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Subacute Care in Urban Hospitals: A Case for Urban Swingbeds

Sarah A. Grim, MHA

The changing nature of the American health care system, most notably the introduction of the Medicare prospective payment system (PPS), encouraged providers to develop the most cost-effective and efficient method of health care delivery. As a result of PPS, postacute care, which is characterized as care outside of the acute care system such as home health care and nursing home care, has become a battlefield with increasing demand from consumers and payers on one side and a decreasing supply of resources on the other. Today, seven years after PPS changed how hospitals were reimbursed for patient care, a number of other factors are forcing this country to expand the tripartite of postacute care (home health, nursing home, and community-based care) to include subacute care.

Subacute care, as defined by the Prospective Payment Assessment Commission (ProPAC), is care "provided to patients who do not meet established criteria for medically necessary acute care" (1). I believe that subacute care can be provided safely and effectively in urban hospital swingbed pilot programs in geographic areas where the supply of postacute care services is unable to keep pace with the demand for these services. In these specific circumstances, the use of pilot projects to test the cost-effectiveness and efficiency of urban swingbeds to deliver subacute care is critical and will help shape health care policy for the year 2000.

Factors Impacting Health Care Delivery

Five critical factors are impacting the delivery of health care services in this country: the aging of the population, health care capacity, medical technology, health care costs, and manpower.

Aging of the population

By the year 2000, the United States’ population will have increased by 23 million. The aging population is expected to double by the year 2030. The elderly already consume more health care resources than any other portion of the population and will continue this trend into the 21st century, requiring 15% more hospital beds and 5 million more long-term care beds. As a result of increases in overall longevity and specifically the number of the frail elderly, long-term care demand continues to outstrip the supply of long-term care beds.

Health care capacity

The American Hospital Association (AHA) is tackling the issue of excess hospital capacity at a time when at least 50% of all hospital beds are empty. Nationally, most hospitals operate at 62% or less occupancy (using licensed or registered hospital acute beds). The Michigan Hospital Association fully expects many of its hospitals to close, merge, or change the nature of their services after the year 2000. AHA regional policy boards have recently considered advocating increased flexibility in the use of hospital beds for other services, especially through federal and state demonstrations, to allow hospitals and their communities to determine the best structure for local health care systems.

While hospital capacity is viewed as overabundant, the perspective on long-term care is divided. In most states, state planning agencies estimate an oversupply of nursing homes. In certain areas—especially urbanized cities such as Dayton, OH, Washington, DC, Seattle, WA, New York City, Philadelphia, and Flint, MI—the supply of long-term care beds is wholly inadequate to meet growing patient and payer demands. While not characteristically true in all metropolitan areas, the lack of alternatives to nursing homes increases health care costs to private payers through "cost shifting."

Medical technology

The 20th century has provided a legacy of health improvements unmatched in previous centuries. Our population is healthier and living longer. However, the cost of technology has greatly affected the patient. Changes in payment reimbursement methods delay entry into hospitals and boost acuity levels upon admission and at discharge. The home health agency and the nursing home of seven years ago cannot meet the high level of sophistication needed to provide those same services in the 1990s. The acquired immunodeficiency syndrome has introduced new terminology and technology into the health care delivery system as have the now common subacute care patients with multiple technology needs.

Health care costs

The problem of increasing health care costs was not solved by the Medicare prospective payment system and indeed became a priority issue with the Medicare Catastrophic Health Care Act of 1988. Last year Congress wrestled with the financial facts and failed to understand the significance of expanding Medicare
skilled benefits. Prior to the Catastrophic Act, Medicare paid for 100 days of skilled care per spell of illness, with beneficiaries picking up coinsurance after the 21st day of care. After enactment of the Catastrophic Act, Medicare paid for a total of 150 days of skilled care per year, with beneficiaries paying for the first eight days of coinsurance. Congress predicted in 1988 that this expansion would cost an additional $400 million. In 1989, the cost estimates had grown to $2 billion and thus by the year's end the Catastrophic Act was repealed.

Congress has continued to debate the need to provide for those without any health care insurance versus the need to expand long-term care coverage. The perspective of many close to Congress is that the needs of the 37 million uninsured outweigh those of the 3 million to 6 million persons needing long-term care. The uninsured—not the elderly, especially after the demise of the Catastrophic Act—will probably be the next focus of attention from Congress in 1990 and beyond.

A change in the perspective of the federal government is gaining momentum, especially within the Bush administration. Dr. Louis Sullivan, Secretary of the Department of Health and Human Services (DHHS), has stated that the time has come for a thorough nationwide review of what works in health care and to put the emphasis in those places.

Manpower

Manpower and who will control it in the next ten years is where all industries and companies are waging war. The nation's labor force, particularly the critical 19- to 24-year age group, is dwindling with the aging of the "baby boomers." Even MacDonald'sTM has entered into the war by paying $5 per hour and providing benefits to its workers. The demand for health care workers will grow while the supply of workers simultaneously decreases. The American Association of Homes for the Aging states that the nursing homes—where demand is growing—are losing the manpower war to payment rate differences between nursing homes and hospitals. Hospitals routinely pay an average of 13% more than nursing homes. Turnover in the nursing home field is especially high.

Studies on Postacute Care

The literature on subacute care includes more than 50 articles among hospital, long-term care, physician, and health-related journals. It is possible that the term was not even known in 1983, but fortunately subacute care is gaining in acceptance through research and studies by ProPAC, the Urban Institute, the RAND Corporation, and many state planning or Medicaid agencies.

Since 1986, ProPAC has studied the effect of PPS on the quality of patient care. These studies have investigated the phenomenon called "sicker and quicker patient discharges from hospitals" following the implementation of PPS. ProPAC (1) defined subacute care as that "provided to patients who do not meet established criteria for medically necessary acute care. Such care may be necessary but may not meet established criteria for payment as an acute inpatient hospitalization." A 1988 ProPAC study found that 50% of hospitalized subacute care patients were awaiting placement in skilled nursing facilities (SNFs) or intermediate care facilities and that subacute care patient lengths of stay were longest for patients requiring complex levels of care not available in typical nursing homes. ProPAC also found that 50% of all hospital subacute care costs cannot be billed to Medicare and, in all probability, are cost-shifted to patients and other payers.

The RAND Corporation also studied the subacute care phenomenon and found that posthospitalized patients were less chronic than before PPS and that a limited number of diagnoses-related groups (DRGs) accounted for the majority of postacute care Medicare hospital discharges (i.e., cerebrovascular accidents, hip fractures, major joint procedures, pneumonia and respiratory diseases, nutritional and metabolic disorders, heart failure and shock, and diabetes, among others) (2).

In 1986, the Ohio Department of Health conducted a study to determine whether access to subacute care services was creating a quality of care problem for Ohio citizens. The Department found that access to subacute care was a problem in selected areas of the state. The Department's definition of subacute care complements that selected by ProPAC: “a primary focus to prevent further physical deterioration, to restore or rehabilitate and/or to provide terminal care for patients who no longer require acute care but require 24 hour, 7 days a week nursing care by a professional nurse, who need the availability of emergency backup, and may require two or more procedures or therapies provided by a licensed nurse or therapist” (3).

Subacute Care Models

While subacute care has yet to be adopted by Medicare for payment of benefits, the concept of subacute care has been implemented in a variety of settings across the country, most notably through the use of rural swingbeds, hospital-based skilled care units or facilities, and freestanding nursing homes.

Rural swingbeds

Swingbeds allow hospitals with either 49 or less beds or with 99 or less beds to utilize their acute care beds for acute, skilled, or intermediate care services without a change in licensure. Swingbeds are restricted to hospitals in rural areas, and these providers must meet certain Medicare conditions of participation for SNFs. Payment for both the 49 or less beds and the 99 or less beds facilities is based upon state-specific SNF Medicaid per diem for Part A services and on a reasonable cost basis for Part B services.

Advantages to swingbeds include: 1) the ease and cost of administration, 2) the limited nature of the Medicare certification process, 3) their proven experience in meeting the needs of post-acute care patients, 4) use of existing hospital capacity versus building new long-term care facilities, 5) stabilization of rural hospital financial operations, 6) increased access to postacute care services and enhanced quality of care to postacute care patients, and 7) the ability to meet local community needs for long-term care.

Disadvantages to swingbeds include: 1) restrictions to rural location and size of hospitals, 2) low and inadequate payment rates, 3) inability to provide comparable long-term care when...
compared to nursing homes, 4) nursing home opposition, 5) additional restrictions against Medicaid participation in states, and 6) state regulatory restraints such as certificate of need, licensure, and limits on beds that can be classified as swingbeds.

Hospital-based skilled nursing care units

Hospitals also have the ability to convert acute care beds to skilled or intermediate care beds in order to provide subacute care. Medicare even considers a freestanding hospital-based skilled nursing facility (HB/SNF) as the same as the in-house HB/SNF as long as both are tied to common governing boards and operations. Once common in many communities, support for HB/SNFs decreased in the 1970s under cost reimbursement. HB/SNFs saw a resurgence with PPS because of increased pressure to discharge patients earlier, the need to carve cost centers out from the DRG system, and renewed problems with patient placement. HB/SNFs must meet the same requirements under Medicare and Medicaid as nursing homes, but they do receive a higher rate of reimbursement than nonaffiliated freestanding facilities.

Advantages to the HB/SNF include: 1) cost-based reimbursement, 2) ability to obtain waivers and exemptions from some Medicare requirements, 3) integration of subacute care and acute care services, 4) ability to provide a continuum of care under one roof, 5) use of excess hospital acute care beds, and 6) reduction in problems associated with patient placement following hospitalization.

Disadvantages include: 1) the October 1, 1990, Medicare and Medicaid requirements for long-term care facilities, 2) TEFRA cost limits after three years of operation, 3) lack of “deemed status” under the Joint Commission on Accreditation of Health Care Organizations, 4) certificate of need or bed moratoriums, and 5) opposition by other providers, mostly nursing homes.

Freestanding long-term care facilities

Hospitals can also build, manage, or lease their own long-term care facilities to provide access to all levels of long-term care. Most hospitals find long-term care to be a different business than that of hospital operations. Such operations require careful management in order to be cost-effective and profitable. However, recruitment and retention of staff in hospital-owned long-term care facilities may be an advantage as the hospital can provide comparable salary and benefit packages to the long-term care facility. State restrictions on new long-term care construction is a major barrier for hospitals as is the cost of purchasing existing long-term care beds (sale prices range from $10,000 to $35,000 per bed).

The Need for New Subacute Care Models

While other options are available for hospitals interested in entering the subacute care market, the swingbed option is the most sensible. Swingbeds, while limited to rural hospitals, are available to other hospitals through the 1980 enabling swingbed legislation. However, since the implementation of PPS in 1983, the DHHS has been reluctant to pursue the expansion of swingbeds to other hospitals and to other locations. Yet the option exists, should DHHS elect to pursue it.

The urban swingbed subacute care model has several advantages:

Provides a short-term solution to current demand for services. This would allow Congress to develop more comprehensive policies for meeting long-term care needs in the country. Urban swingbeds would improve quality of care by eliminating “transfer trauma” associated with patient transfers to long-term care, reducing patients readmissions to acute care hospitals, reducing Medicare costs for acute care readmissions, and reducing Medicaid costs for unnecessary long-term care placements. Urban swingbeds would also help private payers by eliminating cost-shifting and patient backups in hospitals.

Enhances quality of care provided to patients. Hospitals will continue to do better than the long-term care industry in recruiting and retaining health care workers. Solid, stable health care staffs mean enhanced patient quality of care and continuity of care. The Health Care Financing Administration’s evaluation of the rural swingbed program has found that hospitals are more therapeutically oriented than most nursing homes.

Increases physician involvement in postacute patient care. Subacute care patients are characterized as requiring more physician and staff involvement due to patient acuity levels and complex care requirements. Physicians do not visit long-term care facilities with the same frequency noted in the hospital setting. The urban swingbed model could provide opportunities to gather data on physician interaction with subacute care patients from a physician payment, cost, utilization, and quality of care perspective.

Ties quality of care to outcomes measures. The urban swingbed would allow DHHS to study the relationship of new programs to outcomes measures that promote the efficient use of limited federal health dollars. An important feature of the urban swingbed model would be the use of case managers to match patient care needs with appropriate patient care services. Data would be gathered to evaluate the additional costs associated with such case managers as well as the effectiveness of such strategies.

Provides policy directions for federal and state legislators. Demonstrations such as urban swingbeds provide federal and state health policymakers the opportunity to test different approaches to structural and financing changes in the health care delivery system. The urban swingbed model could provide a needed level of support in selected areas of the country with demonstrated need for additional subacute care services pending congressional or executive office policy directives. The Center for Health Services Research at the University of Colorado supports the use of evolution-shaping demonstrations to guide and constructively alter the direction taken by the nation’s health care programs.

Operational Questions for Urban Swingbed Models

A number of operational questions must be addressed before any urban swingbed subacute care model can be implemented.
by hospitals in this country. Health care policy will likely take a different route than the model discussed here. It is also likely that health care policy will continue to struggle along with little or no significant change in the infrastructure of the system or payment reform. However, should DHHS consider seriously the urban swingbed model, direction must be given in the following areas:

- Impact on quality of care and access to care?
- Use of urban swingbeds versus other system changes?
- The need for Medicare or Medicaid urban swingbed waivers?
- Urban swingbed requirements under Medicare?
- Urban swingbed reimbursement methodologies and rates of payment?
- Certificate of need for urban swingbeds?
- Availability of federal or state grants to support the projects?
- Effect on beneficiary or recipient benefits?
- Role of and payment for case management services?
- Role of and payment for physician services?

**Conclusions**

Demand for subacute care exceeds 3 million patient days per year according to the AHA, and it will continue to grow as government financing and other payers encourage limited hospital utilization and shorter lengths of stay. In many areas, nursing homes are operating at 95% occupancy. State certificate-of-need laws or bed moratoriums continue to decrease the long-term care bed supply artificially at a time when experts predict that the nursing home population will increase by 58% by the year 2003, assuming constant mortality, or by 115%, assuming declining mortality.

Demonstrations offer an important opportunity to test new strategies for addressing the health care issues facing this country. The urban swingbed concept as a demonstration to provide additional subacute care services to patients could play a key role in the development of health policy in this country over the next ten years. It is critical that we be given the opportunity to see if it will work before looking elsewhere for solutions.

**References**