



Petersburg Medical Center

Quality Skilled Swing Bed Report October 2025

Workforce Wellness

The Swing Bed program is staffed by our Acute Care Registered Nurses. (Swing Bed refers to a hospital room utilized for skilled nursing care.) Our Acute Care team currently includes 8 travel nurses and 6 permanent staff, along with one local RN who works PRN night shifts—meaning they fill in as needed to support coverage. We aim to staff 2 RNs on days and 2 RNs on nights whenever possible. The addition of the second night RN position has been a positive change and is working well. Having an additional night nurse improves quality, safety, and overall patient care.

Community Engagement

Referrals are carefully reviewed to ensure patients are matched to the appropriate level of care and that insurance requirements are met. Recently, several referrals have required a higher level of care with surgical capabilities. We continue to network with larger hospitals in Alaska, including ANMC, Alaska Regional, and Providence Anchorage, to build and strengthen referral relationships. In addition, referrals from Seattle-area hospitals such as Swedish, Virginia Mason, and Harborview are reviewed online. Most non-local skilled patients continue to come from Bartlett Regional Hospital in Juneau, with a recent referral from Swedish. Regular communication is maintained with Bartlett—typically weekly or more often—to coordinate care and transitions. Each referral is screened using standardized tools such as the Skilled Screener, LTC Needs Assessment, and Infection Control Transfer Form to confirm medical appropriateness and determine the required level of care. Insurance coverage and discharge plans are also reviewed in advance to support a smooth transition after the skilled stay. The Nursing Department evaluates referrals for skilled nursing needs, while the PMC Rehab team reviews them for rehabilitation benefit and qualification. Once both assessments are complete, the referral is sent to a PMC physician for approval and physician-to-physician communication. Finally, Swing Bed authorizations through LTC Medicaid must be approved by DHSS before the patient can travel and be admitted. While expanding our recruitment radius has brought in some new opportunities, results have been mixed due to factors such as payor source, medical or psychiatric complexities, and discharge planning challenges.

Patient Centered Care

Our goal is to develop metrics that improve quality of care and support optimal patient outcomes. Extensive discharge planning is beginning to show positive results despite payor eligibility restrictions. Coordination is ongoing with the patient care navigator, state representatives, PMC staff, and Riverview. A Quality Improvement Plan has been implemented to ensure that within one week of identifying a patient's need for long-term care or Medicaid application assistance, the appropriate team members—including Jen Ray, PMC LTC Medicaid expert, Brandy Boggs (HHSW), and Helen Boggs (LTC DON)—are notified. Paid in-person visits have been used to successfully advocate for patient placement. Current areas under review include readmissions, falls, skin breakdown, Notices of Non-Coverage, and skilled patient days. Efforts are underway



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to improve communication between local and receiving providers for referrals, medevacs, and patients requiring skilled care, ensuring better dissemination of information on services offered. We continue to highlight PMC Skilled Nursing Facility's 24/7 RN staffing for IV therapy, medication management, and wound care provided by certified specialists. Additionally, HelloSign forms have been edited and sent to the IT department, with plans to develop a template—similar to the LTC MDS template—to automatically recertify Skilled patients at 2 weeks and again within 4 weeks of the original recertification.

Facility

Financial Wellness

From September to October 2025, Skilled Swing Bed (SNF SB) patients accounted for a total of 92 care days. The average census, including all Swing Bed stays (some at long-term care level), was 3 patients, with the current census showing 2 SNF SB patients and 1 ICF SB patient. During this period, there were 2 skilled readmissions within 60 days. There were no low inpatient census days, and no patients required 24-hour supervision. When the census is low at night, a single Acute Care CNA can provide support for long-term care patients as needed.

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