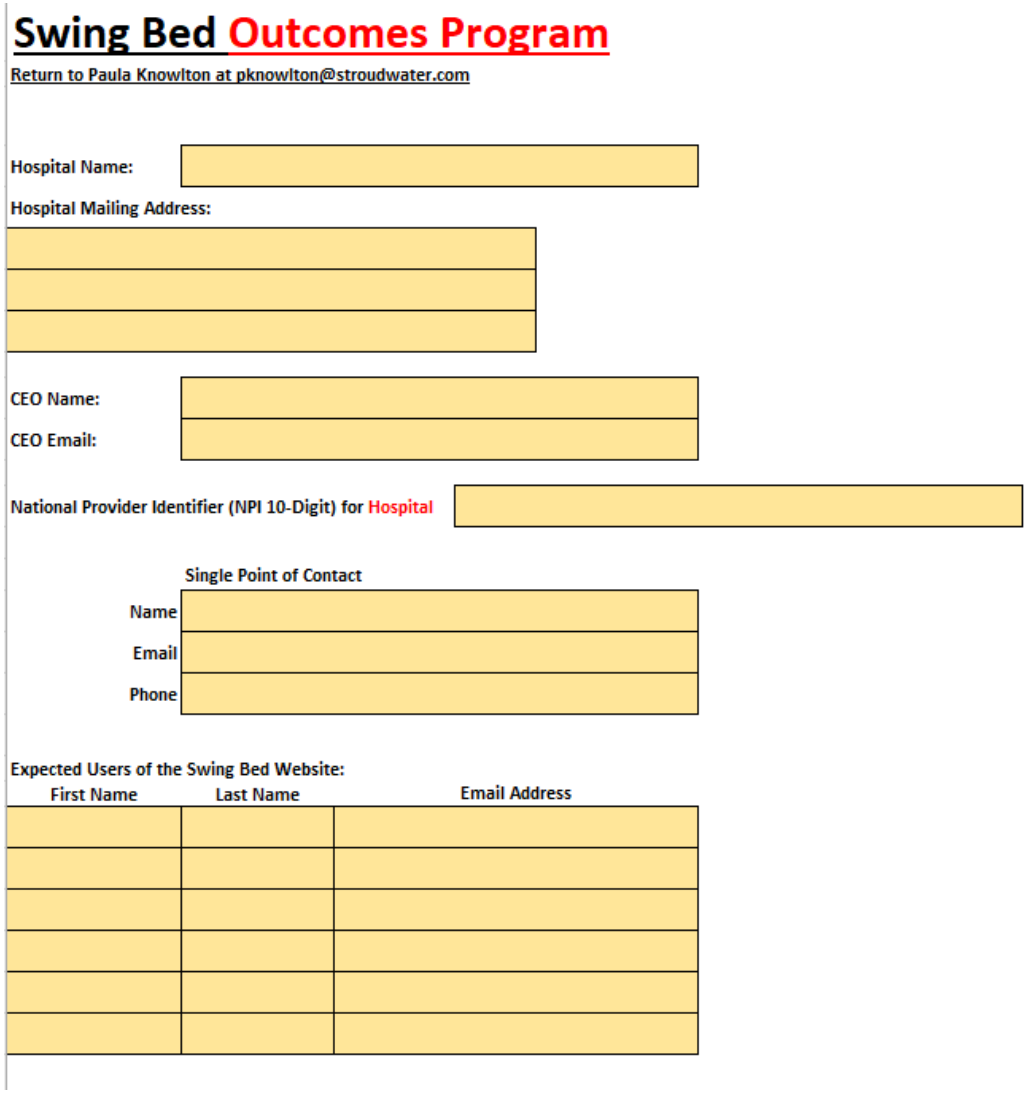
The Medicare swing-bed program allows rural hospitals with fewer than 100 beds to use their inpatient beds either for acute care or skilled nursing facility (SNF)-level swing-bed care.[1] Swing-bed services provided in rural Prospective Payment System (PPS) hospitals are paid for under the SNF PPS, while 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]

Process to Get Started

End User Form



Swing Bed Outcomes Program

Return to Paula Knowlton at pknowlton@stroudwater.com

Hospital Name:

Hospital Mailing Address:

CEO Name:

CEO Email:

National Provider Identifier (NPI 10-Digit) for Hospital

Single Point of Contact

Name

Email

Phone

Expected Users of the Swing Bed Website:

First Name	Last Name	Email Address

- This is required and tracks who in your organization can have access to the portal

Master Subscription Agreement

STROUDWATER

MASTER SUBSCRIPTION AGREEMENT

This Subscription Agreement ("Agreement") is made and entered into this XX day of MONTH, YEAR by and between STROUDWATER ASSOCIATES, a Maine corporation with principal places of business in Portland, Maine and Atlanta, Georgia ("Stroudwater"), and HOSPITAL NAME of HOSPITAL LOCATION ("Client").

WHEREAS, Stroudwater provides software applications and products along with the associated database that assists clients in analyzing their performance data (the "Programs") and Client wishes to access and utilize the Programs;

NOW, THEREFORE, in consideration of the mutual promises covenants and agreements set forth herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound hereby, agree as follows:

1. **Right to Access Software**. Stroudwater does hereby grant to Client a revocable, nonexclusive and non-transferable license to use the Programs described in Exhibit A attached hereto and incorporated herein by reference, Client may not allow any other person or entity to use the Programs.

2. **Terms and Payment**. Client shall pay to Stroudwater the annual fees set forth in Exhibit A, payable as set forth therein.

3. **Term and Termination**.

(a) **Term**. The term of this Agreement shall commence on the date set forth in Exhibit A (the "Commencement Date") and shall continue as set forth therein.

(b) **Termination**.

(i) **Termination for Good Cause**. If either party materially breaches this Agreement and the breach is of such a nature that it cannot be cured within fifteen (15) days, or if the breach could be cured but is not cured within fifteen (15) days of the breaching party's receipt from the other party of written notice describing the breach in reasonable detail, the other party may immediately terminate this Agreement by giving written notice of termination to the breaching party. A breaching party shall be permitted one (1) opportunity to cure a breach of this Agreement while such Agreement is in effect. Thereafter the non-breaching party may elect to terminate this Agreement effective upon notice to the breaching party without providing a cure period.

(ii) **Termination by Mutual Agreement**. This Agreement may be terminated at any time by written agreement of the parties.

(iii) **Termination Without Cause**. Either party may terminate this Agreement at the end of any annual term and for any reason by giving not less than thirty (30) days advance written notice to the other party.

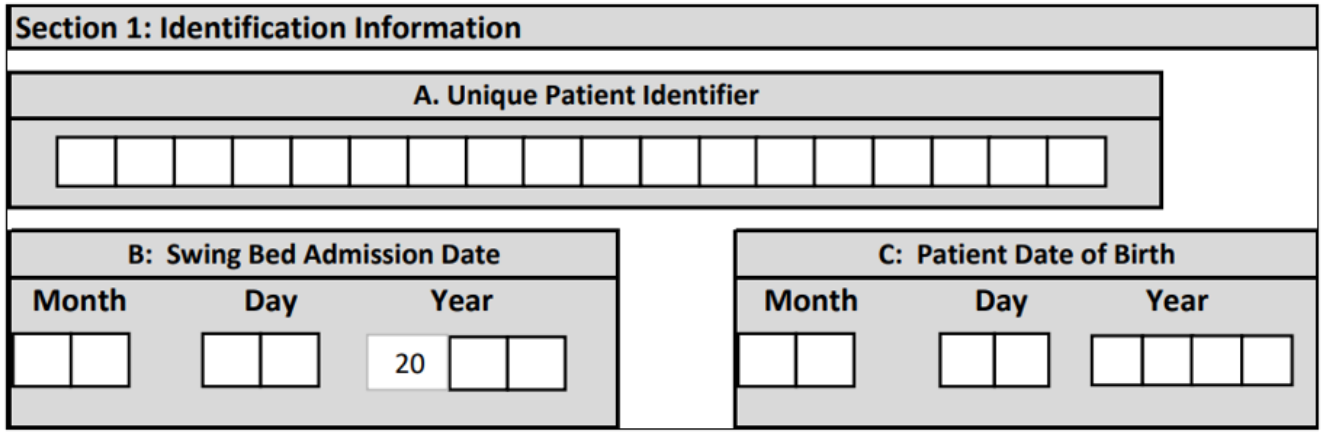
- This agreement is between Stroudwater and the hospital
- Covers HIPAA Compliance and PHI
- Please review, sign and return
- No access to the portal will be granted until the agreement is executed

Training

- Training is available via webinar

Section 1: Patient Identification (A-B-C)

STROUDWATER



A. Unique Identifier #: anything works as long as you remember the system you use so that you may be able to refer back to the medical record – Many choose to use the patient's account #. NEVER use the Patient's Medical Record #

B. Admission Date: This is much improved but please double-check that you entered the month and year correctly – we have records of patients discharged before they were admitted!!

C. DOB: Also much improved but please double-check the year – based on wrong input, we have had records of young children and "ancient" patients!!

Support for the Process

- Three patient scenarios
- Code on paper data request form
- Gives your team a sense of the process
- Helps to put processes in place for success

Stroudwater Swing Bed QAPI Project – IRR Scenario #2

Patient Name: Steve B

DOB: 07/7/1946

SB Admission Date: 02/1/2018

Insurance: Blue Cross

Admitting Diagnosis: S/P ischemic Left CVA with Rt. Hemiparesis

Chief Complaint: weakness, loss of balance, difficulty walking and using rt. arm

Assessment & Plan

72 y.o. African American male S/P ischemic CVA with severe Rt. Hemiparesis admitted to XX swing for therapy rehabilitation

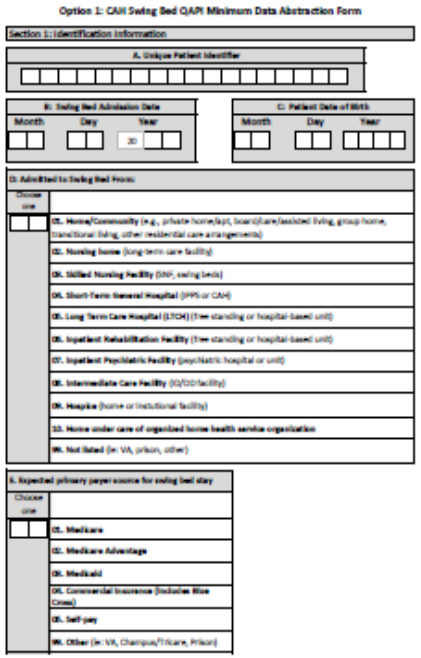
Plan is to:

1. Provide PT & OT to regain functionality
2. Insulin sliding scale to manage his type 2 diabetes mellitus
3. HTN, last BP 150 / 86: will continue monitoring, and adjus
4. Acute Renal impairment: improved from acute stay. Last
   monitor
5. Hypomagnesemia, last magnesium 1.5: will increase supp
6. Stasis dermatitis, with BLE edema: feet raised when seate
   using mild liquid cleansers to help remove scaling, and ap
   hydrocortisone after cleaning
7. DVT prophylaxis: will continue heparin BID for now and m
8. Continue treating hypercholesterolemia

Precautions: safety issues due to hemiparesis and lack of awarene

HPI

72 y.o. obese African American male who lives alone at home whe
weeks but at this time, I am unsure if that will be possible. Under
his diabetes, HBP, and high CHO. Uses a walker for community ou
ADLs and ambulation in his home. Admits not following his diet. H
obesity. On 1/26/2018 he experienced lack of balance, light head
was visiting and called 911. He was transported to XXX Hospital ar


Option 1: CAH Swing Bed QAPI Minimum Data Abstraction Form

Section 1: Identification Information

A. Unique Patient Identifier

B. Swing Bed Admission Date — Month Day Year

C. Patient Date of Birth — Month Day Year

D. Admitted to Swing Bed From:

Choose one

01. Home/Community (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)
02. Nursing home (long-term care facility)
03. Skilled Nursing Facility (SNF, swing beds)
04. Short-Term General Hospital (IPPS or CAH)
05. Long Term Care Hospital (LTCH) (free standing or hospital-based unit)
06. Inpatient Rehabilitation Facility (free standing or hospital-based unit)
07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
08. Intermediate Care Facility (ICF/IID facility)
09. Hospice (home or institutional facility)
10. Home under care of organized home health service organization
99. Not listed (ie: VA, prison, other)

E. Expected primary payer source for swing bed stay

Choose one

01. Medicare
02. Medicare Advantage
03. Medicaid
04. Commercial Insurance (including Blue Cross)
05. Self-pay
99. Other (ie: VA, Champus/Tricare, Prison)

Participation

PARTICIPATION

- Open to all CAHs in Kentucky
- Cost is covered by the Flex Grant through your Office of Rural Health

- Deaconess Union County Hospital and Wayne County Hospital are actively participating

In addition, the following have all documents in place to participate

- Caldwell Medical Center
- Casey County Hospital
- Cumberland County Hospital
- Jane Todd Crawford Memorial Hospital
- Livingston Hospital and Healthcare Services
- Marcum and Wallace Hospital
- Ohio County Healthcare
- Russell County Hospital
- The Medical Center at Caverna
- The Medical Center at Franklin

Benefits from the Field

Benefits from the Field

- Increased and better documentation which is important for patient care, liability and insurance purposes
- Better communication between therapy and nursing
- Easily track with trending data where we are going with our performance improvement activities
- Easily share reports with senior leadership and in some cases board members
- Review data at monthly staff meetings
- Establishes common goal for care team

Case Studies

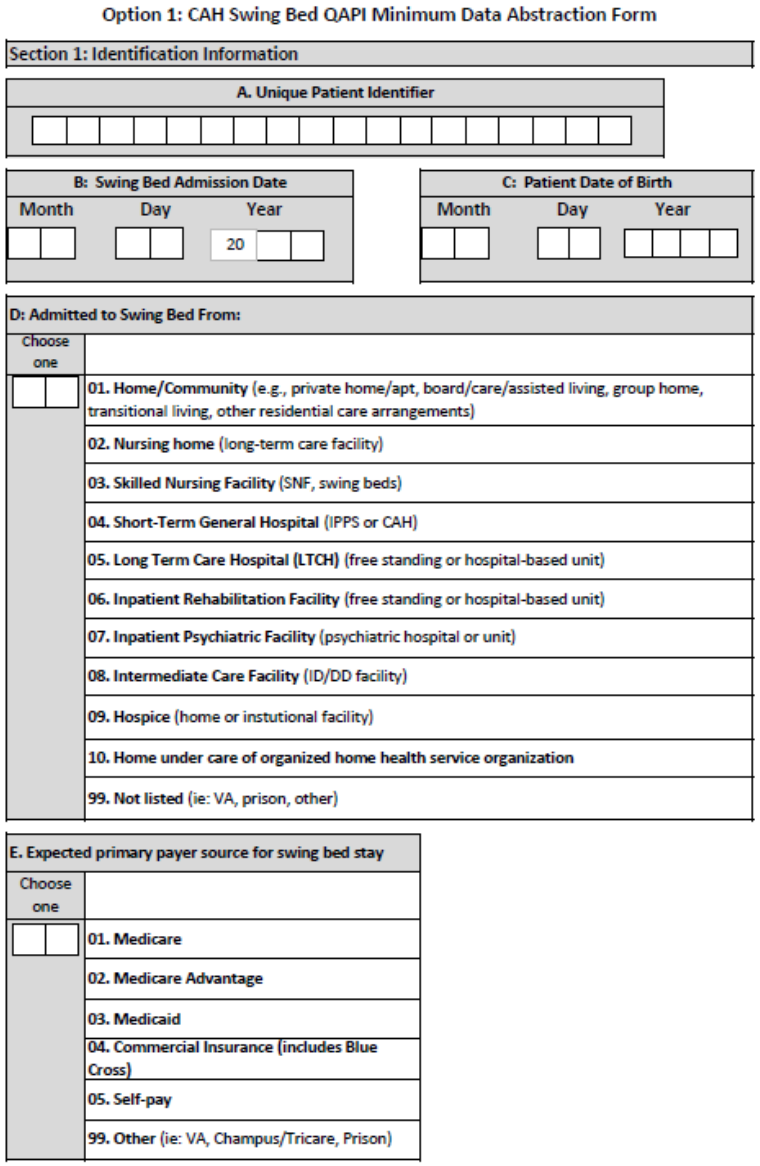
Pennsylvania CAH. Conemaugh Meyersdale Medical Center Uses Swing Bed Tool to Simplify Data Collection, Maximize Insights, and Gain Instantaneous Multiple-hospital Benchmarking

Montana CAH. Central Montana Medical Center Uses Swing Bed Tool to Help Return Patients to Prior Living Situations and Prevent Avoidable Readmissions

New York CAH. Ellenville Regional Sees Major Improvement in Self-care From Admission to Discharge Using Swing Bed Tool

Process to Collect/Enter Data

Paper Tool



Option 1: CAH Swing Bed QAPI Minimum Data Abstraction Form

Section 1: Identification Information

A. Unique Patient Identifier

B: Swing Bed Admission Date			C: Patient Date of Birth		
Month	Day	Year	Month	Day	Year
		20			

D: Admitted to Swing Bed From:

Choose one	
	01. Home/Community (e.g., private home/apt, board/care/assisted living, group home, transitional living, other residential care arrangements)
	02. Nursing home (long-term care facility)
	03. Skilled Nursing Facility (SNF, swing beds)
	04. Short-Term General Hospital (IPPS or CAH)
	05. Long Term Care Hospital (LTCH) (free standing or hospital-based unit)
	06. Inpatient Rehabilitation Facility (free standing or hospital-based unit)
	07. Inpatient Psychiatric Facility (psychiatric hospital or unit)
	08. Intermediate Care Facility (ID/DD facility)
	09. Hospice (home or instutional facility)
	10. Home under care of organized home health service organization
	99. Not listed (ie: VA, prison, other)

E. Expected primary payer source for swing bed stay

Choose one	
	01. Medicare
	02. Medicare Advantage
	03. Medicaid
	04. Commercial Insurance (includes Blue Cross)
	05. Self-pay
	99. Other (ie: VA, Champus/Tricare, Prison)

Ways of using the paper tool:

- Color code the sections by who is responsible. Example: admission and discharge blue; risk adjustment and history pink for nursing; and functional assessments yellow for rehab, etc.
- If all the data is in your EMR then extract directly from EMR onto paper form and enter into Swing Bed portal. Or skip the paper form in the case.

Collecting and Entering Data

https://www.stroudwateranalytics.com/Account/Login

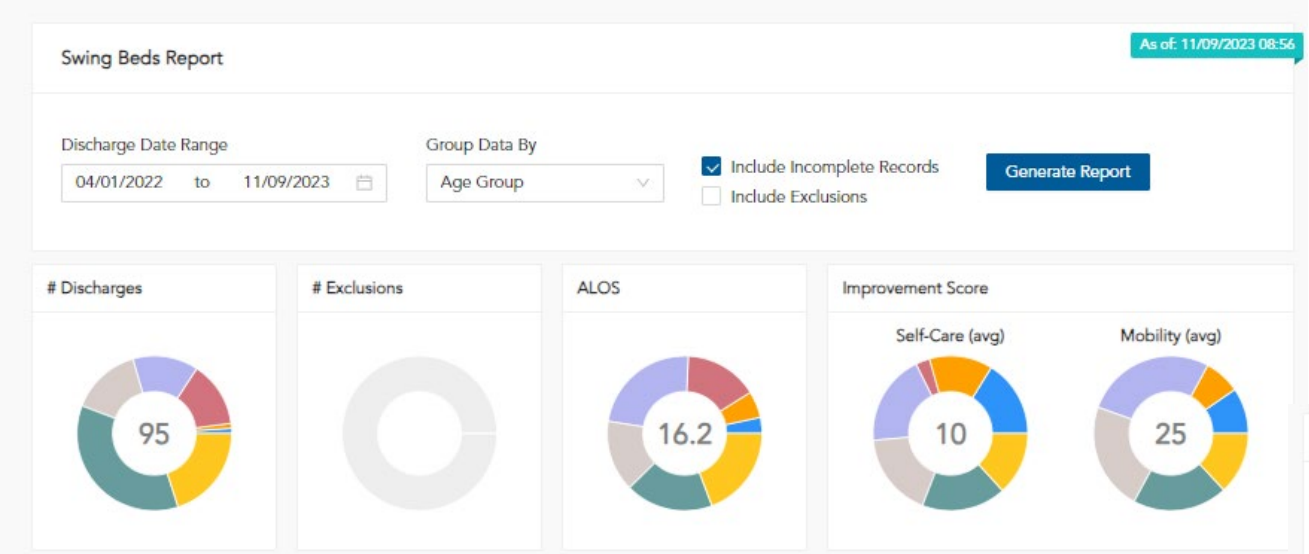
Collecting:

- Use the paper tool

Enter Data:

- Best Practice: Enter your data when the patient is discharged and then update the case when the 30-day follow-up is completed
- You can have as many end users as you like
- Anyone can enter the data. It doesn't need to be a clinical person

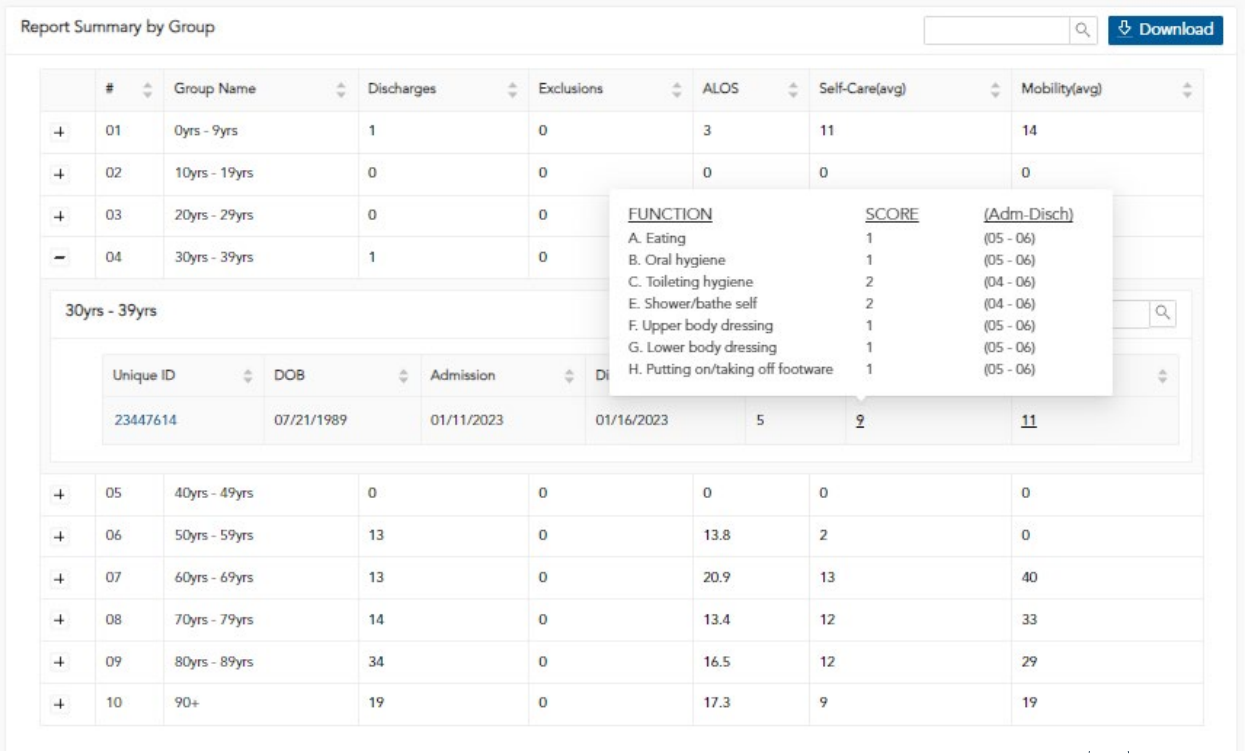
Data Analysis



Run this report for any time period

Check on data integrity

See how patients are performing



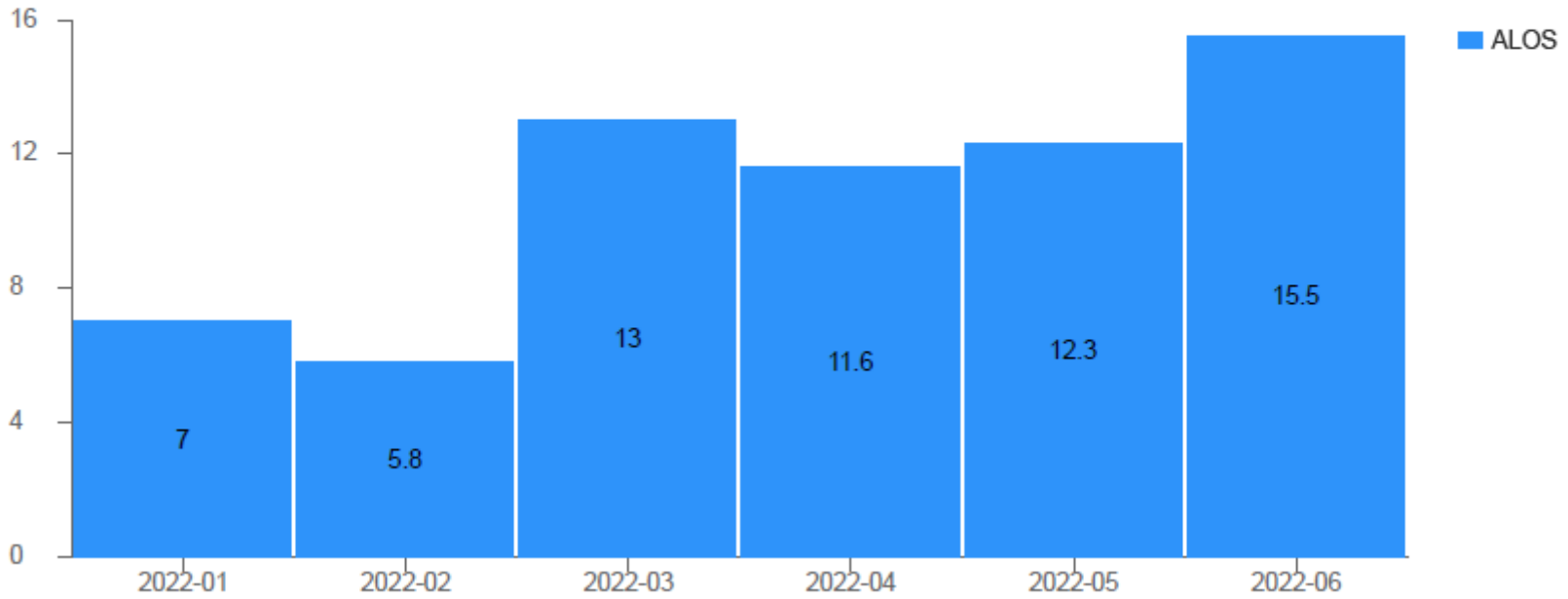
Monthly Hospital Report

Month over month trending report

All metrics are defined on the reports

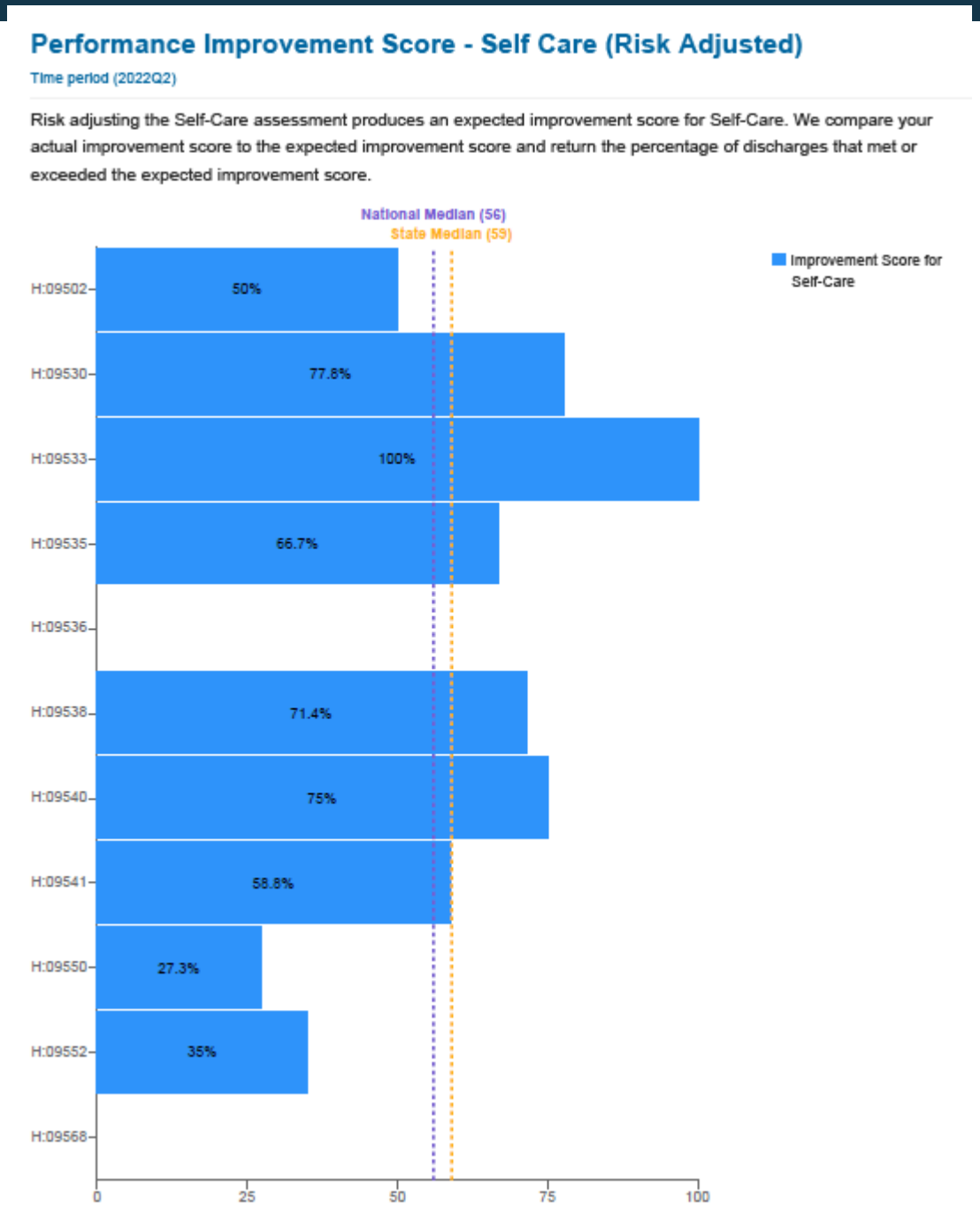
Average Length Stay

Average Length of Stay is total swing bed days divided by number of discharges for the time period



State Benchmark Report

- Comparison to CAHs within your state and to the National median



Performance Report

- Tell your community about your Swing Bed program
- Compare your quality scores to your competitors
- Market your Swing Bed program
  - Build volume

Stroudwater Hospital

Our Swing Bed Program supports our motto, "Where you are a name and not a number" in that it provides a comfortable, quiet and supportive environment where individuals can recover after surgery, injury, illness or stroke. Our professional staff of physicians, nurses, social workers, rehabilitation therapists, respiratory therapists, pharmacists, and dietitians work diligently with patients and families to help meet their physical, social, and psychological needs, which may otherwise negatively impact their recovery. Hospital was recently selected as a Top 20 Critical Access Hospital-patients receive high-quality care close to home near friends, family and loved ones.

	2023\Q3	2022\Q4 - 2023\Q3
Measure 1. Return to Acute Care from Swing Bed This measure scores the percentage of the hospital's swing bed patients who were re-hospitalized after a swing bed admission. Lower score is better.	0%	9%
Measure 2. Return to Acute Care Post Discharge This measure scores the percentage of swing bed patients who were readmitted to the hospital's acute unit within 30 days from swing bed discharge date. Lower score is better.	0%	6%
Measure 3. Improvement in Mobility This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in mobility based on 17 measured items. Higher score is better.	75%	67%
Measure 4. Improvement in Self-Care Improvement in Self-Care - This measure scores the percentage of risk-adjusted swing bed patients who made at or above average improvement in self-care based on 7 measures. Higher score is better.	50%	49%
Measure 5. Discharge to Community This measure scores the percentage of the hospital's swing bed patients who were discharged to home/community (includes d/c to home, hospice, ID/DD and home with home health care). Higher score is better.	67%	62%

About Swing Beds

Swing beds provide a comprehensive post-acute inpatient program for the patient who has had an acute medical or surgical event as a result of an illness, injury or exacerbation of a disease process. The patient needs these skilled services for a medical condition that is either a 1.) Hospital-related medical condition that they were admitted with and treated for during a qualifying three-day inpatient hospital stay or 2.) Skilled level of care need that developed while hospitalized, even if it was not the reason they were admitted to the hospital. Swing beds offer an outcomes-focused interdisciplinary approach comprised of the patient and family, and utilizes a professional team including physicians, nurses, therapists, dieticians, pharmacists and respiratory therapists as needed to deliver clinical interventions (medical and/or physical rehabilitation). Compared with Skilled Nursing Facilities (SNF), swing beds traditionally have shorter lengths of stay, lower hospital readmission rates during the hospital stay and lower readmission rates to acute care within 30 days post swing bed discharge.

METRICS

- Discharge and Exclusions
- Swing Bed Days
- Average Length of Stay
- Average Daily Census
- Entered from as % of Discharges
- Primary Payor as % of Discharges
- Age Group as % of Discharges
- Primary Medical Condition
- ALOS by Primary Medical Condition
- Clinical Program
- ALOS by Clinical Program
- Therapy by Discipline Received
- Exclusions by Reason
- Performance Improvement – Self-Care (Actual and Risk-Adjusted Score) – overall, by Primary Medical Condition and Clinical Program
- Performance Improvement – Mobility (Actual and Risk-Adjusted Score) – overall, by Primary Medical Condition and Clinical Program
- Percentage of Goals Met
- Discharge Disposition
- Clinical Post-Discharge Follow-up
- Post Swing Bed 30-Day Discharge Follow-Up
- Return to Acute Care Post Discharge
- Fall Rate
- Medication Reconciliation
- Influenza Vaccine
- Pneumococcal Vaccine
- Acquired Pressure Ulcers/Injury & Nosocomial Infection

Swing Bed QI Project

ACTION PLAN

December 1, 2023

SWING BED QUALITY IMPROVEMENT: CAH ACTION PLAN TEMPLATE

Hospital Name/State	
Contact Name	
Email & Phone Number	

ACTION PLANNING (due no later than December 31, 2022)

Focus Measure	Choose a Metric
Baseline Measure Value	
Baseline Discharges (D/C)	
Baseline Reporting Quarter	
Issues & Opportunities	•
Target Measure Value	

Planned Interventions	Expected Outcome	Person(s) Responsible	Target Implementation Date(s)
1.	•		
2.	•		
3.	•		
4.	•		
5.	•		

EXECUTION UPDATES

For Measures 1, 3, 4, and 5: Submissions due by April 30 (for Q1) and July 31 (for Q2)
For Measure 2: Submission due by May 31 (for Q1); final submission (for Q2) due date TBD

	Measure Value	D/C	Measure Value & D/C Month(s)[2]	Has the measure improved vs. baseline?	What happened?	What will we change for next month?
Jan			Dec	Choose an item.	•	•
Feb			Jan	Choose an item.	•	•
Mar			Feb	Choose an item.	•	•
Q1			Jan - Mar	Choose an item.	•	•
Apr			Mar	Choose an item.	•	•
May			Apr	Choose an item.	•	•
Jun			May	Choose an item.	•	•
Q2			Apr - Jun	Choose an item.	•	•

1. For Measures 1, 3 ,4 and 5, the value month will be for previous month. For example, a CAH providing an Execution Update in the month of February will be examining data from January. For Measure 2, the value month will be two months prior. For example, a CAH providing an Execution Update in the month of February will be examining data from December.

- Chose 1 of the 5 key metrics
  - Return to Acute (unplanned)
  - Return to Acute Post 30-day Discharge
  - Improvement in Self-Care (Risk Adjusted)
  - Improvement in Mobility (Risk Adjusted)
  - Discharge to Community
- Create Action Plan
- Track results
- Networking with other KY CAHs

If interested contact Paula at pknowlton@stroudwater.com

Website Demo

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.

Thank you!

Paula Knowlton
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