Washington Critical Access Hospitals Best Practices and Leveraging Swing Beds

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Agenda

- Overview
- General Eligibility
- Growing your Program
- Quality Improvement
- Swing Bed Economics
- Q & A

Overview-Why Swing Beds

Access

- Patients remain local and close to families
- Care is coordinated within a region

Quality

- Reduced readmissions and avoidable ED visits
- Shorter lengths of stay

Financial

- Compliance with the annual 96-hour length of stay
- Financial benefit to the hospital

Overview

- With uncertainty around a majority of significant provisions, such as payment, insurance, and delivery-system reforms, the healthcare industry must address future market changes
- Swing-bed services provide an important care resource for rural patients and a volume growth opportunity for the hospital
  - Best practice peer rural hospitals target swing-bed ADC at a minimum of 4.0 per 10,000 population
- An effective swing bed strategy and process will have a significant impact on the number of patients in your swing bed program

General Eligibility Criteria

In order to charge Medicare for a Swing Bed patient, the following criteria must be met:

- The patient must be a Medicare Part A enrollee and have benefit days available;
- There must be a three-day qualifying stay;
- Medicare age or disability/disease eligibility requirements must be met;
- Patient's Swing Bed admission condition is the same as the qualifying stay condition;
- Patient is being admitted to Swing Bed within thirty days of discharge; and
- The patient's condition meets criteria to necessitate daily inpatient skilled nursing rehabilitation or combination of these services.

Growing Your Swing Bed Program

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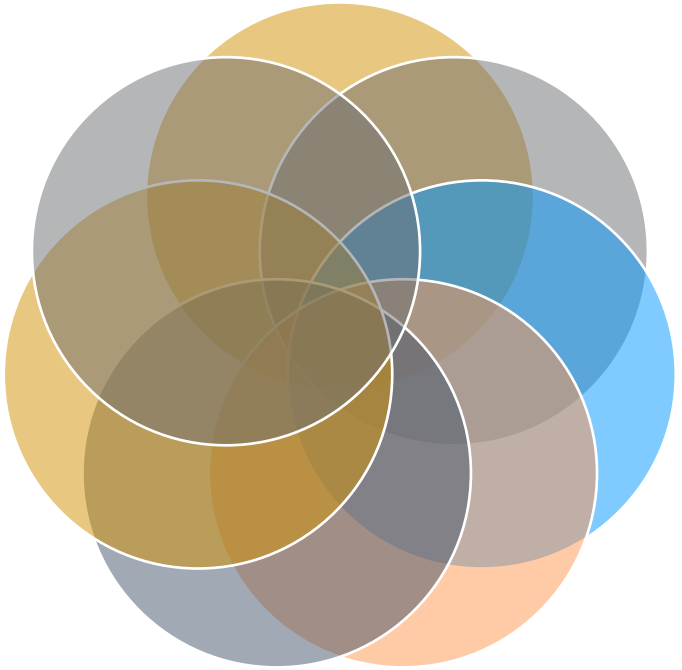
Clinical Care Delivery Spectrum

Nursing

Case Management/
Utilization Review

Pharmacy



Supplies/equipment

Providers

Consulting specialty
services

Business Office

Care Spectrum

- Best practice rural hospitals define the Care Spectrum (those patients able to receive care at your facility) across applicable departments (Med/Surg, ED, Rehab, etc.) as a collaborative, multi-disciplinary group inclusive of the following categories:
  - Medical Staff, Nursing, Pharmacy, Medical Equipment, Rehabilitation, and Business Office

Care Spectrum - Example

Example: Cardiac Rehab Clinical Program

	Yes The Hospital **HAS** the Resources Stroudwater says it needs to effectively provide Cardiac Rehab services	**No** The Hospital **DOES NOT HAVE** the Resources Stroudwater says it needs to effectively provide Cardiac Rehab services
Yes The hospital indicates that their swing bed program **PROVIDES** Cardiac Rehab services	**"MATCH"** The hospital **DOES HAVE** all the necessary Resources and they **DO** provide Cardiac Rehab services	**"CONFLICT"** The hospital **DOES NOT** have all the necessary Resources but they **DO** provide Cardiac Rehab services
No The hospital indicates that their swing bed program **DOES NOT PROVIDE** Cardiac Rehab service	**"OPPORTUNITY"** The hospital **DOES HAVE** all the necessary Resources but they **DO NOT** provide Cardiac Rehab services	**N/A** The hospital **DOES NOT** have all the necessary Resources and they **DO NOT** provide Cardiac Rehab services

Post-Stroke Rehab

Post-Stroke Rehab	Response
AFO & Prosthesis (donning & doffing)	No
All RNs have ACLS certification within 3 months of employment	Yes
All RNs have competency in Non-Invasive Vascular Assessment	No
O2 Sat measure & management (all staff with appropriate competencies)	Yes
Status Post Stroke Care (all staff with appropriate competencies)	No
All RNs & LPNs understand the principles of Edema Management	Yes
At least 1 RN/shift is trained in cardiac arrythmia monitoring and assessment	Yes
All RNs & LPNs can perform nasopharyngeal and oral pharyngeal suctioning	Yes
Competency in skilled rehab model (principle & rehab specific expertise)	No
Standards of care for PE & thrombophlebitis prevention	No
All RNs/LPNs are trained in using Stoplight Patient Education Tools	No
Palliative Care with Skilled Need	No
All RNs/LPNs are trained in documentation to support skilled needs	Yes
On-site Care Management	No

Post-Stroke Rehab	Response
Physical Therapy/Occupational Therapy trained in inpatient skilled rehab	No
Physical Therapy trained in balance retraining	Yes
Speech Language Pathology	No
Process to obtain all pertinent info from the referring hospital	Yes
Referrals are approved or denied within 1 hr in most cases	Yes
Discharge assessments initiated within 24-48 hrs of admission	Yes
Discharge goals are agreed to by interdisciplinary team within 3 days of admission	Yes
Discharge summary and med rec shared with patient/family, PCP and/or next level of care	Yes
Post-discharge clinical follow-up call within 24 to 72 hrs	No
Post-discharge follow-up call as necessary for at least 30 days to prevent readmission	Yes
Onsite Gym/Therapy Room(s) with basic assessment tools, mats and equipment	Yes
BiPAP/CPAP	Yes
Rehab Positioners	No
Balance Training tools/equipment	Yes
Tilt Table for Physicial Therapy rehab	Yes

Active Patient Pursuit

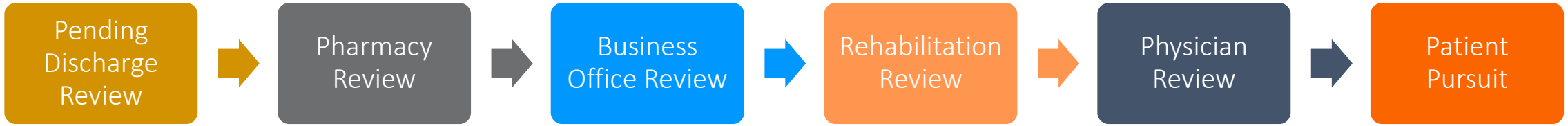
With a limited number of swing bed patients, hospitals need to actively pursue patients to increase volumes

Best-practice rural hospitals will establish relationships with larger hospitals and actively pursue swing bed patients whenever beds are available

- One of the primary concerns of an acute care PPS hospital looking for swing bed placement is to free up the bed for future acute admissions
- The goal of the swing bed program is to establish a relationship with the other hospital so that you are the first hospital they consider when swing bed services are needed (Pull not Push)

Best-practice rural hospitals will ensure patients who are transferred for acute services elsewhere return when needing swing bed services

Admission Process



Pending Discharge Review

- This can be done electronically through an EHR or by contacting a Case Manager
- This should be done by a nurse or other individual who understands the care abilities of the CAH

Pharmacy Review

- Determine the drugs necessary for each patient who could receive care at the CAH
- Determine the cost of the drugs necessary
- Determine if the Pharmacy has the drugs necessary to provide care
    - If the pharmacy does not have the drugs, how long until they could receive the drugs

Business Office Review

- Determine the insurance type of each patient needing placement
- Insurance verification for each patient can include the following:
  - Receiving prior authorizations when necessary
  - Confirming the patient has enough eligible Medicare days
- Confirmation, if possible, with insurance company that patient had a qualifying admission justifying Swing Bed service need

Rehabilitation Review

- Evaluation of the rehabilitation services needed by the patient
- Determining if the rehabilitation service meets the skill requirement for Swing Bed services
- Determining if the hospital has the available staff to provide the skilled services

Physician Review

- The physician should be the last person approached and possible patients should only include those patients that passed all prior steps

- This should be done by a nurse or other individual who understands the care abilities of the CAH

Patient Pursuit

- You will most likely not receive most of the patients you pursue while establishing a relationship with other hospitals
- The earlier you reach out to other hospitals, the more likely you are to receive patients

Quality Improvement

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Quality Metrics

Metric	Q2 2022 WA CAHs	National Q2 2022	National 2021 Average
Discharges	27	12	13.8
Swing Bed Days	391	151	169.8
Average Length of Stay	13.6	11.5	12
Average Daily Census	4.3	1.7	1.9
Therapy Received	47%	100%	99%
Performance Improvement - Self-Care	6.5	8.1	7.7
Risk Adjusted Performance Improvement - Self-Care	35%	52%	49%
Performance Improvement - Mobility	9.6	19.3	19.9
Risk Adjusted Performance Improvement - Mobility	10%	33%	33%
Fall Rate			0
Medication Reconciliation at Admission			94%
Medication Reconciliation at Discharge			93%
Discharge to Home	32%		74%

Quality Metrics

2021 Participation Level

- Option 1 = 83 CAHs
- Option 2 = 76 CAHs

Option 1 Metrics
Discharges
Swing Bed Days
Average Length of Stay
Average Daily Census
Entered From as % of Discharges
Primary Payor as % of Discharges
Age Group as % of Discharges
Primary Medical Condition
ALOS by Primary Medical Condition
Therapy Received and by Discipline
Exclusions by Reason

Option 1 Metrics
Performance Improvement – Self-Care
Risk Adjusted Performance Improvement – Self-Care
Self-Care Improvement by Primary Medical Condition
Risk Adjusted Self-Care Improvement by Primary Medical Condition
Performance Improvement – Mobility
Risk Adjusted Performance Improvement – Mobility
Mobility Improvement by Primary Medical Condition
Risk Adjusted Mobility Improvement by Primary Medical Condition
Discharge Disposition
Post Swing Bed 30-Day Discharge Follow-up
Return to Acute Care Post Discharge

Option 2 Metrics (all of Option 1 Metrics included)
Discharges by Clinical Program
ALOS by Clinical Program
Self-Care Improvement by Clinical Program
Risk Adjusted Self-Care Improvement by Clinical Program
Mobility Improvement by Clinical Program
Risk Adjusted Mobility Improvement by Clinical Program
Percentage of Goals Met
Clinical Post-Discharge Follow-up
Fall Rate
Medication Reconciliation
Influenza Vaccine
Pneumococcal Vaccine
Acquired Pressure Ulcers & Nosocomial Infections

Swing Bed Economics

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Swing Bed Economics

- Deliver additional inpatient (IP) rehabilitation services to the community
- Provide increased reimbursement while assisting in length-of-stay management
- Help to dilute fixed and step-fixed costs in the nursing unit
- The financial benefit occurs by increasing the proportion of IP costs that are reimbursed on a cost basis
  - Reduces overall unit costs by diluting fixed costs related to IP services
  - Lower unit costs = greater efficiency
  - Greater profitability on inpatients with fixed reimbursement fee commercial payor sources

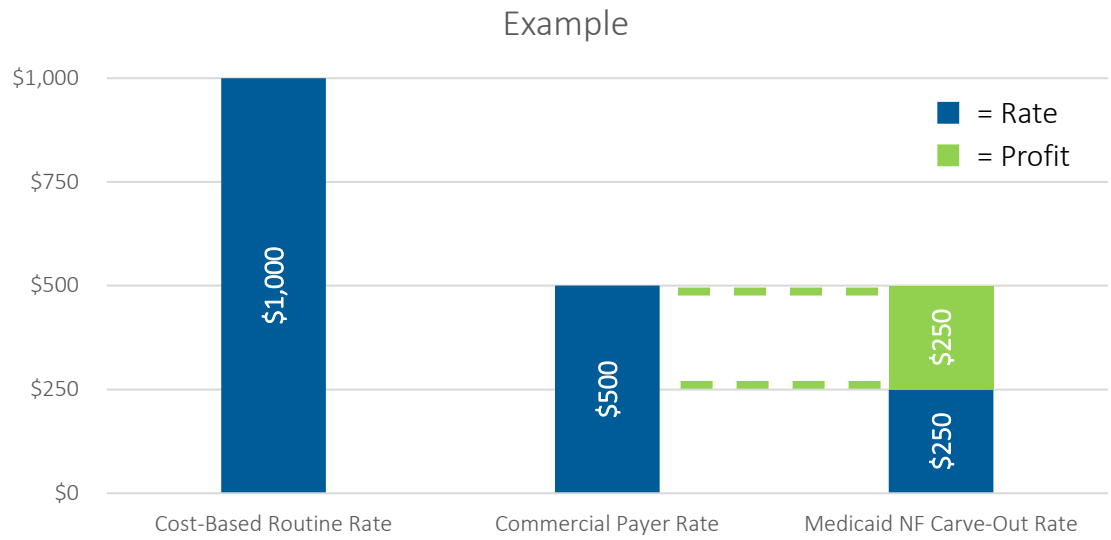
Fixed versus Variable Costs

- Fixed costs are those which exist irrespective of volume
  - Unit staffing, medical direction, medical equipment, par levels of supplies
- Variable costs are those which would be incurred with each additional IP day
  - Incremental medical supplies, pharmaceuticals, food for patient meals
- In comparison to fixed costs, variable costs represent only a fraction of IP costs
  - As volume grows, fixed costs are diluted faster than variable costs grow

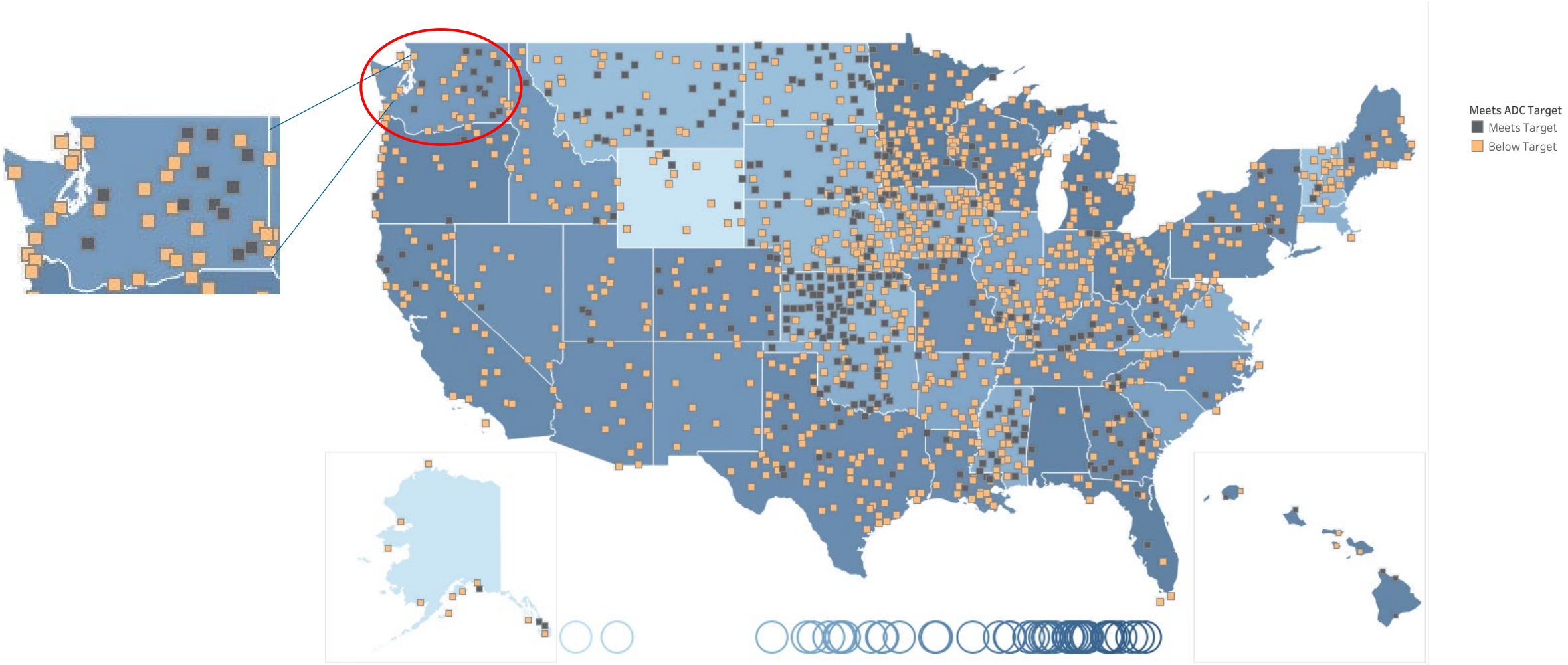
Non-Cost-Based Swing Bed Days

- Cost-based reimbursement will only ever allow a hospital to break even

  - <u>Common misconception:</u> If contracted reimbursement rate is less than cost-based rate, negative financial impact
    - Medicaid NF carve-out rate
      - Carved out of routine costs at statewide
      - Do not negatively impact cost-based rates
  - If contracted reimbursement rates exceed statewide NF carve-out rate, **the hospital makes profit**



Swing Bed Utilization



Swing Bed Growth Example

- Actual example of a CAH's inpatient unit profitability analysis using its cost report info and some assumptions developed over the years of performing this analysis

BASE CASE: INCLUDES ALL COST BASED DAYS

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc. ICU)	5.7	2,084	83%	1,725	359	$ 1,500	$ 538,500
Observation	2.8	1,010	27%	272	738	$ 1,200	$ 885,376
Swing Bed - SNF	3.1	1,114	96%	1,069	45	$ 1,200	$ 54,000
Swing Bed - NF	0.0	10	0%	-	10	$ 250	$ 2,500
Total Days	11.6	4,218		3,066	1,152		$ 1,480,376
Net Acute/SB SNF/Obs		4,208	73%	3,066	1,152		
Inpatient Fixed Costs		$ 6,717,653	[1]				
Inpatient Variable Costs		$ 919,700	[2]				
Net Inpatient Costs		$ 7,637,353					
Inpatient Costs Per Day		$ 1,814.96		$ 1,814.96			
Cost Based Payment				$ 5,565,008			$ 5,565,008
Total Payment							$ 7,045,383
Inpatient Costs							7,637,353
Net Margin							$ (591,970)

Swing Bed-SNF Census Increase

	ADC	Total Days	Cost Based Payer Mix	Cost Based Days	Other Days	Payment Per Day	Other Payment
Acute (inc. ICU)	5.7	2,084	83%	1,725	359	$ 1,500	$ 538,500
Observation	2.8	1,010	27%	272	738	$ 1,200	$ 885,376
Swing Bed - SNF	5.1	1,862	96%	1,786	75	$ 1,200	$ 90,234
Swing Bed - NF	0.0	10	0%	-	10	$ 250	$ 2,500
Total Days	13.6	4,966		3,783	1,182		$ 1,516,610
Net Acute/SB SNF/Obs		4,956	76%	3,783	1,182		
Cost Based Rate Calculation							
Inpatient Fixed Costs		$ 6,717,653	[1]				
Inpatient Variable Costs		1,050,513	[2]				
Net Inpatient Costs		$ 7,768,165					
Inpatient Costs Per Day		$ 1,567.58		$ 1,567.58			
Cost Based Payment				$ 5,930,943			$ 5,930,943
Total Payment							$ 7,447,553
Inpatient Costs							$ 7,768,165
Net Margin							$ (320,612)
Difference							**$ 271,357**

Questions?

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