

# Post-Acute Care

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COMMUNICATING THE VALUE

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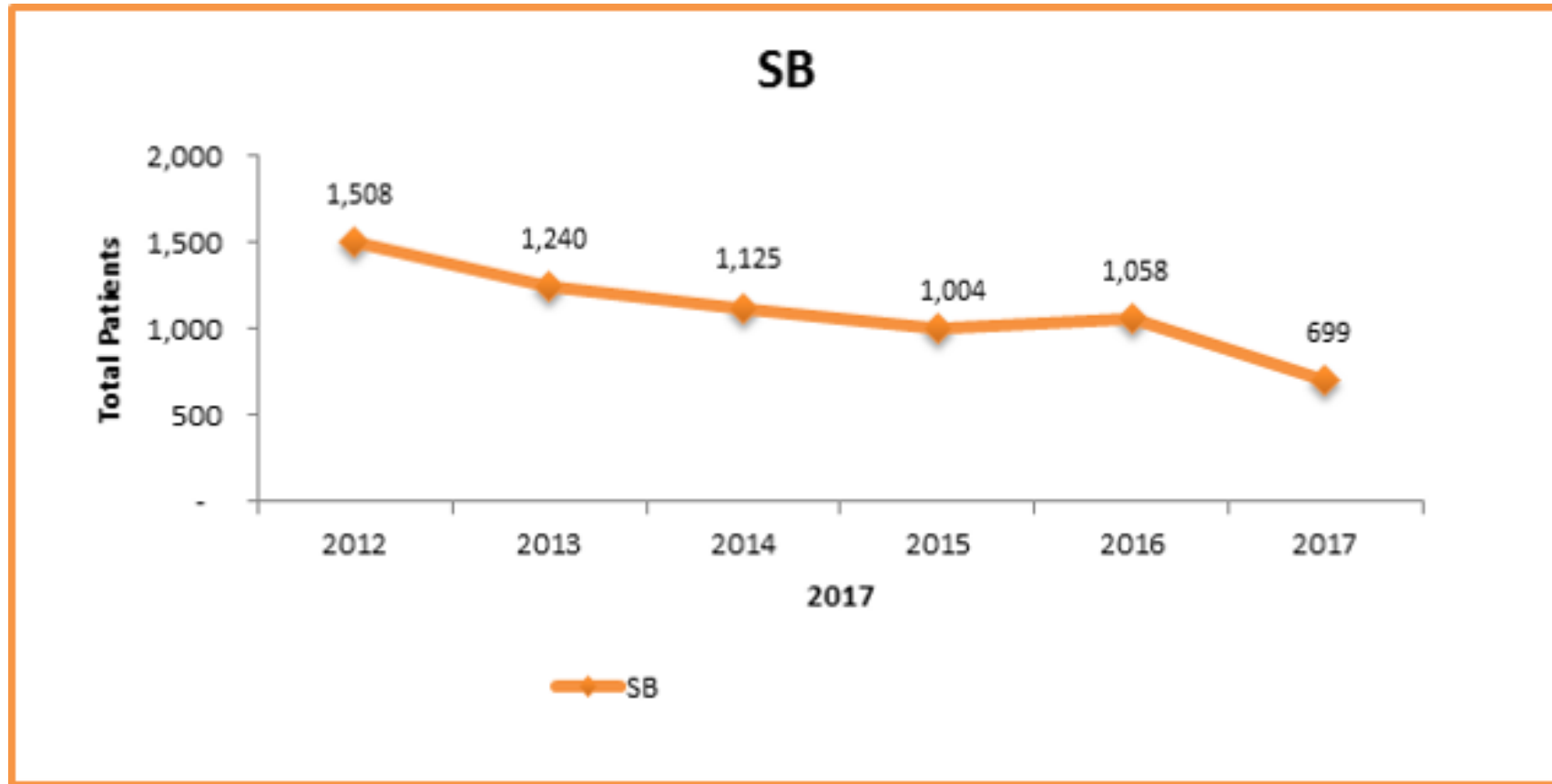
# Swingbed – CMS Definition

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Initially communicated to patients as a way to avoid a premature admission to a nursing home

# Decline in Swingbed Admissions at LRHC

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# Factors

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## ACO

- In 2013 the only medical group in town joined an ACO

## Bundled joint program

- The tertiary hospital closest to Lexington was involved in a bundled payment program
- These two factors pushed Nebraska providers to either send patients home earlier than they would have done in the past and/or induced them to admit patients to nursing homes rather than using swingbed services as they would have in the past.

# The Longview

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## Cost to Medicare program overall

- CAHs are cost-based so as volume decreases, in this case because of the decline in swingbed services, costs increase. These costs are paid by the Medicare program regardless of patient disposition to an SNF.
- The per diem costs of a nursing home are less than the per diem, so to speak, cost of a CAH swingbed program. The increased costs of care at the CAH combined with the per diem rate create increased costs for the Medicare program even as stakeholders in the bundled payment program receive financial returns for their per diem savings.

# The Longview

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- Some studies and data suggest that increased acuity in SNF has created situations where patients either stay much longer in a SNF or experience a decline in functionality, an increase in readmissions or even increased mortality – this phenomenon is bearing out in recently published studies.
- April 11, 2017 Mayo Clinic Proceedings looked at HF patients discharged to a SNF (N=1498). The study looked at data between the years 2001-2010. Their findings included information about LOS; ‘although patients are often told they will have a short stay at the SNF, the ALOS was 144 days.’ Rogers acknowledges that increased activity is key – independence in ADLs was strongly correlated to readmissions (the more independent a patient was in completing ADLs the less likely they were to be readmitted to the hospital) (<http://www.medscape.com>, 2017)
- Peter Dizikes reports that a study co-authored by MIT economists that more spending on inpatient care yields better results, per dollar spent, than those that assign relatively more patients to skilled nursing facilities (MIT News Office, July 2017). Joseph Doyle, Erwin H. Schell Professor of Management at MIT Sloan School of Management says “ we find that patients who go to hospitals that rely more on skilled nursing facilities after discharge, as opposed to getting them healthy enough to return home, are substantially less likely survive over the following year” (Doyle, 2017). Doyle goes on to say that these findings may have health insurance policy implications and that bundled payments should consider the composition of spending since high initial spending and low downstream spending is associated with better outcomes and less overall spend. (Doyle, Graves and Gruber, Journal of Healthcare Economics)

# The Best of Both Worlds?

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**We would argue that Critical Access Hospitals provide high levels of care, most provide the same level of care as they do to those patients in acute care but a lesser cost overall. By keeping CAHs fully occupied with a mix of swing and acute care patients, Medicare costs are lower, health care spend is less and value is created**

# Skilled Nursing Care v. CAH Swingbed Program

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Allow for care of sicker patients

A. Specialized equipment

- Post-acute patients with needs including: ventilator care, bariatric care, dialysis, IV antibiotics, wound care specialty equipment, etc. can continue to receive these specialized services

B. Higher level care of staff

- Less than 15% staff in nursing homes are RNs
- With change of status, transfer to another facility is not necessary if needed, higher level of care able to address these changes of status

C. Continuity of care

- Same staff continuing to provide services for patient; decreases anxiety of change for patient

D. Majority of CAH's are Not for Profit – do not discriminate based on patient's ability to pay

E. Shorter length of stay

[www.ruralhealthresearchgateway](http://www.ruralhealthresearchgateway)

# LRHC – Swingbed Quality Outcomes Analysis

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Length of Stay

Discharge Location

Readmission

Emergency Room visit

Skilled Services received

FIM score – measures the level of disability; patient's ability to complete ADL's

- Admission, Discharge, 6-month f/u, 1 year f/u, 18 month f/u

Medically Managed Program Screen at 6 months, 1 year, 18 months etc.

# Medically Managed Program

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Multidisciplinary Program currently self-pay

- LMiHP, PT, OT, Speech, Cardiac Rehab RN, Wellness Coach, Diabetic Educator
- Integration with Transition Care Team
- Demonstrate value then continue efforts to secure funding

# Value

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## Reduction in readmissions

- Transition Team creation
  - LRHC has seen a substantial decline in their readmission rate
  - The team completes a stratified risk assessment on admission and begins discharge planning immediately
  - The team deploys CHWs, clinic staff, dieticians, mental health providers and social services to improve quality of life post-discharge.
- Collaboration of care
  - The team collaborates with all providers and ensures that transition care calls and visits continue after dismissal
  - Patients that are found to be at high risk for readmission or poor management of care are referred to our Medically Managed program –

## Functional Capacity and Independence

- Setting up study to examine patients receiving care through LRHC swingbed services v. SNF
  - Criteria
    - Age
    - Functional Capacity
    - Length of Independence

# RESULTS

70.98% reduction in readmissions since 2012



# Readmission Worksheet

## Hospital wide All-Condition, All-Payer, and Payer-Specific Readmission Analysis

Table 1. Readmission Rate	All	Medicare	Medicaid	Commercial	Uninsured
# discharges	57	17	9	31	0
# readmissions	2	1	1	0	0
Readmission rate	3.5%	5.9%	11.1%	0.0%	#DIV/0!
Table 2. Percentage of Discharges and Readmissions	All	Medicare	Medicaid	Commercial	Uninsured
% of total discharges by payer	100.0%	29.8%	15.8%	54.4%	0.0%
% of total readmissions by payer	100.0%	50.0%	50.0%	0.0%	0.0%

Table 6. Discharge Disposition	All	Medicare	Medicaid	Commercial	Uninsured
# of discharges to home (without home health)	41	8	7	26	0
# of discharges to home health	3	1	0	2	0
# of discharges to skilled nursing facility (SNF)	8	7	0	1	0
% of discharges discharged to home (without home health)	72%	47%	78%	84%	#DIV/0!
% of discharges discharged with home health	5%	6%	0%	6%	#DIV/0!
% of discharges discharged to SNF	14%	41%	0%	3%	#DIV/0!
Table 7. Readmissions by Discharge Disposition	All	Medicare	Medicaid	Commercial	Uninsured
# of readmissions following discharge to home (without home health)	1	0	1	0	0
# of readmissions following discharge to home health	0	0	0	0	0
# of readmissions following discharge to skilled nursing facility (SNF)	1	1	0	0	0
Readmission rate following discharge to home (without home health)	2%	0%	14%	0%	#DIV/0!
Readmission rate following discharge to home health	0%	0%	#DIV/0!	0%	#DIV/0!
Readmission rate following discharge to skilled nursing facility (SNF)	13%	14%	#DIV/0!	0%	#DIV/0!
Table 8. High Utilize Population	All	Medicare	Medicaid	Commercial	Uninsured
# of patients hospitalized 4 or more times in the past year					
# of discharges by patients hospitalized 4 or more times in the past year					
# of readmissions by patients hospitalized 4 or more times in the past year					
% of readmissions by patients hospitalized 4 or more times in the past year	0%	0%	0%	#DIV/0!	#DIV/0!
Readmission rate of patients hospitalized 4 or more times in the past year	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

	RN	MW
Readmitted in _____ days	13 days	26 days
Planned readmit?	no	no
Was follow up noted/scheduled on discharge?	yes	yes
Was the readmission prior to follow up?	no	no
Did the patient have services arranged prior to dismissal?	no	yes- Assisted Living
Was the readmission r/t problems present on 1st admission?	no	no
Was this readmission avoidable?	no	no
Summary	<p>Patient was readmitted to hospital to be transferred to Children's 13 days after discharge from birth. Patient had passed congenital screening first attempt at 28 hours. Patient was transferred to Children's - CHF</p>	<p>Patient was readmitted 28 days after discharge from inpatient. Patient was in SWG for 15 days. The patient was discharged to assisted living - a change for the patient. Admitted with CHF – no s/s or history of this on discharge.</p>

# Overcoming Barriers to Admission to Swingbed

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While Medicare provides choice to patients they are frequently not aware of that right and/or have to fight to be admitted to a CAH swingbed service – how are we tackling that challenge?

## Patient Order prior to acute stay

- Physicians and staff provide an 'order' for the patient to give their specialist or provider at the PPS hospital so that they understand that they can return home
- Primary care providers and staff educate patients on the merits of receiving post-acute care at LRHC.
- Patient choice is explained during the PCP or ER visit

## Communicating the benefits of the Swingbed Program

Advocacy at the national level- explaining to representatives the real cost to the patient and to Medicare.

Ensuring community understands what 'Swingbed' means- patients do not understand what 'swingbed' even means. They are better able to understand that we will help them make the transition from their acute stay to their home or assisted living. We provide literature and have advertising efforts like radio ads and commercials that share what LRHC can offer to patients post acutely.

# LRHC Transition Care

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