Tips on How to Recognize Patient Needs Post-Acute Care

By Sean Muldoon, *Chief Medical Officer, Kindred Healthcare*

Long-term acute care (LTAC) hospitals deliver care for the most difficult-to-treat, critically ill and medically complex patients—such as patients with respiratory failure, septicemia, traumatic injuries, wounds, or other severe illnesses complicated by multiple chronic conditions.

The LTAC level of care, and an early assessment by a post–acute care representative, may provide care management solutions for referring hospitals and can have a positive impact on patient outcomes.

Changes in Payment Criteria

As a result of the Pathway for SGR Reform Act of 2013, beginning in 2015, the Centers for Medicare & Medicaid Services (CMS) implemented payment criteria for LTAC hospital stays to ensure that appropriate patients are admitted to LTACs and that payments are appropriately aligned with patient care costs.

As a result of the payment criteria, there are two distinct levels of reimbursement (see Figure 1):

- Post–Intensive Care (PIC)—patients who most recently spent 3 or more days in an intensive care unit (ICU) or require prolonged dependence on a ventilator
- Complex Medical (or site neutral)—all other patients that can benefit from LTAC hospital-level specialized care, but do not meet the PIC criteria

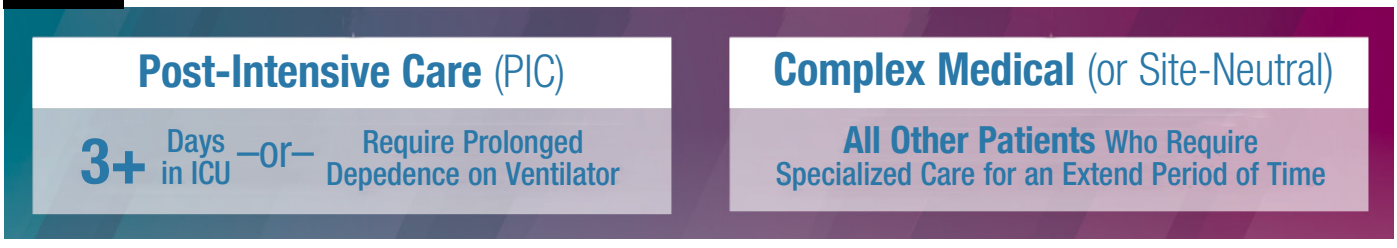
By establishing these specific thresholds, short-term hospitals have the option to discharge ICU/CCU and ventilator patients to LTAC hospitals at a time when they can best benefit from this level of care. This provides new solutions for hospitals and physicians to consider discharge to a LTAC hospital as soon as it is determined that a patient will need longer acute care.

Benefits of Early Post–Acute Care Assessments

During a stay in an ICU, the critical care team can generally tell if a patient will need extended care around days 3 to 7 of the stay. As stated by a report in *Chest*, "While acknowledging that liberation from mechanical ventilation can be unpredictable, but recognizing that by as early as day 7, the need for a prolonged course is likely," a large Consensus Conference on prolonged mechanical ventilation (PMV) made the formal recommendation that clinicians "begin consideration for PMV-focused care when tracheostomy is first considered."[1] As soon as it is determined a patient will need longer acute care, it is important for the clinical team to reach out to post-acute representatives to determine the best options for site of care and a longer recovery process.

Post ICU/CCU-level patients often require the specialized, interdisciplinary care that is only available in LTAC hospitals. This is because these patients are significantly sicker—with a much higher case mix index—than their acute hospital counterparts.

FIGURE 1 **CMS Levels of Reimbursement**



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Once it is determined that an ICU/CCU patient will require prolonged care for a full recovery, it is important that discharge from the unit to the most appropriate level of care not be delayed as patients who experience a delay may experience adverse outcomes.

Early assessments by post-acute networks provide benefit to the patient and referring hospital:

- Improved patient experience through a smoother transition between facilities, better coordination, less disruption
- Enhanced efficiency in case management—earlier identification that the care needs are exceeding the short-term facility; potential to help in denial management

LTACs Drive Strong Patient Outcomes

LTAC hospitals have long been recognized for their strong performance in successfully weaning patients off of ventilators. Additionally, recent research looking at nonventilator patient populations found that for patients with 3 or more days in intensive care in a short-term hospital, LTAC hospital care "is associated with improved mortality and lower payments."[2] The study also concluded that the effects of LTAC hospital care tend to "be more favorable for patients with either multiple organ failure or ≥3 days in an ICU/CCU as compared with patients without these characteristics."[2]

Capabilities of Treating High-Acuity Patients

Unlike other post-acute settings, LTAC hospitals, which are licensed, certified, and accredited as acute-care hospitals, treat patients that have ongoing acute medical needs. Patients benefitting from this elevated level of care are among the hardest-to-treat patients, often with major complications or multiple chronic conditions in addition to their acute care needs. LTAC hospitals specialize in treating critically ill patients, including those dependent on ventilators for life support, patients with complex wounds, and patients with multiple organ system failure who require extended treatment in a hospital setting.

While LTAC hospitals can successfully treat a wide range of difficult-to-treat patients who require a prolonged recovery, 66% of the patients treated in 2015 were in 25 diagnosis-related groups (DRGs). That same year, 9 of the top 25 DRGs were respiratory conditions or involved prolonged mechanical ventilation. In fact, the most frequent diagnosis in LTACs in 2015 was pulmonary edema and respiratory failure.[3]

Given the LTAC hospital's unique ability to treat post-ICU and ventilator-dependent patients, CMS and Congress affirmed the value of this specialized care through passage and implementation of LTAC hospital patient payment criteria. However, the criteria also recognize the value of LTAC hospital care for other medically complex patients to benefit from the specialized care delivered in these hospitals without needing to meet the 25-day average length of stay.

What to Look For in a LTAC Hospital

LTAC hospitals, also known as *transitional care hospitals*, should provide expert interdisciplinary care to meet the unique needs of each patient who can benefit from this level of care. Treatment should be led by physician specialists and supported by a full complement of disciplines. Additionally, the hospitals should feature ICU-level units, telemetry units with on-site laboratories, radiology services, and operating rooms. The comprehensive team approach with condition-specific clinical programs can help ensure appropriate lengths of stay and facilitate improved outcomes and a greater chance of recovery.

LTAC hospitals should have average lengths of stay of about 30 days[3] and a 30-day readmission rate less than 10%.[3] These characteristics can provide new strategies for referring hospitals to manage readmissions and provide effective care management. Additionally, physician-led, interdisciplinary teams have a strong reputation for successfully weaning patients off mechanical ventilation.

As part of determining the most appropriate site for prolonged acute care, some LTACs employ clinical liaisons who can provide patient assessments, helping physicians and other attending clinicians to determine if a patient is appropriate for LTAC hospital services.

By working closely with LTAC hospitals, case managers can get help in determining whether patients are good candidates for post–acute care.

Case Study: ICU Transitions Pilot Results in an Increase in STAC Savings and LTAC Admissions

Opportunity

Many short-term acute care (STAC) hospitals have the opportunity to improve their discharge processes to better align with the STAC Geometric Mean Length of Stay (GMLOS). This was the case with Valley Health System (VHS) Hospitals, a close referral partner to Kindred LTAC hospitals in Las Vegas. Utilizing a robust analysis of MedPac data of the individual acute hospitals in this system, 5 key DRGs were found to have the largest potential impact. The LTAC hospital combined the GMLOS analysis of these DRGs with the cost savings potential due to avoidable day expenses and discovered a large opportunity in savings for the VHS hospitals.

Solution

The ICU Transitions Program of this LTAC hospital system was created to address this opportunity. In the pilot, the LTAC system partnered in a formal and structured way with leadership, case management, and intensivists/physicians at the short-term acute hospitals of VHS to assist them in reducing ICU length of stay for selected DRGs. Leaders from all of the participating hospitals carried out a comparative analysis of the protocols related to these DRGs and developed a new discharge transition process between hospitals. This revised process permitted LTAC clinical liaisons to begin the patient analysis in alignment with the STAC GMLOS.

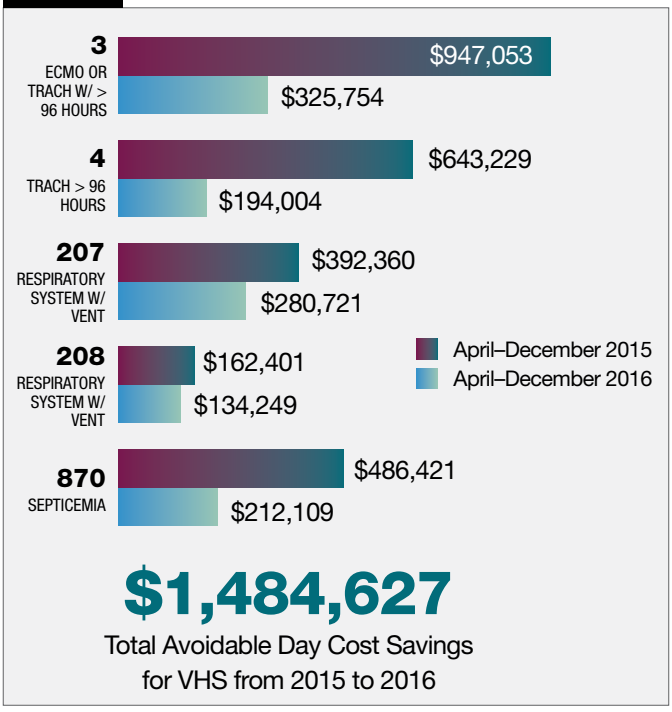
The program decreased the patient's avoidable days at the STAC, allowing for earlier transitions to a lower level of care with the guidance of the LTAC hospital.

Results

The pilot hospital within the Valley Health System saw $1,484,627 in avoidable day cost savings, when comparing financial data from April to December 2015 to the same months in 2016 (Figure 2). In total, 116 patients were tracked, 40 of which aligned with the 5 selected DRGs:

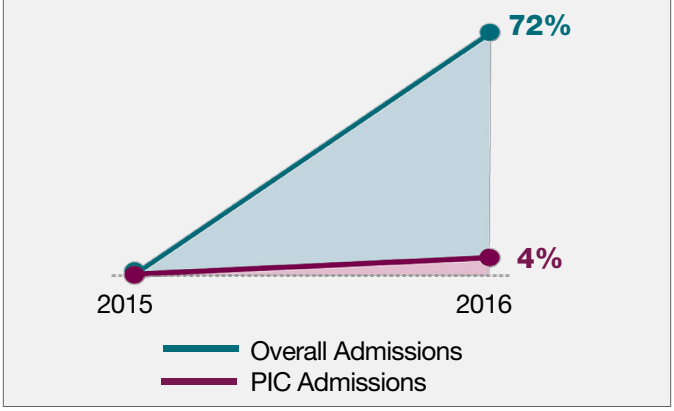
- 003: ECMO or trach with >96 hours
- 004: Trach >96 hours
- 207: Respiratory system with vent 96+ hours
- 208: Respiratory system with vent <96 hours
- 870: Septicemia

FIGURE 2 Change in Avoidable Day Costs for VHS by DRG



The LTAC hospitals saw a 72% increase in admissions from VHS overall (Figure 3), including a 4% increase in PIC admissions. The patients received the appropriate level of care at the right time, as indicated by the near or above benchmark clinical outcomes. Additionally, they experienced an improved transition of care from VHS to the LTAC hospital because of the enhanced integration of care teams. As a result of these initial outcomes, this program is being implemented in all 6 VHS hospitals in Las Vegas.

FIGURE 3 Increase in Admissions to Kindred Hospitals from VHS



Case Study: Patient Success Spotlight

Against all odds, John* staged a miraculous recovery.

John suffered a horrific accident that nearly claimed his life. The impact resulted in multiple facial and skull fractures, and severe injury to his brain. He also was found to have a lacerated liver, fractured ribs, and a collapsed lung as well as numerous other contusions and fractures.

When he arrived at the general hospital, emergency department physicians worked feverishly to save John's life. He was successfully treated, stabilized, and transferred from the operating room into the ICU of the hospital. At that time, John was in a coma and faced a long journey to recovery. His prognosis became further uncertain when he suffered respiratory failure from pneumonia and a stomach bleed.

It wasn't until 3 weeks after the accident that John woke from his coma and started to show signs of recovery. It was shortly after he awoke that he was transferred to a Kindred LTAC hospital for respiratory therapy, continuation of treatment for his wounds and fractures, and rehabilitation in the hope that he would be able to return to a normal life. With his parents at his side every day and numerous family visitors dropping in to lend support and encouragement, John visibly rallied and started to recover.

John's interdisciplinary care team at the LTAC facility developed a customized plan of care that would address his specific medical needs, beginning with pulmonary care. Through a coordinated effort, soon after he arrived at the LTAC facility, John's respiratory team was able to successfully wean him from the ventilator, and he started to make even greater gains toward recovery. Working with his speech therapist, John relearned and regained the ability to swallow and speak, both incredibly challenging after having been on the ventilator for so long. Through his occupational therapy, his cognitive abilities started to improve and he regained the ability to do the simple things we all take for granted. John's physical therapists helped him begin to walk again, and with each session in the rehab gym, he made big steps forward to rejoining his family and community.

**Patient name has been changed to protect their privacy*

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