

Swing Bed Usage and Access to Post Acute Care in Rural Minnesota

Report to the Minnesota Legislature 2007

Minnesota Department of Health

January 31, 2007



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Executive Summary

During the 2005 Minnesota Legislative Session, the Legislature amended Minnesota Statutes section 144.562, allowing eligible hospitals to increase the total number of days for swing bed use per year to conform with a change in federal Medicare law and regulations. The Legislature directed the Commissioner of Health to review swing bed usage and related data to assess the impact of this change. Data gathered included use of swing bed days, occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds, and information from rural providers on the use of swing beds and the adequacy of services across the continuum of care.

Overall little change was noted in either swing bed usage or nursing home occupancy rates during the period assessed (2003-2006). Nursing home occupancy remained stable, ranging from 89 percent to 92 percent, with slightly higher rates in rural Minnesota compared to the seven-county metro area. A small increase in the number of swing bed admissions was noted with the majority of admissions coming from within the hospital, consistent with the trend since 1998. More than half the swing bed discharges were to home and this was also consistent across the time period. The number of days paid for by Medicare for rural skilled nursing facilities increased slightly over the three-year time period from 8.9 percent to 9.7 percent with no difference found between communities where nursing homes were attached to local hospitals and communities with unattached, independent nursing homes.

Focus groups conducted in December 2006 provided input from providers on the use of swing beds and on the continuum of care. Representatives from nursing homes, hospitals and public health participated. In general, concerns included staffing shortages, inadequate payment for care in nursing homes, lack of nursing home beds in some areas, the burden of paperwork in both nursing home and hospital settings, lack of respite capabilities and lack of capacity to handle patients with mental and behavioral health issues. Participants felt they had good working relationships among facilities in their communities to coordinate patient care. Participants felt swing beds added an important component to the continuity of post-acute care.

Given the indications from this report that there have been no significant changes in swing bed use, nursing home occupancy or Medicare days, the Minnesota Department of Health (MDH) recommends:

- MDH should regularly review existing data on swing bed usage to monitor trends.
- MDH should monitor developments affecting the availability of post-acute services in rural Minnesota.
- Policymakers should take into consideration the information and recommendations from the focus groups for future planning and coordination on long term care services in Minnesota.

I. Background

During the 2005 Minnesota Legislative Session, the Legislature amended Minnesota Statutes section 144.562, allowing eligible hospitals to increase the total number of days for swing bed use per year. The change in swing bed regulations was implemented to move toward conformance with 2003 changes in federal Medicare law and regulations¹. Amendments to the state statute include:

- Full swing bed conformity with federal law for Critical Access Hospitals with attached nursing homes or nursing homes in the same municipality as the hospital.
- An increase in the annual limit on swing bed days for all other hospitals from 1,460 to 2,000 days.
- Exceptions for six cases each year for hospitals subject to the 2,000 annual day limit.
- A health care system may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

This report has been prepared in response to the Legislature's requirement that "the Commissioner of Health review swing bed and related data reported under Minnesota Statutes, sections 144.562, subdivision 3, paragraph (f); 144.564; and 144.698. The commissioner shall report and make any appropriate recommendations to the Legislature by January 31, 2007 on:

- use of swing beds days by all hospitals and by critical access hospitals;
- occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds; and
- information by rural providers on the use of swing beds and the adequacy of services across the continuum of care."²

Swing Beds

A national swing-bed program was first authorized in the 1980 Omnibus Budget Reconciliation Act (Public Law 96-499) allowing Medicare and Medical Assistance reimbursement of swing-bed care in rural hospitals with fewer than 100 beds. The term "swing bed" is used to describe the level of care hospitalized patients receive once they are no longer in need of acute care. Swing bed admissions are limited to patients who require some level of skilled nursing care and are currently in a hospital acute care bed. Patients cannot be admitted to a swing bed from either the community or a skilled nursing facility unless they have spent three days in an acute care hospital bed for related service needs within the past 30 days. Swing bed days are generally limited to 40 days per patient under state law.

According to the Centers for Medicare and Medical Assistance (CMS), a swing bed hospital is a hospital or Critical Access Hospital (CAH) participating in Medicare that has been approved to provide post-acute extended care services, sometimes called "sub-acute care." Today, hospital participation in the federal swing-bed program is nationwide and limited to small, rural hospitals with fewer than 100 beds. Hospitals eligible for the federal

¹ See Medicare conditions of participation for swing beds under Code of Federal Regulations, Title 42, Section 482.66.

² Laws of Minnesota 2005, First Special Session, Chapter 4, Article 6, Section 54.

swing-bed program must also comply with state regulations. In Minnesota, hospitals meeting federal criteria must also comply with state statute 144.562, which sets the conditions for licensing swing beds. A total of 85 rural hospitals in Minnesota are currently licensed as swing bed providers, of which 80 are Critical Access Hospitals.

The Minnesota Department of Health (MDH) has studied swing-bed usage in a number of reports over the past 20 years. A 1989 MDH report stated, "Subacute days as a percentage of total hospital days remains slight and fairly consistent at 1.4 percent of total hospital days and 0.3 percent of nursing home days. (Minnesota Department of Health, 1989, p.17) A 1992 MDH report found that compared to nursing home short stay residents, slightly more swing-bed patients return home (48 percent vs. 45 percent), fewer swing bed patients are re-hospitalized (8 percent vs. 12 percent) and fewer die (11 percent vs. 19 percent). Average length of stay in the swing bed in 1989 was 11 days. (Minnesota Department of Health, 1992, p.9)

Small rural hospitals were allowed to convert to Critical Access Hospital status under the 1997 federal Medicare law. A national study published in 2006 examined the experience of Critical Access Hospitals with swing beds between 1997 and 2004. During this time period, swing bed care declined as a share of all hospital-related skilled nursing days. The report concluded that "there is little evidence (at least for the period through 2003) that the swing bed payments available to Critical Access Hospitals translated to a competitive disadvantage for community-based facilities [skilled nursing facilities]." (Dalton et. Al., 2006, p.4)

Long Term Care in Minnesota

Swing beds are part of a continuum of care in rural Minnesota that includes acute, post-acute and long term care. Long term care is undergoing a period of change due to a number of factors. Over the past five years, considerable work has been done to try to "rebalance" long term care to provide more services in the home and community rather than in nursing homes. Rebalancing efforts have included funding more of these services.

A number of programs through the Minnesota Department of Human Services are aimed at supporting more home and community based services. In 2001, the Community Service/Service Development grant program was initiated to promote the development of local community capacity in home and community-based services. Since its inception, the grant program has awarded about \$22.4 million to 181 projects in 82 counties across Minnesota. The Elderly Waiver and Alternative Care grant programs provide funds for home based services for eligible people. Additionally, a new program entitled Consumer-Directed Service Options permits eligible clients to use an allowance based on service needs that may be used to hire the worker of their choice to provide needed personal care services, including hiring family members, neighbors or friends (Minnesota Department of Human Services, 2006).

The number of nursing homes and licensed beds in Minnesota has been declining since 1987 when there were 468 facilities with 48,307 beds. Since that time 57 facilities have closed altogether and 9,538 beds have been de-licensed. Along with the decline in the number of beds has come a decline in nursing home utilization. In 1984, 8.4 percent of persons age 65 and over used nursing homes. By 2005 that number had dropped to 4.9

percent, a 42 percent decrease. The utilization rate for people age 85 and over has dropped even more dramatically, by 52 percent (Minnesota Department of Human Services, 2006).

More of the elderly who used to occupy nursing home beds are remaining in their own homes or opting to move into assisted living facilities. Assisted living facilities represent a fast growing senior housing alternative. These facilities provide a range of services focused on keeping residents independent. According to data from the Minnesota Department of Health Division of Compliance Monitoring, the capacity of Housing with Services' clients in the state rose from 43,042 in 2004 to 58,011 in 2005, a gain of 14,969 units. In the same period, the number of nursing home beds dropped from 36,868 to 35,999, a loss of 869 beds (Minnesota Department of Human Services, 2006).

II. Report Methods

To comply with the request of the Minnesota Legislature to study the trends in swing bed utilization after the 2005 change in regulations, the MDH Office of Rural Health and Primary Care looked at both quantitative and qualitative data. Quantitative data included:

- Nursing home occupancy data gathered and calculated by the MDH Division of Compliance Monitoring.
- A survey of 81 hospitals licensed as swing bed providers in Minnesota reporting swing bed usage from August 2003 through July 2006. This survey was done in partnership with the Minnesota Hospital Association (MHA) to obtain two years of data prior to and one year of data following the 2005 legislative change in swing bed regulations.
- Analysis of data from the Health Care Cost Information System's Hospital Annual Report (HCCIS).
- Nursing home Medicare days as reported to the Minnesota Department of Human Services. Medicare days are the number of days of care in a nursing home paid for by Medicare and generally represent a higher reimbursement for the nursing home than days paid by Medical Assistance.

Qualitative data on the use of swing beds and the adequacy of services across the continuum of care was obtained through four focus groups with rural providers. The focus groups were conducted and analyzed by an independent focus group facilitator. (See Appendix D for more information on the methodology used to obtain the quantitative and qualitative data in the report.)

III. Data Results

Occupancy Data

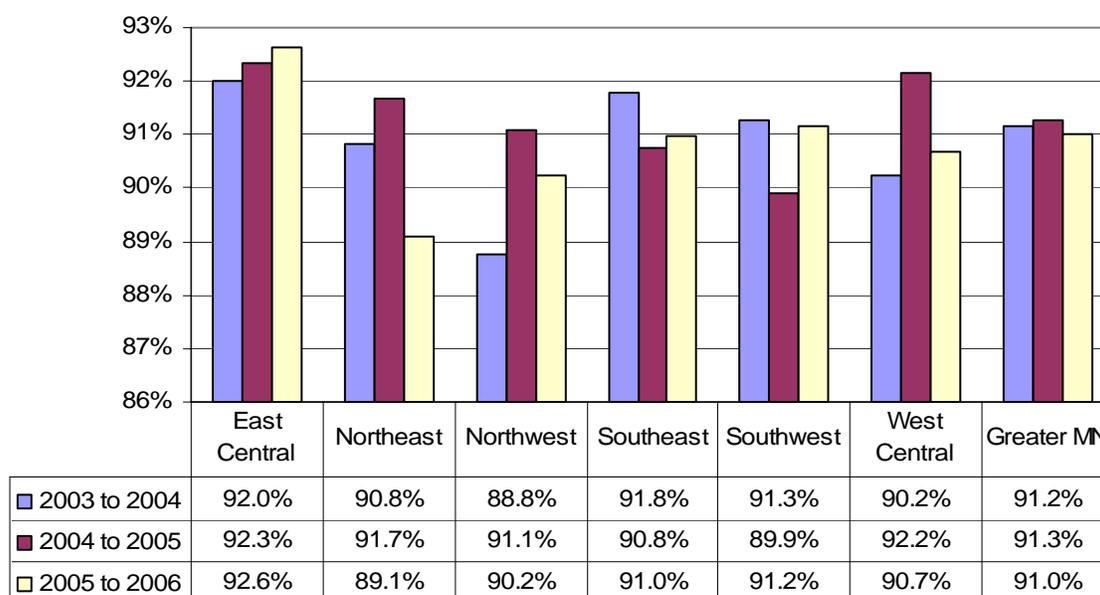
Swing bed and nursing home occupancy data cover the following time periods (the exception is Medicare days, which are reported by federal fiscal year beginning October 1 and ending on September 30 of the following year):

1. August 1, 2003 to July 31, 2004
2. August 1, 2004 to July 31, 2005
3. August 1, 2005 to July 31, 2006.

For the selected time periods, statewide nursing home occupancy declined slightly from 86.3 percent (12,084,916 resident days) to 85.3 percent (11,524,133 resident days) to 84.7 percent (11,155,730 resident days).

Regionally, (excluding the seven-county metro area) occupancy rates in nursing homes have varied to some extent ranging from 89 percent in the Northeast to as high as 93 percent in the East Central region during time periods 2003 to 2004 through 2005 to 2006. Regional data are based on regions established by the Minnesota Health and Housing Alliance and are used in the analysis of nursing home occupancy rates and Medicare days.

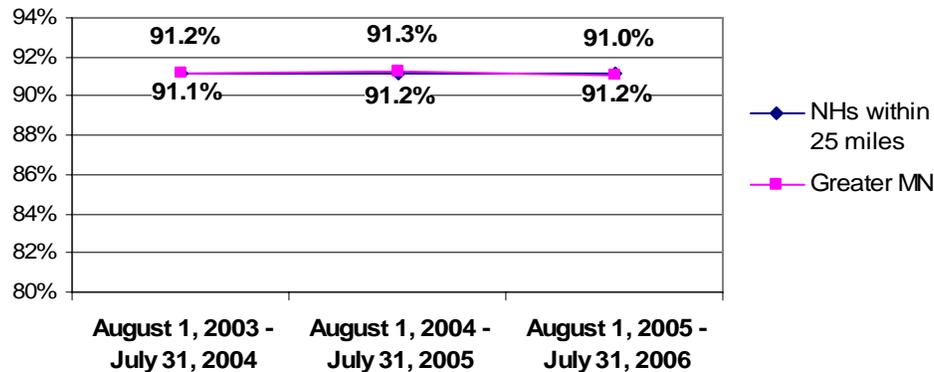
**Variation of Nursing Home Occupancy Rates
by Region in Minnesota**



Nursing Homes Within a 25-mile Radius

Aggregated occupancy rates for nursing homes within a 25-mile radius of a swing bed provider remained stable at 91 percent during the specified time periods and did not vary from aggregated occupancy rates observed in nursing homes located throughout Greater Minnesota.

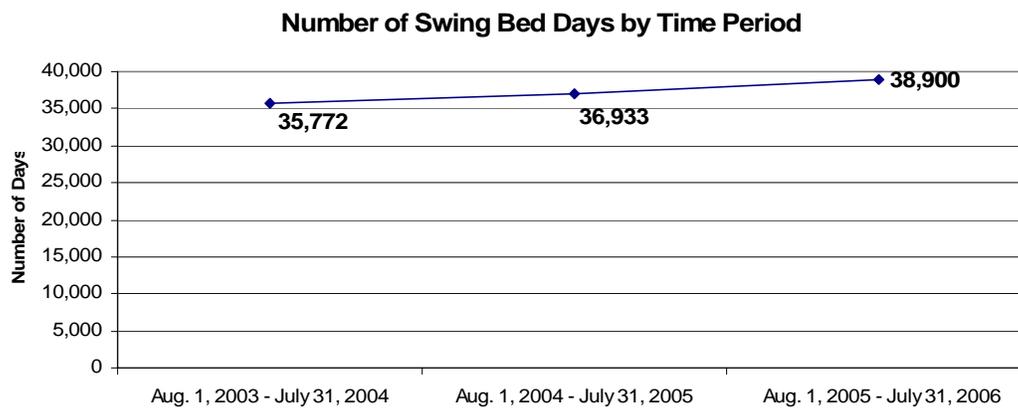
Occupancy Rates for Nursing Homes Within 25-mile Radius of a Swing Bed Provider



Swing Bed Survey Results

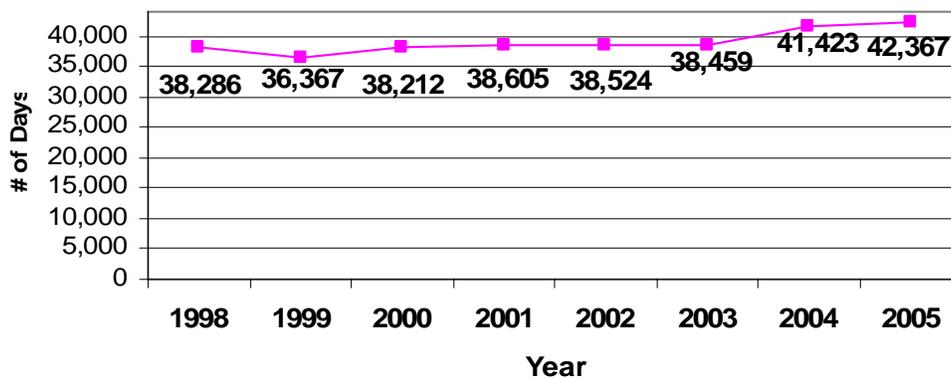
Swing Bed Utilization

Among the 68 hospitals responding to the Minnesota Hospital Association survey, an increase in the total number of swing bed days was reported for each time period. The time period from August 1, 2005 to July 31, 2006 showed an increase of 5.3 percent from the previous time period.



Trend analysis of Health Care Cost Information System data from 1998 to 2005 is similar to the data from the Minnesota Hospital Association survey. Overall, Health Care Cost Information System data shows a general increase (7.7 percent) in swing bed days from 2003 to 2004, albeit a smaller increase of 2.3 percent from 2004 to 2005.

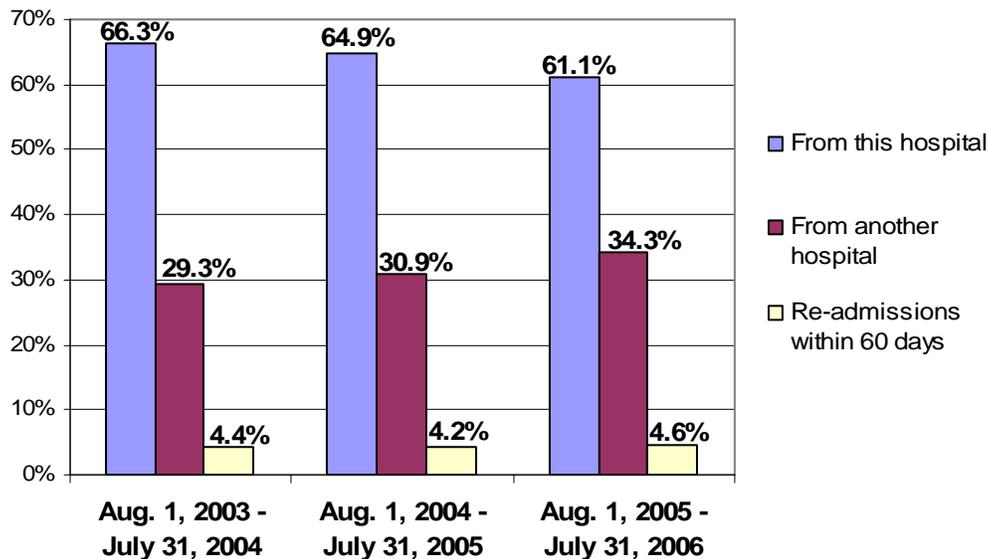
HCCIS Swing Bed Patient Days 1998-2005



Swing Bed Admissions

Among the hospitals reporting admission data from the Minnesota Hospital Association hospital survey, the predominate source of swing bed admissions are transfers from within the hospital, ranging from 66.3 to 61.1 percent for the reported time periods.

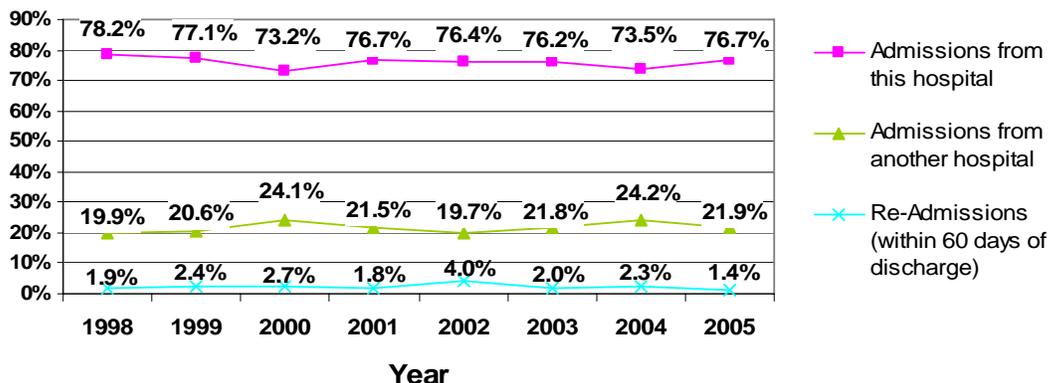
Swing Bed Admissions by Time Period



Hospitals with missing admissions data were not included.

Health Care Cost Information System data from 1998 to 2005 reflect similar admission trends ranging from 73 percent to 78 percent of swing bed admissions occurring from within the hospital, and approximately 20 to 24 percent originating from another hospital.

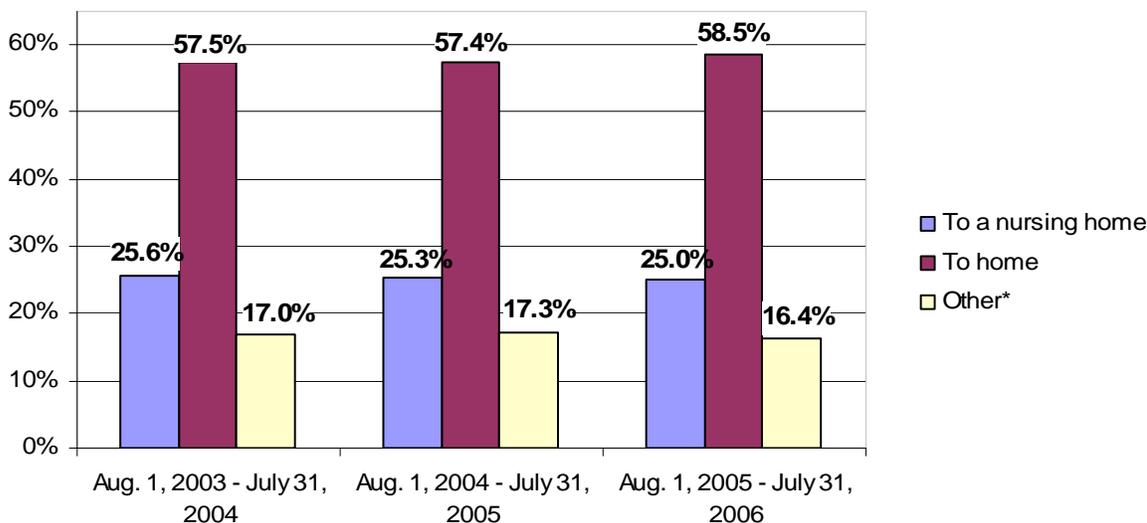
HCCIS Swing Bed Admissions 1998-2005



Swing Bed Discharges

Hospital survey data shows little change in percentage of swing bed patients being discharged to home during the selected time periods: From 57.5 percent to 57.4 percent to 58.5 percent. The percentage of swing bed patients being discharged to nursing homes has also remained fairly constant during the same time periods: At about 25 percent.

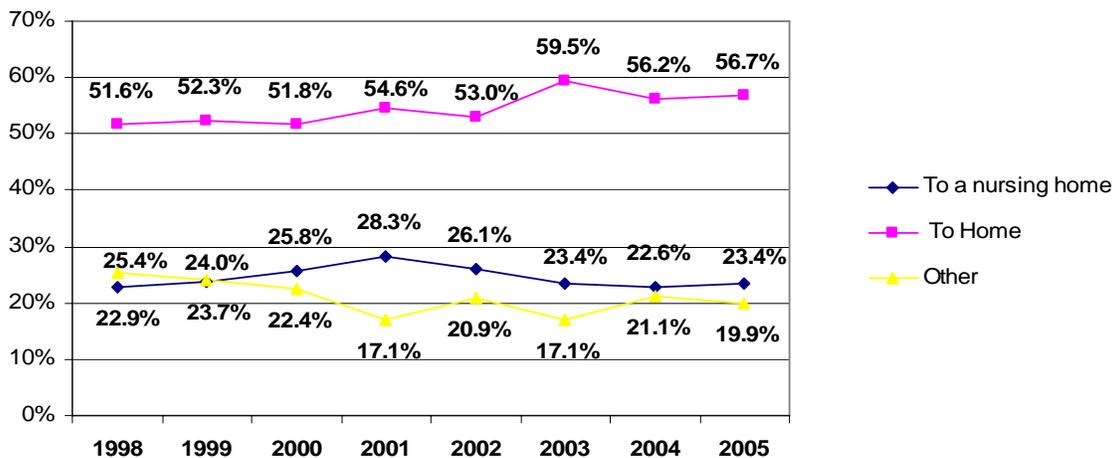
Swing Bed Discharge Locations by Time Period



*includes other hospital units, assisted living facilities, group homes or death.

Data from 1998 to 2005 reflect the same swing bed discharge trends in the Health Care Cost Information System data showing more than half of swing bed patients being discharged to home. During the same years, nearly a quarter of swing bed patients were discharged to nursing homes.

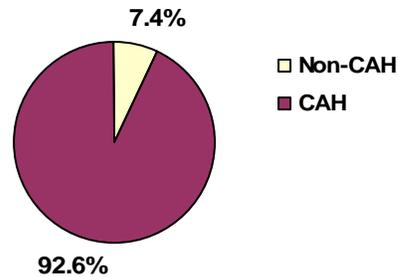
HCCIS Swing Bed Discharge Locations 1998-2005



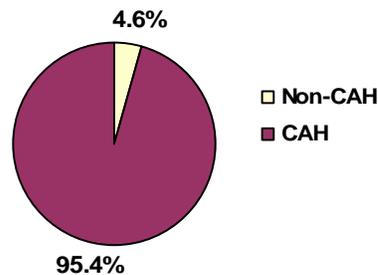
Swing Beds and Critical Access Hospitals

In Minnesota, a total of 80 hospitals are designated as Critical Access Hospitals (CAHs), and all are licensed swing bed providers. Only five hospitals located outside the seven-county metropolitan area are not designated as Critical Access Hospitals, but are licensed as swing bed providers. Among the 68 hospitals responding to the Minnesota Hospital Association survey, 63 (92 percent) were Critical Access Hospitals with only five (8 percent) identifying themselves as being a non-Critical Access Hospital. A comparison of Critical Access Hospitals and non-Critical Access Hospitals responding to the Minnesota Hospital Association survey shows swing bed use in Critical Access Hospitals is proportionate to the number of Critical Access Hospitals throughout Greater Minnesota.

Percent of Hospitals Responding to Survey by Type



Percent of Swing Bed Days Reported from August 1, 2005-July 31, 2006 by Hospital Type

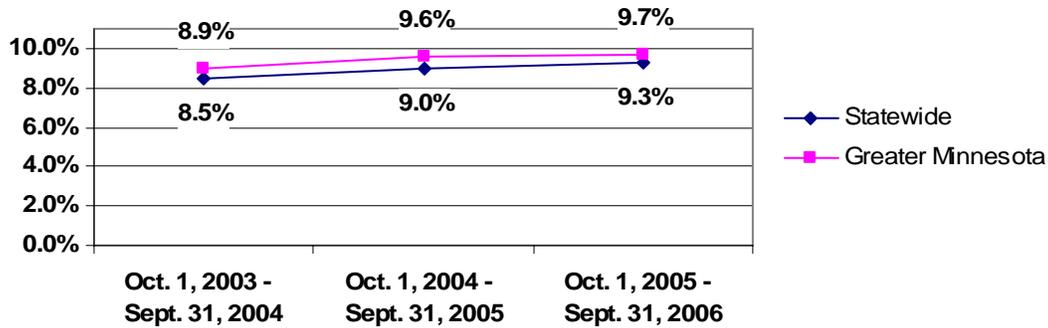


From the survey, 39 hospitals (57 percent) indicated they had an attached nursing home, while 29 hospitals (43 percent) responding to the survey indicated they did not have a nursing home attached. Data analysis of swing bed days reported by hospitals in the Minnesota Hospital Association survey indicates swing bed use is higher among hospitals with nursing homes compared to hospitals without.

Medicare Days

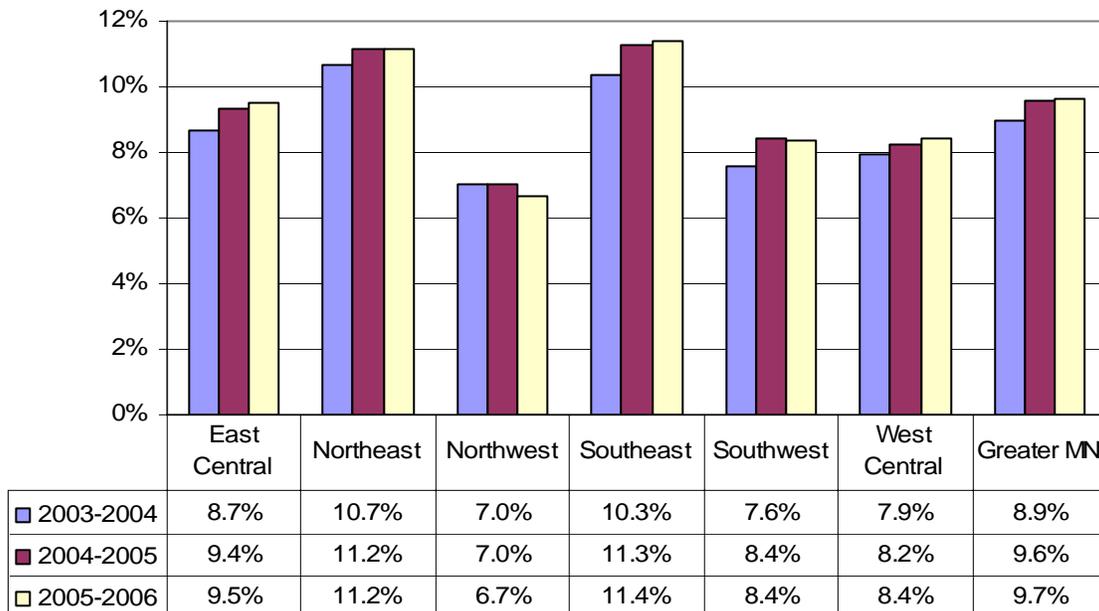
For the three-year time period of FY2003-04 to FY2005-06, nursing home stays paid by Medicare have averaged 8.9 percent statewide. Nursing home stays paid by Medicare in Greater Minnesota have been slightly higher, averaging 9.3 percent during the same time period.

Percent of Medicare Days Reported for Nursing Homes Statewide and Greater Minnesota



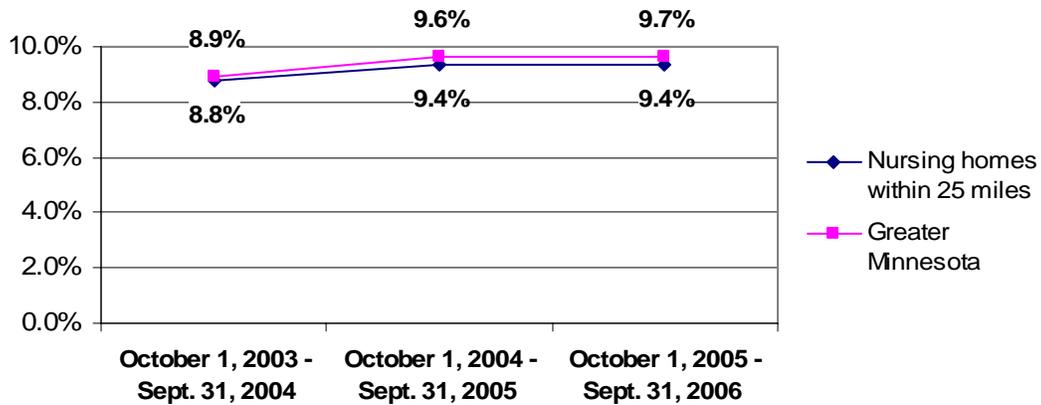
A regional (excluding seven-county metro) analysis of Medicare days indicates some deviation from the statewide average especially in the Northeast and Southeast regions where the percentage of Medicare days peaks at 11.4 percent during the three-year time period. The Northwest region has the lowest percentage of Medicare days at about 7 percent. With the exception of the Northwest, from FY2003-04 through FY2005-06, the percentage of Medicare days appears to be remaining steady or increasing in all regions.

Variation in Percentage of Medicare Days in Nursing Home by Region in Minnesota 2003-2006



Separate analysis of nursing homes within a 25-mile radius of a swing bed hospital within the time periods also shows little difference from the percentage of Medicare days observed in nursing home facilities throughout Greater Minnesota.

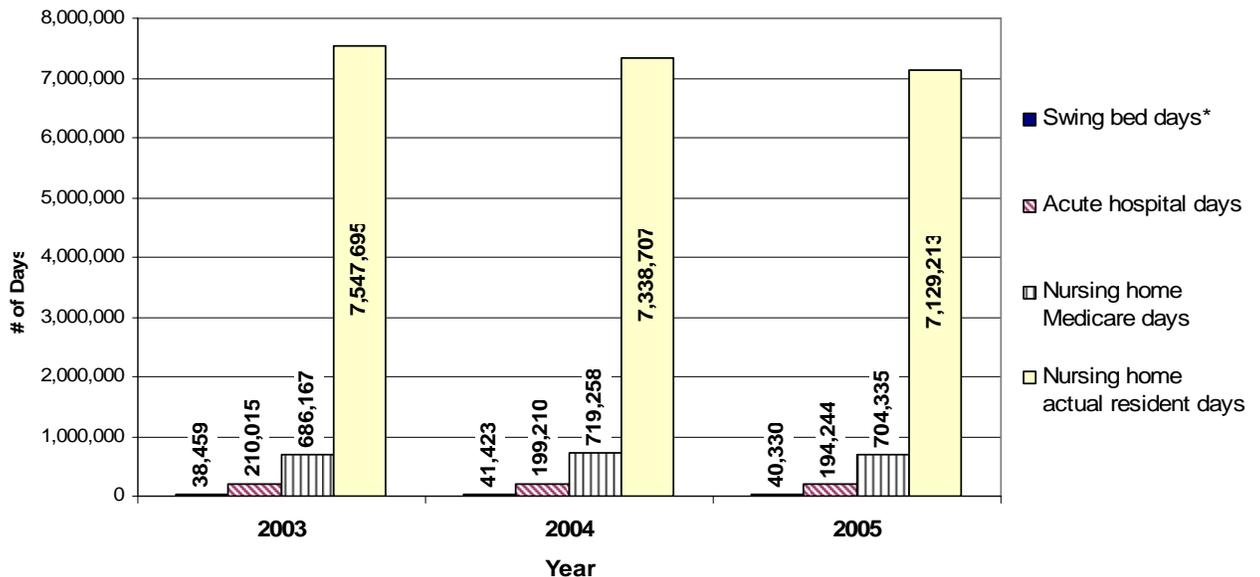
Medicare Days for Nursing Homes Within 25-mile Radius of a Swing Bed Provider



Hospital and Nursing Home Days

Differences exist in the total number of days patients spend in swing beds compared to days in acute care or days in a skilled nursing care facility regardless of payer. A side-by-side comparison of swing bed days from 2003 to 2005 in Greater Minnesota shows more days being reported in acute hospital beds and nursing home beds.

Comparison of Days by Swing Bed Providers and Nursing Homes Greater Minnesota 2003-2005



*Includes Medicare and Medicaid paid days

IV Focus Group Results

Purpose

MDH used four focus groups to gather information from rural providers on the use of swing beds and the adequacy of rural services across the continuum of care. **Information gathered from the focus groups represents the perceptions and the opinions of the participants and cannot be generalized to all providers and all communities in Minnesota. However, these focus group discussions do provide a sense of the issues and concerns facing the participants.**³

Organization of Focus Groups

An independent consultant was contracted to conduct four focus groups in two different regions of the state with approximately 10 to 12 attendees per group. Included in the focus groups were participants from Critical Access Hospitals, freestanding nursing homes and nursing homes attached to Critical Access Hospitals, home health care agencies and public health personnel.

The two regions selected – West Central and Southwest – were regions in which the staff and consultant felt that there was the most significant mix of both freestanding nursing homes as well as Critical Access Hospitals with attached nursing homes and Critical Access Hospitals without attached nursing homes.

The Office of Rural Health and Primary Care sent letters of invitation to social workers, discharge planners and chief executive officers to attend the focus groups and follow-up calls were made to ensure adequate attendance.

The consultant conducted the groups in each of the two locations with no personnel from the Minnesota Department of Health present to ensure the most comfortable environment for feedback by the participants.

Focus Group Attendance

A total of 43 people attended the groups, including 15 from freestanding nursing homes, 10 from Critical Access Hospitals with attached nursing homes, 12 from Critical Access Hospitals with no attached nursing homes, and four from public health agencies.

In most instances, after the first question was introduced the discussion progressed so that all of the questions were addressed in the discussion. The following focuses on the major themes that emerged during the discussion. (A complete list of questions presented in each focus group is available in Appendix C.)

Theme 1: Relationship Between Swing Beds and Skilled Nursing Beds

Based on the occupancy of the nursing homes in the market, the perceptions about the relationship between the swing bed program and the skilled nursing facilities varied. In the West Central region, the nursing homes were experiencing full occupancy at the time

³ The issues and concerns represent the views of the focus group participants and not the Minnesota Department of Health.

of the focus group discussions, and in the Southwest, there were vacancies in most of the nursing homes.

In the West Central area nursing homes, for the most part, felt that the swing beds were appropriately used by the hospitals for short-term stays. Participants felt that physicians have a significant impact on where residents go, and some felt that physicians “promise” patients that they do not have to go to the nursing home and can stay in the swing bed. If patients are asked whether they want to go to a swing bed in the hospital or to the nursing home, the preference is always the swing bed in the hospital.

In both regions, participants pointed out that some patients who stay in swing beds are residents who the nursing home could not afford to take because their medications cost more than the per diem nursing home payment.

Freestanding nursing homes in the Southwest had the greatest concern about the use of swing beds. Many of them felt that they were receiving longer-term residents after they had used all of their Medicare eligibility in the swing bed. Medicare payment is critical, according to them, in remaining financially viable. Several have seen their percentage of Medicare business decline.

Part of the discussion focused on the fact that nursing homes are not adequately reimbursed for some of the patients, and some participants expressed the opinion that Medicare pays for the same patient in a swing bed at a Critical Access Hospital at over five times the rate the skilled nursing facility would be paid.

Some participants noted that their facilities could not take persons needing 24-hour IV therapy because of their registered nurse staffing levels.

Several of the hospitals indicated that they follow strict criteria for use of swing beds. One hospital reported that they had a swing bed committee that reviewed every admission to a swing bed, and the committee could overrule a doctor’s “preference” if the placement was inappropriate. The hospital personnel participating in the groups indicated that they try hard in their communities not to compete with the nursing homes.

Several of the busiest hospitals indicated that they need to strictly limit the use of swing beds because of the fluctuation in their acute care census and because they do not want to turn away an acute admission because of bed capacity.

Theme 2: Role of Managed Care* and Medical Assistance

*(Minnesota Senior Health Options program (MSHO), is a state managed care program for seniors dually eligible for Medical Assistance and Medicare)

Every group discussed the role of managed care in the future and its potential impact. For the most part, participants felt that the case managers for some of the MSHO contractors were not adequately trained, and the system was causing a lot more paperwork for everybody. The system has not been “thought through” from the patient/resident’s point of view.

Hospitals need to call to justify keeping a patient in a swing bed rather than a skilled nursing facility. The plans do not take into account the paperwork and time it takes to admit a person to a nursing home for a three-day stay.

Several participants commented that any money MSHO is saving is costing more in other parts of the system because of the paperwork, telephone calls, justifications, etc. They also noted that Medical Assistance will not pay for a swing bed stay.⁴

Theme 3: Community-Based Services

The adequacy of community-based services varies by community.

Assisted living is the most likely option for many persons needing some support but not a nursing home level of care. It is full all of the time in some communities.

Home care is available for periodic home care; however, in all communities the ability to find staff for short-term, 24-hour, in-home care was nearly impossible. These patients needed to remain in the nursing home or be in 24-hour staffed assisted living. This is further complicated because most assisted living facilities do not want to take persons for short stays if there is a longer stay resident desiring the same accommodations.

Short-term respite care needs are a problem in general. Many times a patient can be hospitalized, leaving a spouse who cannot be home alone. They can make it together, but not individually. A short-term stay is problematic for the nursing home because of the admission process.

Theme 4: Coordination of Care

Participants reported generally good working relationships among facilities in a given community. Staff know one another and work together for the benefit of the patient.

Problems can develop when physicians do rounds later in the day, and then decide that a patient can be discharged to the nursing home that day. One of the biggest issues for the freestanding nursing homes taking a patient late in the day or early evening is that they do not have access to pharmacy services until the next day. A new patient can be admitted but will not have prescriptions filled until the next day.

Hospital discharge planner participants indicated that it is very difficult when there are no beds available in the community. Older persons want to stay in their own communities when they need assistance and would prefer, in most instances, to go into the nursing home in their home community over assisted living in another community.

Participants also indicated that relationships with larger, e.g., Twin Cities or Sioux Falls, hospitals do not always work well. The hospital may call to inquire about bed availability in the nursing home, and then do nothing further. A number of facilities have had patients arrive from larger hospitals believing that they would be admitted only to find out the facility is full or unprepared to take them.

⁴ Minnesota Statutes 2006, section 256B.0625, subdivision 2 permits a small number of hospitals to be reimbursed by Medical Assistance for swing bed stays.

Theme 5: Care Needs not Being Met in the Region

All participants concurred that it is difficult to place persons with significant behavior issues associated with mental illness or dementia. Nursing homes cannot accommodate these patients because they do not have adequate staff to manage the medications or have access to a psychiatrist, and the patients present a real danger to other patients and to staff. It is very difficult, when these individuals present in the emergency room, to place them in a nursing home. It is also difficult for the hospital when a nursing home will not re-accept a patient after hospitalization.

The bariatric (obese) patient presents problems for most of the nursing homes. Though equipment can be rented short term, most of the nursing homes are not designed to accommodate oversized equipment. Furthermore, bathroom design limitations can impede proper care and toileting.

There is variation among nursing homes about taking persons with complex medical needs, particularly if they need IV therapy. It is also difficult for some nursing homes to take persons late in the day because of pharmacy availability.

Theme 6: Focus Group Recommendations for Change in the System⁵

- Allow nursing homes to exceed their current number of licensed beds to accommodate the fluctuations in demand if they have adequate physical space available.
- Allow nursing homes to take respite residents without requiring the Minimum Data Set (MDS) and total admission process.
- Change Medicare's definition of homebound for home health care.
- Eliminate the bed hold financial penalty so that nursing homes keep more licensed capacity in rural areas.
- Do local and regional planning for specialty units so that they are full and successful, and consider different payments for different types of units.
- Ensure that the "rules" for assisted living prevent assisted living facilities from keeping persons who should be in a nursing home.
- Ensure patient choice about going to a nursing home or staying in a swing bed. Let the money follow the patient so that nursing homes can afford to take patients they cannot currently afford.
- Empower family members to care for older family members by providing some financial assistance. This is particularly important in rural areas.
- Allow non-Critical Access Hospitals to contract with nursing homes to ensure bed availability in regions where nursing homes are frequently full.

⁵ Some recommendations suggested by the focus groups would require changes to federal statutes.

V. Discussion of Data

Nursing Home Occupancy Rates

Regional data from August 2003 to 2006 show occupancy rates in nursing homes higher compared to the statewide rates of 85 to 86 percent and range from 89 percent in the Northeast to 93 percent in the East Central despite the decline shown in the statewide nursing home occupancy data. Nursing homes within a 25-mile radius of a swing bed provider with no attached nursing home remain at 91 percent occupancy, similar to what is being observed regionally. The 2005 change in swing bed regulations appears to be having no effect on nursing home occupancy rates so far. Occupancy rates are based on the average number of beds licensed by the nursing home facility during the reporting periods and do not reflect the layaway or closing of nursing home beds due to declining need for skilled care beds. Also, a few nursing homes reported over 100 percent occupancy, due to a failure of the nursing home to submit discharge forms for the time periods shown in this report, which can affect occupancy rates.

Swing Bed Survey Data

Hospital respondents to the Minnesota Hospital Association survey report an increasing total number of swing bed days from 2003 to 2006, especially during the time period after the 2005 swing bed legislation went into effect. Hospitals also report more than half of swing bed admissions come from within the hospital, while a remaining 25 percent of swing bed admissions are from another hospital. The patient's home is the most frequent location reported for discharging swing bed patients, and nursing homes are the second most frequently reported location, according to the survey.

Hospitals with attached nursing homes responding to the Minnesota Hospital Association survey, report higher swing bed utilization compared to unattached hospitals, which is likely to be an indication of the closer arrangements that exist between co-located and jointly-owned hospitals and nursing homes.

Survey results show swing bed days in Critical Access Hospitals is proportionate to the number of Critical Access Hospitals in Minnesota. For the year ending July 31, 2006, 92 percent of swing bed hospitals were Critical Access Hospitals, and 95 percent of swing bed days were provided by Critical Access Hospitals.

Additionally, swing bed findings from the Minnesota Hospital Association survey are supported by Health Care Cost Information System reports, although the different Health Care Cost Information System timeframe limits direct comparisons.

Two survey questions asked respondents to comment on the future of swing bed use in their communities and what barriers, if any, prevented patients from being discharged to nursing home facilities. Respondents' expectations for swing bed use varied. Some anticipated no increase in swing bed volume for their hospital, while others projected that the need for swing beds will increase during the next decade given the growing population of elderly in rural communities and the de-licensing of nursing home beds. Some hospitals are experiencing an increase in surgical patients and anticipate a greater use of swing beds for rehabilitation before discharging the patients to their homes.

Many hospitals commented that there were no barriers impeding the discharge of patients to nursing home facilities. However, among hospitals that did encounter barriers, the most common ones were a lack of nursing home bed availability, the limitations of some nursing homes to manage complex patient care, and staff shortages preventing nursing homes from receiving patients during weekends or beyond standard working hours.

Medicare Days

Medicare days reported by nursing homes for FY2003-04 through FY2005-06 provides another way of assessing the possible impact of changes in swing bed regulations on nursing homes. Analysis of Medicare days during time periods before and after changes were made in swing bed regulations indicate there has been little impact so far. The percentage of Medicare days reported by nursing homes in Greater Minnesota remains stable and is slightly higher compared to the percentage of Medicare days reported by nursing homes statewide. An aggregated regional comparison of nursing homes in Greater Minnesota also indicates a slight increase in the percentage of Medicare days with the Northwest area being the only region showing a decline. A separate analysis of Medicare days for nursing homes within a 25-mile radius of a swing bed hospital without an attached nursing home show little difference from the percentages reported for nursing homes throughout Greater Minnesota. In fact, one year after the 2005 change in swing bed regulations, the percentage of Medicare days was unchanged and remained at 9.7 percent for nursing homes with a 25-mile radius of a swing bed provider.

Overall, swing bed days total a much smaller quantity compared to the number of acute care, nursing home resident and Medicare days reported from 2003 to 2005 for Greater Minnesota.

Focus Groups

Themes from the focus groups reveal some overarching concerns regarding the financial stability of nursing homes, the importance of fostering a continuum of care, the burden of paperwork, ongoing staffing shortages, and lack of post-acute care options for some patients, such as those with mental health or bariatric issues. Participants agreed that good working relationships existed among facilities in the coordination of a patient's care. Participants also expressed concerns about providing care across the continuum due to the MSHO program

Participants noted that nursing homes are taking on a greater role of rehabilitation and post acute care and pointed out the important role swing beds play in the rural continuum of care, particularly for those who need short-term post acute care before returning home. Concern over short-term post acute care accommodation is further complicated by limited nursing home admission hours and some patients' complex medical care needs.

As for existing care needs not being met in the community, gaps in the long term care system that include a lack of mental health beds and support, along with the lack of respite care capability were significant issues mentioned in each of the focus groups. Participants noted that older persons want to stay in their own communities when they need long term care. Ensuring that older patients are informed of the options that are available was the primary concern among focus group participants.

VI. Recommendations

Given the indications from this report that there have been no significant changes in swing bed use, nursing home occupancy or Medicare days, the Minnesota Department of Health's recommendations are limited, but address ongoing needs for monitoring post-acute care and the continuum of rural care.

- MDH should regularly review existing data on swing bed usage to monitor trends.
- MDH should monitor developments affecting the availability of post-acute services in rural Minnesota.
- Policymakers should take into consideration the information and recommendations from the focus groups for future planning and coordination on long term care services in Minnesota.

References

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Appendix A

MHA Survey of Swing Bed Utilization

On behalf of MN Department of Health's Office of Rural Health

Name:	
Facility:	
CAH?: Y/N	
Email:	
Phone:	
Attached SNF? Y/N	

	Aug. 1, 2003 - July 31, 2004	Aug. 1, 2004 - July 31, 2005	Aug. 1, 2005 - July 31, 2006
Total number of Swing Bed days:			

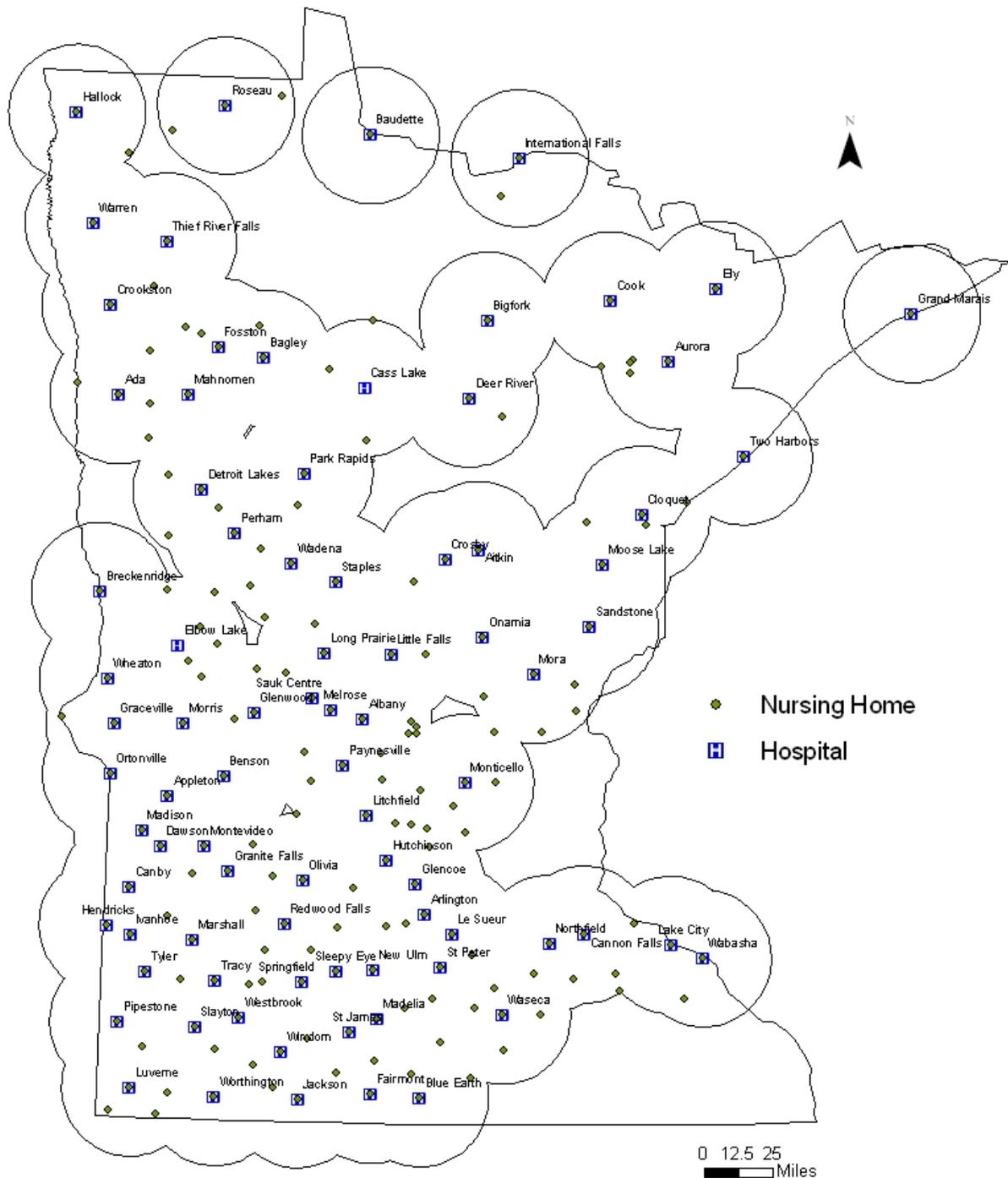
	Aug. 1, 2003 - July 31, 2004	Aug. 1, 2004 - July 31, 2005	Aug. 1, 2005 - July 31, 2006
Admissions from this hospital			
Admissions from another hospital			
Re-admissions (within 60 days of discharge)			
Total number of Swing Bed Admissions			

	Aug. 1, 2003 - July 31, 2004	Aug. 1, 2004 - July 31, 2005	Aug. 1, 2005 - July 31, 2006
Discharges to another unit of this hospital			
Discharges to a Nursing Home			
Discharges to Home			
Deaths			
All other discharges			
Total number of discharges			

What are your thoughts about the future of swing bed care in your community?	
Have you experienced any barriers to discharging patients to nursing home facilities? If so, please describe.	

Appendix B

Nursing Homes Within a 25-mile Radius of a Swing Bed Provider - Minnesota



Appendix C

The following questions were addressed in each of the focus groups:

1. What, if any, issues arise in providing patients the range of post-acute care services and setting they need? Are all needed services available in your area in a timely fashion, e.g., skilled care in a nursing home or swing bed, assisted living home care, rehab, hospice?
2. Please discuss how discharge planning works in your community. Is care coordination happening as it needs to?
3. What, if any, issues arise in the movement of patients from the acute care setting to the skilled nursing setting? Are the issues the same for movement from acute care to a swing bed as movement from acute care to a nursing home?
4. If capacity is an issue, what recommendations would you have for being better able to accommodate area needs?
5. Are there certain types of patients that are difficult to place for their immediate post-acute needs? Is appropriate care available in your area for these patients?
6. What recommendations would you have for how these types of patients can be better accommodated?
7. What are the criteria for placement of a person in a swing bed rather than a skilled nursing facility? What roles do discharge planners, social workers and family members play in post-acute placement decisions?
8. Are there persons in the skilled nursing setting who could function at home if additional services were available? What would those services be?
9. Are there any other issues or concerns that should be discussed today that we have not addressed?

APPENDIX D REPORT METHODS

Hospital Swing Bed Survey

In partnership with the Minnesota Hospital Association (MHA) an electronic survey was distributed to 81 hospitals licensed as swing bed providers in Greater Minnesota. Most hospitals located in the seven-county Twin Cities area do not qualify for swing bed provider status and were excluded from analysis. The survey the Minnesota Hospital Association sent to 81 hospitals reporting swing bed use during 2003 through 2006. A total of 68 responses were received after follow-up phone calls to all eligible hospitals was conducted providing a response rate of 84 percent. Responding hospitals represent an estimated 87 percent of the swing bed volume.

Nursing Home Occupancy Rates

Nursing home occupancy data was gathered and calculated by the Division of Compliance Monitoring of Minnesota Department of Health. Nursing home occupancy rates are computed by dividing the total number of resident days for the reporting period by the maximum number of resident days available for the reporting period. The source for calculating the number of resident days by facility comes from the Minimum Data Set.

$$\text{Occupancy Rate} = \frac{\text{Total Resident Days Used}}{\text{Maximum Number of Resident Days Possible}}$$

The maximum number of resident days possible is calculated by taking the average number of beds for the facility for the reporting period and multiplying that number by the number days in the reporting period. The average number of beds is computed by totaling the number of licensed beds for each day in the reporting period and dividing by the total number of days in the reporting period.

$$\text{Average Number of Beds} = \frac{\sum \text{of beds available for each day of reporting period}}{\text{Total Number of days in the reporting period}}$$

In this report, total resident days used is computed by counting the number of days a resident is considered a resident of the nursing home during the reporting period. If a resident was hospitalized during the reporting period and the nursing home expected the resident to return to the facility the hospital days are counted as nursing home resident days. If a resident was discharged from the nursing home and not expected to return then the count of resident days stopped on the day the resident was discharged from the facility. If a resident was discharged from the facility and return was expected but the resident did not return then count of resident days was stopped on the day of discharge.

The maximum number of days for each reporting period is as follows:

August 1, 2003 - July 31, 2004	366
August 1, 2004 - July 31, 2005	365
August 1, 2005 - July 31, 2006	365

Nursing facilities that ceased operation during a reporting period had their occupancy rate computed only for the days the nursing home was in operation.

Nursing Home Medicare Days

Nursing home Medicare days was obtained from annual reports submitted to the Minnesota Department of Human Services (DHS) by the nursing homes. Medicare days are reported by federal fiscal year beginning October 1 and ending on September 30 of the following year. Medicare days represent the number of days that Medicare Part A paid a portion or all the daily cost of a nursing home stay. Medicare days allow for a more detailed examination of nursing home stays and are included as a supplement to the occupancy data in this report.

The Health Care Cost Information System's Hospital Annual Report (HCCIS) is a source of information about the financial, utilization and service characteristics of hospitals in Minnesota and is reported annually to the Minnesota Department of Health (MDH). Since Health Care Cost Information System reporting periods vary by fiscal year-end for each facility, a separate survey was initiated to standardize the time period (August 1 - July 31) to obtain two years of data before and additional year of data after the 2005 legislative change in swing bed regulations became effective. The Minnesota Hospital Association conducted the online swing-bed survey to obtain data for three separate, successive time periods starting August 1, 2003 and ending July 31, 2006. Survey questions followed the same content as collected through Health Care Cost Information System sections 47-50. For these time periods, hospitals were asked to report the number of swing bed days, the origin of swing bed admissions, and the location of swing bed discharges, and whether the hospitals had a nursing home attachment. A copy of the survey instrument is provided under Appendix A.

To supplement the Minnesota Hospital Association hospital survey, swing bed data from annual Health Care Cost Information System reports are also provided to present a comprehensive picture of swing bed utilization in Minnesota. Health Care Cost Information System data appearing in this report include the number of swing bed days, origin of swing bed admissions, discharge locations of swing bed patients, and swing bed utilization in hospitals with nursing home attachment.

Nursing Homes Within 25 Miles

The Legislature requested that occupancy rates in skilled nursing facilities within 25 miles of a hospital with swing beds also be reviewed. A GIS mapping system was used to measure distance between nursing homes and hospitals with swing beds. Hospitals and nursing homes were geocoded by city location, and a 25-mile radius was drawn around each swing bed hospital. Nursing homes falling within the 25-mile radius were identified

(See map under Appendix B). Occupancy rates and Medicare days for identified nursing homes were aggregated and analyzed separately.