Managed Care Practices: Watch Out for Skilled Nursing Facility Care
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Medical groups starting out under capitation appropriately focus energies on addressing the major driver of cost: inpatient hospital days. This often requires a combination of enhanced inpatient medical coverage (hospitalist care, multiple daily rounds), proactive interventions to avoid hospitalization, and the development of post-acute care alternatives to hospitalization. As acute care days decline, groups often find that this action has been accomplished through increased use of skilled nursing facilities (SNFs). SNFs provide restorative services and moderate-intensity acute and chronic medical care to individuals whose poor functional status leaves them unable to be cared for at home. Medicare (managed and regular) is the usual payer for short-term, “skilled” nursing care; Medicaid is the usual payer for chronic, custodial care in extended care facilities. Typical short-term SNF patients are those recovering from hip or knee surgery, strokes, pneumonia, or chronic obstructive pulmonary disease exacerbations who require rehabilitative services or support of activities of daily living before regaining independent function and returning home.

Admission to SNFs
SNF use is measured using 2 factors: the number of admissions and the length of stay. The number of SNF admissions increases as groups seeking to contain costs use SNFs to shorten acute care hospital stays and to avoid hospitalization altogether for patients whose care needs can be met appropriately in an SNF. Unlike regular Medicare patients, managed Medicare patients do not have to spend 3 days in the hospital to trigger their Medicare SNF benefit. Accordingly, they can be admitted to an SNF directly from home, office, or the emergency room without prior hospitalization. The resultant increase in admissions to SNFs is appropriate and is the by-product of a cost-effective strategy for managing patients unable to be cared for at home.

Most physicians have developed a medical management model for patients in nursing facilities consistent with the Medicare and Medicaid regulations governing the care of these patients. Medicare requires that patients be seen by a physician within 48 hours of admission for a physical examination, establishment of a care plan, and certification that the patient requires skilled nursing care. The physician must recertify that the patient continues to require skilled services at weeks 2, 6, and 10. If the documenting physician managed the care of the patient in the hospital prior to SNF placement, admission documentation can occur as late as a week after admission. State Medicaid regulations mandate that patients receiving chronic care (as contrasted with skilled care) in these facilities be seen at 60- to 90-day intervals. As a result of these regulations, physician presence in SNFs is often very limited. Further, under a non–managed care model, there are no incentives for physicians to shorten length of stay or to manage some acute problems in the nursing home to avoid hospitalization. The result is low-intensity, intermittent medical management of SNF patients.

The Need for More Intensive Oversight
Whereas most groups recognize the need for more intensive inpatient supervision for hospitalized patients, few make a similar adjustment in medical oversight for their managed care SNF patients. In the absence of high-intensity management in the hospital, it is impossible to transfer patients whose care needs could be appropriately met in a SNF rather than in an acute care hospital. In the absence of high-intensity management in the SNF, the readmission rate to acute care hospitals and the average length of SNF stay increase. Unless the supervising physician establishes the clinical and functional goals of the SNF admission and regularly assesses the patient to determine if they have been met, the patient will likely remain in the SNF beyond the time necessary. Under the typical per diem reimbursement plan, SNFs have an incentive to increase length of stay as much as possible. When the responsibility of determining the length of stay is left to the SNF, length of stay and use of ancillary services increase.

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Table. Steps in Reorganizing the Care of Patients in Skilled Nursing Facilities (SNFs)

**Step 1. Collect data**
- SNF days/1000 patients
- Hospital days/1000 patients
- Home care visits/1000 patients
- List of all SNFs used by practice
- List all physicians seeing patients in SNFs, indicating whether they cover only their own patients or others’ as well

**Step 2. Analyze data**
- Compare utilization to Milliman & Robertson benchmarks
- Estimate potential savings to group from improved management of SNF days (cost of SNF day equals approximately 25% to 30% of the acute hospital day charge)

**Step 3. Develop consensus**
- There is a significant opportunity to improve performance
- It is reasonable to commit resources to improved SNF management
- It is necessary to develop a system for SNF care that increases the intensity of medical management to more closely match the complexity of the patients being transferred
- It is necessary to reduce the number of SNFs used by the practice in order to gain leverage from referrals and simplify coverage arrangements
- All managed care SNF patients will be covered by the practice and not by outside physicians to assure that they are managed by physicians who share the risk
- It is necessary to develop fund flow that promotes effective SNF care by providing physicians with appropriate incentives

**Step 4. Assess resources**
- Physician: availability, interest, training, and quality
- ANP: need, potential contribution, availability, physician interest and willingness to share care and financial impact
- CC: availability, managed care knowledge, SNF/rehabilitation experience
- SNF: availability, managed care readiness, 7×24 admissions, enhanced in-house treatment, high-level nursing assessment, staff improvement plans, quality of care, geography, accessibility (need for bed reservation system), medical directorship

**Step 5. Choose among potential coverage models**
- Agree on minimum coverage standards: physician 2×/wk, ANP 3×/wk, CC 2×/wk, weekend admissions, early initiation of treatment plan (within 24 hr of admission)
- Increase communication and collaboration between CC and ANP
- Set practice standards: everyone follows patients in SNFs
- SNF-ist/ANP team
- Individual physicians assigned to individual homes
- Physical medicine and rehabilitation physicians set up initial rehabilitation program for patients following stroke or orthopedic surgery
- Link to home care for early discharge, home assessment
- Participate in SNF patient care meetings (ANP, physician, and/or CC)
- Assign responsibility for SNF coverage on weekends, vacations, and holidays

**Step 6. Meet with preferred provider SNFs**
- Clarify SNF responsibilities
  - 7 day/wk admission
  - 6 day/wk therapy (7 preferred)
  - Cooperation with practice goals of limiting referrals back to the emergency room by increasing ability to manage more complex patients at the SNF
  - Thoughtful use of ancillaries, therapies
  - Timely discharges
  - Managed care sensitivity
  - Improved nursing training
- Clarify practice responsibilities
  - Standards for physician call-back
  - Help with managing Medicare pharmacy, ancillaries, transportation
  - Rounding standards
  - Selectively sending patients to preferred providers

**Step 7. Monitor outcomes**
- Weekly utilization review of all SNF patients
- Twice weekly care plan review with CC and responsible SNF physician
- Monthly review of practice utilization of SNF, acute hospital, and home care (admits, LOS, total days in each)
- Set CQI outcome studies based on expectations (% patients seen within 24 hrs, % care plans started within 24 hrs, % patients seen over weekend, % patients referred to home care seen initially in SNF)

ANP = adult nurse practitioner; CC = care coordinator; CQI = continuous quality improvement; LOS = length of stay.
The managed care goal of providing care in the most cost-effective manner cannot be met by the old system because the intensity of medical management is too low. In managed care practices, the total number of SNF days used is measured in days per 1000 patients per year, or days/1000. In our network of primary care practices, some groups experienced a 4-fold rise in SNF days/1000 as their acute care days/1000 declined. As SNF use accelerates, it becomes a cost driver worthy of tighter management. Although the cost of an SNF day is usually on the order of 25% to 30% of the cost of an acute hospital day, when utilization is 2 to 3 times the national benchmarks there are opportunities for savings. For every 1000 SNF days/1000 that a group is over the Milliman & Robertson (a nationally recognized health care actuarial firm) benchmark (610 days/1000 in a “tightly” managed network, 1997), the additional per member per month cost is approximately $20 to $25. This may represent the entire operating surplus of the practice.

An Approach to Reorganizing Care
To address overutilization of SNFs, our network developed a 7-step process to reorganize the care of our patients in these facilities (Table). The first 2 steps are to obtain and review SNF utilization data. If your practice is not currently tracking this information, it should start. These data are important for setting priorities for intervention as well as for monitoring change. National benchmarks are helpful, as are health plan-specific utilization data comparing the group to the network as a whole. These data can often be obtained directly from the health plans through the provider relations department.

Step 3 is critical for driving change. If consensus within the practice cannot be achieved, it is unlikely that change will occur. This is particularly true because addressing SNF utilization requires changes in physician and nurse workloads, schedules, and income. Until consensus is reached that the goals are worth the effort, it is impossible to develop the SNF coverage/utilization plan. We have found that the data are often compelling when the financial impact of appropriately reducing SNF utilization is presented.

Practices vary regarding the number, training, and interest of their nurses and physicians who are willing to devote more of their practice to SNF care. Access to SNFs also varies by practice and geography. Step 4 involves identifying which physicians and nurses will manage patients at which facilities, setting performance standards for the SNFs and coverage groups, and identifying the smallest number of SNFs that can meet the requirements of the practice. There are 2 advantages to limiting the number of SNFs: the first is that medical resources can be concentrated more easily on fewer facilities to achieve the intensity of SNF utilization. The second is that the referring group can have more influence on the performance of the SNF if it refers more patients. Practices may find that they need to add physicians or nurses to take on this role; or they may find that manpower is adequate to cover a smaller group of preferred provider SNFs. This is a complex task and requires an iterative process of simultaneously assessing manpower and SNF resources.

The choice of model (step 5) is dependent on the resources available. The simplest model is to reorganize the practice’s physicians so they are assigned to 1 or 2 SNFs and take on the care of any patient of the practice who is admitted there. Next in complexity are physician–adult nurse practitioner (ANP) teams. The most complex in terms of practice reorganization is the “SNF-ist” model. The SNF-ist is a physician who practices full-time in the SNF (as a hospitalist practices full-time in the hospital). Performance within our network suggests that the most cost-effective model is a full-time physician–ANP team that manages all SNF patients for the practice.

The care coordinator (CC) is an important member of the team whose role is not to manage the care of the patients but rather to coordinate the implementation of the patient’s care plan. Part of the minimal standards that we developed for our practices is to have the CC communicate with the physician, ANP, and SNF at least twice a week about the progress of the care plan. When the patient is not meeting initial goals, alternative plans are developed, such as discharge to home or to a long-term care facility.

The next step (6) is to make operational the new relationship that your practice is establishing with its preferred SNFs. Some of this is done during the process of identifying SNFs that might become preferred providers. Expectations of the practice for the SNF and vice versa need to be clarified, made explicit, and reviewed frequently (step 7). This forms the basis of performance monitoring and quality improvement.

We have found that this process has helped our network move toward national benchmarks and more cost-effective care. If your practice has managed care patients, it might be time to review your SNF performance.