HealthTech

An Innovative Approach to Rehab in a CAH Swing Bed Program

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Sept 2025 – Jan 2026 webinars

All webinars are recorded for on-demand viewing.

New CoPs for safe obstetrical care

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: September 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oI6G5i

HR 101: What matters most

Presenter: Kimberly Butts - Human Resources
Date: September 19, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3V8TIjw

QAPI that matters

Presenter: Susan Runyan, Chief Executive Officer - Runyan Health Care Quality Consulting
Date: October 3, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45oIi15

An innovative approach to rehab in a CAH Swing Bed program

Presenter: Stephen Leone, PT - CEO of Rural Health Resources
Date: October 17, 2025 | **Time:** 12pm CST
URL: https://bit.ly/4oFNkxO

Swing Bed what's new? - what's changed? - what's the same?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: October 24, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Ve3iS9

Care Coordination service lines & you

Presenter: Marcella A Wright, DNP, MS, RN, Director Care Coordination & LEAN Consulting
Date: November 7, 2025 | **Time:** 12pm CST
URL: https://bit.ly/3Jko8wF

Non-Certified / Long-Term Swing Bed

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer.
Date: December 5, 2025 | **Time:** 12pm CST
URL: https://bit.ly/45WBzLZ

Tools to increase employee engagement: Lessons from a 99th percentile hospital

Presenter: Scott Manis - Regional Vice President
Date: January 9, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3UAFRlR

REH 101: A compliance guide for Rural Emergency Hospitals

Presenter: Cheri Benander, RN MSN, CHC, C-NHCE, HACP-CMS
Date: January 23, 2026 | **Time:** 12pm CST
URL: https://bit.ly/41PxdUt

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Leadership Development

$499 - 20 Contact Hours
Leadership Development is a comprehensive course designed to address the critical need for cultivating leadership skills among middle managers who find themselves in leadership roles without formal training and staff members who aspire to grow into management and leadership roles.

Lean Practitioner

$499, 16 Contact Hours
A Lean culture empowers individuals closest to the work to drive meaningful improvements. This Lean co
equips frontline staff with the essential tools, resources, and knowledge to master and apply Lean princip
effectively.

At its core, Lean focuses on enhancing process efficiency through fundamental concepts and tools. The
key principles for designing, assessing, and refining processes include defining the ideal state, identifyi
(muda), applying the four rules, and harnessing the power of observation. Critical tools such as value st
mapping and A3 problem-solving drive this methodology. While some may view Lean as a fleeting tre
evidence-based history proves it to be a reliable, results-oriented approach with a proven track record
success. Lean isn't just a set of processes—it's a transformative mindset and methodology that foster
safe, efficient, and high-quality environment for both patients and healthcare workers.

Care Coordination

HealthTech acknowledges the crucial role Care Coordination plays in driving success and sustainability within primary care. To empower the growth and sustainability of your programs, we provide arange of self-paced, asynchronous courses designed to enhance and expand services under CMS Care Coordination:

- **Care Coordination Fundamentals** – $299, offering 12 contact hours
- **Behavioral Health Integration** – $219, offering 9 contact hours
- **Transitional Care Management** – $159, offering 8 contact hours
- **Annual Wellness Visits** – $199, offering 7.5 contact hours
- **Advance Care Planning** – $149, offering 6 contact hours

These courses are tailored to support the continued development of your care coordination services, ensuring your team stays at the forefront of primary care excellence. Each course is crafted to equip members of the professional primary care team—including nurses, health educators, health coaches, and other qualified health-care providers—with the essential knowledge, skills, and expertise to conduct comprehensive consultative visits and create personalized preventive care plans. Focusing on a team-based care model, the platform prioritizes coordinated care, harnessing the collective expertise
of diverse team members. This approach enhances care coordination for patients with chronic and behavioral health conditions while reinforcing the integration of health promotion and prevention into everyday practice.

Swing Bed Courses for Critical Access Hospitals

The Swing Bed concept allows a hospital to use its beds interchangeably for either acute care or post-acute care. The reimbursement "swings" from billing for acute care services to billing for post-acute skilled nursing services, even though the patient usually stays in the same bed . Swing Bed allows patients to receive care close to home. The two courses Basics and Beyond Basics provide the fundamentals to care for Swing Bed patients and meet regulatory requirements.

Swing Bed Basics for Critical Access Hospitals

$299 - 9 Contact Hours
The Swing Bed Basics course focuses on the elements of a successful Swing Bed program including understanding and implementing CMS regulatory requirements found in the State Operations Manual Appendix W, State Operations Manual Appendix PP, and the Medicare Benefit Policy Manuals.

Swing Bed Beyond Basics for Critical Access Hospitals

$299 – 9 Contact Hours
The Swing Bed Advanced Course is focused on strategies to grow and strengthen the Swing Bed program including understanding the requirements in Appendix PP that apply to Swing Bed strategies for increasing volume. The course is divided into six modules, with one bonus module discussing the MDS which is required for Swing Beds in a PPS hospital. Each module may take up to two-weeks, but the course is self-paced.

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Instructions for Today

Please feel free to write questions in the Chat Box

The webinar is recorded, and you will receive the recording within 2 days

Speakers

Stephen Leone, PT
Stephen is a licensed physical therapist who has worked in the healthcare industry for over 32 years. He has owned and operated rehabilitation companies with multi-state contracts in over 85 facilities. Stephen has also owned and operated outpatient imaging centers and managed ALFs, while consulting in the rehabilitation field for over 20 years. He has experience in all areas of rehabilitation management including ARU, LTAC, SNF, HH, OPT, and SWB. He is the CEO of Rural Health Resources, a consulting and management firm that specializes in partnering with Rural Hospitals to maximize their Swing Bed programs.

Alan Knight, PT
Alan has over 30 years' experience as a licensed physical therapist in several settings to include acute care hospital, outpatient, home health, long term care, and swing bed. Working initially as a staff physical therapist, he progressed rapidly into a regional management role for a large contract therapy company and eventual ownership of multiple successful outpatient therapy clinics. His specialties and interests include the field of manual therapy along with a previous CWS certification that led to cutting edge research and multiple publications in the field of wound care. As COO of Rural Health Resources, he provides expertise in oversight and swing bed program development in the rural healthcare arena.

Description

In the world of rural health, rehab services are such an important component of health care. With the limitations of resources and reimbursement models, CAH swing bed programs are a hidden gem for post acute care, especially when it comes to rehab.

It’s the last arena where we can deliver high quality care without as many limiting parameters that affect delivery of care.

Many programs mismanage, lose track or don’t realize the potential that is within their grasp when it comes to therapy.

Rehab can mistakenly direct services their services into other settings of the hospital and lose the priority of its role in a swing bed program.

We hope to bring a refreshing and new perspective in the delivery of post acute rehab services in CAH skilled care/swing bed programs.

Learning Objectives

1) Understanding the place of SWB in the post-acute rehab continuum.

2) Changing the mindset of your rehabilitation staff regarding SWB

3) Developing true teamwork between your rehabilitation and nursing staff

4) Understanding how to manage and deliver skilled care in all situations, including patients with difficult or challenging diagnoses.

An Innovative Approach to Rehab in a CAH Swing Bed Program

HealthTech Webinar Series

Stephen Leone, PT and Alan Knight, PT

Rural Health Resources

Overview

- This presentation will review the history of the rehab continuum, discuss the ingredients of a successful SWB program, importance of staff development of your therapy team, especially as well as a collaborative team approach with the swing bed team
- In the world of rural health, rehab services are such an important component of health care. With the limitations of resources and reimbursement models, CAH swing bed programs are a hidden gem for post acute care, especially when it comes to rehab. It's the last arena where we can deliver high quality care without as many limiting parameters that affect delivery of care. Many programs mismanage, lose track or don't realize the potential that is within their grasp when it comes to therapy. Rehab can mistakenly direct services in other settings of the hospital and lose the priority of its role in a swing bed program. We hope to bring a refreshing and new perspective in the delivery of post acute rehab services in CAH skilled care/swing bed programs.

RURAL HEALTH RESOURCES

Learning Objectives

- Understanding the place of Swing Bed in the post acute rehab continuum.
- Changing the mindset of your rehabilitation staff regarding swing bed care
- Developing true teamwork between your rehabilitation and nursing staff
- Understanding how to manage and deliver skilled care in all situations, including patients with difficult or challenging diagnoses.

RURAL HEALTH RESOURCES

I. Rural Health Resources

- We are a premier provider of Swing Bed management and consulting services. Our team is comprised of highly educated and skilled clinicians, with over 25 years of experience each, who are dedicated to providing the highest quality of care and superior customer service to our partners.
- Majority of our impact and success comes from our ability to relate to the Rehab department for effective implementation that results in success of the program. Success comes in a manner that promotes better patient outcomes and increased overall satisfaction of their medical care.

RURAL HEALTH RESOURCES

II. History of Post Acute Rehab

- 80' to 90's

  ACUTE ---- ARU/LTAC ----- Home Health/Outpatient Services

- 2000 - 2020

  ACUTE --- ARU/LTAC ---- SNF/SWB ---- HH/OP

- 2020 to present

  Changes in reimbursement affecting Home Health and SNF

  PDPM - Patient Driven Payment Model - SNF

  PDGM - Patient Driven Groupings Model - HH

RURAL HEALTH RESOURCES

SNF

- Pre PDPM (RUG level system)

  500-700 therapy min/week

  144 therapy min/day

- Therapy Driven Model

RUG	DAYS/MINUTES	DISCIPLINES
RU - ULTRA	5 days / 720+	(1) 5x/week (1) 3x/week
RV- VERY HIGH	5 days / 500-719	(1) 5x/week
RH - HIGH	5 days / 325-499	(1) 5x/week
RM - MEDIUM	5 days / 150-324	Combo 5x/week
RL - LOW	3 days / 45 + Restorative Nursing	Combo 3x/week

RURAL HEALTH RESOURCES

SNF

- PDPM (Current system)
- 250-300 therapy min/week for all disciplines
- 45-60 therapy min/day for all disciplines
- Payment determined Functional Scoring and other factors associated with the MDS, no longer therapy - driven
- Extremely complicated payment model

RURAL HEALTH RESOURCES

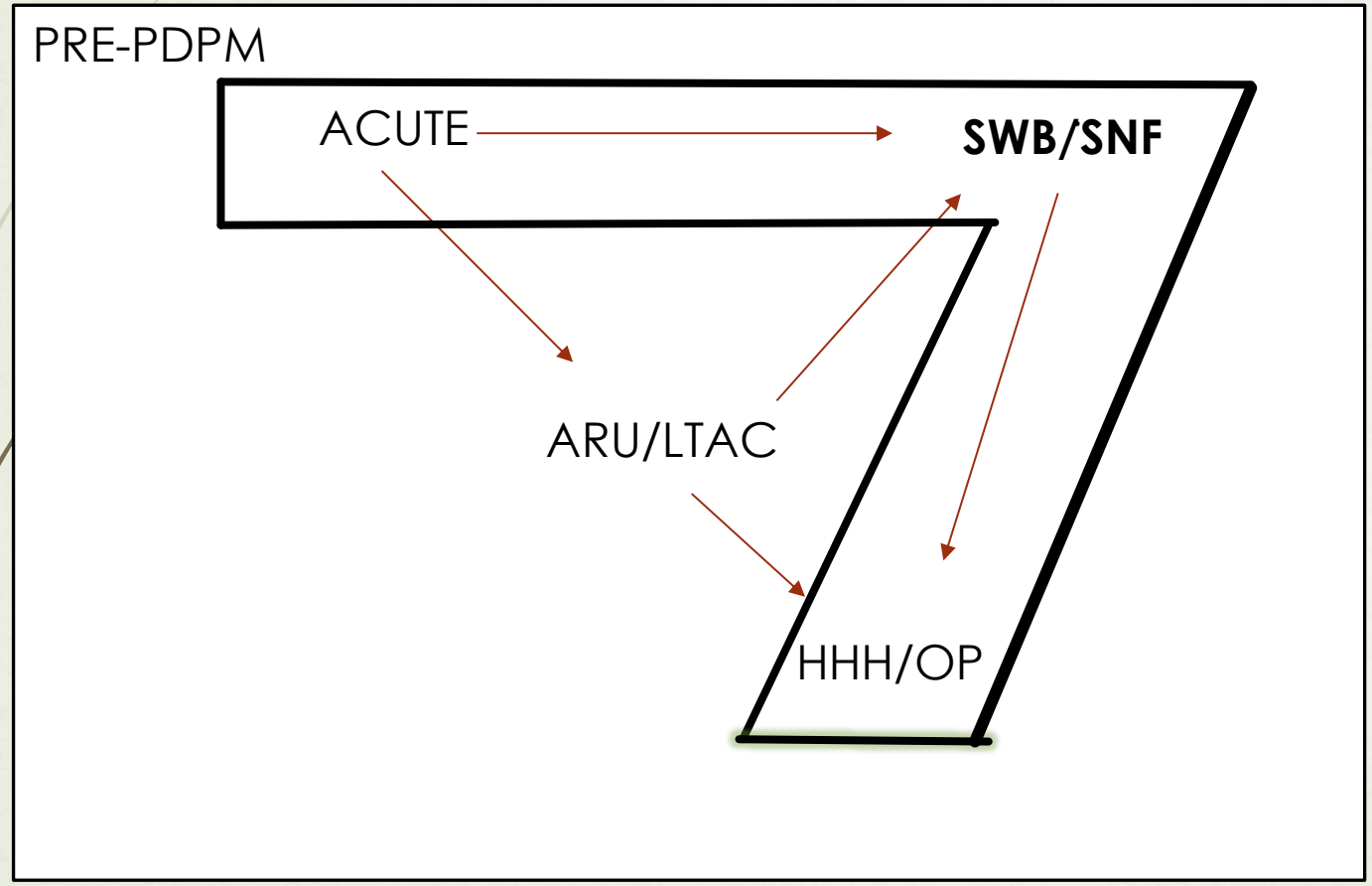
Home Health

- Pre PDGM
  - 15-20 visits/ EOC (60 days)
- Post PDGM
  - 6-8 visits/ EOC (60 days)

Complicated payment model with 432 payment groups

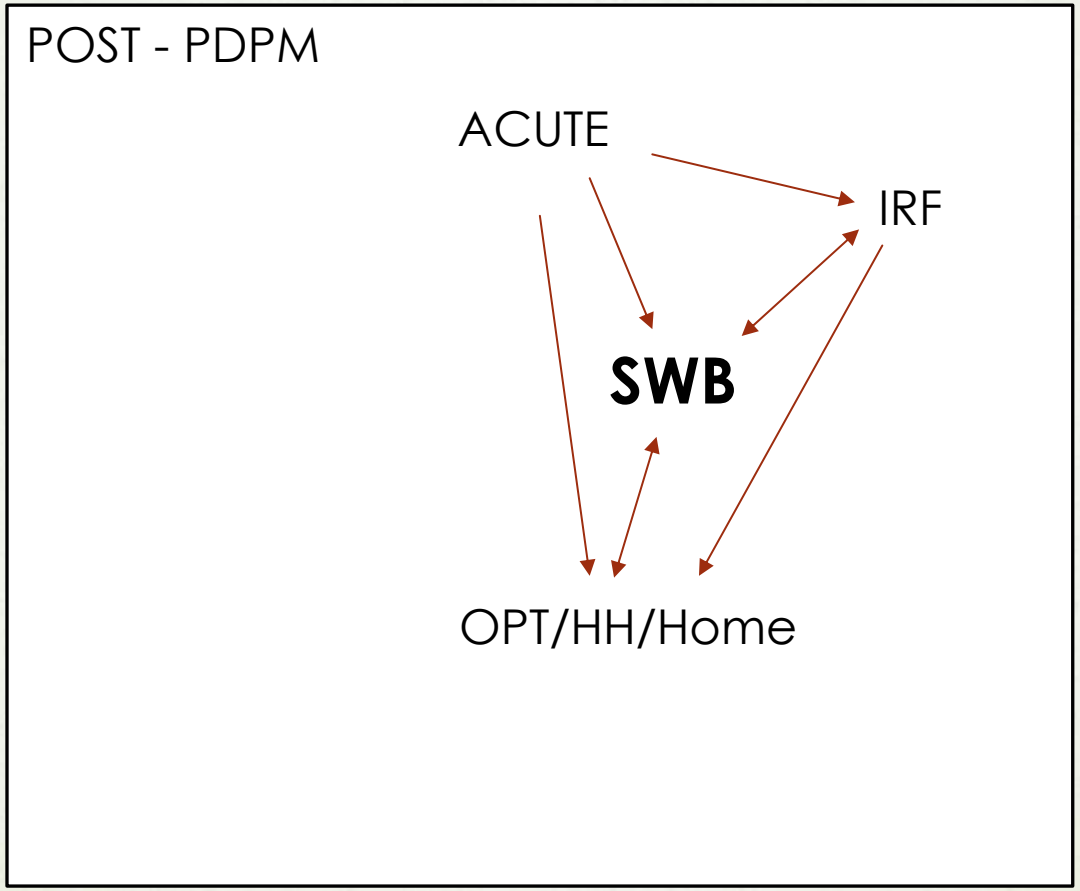
RURAL HEALTH RESOURCES

Where does Swingbed fit in the PAC model



RURAL HEALTH RESOURCES

Where does SWB fit in?



RURAL HEALTH RESOURCES

III. Swing Bed Quality Program Development

- There is no standard outcome measurement tool in CAH SWB programs currently. PPS SWB hospitals have the MDS.
- It is strongly encouraged that a facility adopt an outcome measurement tool to determine and promote the effectiveness of the Swing Bed Program
- Your program must be built around teamwork, communication from all departments, adequate staffing, and adequate resources for the betterment of the patient.

- ONE TEAM – ONE GOAL

- **How is this achieved…….**

RURAL HEALTH RESOURCES

Understanding what a successful SWB program looks like:

Common problem – the SWB pt is only given PT treatments of 15-20 minutes once per day due to a lack of priority. Loss of ADL function is the #1 reason for the loss of independence – OT is vital to your program

- **PT, OT and ST availability**
  - 30-45 minutes of treatment by each discipline BID
  - PT focuses on strength/endurance/balance in order to achieve increased functional mobility
  - OT focuses on ADL's in the morning, UE function in the afternoon
  - ST available for treatments, as needed

** ADEQUATE STAFFING IS KEY TO SUCCESS

RURAL HEALTH RESOURCES

Establishing a SWB program schedule - A SAMPLE DAY in the Life of a SWB patient

MORNING ROUTINE

- 7 am – Breakfast/OT ADL training
- 9 am – PT
- 10 am – Individual Activity
- 11 am – Rest
- 12 pm – Lunch

AFTERNOON ROUTINE

- 1 pm – PT
- 2 pm – OT
- 3 pm – Rest
- 4 pm – Group Activity
- 5 pm – Dinner
- Prepare for bedtime

HIGHLY RECOMMENDED SWB PATIENTS ARE DRESSED IN THEIR OWN CLOTHING

RURAL HEALTH RESOURCES

Communication daily/weekly by all team members

A common problem encountered can be the MD discharges pt early from acute or swing bed program without consulting team

- Weekly IDT meetings to include SWB coordinator, Rehab, Nursing, Social Worker, Dietary, CNO, Pharmacist, MD (if available), and **most importantly the patient and/or family!**
- Daily communication between SWB coordinator, Rehab Director and Nursing Department – which needs to relayed to the provider regular
- Developing a communication system to identify potential Swing bed patients

Maximize Space and Resources

Common problems - No dedicated gym space in hospital leads to treatment performed in patient rooms and hallways. Patient ends up staying in room 24 hours a day (Cabin Fever)

- **Therapy Gym – to include all appropriate equipment**
- **Transition Room – to mimic home setting**
- **Outdoor Area – easily accessible to work on higher level functional activities**

RURAL HEALTH RESOURCES

Healthy Activities Program

Common problem – Most SWB programs show little regard for activities

- Activities Director no longer required per CMS regulations, but activities are still a required component of a SWB program
- Daily interaction from designated activities personnel
- Adequate supplies (games, puzzles, etc.)
- Determine patient's interest
- Group Activities – dinning, bingo, social hour

Staff must support the Swing Bed Program

Common problems – Nursing staff sees SWB pts as 'Nursing home patients' and encourage then to discharge from facility; therapists prioritize OP program and look at the swing bed program as a hassle

- Nurses/Rehab/Case Management
- Staffing Matrix is dependent on a consistent number of total patients
- SWB census is the only area that can be consistently controlled, if managed properly
- SWB can be a consistent revenue source for your hospital
- Reward staff

(You want enthusiasm not dread from your staff!)

IV. Changing the Mindset of Your Rehab Team

- **Shifting the Rehab Dept focus from Outpatient to SWB**
- **Typical Rehab Perspective**:
  - Therapists are trained primarily in the areas of OP, Manual therapy, modalities, etc.
  - SWB pts' are not scheduled/prioritized (seen only when outpatients cancel or no-show)
  - SWB typically seen as a hassle
  - Performed at the minimal requirement of 1visit/day for 15-20 minutes
  - Swingbed patients are treated like acute patients (short stays) to prepare for SNF stays

RURAL HEALTH RESOURCES

New Rehab Department Mindset

- Realize the importance of SWB in the continuum of care.
- SWB rehab targets function and return to independence
- Schedule SWB pts with priority …. Not as an afterthought.
- Debunk the idea of patient turnover should be quick – avoid therapists thinking the next stop is always SNF
- Rehab Director evaluates staff to determine best fit for the SWB program – if possible, 1. place consistent staff into the SWB program. 2. develop monthly rotations in areas of rehab. (SWB, HH, OP, etc.)

RURAL HEALTH RESOURCES

Documentation

Common problems – inadequate documentation creates issues for reviewers and ultimately affects Length of Stay and reimbursement, especially with Medicare Advantage Plan patients

- Quality versus Quantity
- Remembering Safety, function, d/c setting/disposition
- Weekly progress notes are vital
- Progress is good but focus on the negative or the 'needs' of the patient
- Avoid lazy documentation
  - Functional mobility example

*** **Authorization does not guarantee reimbursement**

Team Effort and Coordination of Services

- Important for therapists to involve nursing staff with goals of the rehab program, motivate them to encourage these goals with patient
  - For example - Important for OT to work with nursing staff concerning ADL training
- Develop rapport with nursing staff
- Work with support staff to achieve goals – CNA's allow patients to perform their own dressing, toileting, etc. but with safety in mind

RURAL HEALTH RESOURCES

Importance of ALOS of the SWB patient

- Therapy, as well as nursing, must be the driving force for the swing bed patient when it comes to the length of stay
  - Refers to proper documentation
  - Communicating continued needs of patient to medical staff
  - Goals need to be specific for patient's discharge disposition

Must consider patient's potential vs PLOF/baseline…..

RURAL HEALTH RESOURCES

Prior Level of Function (PLOF) versus Potential

Common problem - Once pt reaches PLOF – ready for d/c. Allow for further improvement or progress.

- Therapist must be careful not to allow PLOF/baseline limit the patient's potential functional outcomes

C-1620 §483.21(b) Comprehensive care plans (1)The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: (i)**The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40;**

RURAL HEALTH RESOURCES

THINK OUTSIDE THE BOX

- Develop new treatment ideas
- Recreate home settings that represent the challenges the patient will face at discharge
- Home assessments
- Therapist can not treat all the patients the same

RURAL HEALTH RESOURCES

Managing the Difficult Patient

- "the train wreck'
- 'the grouch'
- 'the aggressive'
- 'the demented'
- Or a combination….

Are these patients appropriate for swing bed….

RURAL HEALTH RESOURCES

Managing the Difficult Patient

How long is it OK to provide skilled therapy with a dementia patient?

You can provide skilled therapy to a patient with dementia for as long as it is medically necessary and if the patient is still benefiting from skilled interventions – either through improvement, maintenance, or prevention of decline – and the services require the skills of a licensed therapist.

- Justify Therapy Despite Cognitive Decline
- Medicare allows skilled therapy for maintenance purposes if a licensed therapist is required to carry it out.
- Sample Documentation Language:

"Due to the patient's cognitive impairment, skilled intervention may be slower but anticipated and is required to assess safety awareness and provide structured tasks with verbal cueing and hand-over-hand assistance. Family education is being provided to ensure carryover of strategies. Without skilled intervention, the patient is at high risk for functional decline, injury, and caregiver burden."

RURAL HEALTH RESOURCES

Rehab's understanding of the financial Impact of SWB for the Hospital

- Enlighten the rehab team on the financial impact the SWB program offers for the facility
- Financial stability allows for the hospital to continue to provide vital services for the betterment of the community
- Budgeting/Consistent cash flow for CAHs (Acute vs SWB)

Identification of Potential Patients

Internal Sources:

In house conversion of acute patients that meet criteria – Have therapy involved in either evaluating or screening inpatient census

Emergency Department patients that meet criteria – especially Managed Care patients

External sources:

Outpatient Therapy Services
Home Health Services (esp. if operated by the rural hospital)

Why Swing Bed instead of SNF?

- Swing Bed
  - **More Intense therapy (BID)**
  - Onsite ER services
  - Low Nurse to patient ratio
  - Ancillary services available
  - Weekly provider visits
  - Private room
- SNF
  - **QD limited rehab sessions**
  - No ER services – "911" only
  - High nurse to patient ratio
  - No lab, X-ray services onsite
  - Monthly provider visits
  - Semi-private room

* The patient's cost is the same in either setting

RURAL HEALTH RESOURCES

CASE STUDIES

Hospital A

Texas

Previous Program:

Monthly SWB AVG – 58 days

ALOS – 9.1 days

Current Program:

Monthly SWB AVG – 154 days

ALOS – 13.2 days

Functional Outcomes – 25% gain

Hospital B

Oklahoma

Previous Program:

Monthly SWB AVG – 17 days

ALOS – 10.6 days

Current Program:

Monthly SWB AVG – 51 days

ALOS – 14.8 days

Functional Outcomes – 21% gain

Hospital C

North Dakota

Previous Program:

Monthly SWB AVG – 62 days

ALOS – 7.4 days

Current Program:

Monthly SWB AVG – 109 days

ALOS – 12.7 days

Functional Outcomes – 28% gain

RURAL HEALTH RESOURCES

Questions?

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