CAH Swing Bed Webinar

North Carolina Critical Access Hospitals

February 2020

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Collaborating Organizations

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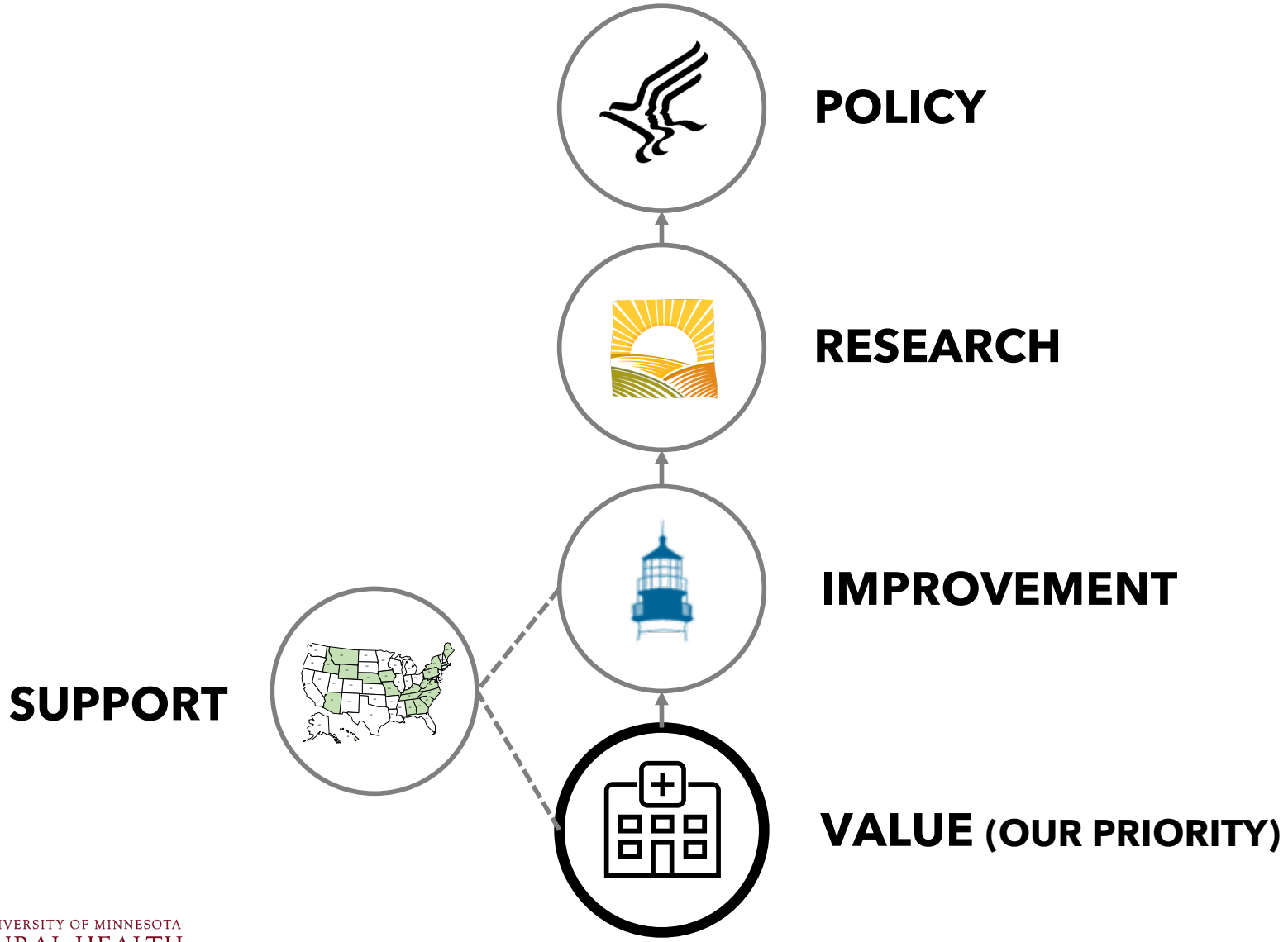

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CAH Swing Bed Quality Measures

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- **Discharge disposition**
  - To home
  - Transferred to a NH/LTC facility
  - Transferred to a higher level of care
- **30-day follow-up status**
  - Readmitted to CAH
  - Readmitted to other hospital
  - ED visit at CAH
  - ED visit at other hospital
- **Functional status**
  - Change in self-care score between swing bed admission and discharge
  - Change in mobility score between swing bed admission and discharge

Research Paper

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Summary Findings

The analytical results indicate a significantly lower overall (i.e. during the swing bed stay and 30 days post swing bed discharge) risk-adjusted hospital readmission rate for swing bed patients (18.6%) compared to the overall risk-adjusted hospital readmission rate for rural SNF patients of 33.3%. Risk-adjusted changes in self-care and mobility scores were similar for patients in CAH swing beds and all SNF patients in the U.S. These results contribute to building an evidence base that quantifies the value of CAH swing beds and allows fair comparisons with rural SNFs and other post-acute care options.

POLICY BRIEF
October 2019

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Quality Measures for Critical Access Hospital Swing-Bed Patients

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Key Findings:

Quality measures relevant for CAH swing-bed patients include:

- Two outcome measures (discharge status of swing-bed patients and 30-day follow-up status after a swing-bed stay)
- Two functional status measures (risk-adjusted change in self-care and mobility scores between admission and discharge for CAH swing-bed patients)

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Background

The Medicare swing-bed program allows rural hospitals with fewer than 100 beds to use their inpatient beds either for acute care or skilled nursing facility (SNF)-level swing-bed care.[1] Swing-bed services provided in rural Prospective Payment System (PPS) hospitals are paid for under the SNF PPS, while Critical Access Hospitals (CAHs) receive cost-based reimbursement for swing-bed services. Currently, approximately 90% of CAHs and 60% of rural PPS hospitals nationally provide swing-bed services.[2,3]

PPS hospitals are required to collect patient data and provide it to the Centers for Medicare & Medicaid Services (CMS) using the swing-bed Minimum Data Set (MDS), a tool for implementing standardized assessment and facilitating care management, which is a subset of the MDS used in SNFs. However, CAHs are exempt from this requirement. The lack of nationally comparable swing-bed quality measure data for CAHs creates two problems. First, CAHs are not uniformly able to demonstrate the quality of care provided to their swing-bed patients or compare it to national benchmarks. Second, the lack of quality data for their swing-bed services limits the ability of CAHs to participate in alternative payment models involving post-acute care, since organizations need outcome data to select appropriate partners.

Swing-bed quality of care has received little attention since a 1990 study compared the quality of care in SNFs and swing-beds.[4] Recent studies have focused on the cost of swing-bed care[5,6] and on comparing swing-bed and SNF patient characteristics and diagnoses.[7] Swing-beds also have not been included in recent national quality measurement efforts. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requires post-acute providers, including Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs), to submit standardized and interoperable patient assessment data that will facilitate coordinated care, improved outcomes, and overall quality comparisons, but does not include CAH swing-beds. Similarly, the National Quality Forum (NQF) Measure Application Partnership project to select post-acute and long-term care quality measures focused on SNFs, HHA, hospice, IRFs, and LTCHs, but did not address swing-beds.[8]

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CMS Discharge Planning Final Rule: Overview (9/26/19)

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- On 9/26/19, CMS issued a final rule regarding discharge from acute care into post-acute care (PAC), a process called "discharge planning."
- The rule is intended to improve care transitions and support interoperability by **"promoting the seamless exchange of patient information between health care settings and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider."**
- The rule **"requires the discharge planning process to focus on the patient's goals of care and treatment preferences"** and **"revises the hospital patient's rights and the facility's requirements regarding a patient's access to their medical records."**
- The following types of facilities must comply with the new requirements in order to participate in Medicare and Medicaid programs:
  - ✓ Long-term care hospitals (LTCHs) and inpatient rehabilitation facilities
  - ✓ Inpatient psychiatric facilities
  - ✓ Children's hospitals
  - ✓ Cancer hospitals
  - ✓ Critical access hospitals (CAHs)
  - ✓ Home health agencies (HHAs)

Source: CMS.gov Fact Sheet, *CMS' Discharge Planning Rule Supports Interoperability and Patient Preferences,* 9/26/19
https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences

CMS Discharge Planning Final Rule: Detail

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- Under the final rule, hospitals, CAHs, and HHAs will be required to:
  - **Assist patients, families, or the patient's representative in selecting a post-acute care (PAC) services provider or supplier by using and sharing PAC data on quality measures and resource use measures.**
  - Comply with new discharge planning process requirements for CAHs and HHAs
    - **The rule requires a hospital (or CAH) to discharge the patient, and also transfer or refer the patient where applicable, along with his or her necessary medical information (current course of illness and treatment, post-discharge goals of care, and treatment preferences), at the time of discharge, to not only the appropriate post-acute care service providers and suppliers, facilities, agencies, but also to other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.**
  - Send all necessary medical information (current course of illness and treatment, post-discharge goals of care, and treatment preferences), to the receiving facility or health care practitioner to ensure the safe and effective transition of care
    - The HHA must comply with requests made by the receiving facility or health care practitioner for additional clinical information necessary for treatment of the patient.
  - Send necessary medical information to the receiving facility or appropriate PAC provider (including the practitioner responsible for the patient's follow-up care) after a patient is discharged from the hospital or transferred to another PAC provider or, for HHAs, another HHA
  - Ensure and support patients' rights to access their medical records in the form and format requested by the patient, if it is readily producible in such form and format *(including in an electronic form or format when such medical records are maintained electronically)*

Source: CMS.gov Fact Sheet, *CMS' Discharge Planning Rule Supports Interoperability and Patient Preferences,* 9/26/19
https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences

Swing Bed Program Participation

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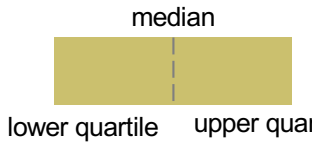
North Carolina CAHs
Participating in Swing Bed Program are highlighted

Hospital	Hospital
Alleghany Memorial Hospital	LifeBrite Community Hospital of Stokes
Angel Medical Center	Montgomery Memorial Hospital
Ashe Memorial Hospital	Outer Banks Hospital
Bladen County Hospital	Pender Memorial Hospital
Blue Ridge Regional Hospital	St. Luke's Hospital
Charles A Cannon Jr Memorial Hospital	Swain County Hospital
Chatham Hospital	Transylvania Hospital
Erlanger Western Carolina Hospital	Vidant Bertie Hospital
Highlands-Cashier Hospital	Vidant Chowan Hospital
J. Arthur Dosher Hospital	Washington County Hospital

Data submission is not consistent

Swing Bed Discharges by Hospital



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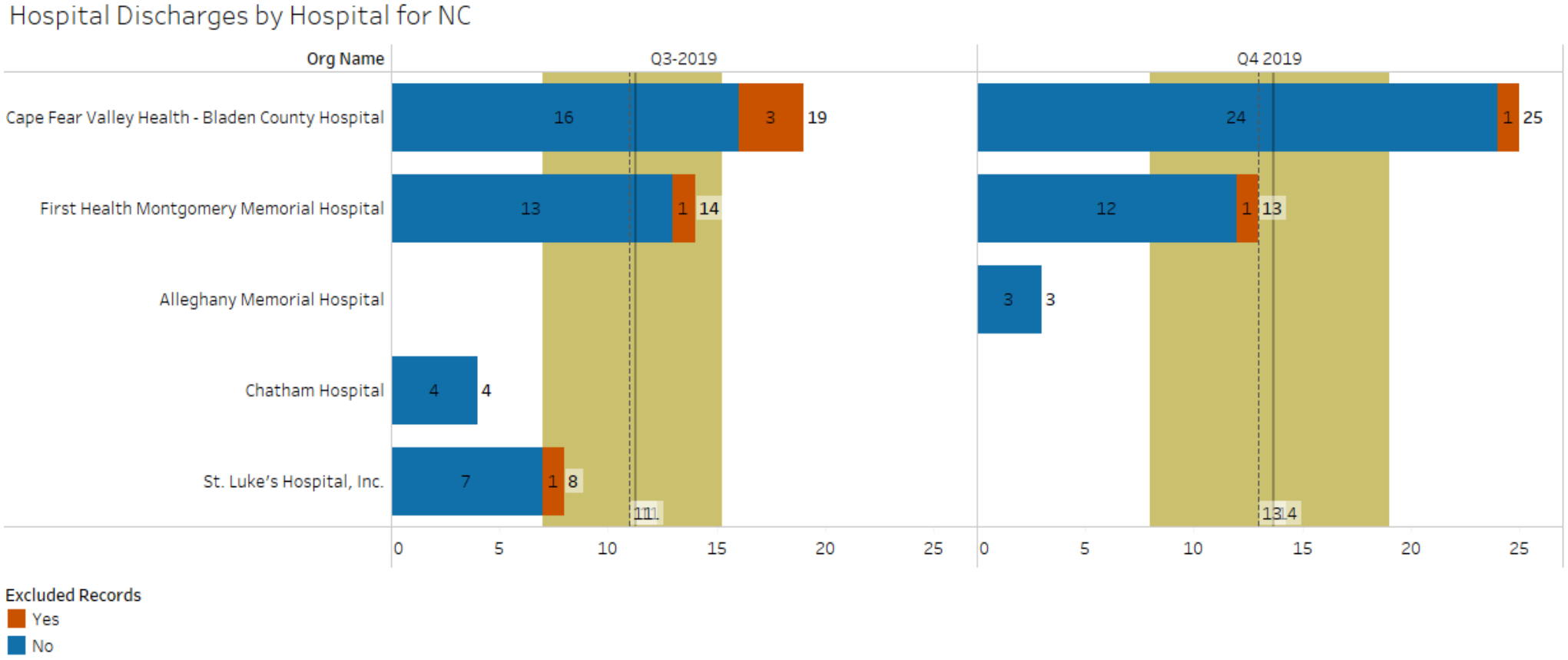

excluded records added

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

SB Average Length of Stay (ALOS)

median
lower quartile upper quartile

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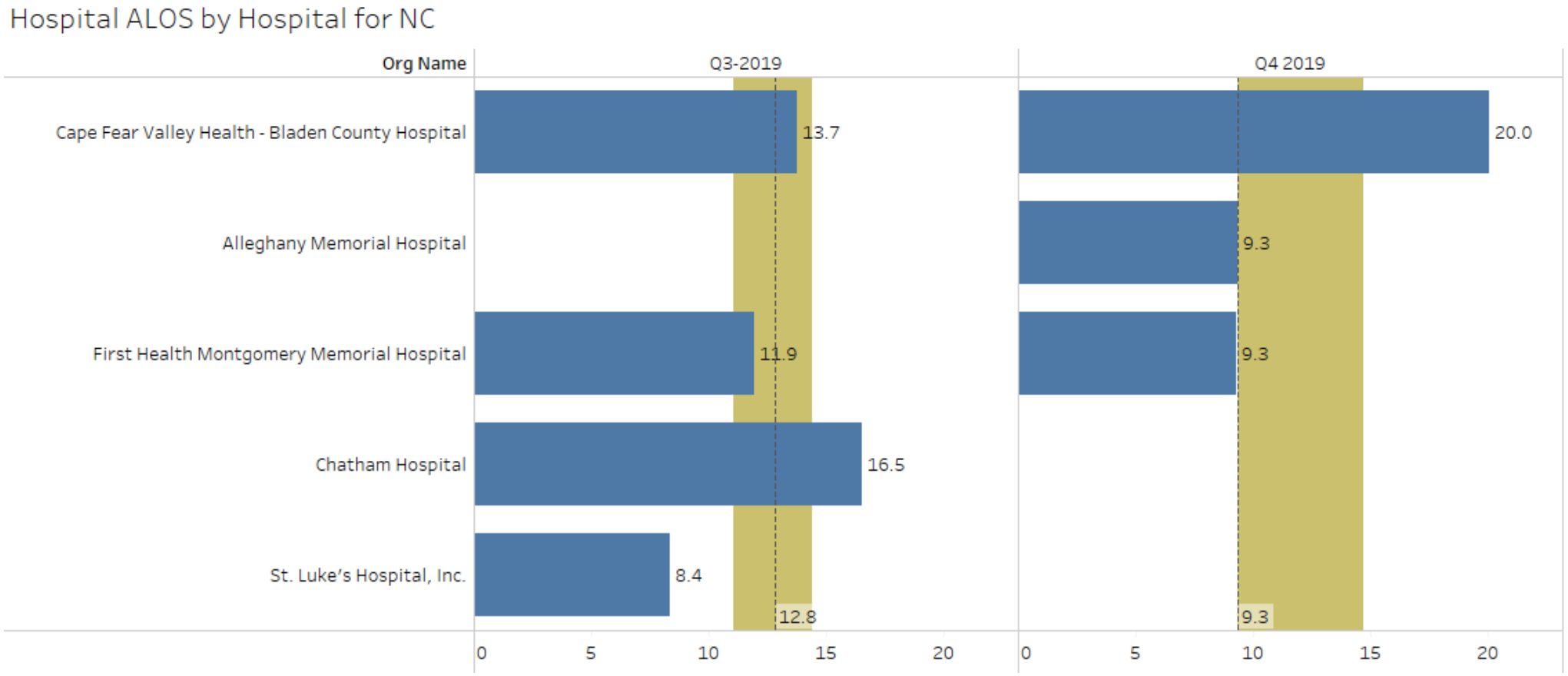

excluded records added

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

State Comparison - July 2018 through December 2019

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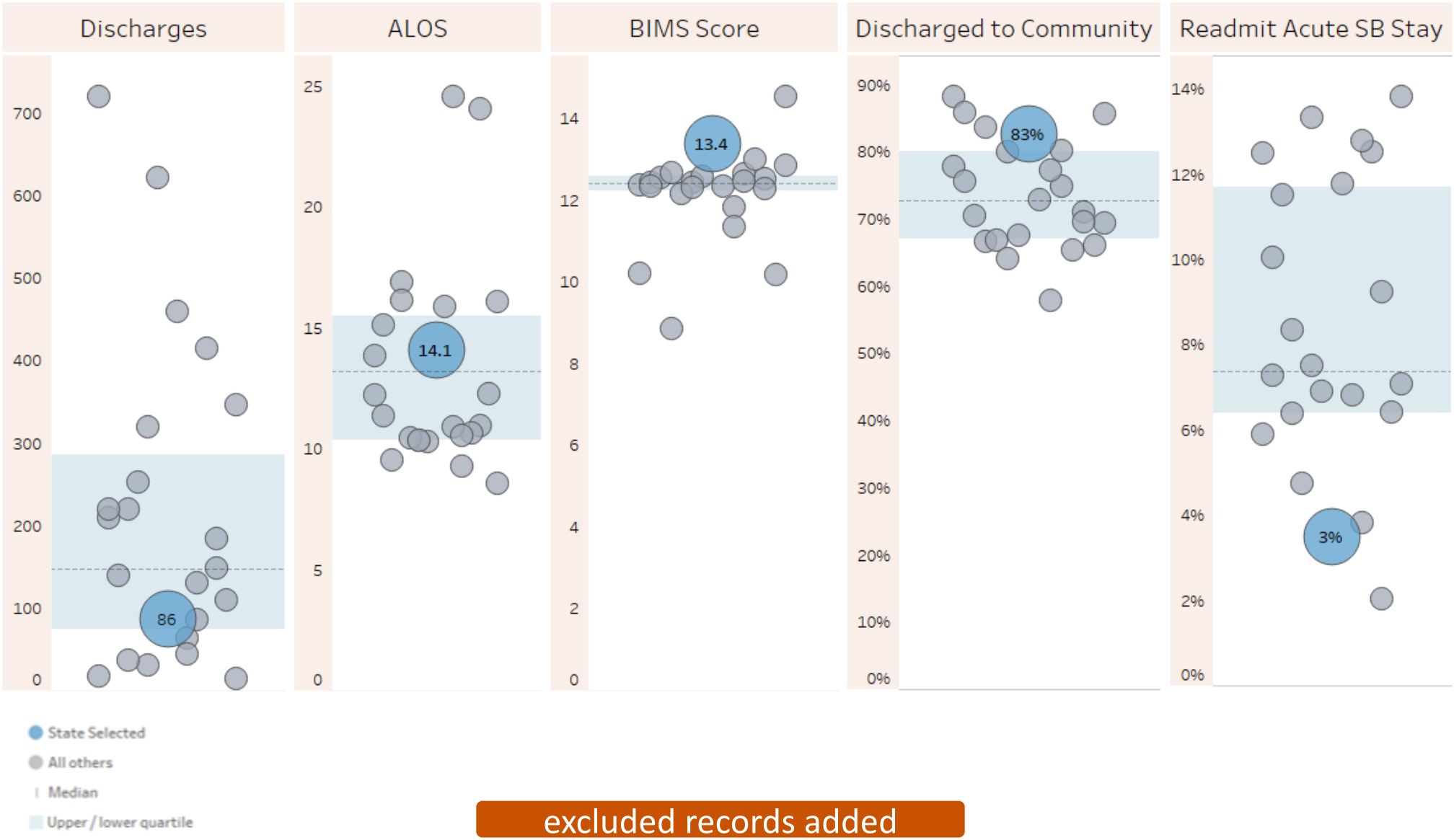

excluded records added

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

State Comparison (July 2018 through December 2019)

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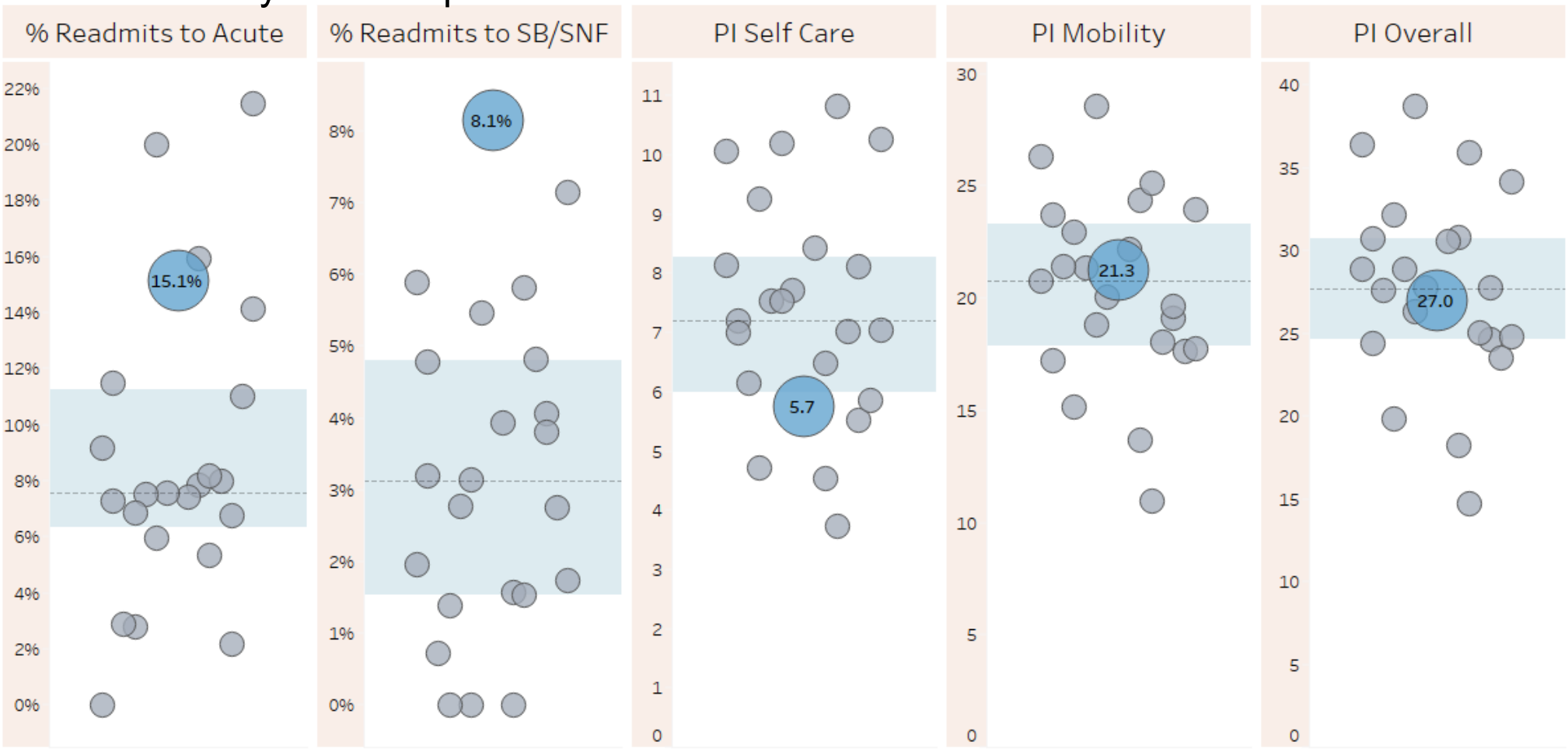
From 30-day Follow Up Calls



excluded records have been removed for PI scores

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

State Comparison (July 2018 through December 2019)
Reason for Admission (count of records)

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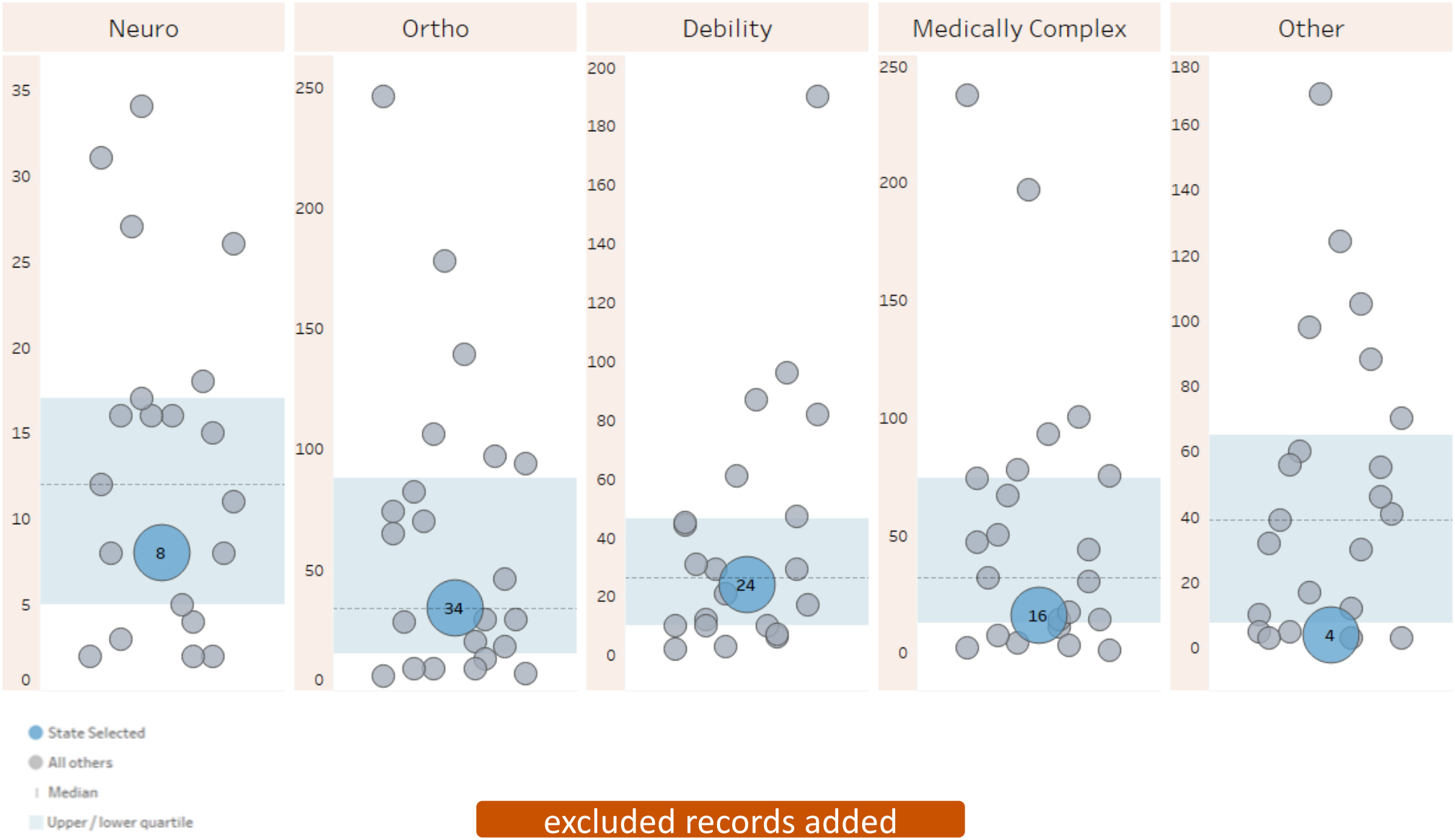
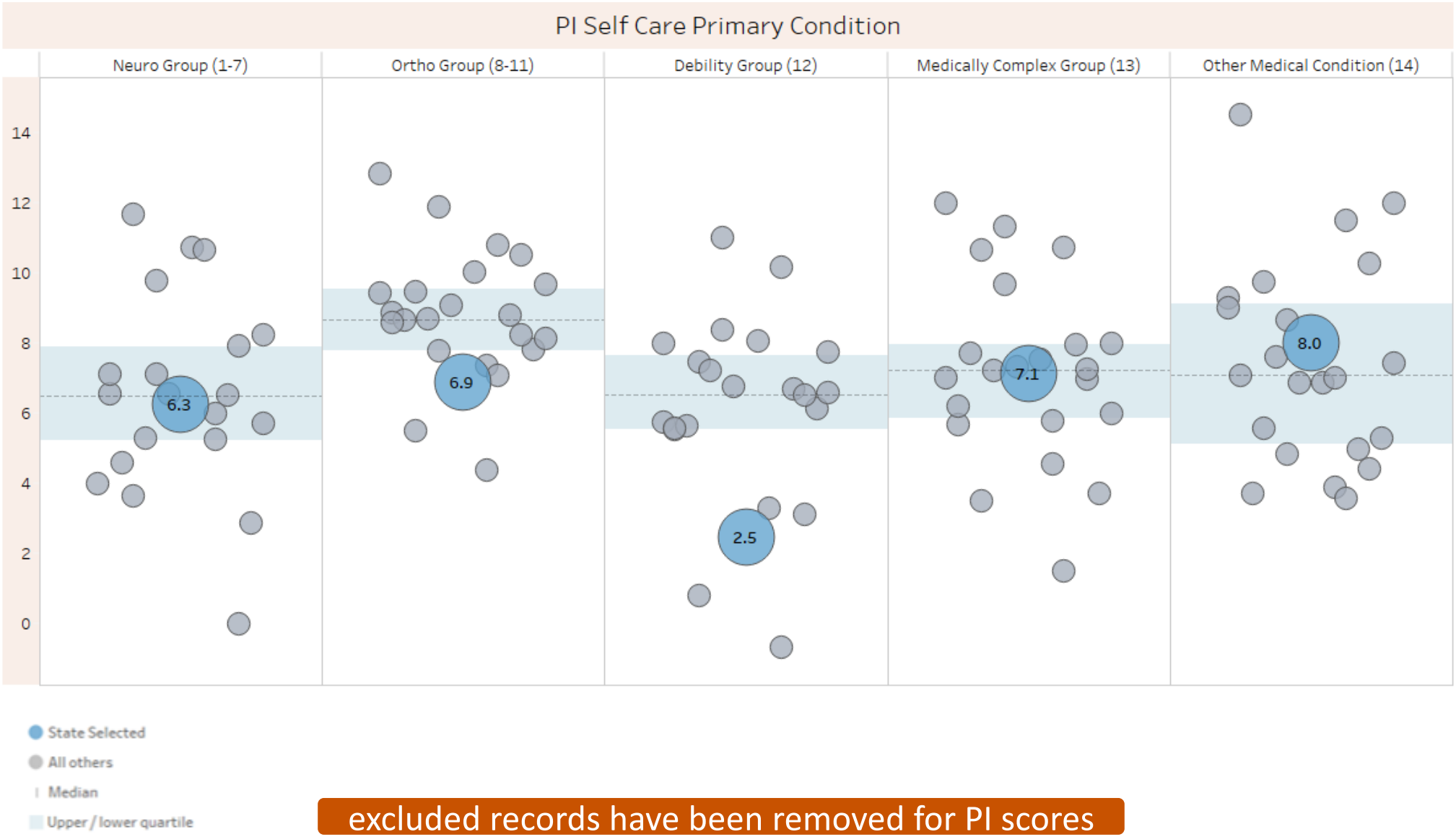


excluded records added

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

State Comparison (July 2018 through December 2019)
PI Self Care by Primary Condition



excluded records have been removed for PI scores

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020

State Comparison (July 2018 through December 2019)
PI Mobility by Primary Condition

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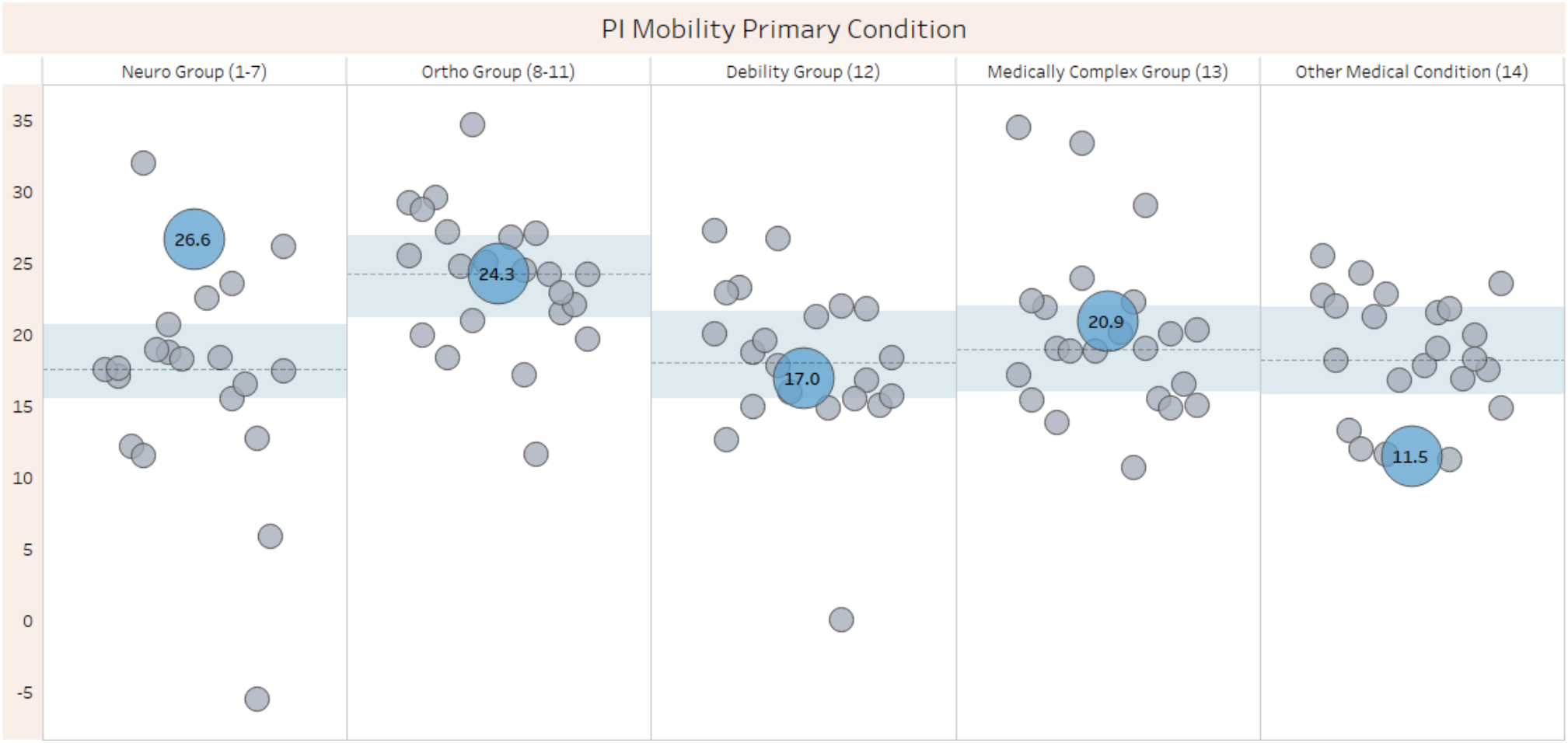

excluded records have been removed for PI scores

Source: Stroudwater Swing Bed Portal 7/1/2019 through 12/31/2019 – Data pulled 2/18/2020