CME CREDIT

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Subacute care: Which patients benefit?

ABSTRACT

The decision about appropriate referral of patients to a subacute care unit is the key to both continuity of care and the financial viability of a hospital's subacute care unit. Patient selection, subacute care admission criteria, patient education, and financial concerns are discussed.

AFTER A PERIOD of unchecked growth and profitability, subacute care programs are now feeling pressure in the form of new Medicare reimbursement policies, along with increased scrutiny from federal regulators. With the viability of subacute care programs at stake, physicians have more responsibility than ever to ensure that patients are appropriately referred to subacute care units.

This article reviews the criteria for admission to a subacute care unit, the role of patient education in subacute care, and directions subacute care may take in the future.

PRINCIPLES OF SUBACUTE CARE

Subacute care is a transition between acute care in a hospital and discharge back to the patient's home. The philosophy is to provide a healing environment and rely less on high-technology interventions.

While subacute care patients may not need intense diagnostic or invasive procedures, they require frequent physician monitoring, nursing care, and rehabilitation,[1] provided by a multidisciplinary team (see "The evolution of subacute care" on the next page).[2,3]

Each patient is treated under an individualized care plan that addresses both medical and functional disabilities. An internist or geriatrician supervises medical care, while a physiatrist ensures optimal use of rehabilitation services, measuring the physiologic impairment—ie, strength, physical fitness, balance, and coordination—to minimize subsequent disability.

PATIENT SELECTION

Subacute care patients are different from nursing home patients: they are younger, have less cognitive impairment, and have a better rehabilitation potential and more favorable functional outcome. The typical length of stay for a subacute care patient is 7 to 30 days, compared with several months to years for nursing home patients.[2,4]

Identify patients early in their acute hospitalization

Identify candidates for subacute care early

To qualify for subacute care, patients must have a definitive rehabilitation goal and identified needs for skilled care. It is important to identify these patients as early as possible during their acute hospitalization to reduce the length of stay in the acute hospital setting. In the case of elective procedures such as coronary artery bypass grafting or joint replacement, patients can be identified in advance and routed for subacute care once stable after the procedure.

Good candidates for subacute care

Examples of patients who can benefit from subacute care include those who need:

- Close monitoring for a chronic medical condition such as diabetes, chronic obstructive lung disease, or congestive heart failure

The rise and fall of subacute care reimbursement

WHY SUBACUTE CARE UNITS WERE CREATED

Subacute care developed rapidly in the early 1980s, spurred by Medicare's prospective payment system (PPS) for acute hospital care based on diagnosis-related groups (DRGs).

Under the DRG system, hospitals found that they could make a profit if a patient could be discharged from the hospital before the limit of the DRG reimbursement was exhausted, and also if they could provide the patient's subacute or skilled nursing care, which was until recently reimbursed on the basis of actual costs, plus a percentage added for profit.

The motive was not entirely financial, however. Subacute care units provide continuity of care after an acute illness and are a good option for patients requiring a transition between acute care and discharge home.[2,5]

HOW REIMBURSEMENT HAS CHANGED

Subacute care services are reimbursed through Medicare, health maintenance organizations, and other insurers, whereas the bulk of long-term or custodial nursing home care is reimbursed through Medicaid.[2,5]

Many hospitals developed their own subacute care units as a way of keeping more revenue in-house. The result was a significant reduction in the length of stay on the acute care side but a significant increase in expenditure on the subacute side. Congress deemed this "double dipping" and imposed the PPS on subacute care,[6] as it had previously done with acute hospital care, to try to control costs.

PPS reimbursement mirrors a capitated insurance model, providing a defined rate per day per patient based on Resource Utilization Groups version 3 (RUGS 3) and Minimal Data Set (MDS) data. MDS is a financially driven tool developed by the Health Care Financing Administration (HCFA) that collects data on the clinical and functional status of patients. MDS data classify an individual patient's daily care needs and assign a daily reimbursement for that care. MDS data, however, do not capture the severity or medical complexity of the patient's condition (eg, related to wound care, total parenteral nutrition, chest tubes), which significantly affects financial reimbursement.[7,8]

These days, subacute care units are receiving much less money, often 50% less than before prospective payment. Their challenge now is to become more cost-effective and give the right amount of care for the least amount of money—a policy of "no more, no less."

Under PPS reimbursement, direct patient care, rehabilitation care, respiratory care, pharmacy, laboratory, radiology, and support services are included under the same prospective payment rate. Excluded from the prospective payment rate and reimbursed separately are fees for physicians and for such "physician extenders" as physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, psychologists, and certified registered nurse anesthetists.[9]

TYPES OF SUBACUTE CARE UNITS

There are 1,700 to 2,000 subacute care units in the United States, 750 hospital-based and 950 freestanding.[5]

Hospital-based units offer opportunities for the acute

- Slow weaning from a ventilator, or aggressive respiratory and nursing care if ventilator-dependent
- Training and education about their disease and symptoms
- Intravenous drugs (eg, antibiotics, dobutamine)
- Wound management or burn care
- Intensive rehabilitation after a stroke or surgery (eg, joint reconstruction)
- Pain management
- Parenteral or enteral nutrition and education
- Continuous ambulatory or cyclic dialysis.

The importance of patient education

Patient education is an essential part of subacute care, since patients stay in the subacute care unit longer than they stay in the hospital. Patient education programs typically cover taking medications (eg, warfarin), stoma or wound care, dietary compliance, and diabetes management. Other specific types of patients needing education are those with congestive heart failure (who need education about fluid restriction and medications) and those receiving peritoneal dialysis. Since the same multidisciplinary team members work with patients throughout their stay, the education can be consistent, continuous, and reinforced.

SUBACUTE CARE ADMISSION CRITERIA

To qualify for subacute care, patients must be medically stable and demonstrate a need for skilled care per Medicare guidelines. Medicare also requires that patients be hospitalized for 3 or more days in the last 30 days, although some payers may waive this rule. Patients with psychiatric disorders, mentally retarded patients, and substance abusers are considered on a case-by-case basis at the discretion of the program's medical director.

care hospital to reduce length of stay while providing complex medical, surgical, and rehabilitation care. In addition to maintaining continuity of care, these centers allow for cost-effective "one-stop shopping" for health care.[10]

Freestanding nursing units are not attached to hospitals or medical centers either physically or contractually. They focus on rehabilitation and provide services to the local community.

Hospital 'swing' beds for subacute care are typical in small community hospitals where beds are used either for hospital care or skilled nursing care. Since the beds may be scattered, the care is not standardized, and outcomes cannot be measured.

SUBACUTE CARE TEAM MEMBERS

The multidisciplinary approach used in subacute care programs is similar to that used in typical acute care settings. The following is a brief listing of team members and their subacute care roles.

The medical director, usually a board-certified internist or geriatrician, oversees the unit, ensures quality of care, assists in forming policy and reviewing utilization and quality, and may be the primary attending physician for some patients.

The administrator is involved in utilization review, managing the cost of running the facility, and negotiating payer source contracts. He or she also assists in developing new policies and ensures that the unit is in compliance with state and federal regulations.

The medical staff includes full-time and consulting physicians, nurse practitioners, and physician assistants. On an average, patients require two or three physician visits per week, depending on acuity.

The director of nursing supervises the nursing staff and is responsible for meeting patient satisfaction standards and assuring quality of care.

Nurses in subacute care programs have a strong clinical background in the care of medical and surgically complex patients. They help with the rehabilitation of patients with cardiac and other conditions, and they train patients in such skills as colostomy care and infusion therapy.

Therapists assess the functional ability of the patient at admission, provide care to meet patients' occupational, physical, speech, and respiratory needs, and make appropriate arrangements at discharge.

Dietitians assist in the care of patients with diabetes mellitus, hypertension, and coronary artery disease, and those requiring enteral and total parenteral nutrition. Since many subacute care patients are elderly, dietitians help to screen patients at nutritional risk and intervene to help prevent complications of malnutrition.

Social workers counsel the patient and family to assist with discharge to home or other levels of care. They also help them complete their Medicare and Medicaid applications and advance directives.

Case managers and discharge planners act as liaisons between the caregivers and the payers. They help in utilization review, balancing appropriate outcomes with the desired cost to the payers. They coordinate admission decisions and discharge dispositions.

Other staff include medical consultants, psychologists, orthotic/prosthesis specialists, pharmacists, recreational therapists, and support personnel.[10–12]

Subacute or custodial care?

Patients who require custodial care only are not eligible for admission to a subacute care program.[2,5] Examples include patients who require only supervision, assistance with activities of daily living, or someone to ensure that they receive their daily medications. For these patients, placement in a nursing home is more appropriate.

Other admission-related issues

Rehospitalization. Since subacute care units have limited diagnostic and monitoring capabilities, any change in a patient's medical condition may require rehospitalization.

Direct admission. If a patient is medically stable, direct admission from the community to a subacute facility would be more cost-effective. Studies show that 4% to 16% of patients currently being admitted to acute care facilities may be candidates for direct admission to subacute units: eg, patients with pneumonia or osteomyelitis or patients who have fallen.

The practice of direct admission may affect future rules governing admission to subacute care units, allowing certain patients to bypass the Medicare 3-day hospital requirement, thus reducing health care costs. This can also ensure that rehabilitation is initiated immediately and avoids inconvenience to the patient from being shifted to a different part of the hospital or to a different institution, which can contribute to confusion in a geriatric patient. At present, Medicare does not allow direct admission, but some private payers do.

FUTURE CHALLENGES

Because of concerns by governmental and private insurers, the future viability of subacute care programs rests in balancing quality of care and outcome with an acceptable length of stay and cost of care.

Measuring patient outcomes

To maintain the support of insurers, subacute care units will need to measure patient outcomes more accurately and develop standards of care.

Outcome measurement must assess quality of care and desired outcomes balanced within an acceptable length of stay and appropriate cost. The response of the patient to the level of care should be monitored, and new programs implemented based on the findings. Outcome data can provide insight into variations in medical practice and help in designing clinical pathways for patients with a common diagnosis.[3]

Adapting to reimbursement changes

Subacute care units will continuously need to adapt to changes in reimbursement and the practice of medicine. Standardization of clinical care through the use of practice guidelines will be necessary. Formularies for pharmacy, medical supplies, and parenteral nutrition will need to be developed. The medical record will need to be simplified to permit one-time documentation of any required data.

Medicare now uses the prospective payment system in subacute care *and* hospital care

The transfer rule. In addition to introducing the PPS, the Balanced Budget Act of 1997 also introduced the Transfer Rule, under which 10 DRGs (eg, joint replacement, amputations, stroke) for which discharge from the hospital to a subacute care unit will be considered as a transfer rather than a discharge. As a result, only a partial DRG payment will be made to the hospital if the patient is transferred to a subacute facility before the mean length of stay allocated by the DRG is completed. It is not yet clear what impact this change will have on the use of subacute care units.

Regulatory oversight

Subacute care units will continue to face scrutiny from a variety of regulators and will need to meet standards that are outcome-driven and patient-centered.

Subacute units are regulated by HCFA under federal long-term care standards and under guidelines set by each state health department's division of long-term care. Many also are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Long-term care regulations govern the monitoring of clinical practices linked to patient rights, use of restraints, assessment of falls, and the use of psychotropic medications and advance directives.

Medicare-certified subacute units are under the surveillance of HCFA's Operation Restore Trust initiative to detect fraud, and compliance programs are being established at the subacute level to assure adherence to federal regulations regarding the financial and clinical aspects of patient care.

When are reimbursement cuts too deep?

Although some of the recent changes in the reimbursement of subacute care may have been necessary to control costs and prevent abuse, it is not clear when the cuts may become too deep. Declines in quality outcome and patient and family satisfaction scores should alert us to any decrease in the quality of care.

The constantly changing economic climate will eventually change the patient population that these units will serve in the future.

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