The Stroudwater Swing Bed Project

Central Montana Medical Center
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Objectives/Learning Outcomes

Participants will be able to:

- Identify the multidisciplinary team members needed to positively impact Swing Bed outcomes.
- Utilize the standardized, Swing Bed Pilot Project Data Collection Form.
- Implement 30-day follow-up phone calls with Swing Bed patients.
- Successfully navigate the Stroudwater Analytics website.

Project Partners & Participants

Background

- Critical access hospital (CAH) Swing Bed quality of care is an important Medicare policy issue that has received little attention.
- Concern has been raised about the cost of Swing Bed care.
- Swing Beds have not been included in national efforts to address comparability of post-acute quality measures (e.g., IMPACT Act and NQF).

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Background

- 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 CAH's ability to participate in alternative payment models.

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Motivation and Purpose

Motivation 1: Ensure compliance with CMS requirements/intent regarding Swing Bed care.

Motivation 2: Assess whether Swing Bed patients are getting appropriate care; help them return home as quickly as possible; prevent hospital readmissions.

Motivation 3: CAH desire to increase patient volume in Swing Bed programs, compare Swing Bed care to SNFs.

Purpose: To identify quality measures that can be used to assess the quality of care provided to CAH Swing Bed patients, and implement a field test of these measures.

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CAH Swing Bed Quality Measures

Discharge Disposition
- To home
- Transferred to a NH/LTC facility
- Transferred to a higher level of care

Functional Status
- Change in self-care score between Swing Bed admission and discharge
- Change in mobility score

30-Day Follow-Up Status
- Readmitted to CAH
- Readmitted to other hospital
- ED visit at CAH
- ED visit at other hospital

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Planning for Successful Outcomes:
Ensuring Teamwork and Inter-Rater Reliability

- Submission of three practice cases to Stroudwater Associates for review and correction
- Webinar participation
- Overall, 86% of the items were scored correctly among all hospitals participating (131 CAHs in 14 states; April 1st 2018-March 31st, 2019)

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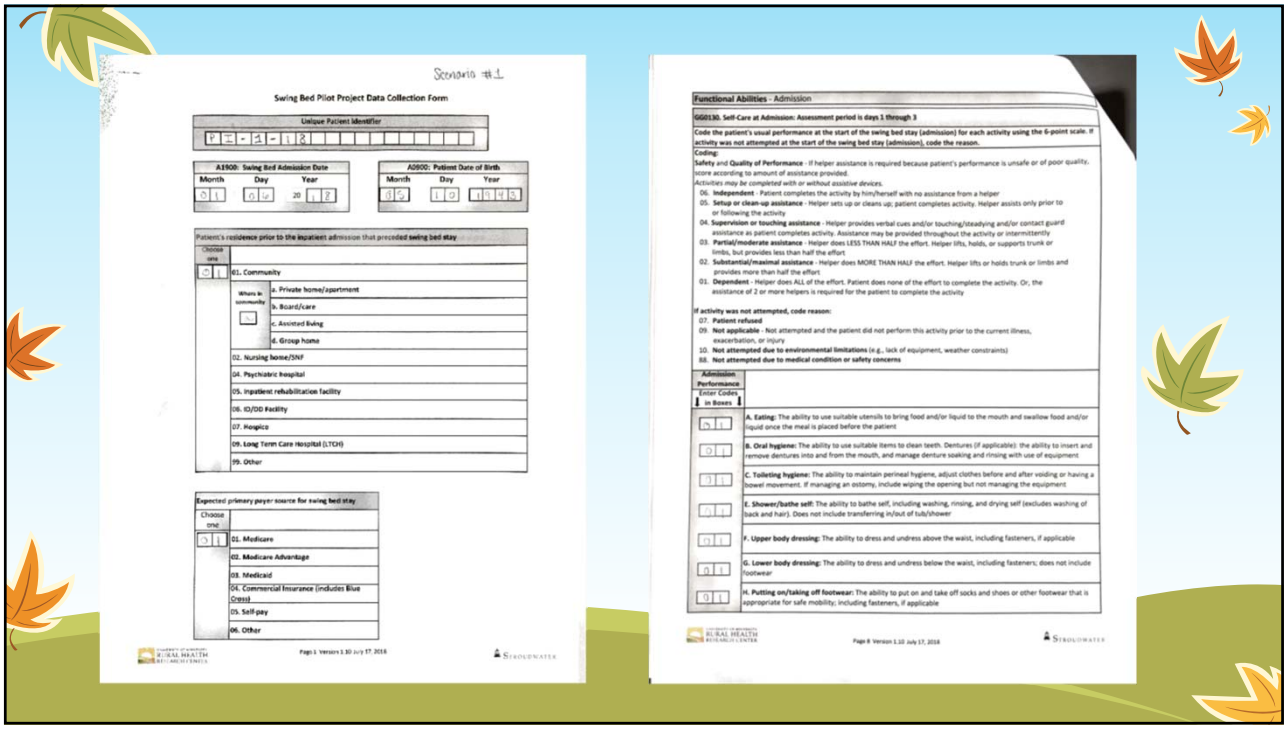

Scenario #1

Swing Bed Pilot Project Data Collection Form

Unique Patient Identifier

A1900: Swing Bed Admission Date — Month / Day / Year

A0900: Patient Date of Birth — Month / Day / Year

Patient's residence prior to the inpatient admission that preceded swing bed stay

Choose one

01. Community
- a. Private home/apartment
- b. Board/care
- c. Assisted living
- d. Group home

02. Nursing home/SNF
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD Facility
07. Hospice
09. Long Term Care Hospital (LTCH)
99. Other

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
06. Other

Functional Abilities - Admission

GG0130. Self-Care at Admission: Assessment period is days 1 through 3

Code the patient's usual performance at the start of the swing bed stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the swing bed stay (admission), code the reason.

Coding:

Safety and Quality of Performance - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. Independent - Patient completes the activity by him/herself with no assistance from a helper
05. Setup or clean-up assistance - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity
04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently
03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity

If activity was not attempted, code reason:

07. Patient refused
09. Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury
10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
88. Not attempted due to medical condition or safety concerns

Admission Performance — Enter Codes in Boxes

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient

B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment

C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing the equipment

E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

F. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable

G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear

H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable

Data Collection and Interpretation: Utilizing the Stroudwater Analytics Website

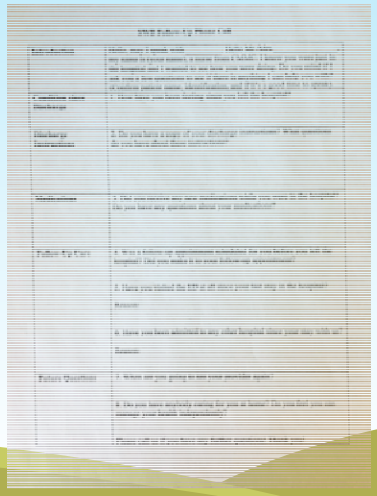
Susie Wilbur, RN
SWB and UR Manager

- Met with Discharge Planning team every morning to discuss every patient and their discharge plan/goals.
- Collaborative approach to the Data Collection Form
- Submitted completed forms to Quality Improvement

Lexie Jelinek, RN, CPHQ
Quality Improvement

- Entered Data Collection Form data into Stroudwater Analytics website.
- The website then gave us the date range of when the 30-day follow-up call needed to be completed. ("In __ days," "due now," or "past due")
- Once 30-day follow-up phone call was completed, the remaining data was entered and a green check mark signified that the chart was 100% complete.

30-Day Follow-Up:
Communication with Swing Bed Patients



Next Steps:
Results and Action Plans for Further Improvement

Results

- Discharges by age group:
  - Field Test: 65% were over age 75
  - CMMC: 87.3% were over age 70
- Discharges by primary payer:
  - Field Test: 90% had insurance coverage from Medicare or Medicare Advantage
  - CMMC: 91.6% had insurance coverage from Medicare or Medicare Advantage
- Discharges by primary medical condition:
  - Field Test:
    - 1. Medically complex conditions
    - 2. Other medical condition
  - CMMC:
    - 1. Medically complex conditions
    - 2. Other medical condition
- Discharges by length of stay:
  - Field Test: Median length of stay=10 days
  - CMMC:
    - 00-09 days= 64.2%
    - 10-30+ days= 35.8%

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Discharges by Discharge Status

- Resided in the community prior to the hospitalization that preceded swing bed stay:
  - Field Test: 94%
  - CMMC: 97.9%
- Patients discharged to a community setting:
  - Field Test: 72%
  - CMMC: 68.4%

Group	Total Discharges	Group %
(01) Community	65	68.4%
(08) Deceased	11	11.6%
(02) Another nursing home or Swing Bed	9	9.5%

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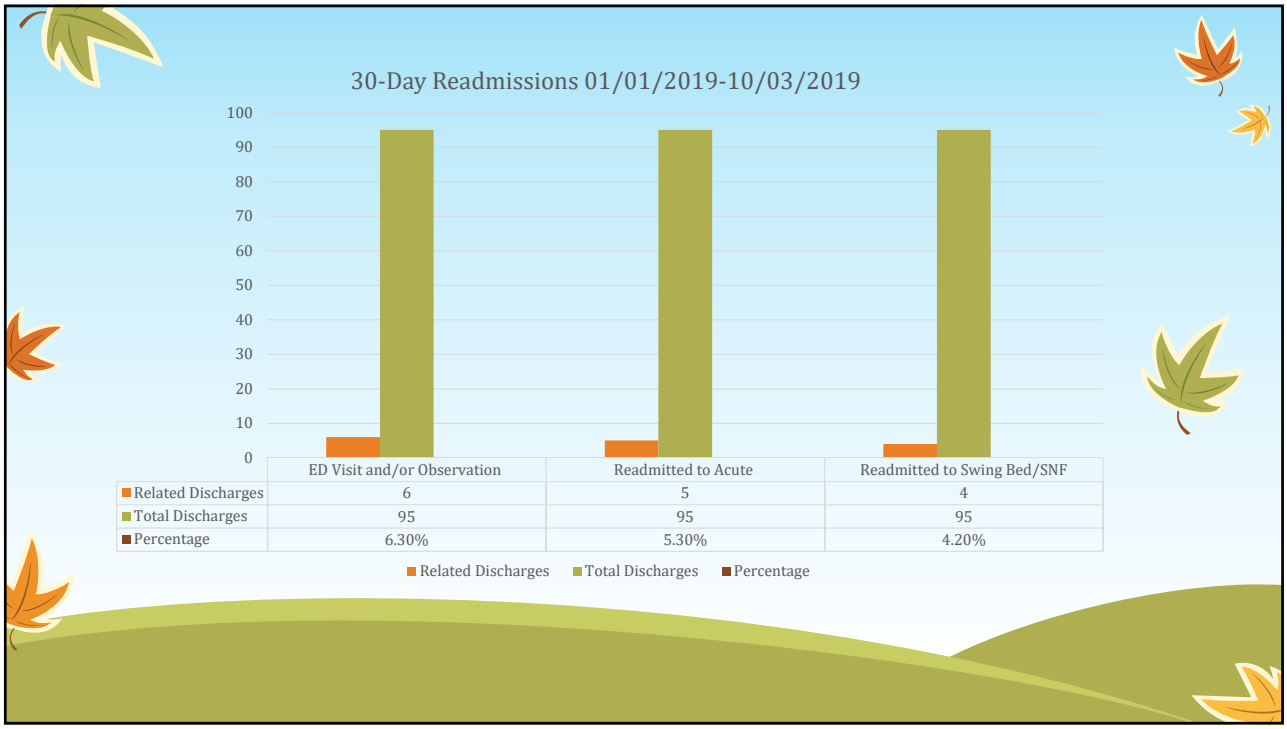

Discharges by Readmission within 30 Days of Discharge

- 30-day readmission rate:
  - Field Test: 14.5%; Risk-adjusted (n=124)= 13.6%
  - Rural SNFs: 21.1% (risk-adjusted)
  - CMMC: 9.5%
- 30-day emergency department and/or observation visit rate:
  - Field Test: 9.3%
  - CMMC: 6.3%

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Quality Care

Patient Self-Care
- Based on 7 items with each item scored on a scale of 1-6 at admission and discharge

Patient Mobility
- Based on 15 items with each item scored on a scale of 1-6 at admission and discharge

Category	Field Test Improvement	CMMC Improvement
Patient Self-Care	7.2 Units	7.0 Units
Patient Mobility	19.7 Units	16.9 Units

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Conclusions

- Almost 70% of our Swing Bed patients returned to their prior living situation or a more independent level of care after their Swing Bed stay.
- Both of our 30-day readmission rates were lower than that of the field tests, as well as much lower than the 30-day risk-adjusted hospital readmission rate for rural SNFs in the U.S at 21.1%.
- Substantial average improvement in patient functional status as measured by change in self-care and mobility scores.

Next Steps

- University of Minnesota Rural Health Research Center's Goal:
  - To have the measures endorsed by the National Quality Forum and used by CMS when assessing the value of Swing Beds.
- Continued efforts toward getting patients back to prior living situation after discharge
- Continued growth of our Swing Bed program
- Continued focus on our 30-day readmission rate

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Questions?

References

- University of Minnesota Rural Health Research Center. (2019). Assessing CAH Swing-Bed quality [PowerPoint slides].
- Wilbur, C. B. (2019). Montana Swing Bed portal data review [PowerPoint slides].