

Critical Access Hospital Swing-Bed Quality Measures: Findings from Key Informant Interviews

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Key Findings:

- CAHs are beginning to measure the quality of care provided to swing-bed patients. Measures being collected include discharge disposition, readmission, functional status, and patient satisfaction measures.
- Challenges to measuring CAH swing-bed quality of care include limited staff resources and difficulty analyzing data separately for inpatient and swing-bed patients
- Adoption of a common set of swing-bed quality measures, with uniform measure definitions and data collection methods, would allow CAHs to compare the quality of their swing-bed care with other post-acute care providers, including Skilled Nursing Facilities and swing-bed programs in rural Prospective Payment System hospitals, as well as with other CAHs nationally.

Introduction

Swing-beds are an important source of post-acute care for many patients residing in rural communities. Approximately 1,182 Critical Access Hospitals (CAHs) (88%) nationally provide swing-bed services.¹ Medicare requires rural hospitals that receive reimbursement through the Prospective Payment System (PPS) to report data on their swing-bed patients through the Minimum Data Set (MDS), but does not require CAHs to collect similar information.²

CAH swing-beds also have not been included in recent national quality measurement initiatives. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requires post-acute providers—including Long-Term Care Hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies, and Inpatient Rehabilitation Facilities—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.³

Purpose

The purpose of this study was to examine how CAHs are currently assessing the quality of care provided to their swing-bed patients.

Approach

We identified CAH networks and hospitals for key informant interviews with input from our University of Minnesota Rural Health Research Center Expert Work Group and through an email survey of State Office of Rural Health and Flex Program contacts in the 45 states with CAHs. We conducted the key informant interviews by phone to discuss efforts to assess CAH swing-bed quality of care, including measures being used or considered by CAHs, data collection strategies, and usefulness of measures. A total of 20 interviews were conducted with three groups: 1) representatives of three CAH networks in Illinois, New York State, and West Virginia; 2) four consultant groups working with CAHs on swing-bed quality issues; and 3) CEOs, quality improvement staff, and nurse managers who are responsible for swing-bed services at 10 CAHs and two rural PPS hospitals in 10 states (Alaska, Kentucky, Minnesota, Montana, Mississippi, Nebraska, New Hampshire, South Carolina, West Virginia, and Wisconsin).

The purposes of the interviews with CAHs, CAH networks, and consultant groups were: 1) to understand how CAHs are currently assessing the quality of care provided to swing-bed patients in their facilities, the resources they have available for quality measurement, and the challenges they face; and 2) to obtain their perceptions about the types of quality measures that they would find useful for measuring CAH swing-bed care. The PPS interviewees were asked about how they are assessing the quality of care provided to swing-bed patients in their facilities, and specifically about their experiences with reporting MDS data. The key informant interview data were summarized and analyzed to identify common themes, including CAHs' motivations to assess swing-bed quality and challenges measuring CAH swing-bed outcomes.

Results

CAH Swing-Bed Patient Characteristics and Trends

The swing-bed programs at interviewed CAHs cared for a mix of patients. All CAHs cared for patients recovering from orthopedic surgery in need of post-acute care, but most CAHs also cared for more complex patients with complicated health care needs. Most CAHs said a common swing-bed diagnosis was deconditioned patients (e.g., patients who experienced functional losses, and declines in muscle mass/strength and ability to accomplish activities of daily living due to a period of inactivity or bed rest).⁴ Several CAHs also said that they had started caring for more patients with multiple comorbidities and more complex medical needs. The majority of swing-bed patients for all CAHs were Medicare patients.

The swing-bed patient census of interviewed CAHs ranged from about 2 to 4 patients per month on the low end up to about 10-15 patients per month on the high end.

Patient Complexity:

"We are seeing a higher complexity of patients in our Transitional Care Unit (TCU) than we ever did. Used to use swing-beds for those really short stays ... for joints. Now we're seeing ... a lot more wounds, patients who need high-flow oxygen (and nursing home can't deliver high-flow oxygen). Also trying to help with weaning of chronically dependent ventilator patients. So the mix of our patients has changed over time."

— Minnesota CAH

"[Our swing-bed patients] are [those who are] so sick, even when they'd be ready to go home from their medical condition, they are physically not able [to go home]. They need physical therapy and occupational therapy for strengthening so they can go home."

— Alaska CAH

"[A lot of our swing-bed patients are] orthopedic post-surgical [patients]: hips and knees, and then COPD, pneumonia, and CHF have been big [as well]."

— Montana CAH

Payer Source:

"Payer source does make a difference... have a lot of patients in a managed care Medicare program that won't approve swing-bed stays. They have to go to a nursing home [for post-acute care]."

— Wisconsin CAH

"The struggle we're having right now is with Medicare Advantage. People that have it think it's the same as Medicare. We have to educate them that it's not the same reimbursement. We have to get pre-authorization ... and that has been a real problem."

— Montana CAH

"We (with our state hospital association) are looking at our swing-bed program and the components that would make us a good post-acute care option, as tertiary centers are looking for good post-acute care ... swing-beds are often not even listed as a post-acute care option ... I've heard the head of a rural ACO [say] 'We do not want our patients to go to swing-beds; we want them to go to skilled facilities because the cost is less'."

— Kentucky CAH

Two CAHs with lower swing-bed patient census reported that, because they had high demand for their acute inpatient beds, they tried to limit the use of their swing-beds. One CAH, for example, has an attached SNF and sends most of their post-acute care patients there, only using swing-beds for patients in need of higher levels of care. Average length of stay varied, with most CAHs keeping swing-bed patients for 9-14 days.

Four interviewed CAHs reported that their swing-bed census was down from previous years. Possible reasons for decreases reported by CAHs included a reluctance on the part of Medicare managed care plans and Accountable Care Organizations (ACOs) to use CAH swing-beds for post-acute care, and loss of referrals from physician groups and tertiary care centers.

A few CAHs reported increases in swing-bed census resulting from actively marketing their programs to other hospitals, including tertiary care facilities.

Current CAH Efforts to Assess Quality of Swing-Bed Care

The interviewed CAHs—particularly those that had higher number of swing-bed patients—recognized the need to find ways to measure swing-bed quality of care, particularly as a means for comparing quality of care to SNFs. As a result of the loss of swing-bed patients to SNFs and difficulty getting tertiary care centers to refer local patients back to their CAH swing-bed program for post-acute care, several CAHs were looking for ways to illustrate that their swing-bed quality of care led to better patient outcomes. Many interviewees also mentioned concern with CAH swing-beds being left out of national payment reform efforts, such as Medicare's post-acute care bundled payment reforms. Determining how best to measure quality of care for swing-bed programs at CAHs was an issue that most CAHs were discussing both internally among hospital administrative staff and externally (e.g., with CAH networks, consultants, and State Offices of Rural Health).

Swing-Bed Census Growth:

"We have seen a growth [in our swing-bed census]. Our growth really started when the State Office of Rural Health came to us to talk about better use of our swing-beds. Previous to that, mostly what we had been doing were orthopedic patients. So we started utilizing our swing-bed program to our full potential and ... had a 5-10 times increase in our swing-bed days."

— South Carolina CAH

"Right now we're getting about 75% [of patients] from our facility and 25% from other facilities. Previously that's where we had seen decrease—from other facilities. Their patients were told that they couldn't come here for those services, so we've been educating patients and families, and we're seeing an uptake in referrals from [those] other facilities."

— Nebraska CAH

"Our tertiary hospitals are quite a distance away from us and they're not real familiar with our communities ... I [have to] reach out to them and let them know what resources we have available in our swing-beds."

— Wisconsin CAH

Assessing Quality of Care:

"We've really focused on what the patient is wanting, whether that's get back to home, get back to assisted living—and then we track how we meet those outcomes."

— Wisconsin CAH

"We've started a case review program for [readmission to inpatient]. We review charts and ask, 'What could we have done differently', 'Was this appropriate', and we watch where they discharge to, what level of care."

— Kentucky CAH

"I was hearing about [swing-bed] patients being admitted on Friday and the therapist can't come on Fridays. You're admitting a therapy patient and you can't treat him for two days? This is part of the underpinning for [why our CAHs] use a measure like [time from admission to evaluation for all therapy services]"

— Consultant working with CAHs

"[Our swing-bed patient satisfaction survey] is a little more real-time, so we can get immediate feedback. Questions like: would they recommend us, did they feel like the team worked together, did they feel involved in their care, did we address their concerns."

— Minnesota CAH

Several CAHs and the 3 CAH networks were either in the process of identifying specific swing-bed quality measures or had just begun collecting quality measures in their hospitals. Table 1 illustrates the types of swing-bed quality measures being collected or considered by CAHs. Nearly all CAHs are formally or informally tracking the discharge disposition of swing-bed patients and the average length of swing-bed stays. CAHs were generally monitoring whether swing-bed patients were readmitted to the CAH. Other types of measures being used by some but not all interviewed CAHs included measures addressing functional status, process of care/teamwork, patient experience of care and patient satisfaction, and measures related to falls, skin integrity, and infections.

Some CAHs share swing-bed quality data with other CAHs in a network or health system in order to benchmark their data and track progress. Less commonly, data are shared with state health agencies (e.g., some states require hospitals to report hospital-acquired infection information), and with tertiary facilities and third-party payers (to document the quality of swing-bed care relative to other post-acute settings).

Recommended Swing-Bed Quality Measure Areas

When interviewees were asked to recommend quality measure areas for CAHs nationally to assess and improve the quality of their swing-bed care, the top recommended category of measures was functional status, followed by discharge disposition, readmissions, falls, pressure ulcers, and infections.

Challenges Collecting Quality Data and Improving Swing-Bed Quality of Care

Some challenges to collecting swing-bed quality measure data and improving the quality of swing-bed care that were reported by interviewed CAHs relate to resource constraints that are common to many quality measurement and improvement initiatives in rural settings.

Table 1. Examples of swing-bed quality measures being collected or considered by CAHs

- **Discharge disposition** (e.g., number of swing-bed patients discharged home and to other settings; percent of swing-bed patients going back to same level of assistance as prior to stay; number of discharges to home or long-term care facility)
- **Average length of stay** (e.g., average number of days for swing-bed stay, average length of stay compared to goal)
- **Readmission** (e.g., number of swing-bed discharges readmitted to the CAH for acute care within 30 days; number of readmissions back to swing-bed; combined CAH acute care readmission rate for acute and swing-bed discharges)
- **Functional status** (e.g., admission and discharge scores on Barthel Index, Functional Independence Measure, or MDS Section GG; various physical therapy and occupational therapy tests to measure walking, gait and balance, sit to stand, and cognitive performance)
- **Process of care/teamwork** (e.g., frequency of team rounds to patient bedside to discuss goals, updating of communication board in patient room, etc.)
- **Patient Experience of Care/Patient Satisfaction** (e.g., HCAHPS survey for discharged swing-bed patients and inpatients combined, consultant-developed survey for discharged swing-bed patients, food satisfaction card with meals, post-discharge follow-up phone calls)
- Additional measures (e.g., falls, skin integrity, infections).

Collaboration:

"At the [state CAH network] meeting last week, a few of the hospitals did not make great strides [on swing-bed measures] like they had before. And ... they have conversations around what happened, and what they could have done differently. And, like MBQIP measures, they learn from each other and can share."

— Consultant working with CAHs

For example, CAHs cited limited staff resources and turnover in key staff positions as a challenge to swing-bed quality measurement. Some CAHs also mentioned the lack of community resources available to patients once they are discharged as a problem that can affect the likelihood of readmissions.

One challenge specific to swing-bed quality measurement reported by several CAHs is difficulties related to collecting and analyzing quality measure data separately for inpatients and swing-bed patients. In some cases, electronic medical record (EMR) systems are not set up to produce reports separately for swing-bed stays, and getting the EMR to report this information would be costly for the CAH. For CAHs with generally low swing-bed patient volume, hospital staff said that they had some capacity to manually abstract data elements for important quality measures. Some CAHs also reported using the same patient satisfaction surveys for inpatients and swing-bed patients, and noted that collecting data separately for just the swing-bed stay might be difficult because patients who do not physically change beds when moving to swing-bed status may have trouble differentiating between care received as an inpatient and as a swing-bed patient.

Conclusions

Measuring swing-bed quality of care is an important priority for many CAHs. Adoption of a common set of swing-bed quality measures, with uniform measure definitions and data collection methods, would allow CAHs to compare the quality of swing-bed care with other post-acute care providers, including SNFs and rural PPS swing-bed programs, as well as with other CAHs nationally.

Data Collection Challenges:

"[Collecting] readmission data is a little hard. Obviously I know if the patient comes back to us. Do I always know if they go to another hospital? No ... but our numbers are small enough that we can call our patients at 30 days to see what's going on. That's one of our strategies as we are looking at developing good post-acute care services."

– Kentucky CAH

"One challenge is follow-up [after swing-bed discharge]. Two to three days, I'll follow-up with a phone call to see if they have any more questions. Medications are usually the biggest thing, if they added on medications at discharge ... The other thing is following up with their primary care 7-10 days after discharge. I think that's a huge part of making sure that there's not a readmission ... That's one nice thing about a small hospital: we walk over to clinic registration and then go back to the patient's room to make sure that [primary care] appointment works for their schedule."

– Montana CAH

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