Subacute Care Service Improves Transitions

BY SHERRY BOSCHERT

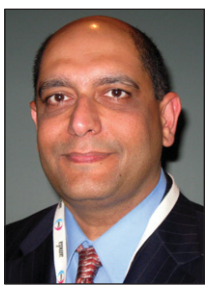
LONG BEACH, CALIF. — Creation of a subacute care service at a university medical center decreased hospital readmissions from nursing homes, reduced the average length of hospitalization, freed up inpatient beds, cut hospital costs by $600,000 a year, and provided the opportunity for an additional $1.6 million in hospital revenues, representatives of the center said.

How? By financially rewarding the University of Michigan's subacute service's faculty for reducing hospital stays and readmissions. The university pays these physicians' salaries at hospitalist levels (30% higher than standard salary rates) and covers half of the nurse practitioners' salaries. And knowing that a university colleague will be managing the transition makes other physicians comfortable with the idea of discharging patients earlier to nonuniversity skilled nursing facilities (SNFs).

"It's a new model of care," Dr. Caroline S. Blaum said in a presentation at the annual meeting of the American Medical Directors Association. In this approach, "SNF-ists" combine the expertise of geriatricians and hospitalists, she explained.

Physicians at the medical center started the subacute service after realizing that the patients with the most difficult hospital discharges and highest readmission rates were those discharged to SNFs, said Dr. Blaum, professor of medicine and geriatrics at the university in Ann Arbor.

The Sub-Acute Care Service began in 2006, working with two local SNFs, and has since grown to include five SNFs. "The University of Michigan does not own any of these facilities. They are all independently owned," Dr. Darius K. Joshi said in the same meeting session.



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DR. JOSHI

The SNFs have been happy to work with the subacute service, and have increased nurse-to-patient ratios higher than the state average in order to meet the university's standards, he said.

Three full-time geriatrician physicians (the SNF-ists) in the service work closely with four nurse practitioners. "In my experience, a nurse practitioner who has a medical-surgical background is an excellent fit for a subacute service" because of comfort with high acuity, said Dr. Joshi, director of the Sub-Acute Care Service at the university.

The salary guarantee liberates the service from having to bill using Medicare relative value units (RVUs), allowing physicians to spend more time with patients and focus on the transitions of care. "If this was a pure RVU service, we wouldn't survive," said Dr. Joshi, who said he sees 10-12 patients per day.

Hospital executives were skeptical when the subacute service was proposed, but ultimately they were won over by the promise of shorter hospital stays.

Data from the first 2 years of the program show that the average length of hospital stay for patients discharged to SNFs decreased from 9.7 days before the service started to 9.2 days. Readmissions within 15 days of discharge to SNFs declined from 12.7% of patients to 11.6%, and 30-day readmissions declined from 17.5% to 15.8%, Dr. Blaum reported. Each difference was of borderline statistical significance.

The service handled 42% of all patients discharged to subacute care during its first 2 years.

Data for its first 3 years suggest that the subacute service saved the hospital 939 days of care, which avoided $600,000 in costs per year and gave the hospital the opportunity to fill those beds with new patients and generate an additional $1.6 million/year in revenue, reported Rick Bluhm, J.D., also of the university.

The university's hospital is always full, so from the perspective of hospital administrators, freeing up beds is an important benefit of the subacute service, according to the presenters. All professional revenue from the service is kept by the division of geriatrics, they added.

One key to clinical success is good transfer of information involving the Sub-Acute Care Service, Dr. Joshi said. All notes, medication changes, new diagnoses or allergies, and changes in advance directives are recorded in the university's electronic medical records system, which can be accessed at each SNF via the Internet. The notes also are printed and placed in SNF paper charts. University laboratories handle lab testing at three of the five SNFs and record results in the electronic system.

"Our goal is to get you to the highest functioning level and preferably back to your home," Dr. Joshi said. Elderly patients with complex medical and psychosocial needs who are discharged from SNFs and can't see their nonuniversity primary physicians within a few days may come to the university's Geriatric Transitional Care Clinic.

Over time, the Sub-Acute Care Service has expanded to handle patients needing specialized care, including some with left ventricular assist devices and patients who underwent liver or bone marrow transplantation. "Some of the highest [rehospitalization rates] we have are these patients," which may skew the service's data on readmissions, Dr. Joshi added.

"We have developed a comfort level," he said. "They have to trust us, and discharge sooner." ■

Disclosures: *The speakers reported having no relevant financial relationships.*