Why Care Settings Matter: LTACHs vs. SNFs

Many patients leaving the intensive care unit (ICU) may benefit from additional care before returning home. Long-term acute care hospitals (LTACHs) and skilled nursing facilities (SNFs) are two settings that are often misunderstood as providing the same level of care. However, a closer look at available staff and services reveals a clear distinction in intensity and quality of care available at each location.

This white paper explores the key differentiators between LTACHs and SNFs regarding clinical capabilities, patient populations and hospital outcomes. Based on these comparisons, it is clear not only that LTACHs efficiently and effectively meet the needs of medically complex patients, but that strategic partnership with a trusted LTACH expert can help enhance patient outcomes, reduce costs and improve hospital throughput.[1]

SETTING COMPARISON: LTACHs AND SNFs

Choosing the appropriate level of care for medically complex and critically ill patients leaving the ICU is essential for achieving optimal outcomes for both patients and providers. The chart below outlines the services and staff available at LTACHs and SNFs, revealing characteristics that allow LTACHs to provide a higher acuity of care for this growing patient population.

LTACHs	SNFs
On-site physician visits at least once per day, sub-specialists available on location.	On-site physician visits at least once every 30 days for the fi st 90 days, sub-specialists seen off si e.
Approximately 1-6 patients per nurse, ratios lower in critical care units; high-acuity care provided by BLS- and ACLS-certified nu ses with advanced critical care training.	Approximately 10-40 patients per nurse.
24/7 respiratory therapy in-house at every location.	Limited respiratory therapy in select locations.
On-site services such as telemetry, radiology, pharmacy, lab and dialysis.	Radiology, pharmacy, lab and dialysis services accessible, but not on site.
CMS-compliant infection control standards with hospital-level air ventilation systems and negative pressure isolation rooms.	Residential-level air ventilation systems.

The differences in available staff and resources between LTACHs and SNFs mean that they are designed to treat different types and severities of conditions.

TOP FIVE CONDITIONS BY SETTING: LTACHs AND SNFs

LTACHs[2]	SNFs[3]
Pulmonary edema and respiratory failure	COVID-19
Respiratory system diagnosis with ventilator for 96+ hours	Urinary tract infection, site not specifie
Septicemia without ventilator support 96+ hours with major complication or co-morbidity	Metabolic encephalopathy
Respiratory system diagnosis with ventilator support ≤96 hours	Sepsis, unspecified o ganism
Respiratory infections and inflammation with major complications or co-morbidity	Encounter for other orthopedic aftercare

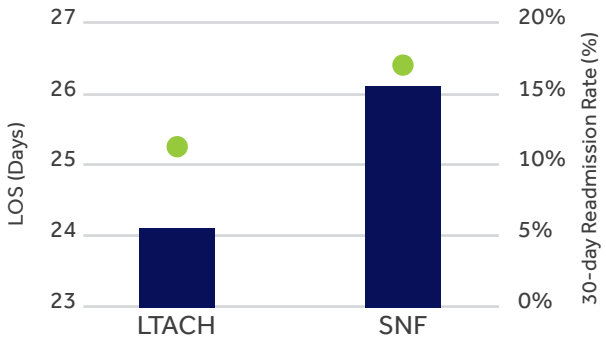
Aside from the differences in principal admitting condition, many of the top conditions treated at LTACHs include a major complication or co-morbidity. The Hierarchical Condition Category (HCC) score, which assigns complexity levels to patients, was almost 2 times higher at LTACHs than SNFs in 2021, indicating that more clinically complex patients with serious medical conditions continue to be admitted and treated within the LTACH setting.[4] With physician-led acute care, LTACHs are able to treat patients with complex conditions, most of which include a pulmonary diagnosis. SNFs, on the other hand, care for a wide range of conditions that can be managed by nursing staff.

Additionally, patients discharged to LTACHs after leaving an ICU or med-surg unit have a higher level on the Severity of Illness (SOI) Index than those discharged to SNFs. While only a small percentage discharged to a SNF present an "extreme" SOI, these patients make up over half the population transitioning to an LTACH.[5] Regardless of overlap in treated conditions, LTACHs have unique expertise in addressing cases of greater severity.

HOSPITAL OUTCOMES: LTACHs AND SNFs

When critically ill patients, especially those with complex pulmonary conditions, receive the specialized acute care available at LTACHs, they are well positioned to fully recover faster. Although patients at LTACHs tend to have more complex conditions, they experience both shorter lengths of stay (LOS) and fewer readmissions than those at SNFs. This is even more clear when looking at pulmonary diagnoses such as diagnosis-related group (DRG) 189, one of the most commonly treated at LTACHs.

National Average Length of Stay and Readmission Rate at LTACHs vs SNFs, All Conditions



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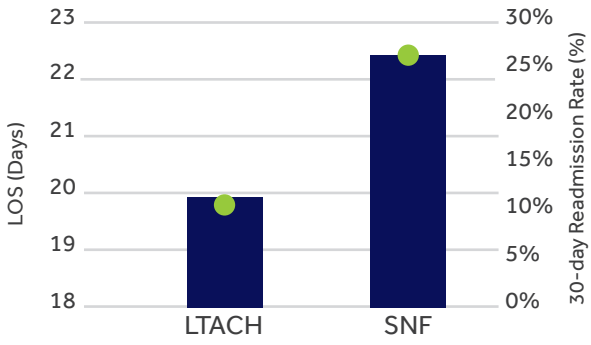
National Average Length of Stay and Readmission Rate at LTACH vs SNFs, DRG 189



HOW PARTNERSHIP WITH KINDRED HOSPITALS CAN HELP

Partnership has become a leading strategy to improve quality while still meeting the needs of the growing medically complex patient population. With the expertise and resources gained through partnership, hospitals can deliver the physician-led treatment and rehabilitation needed to ensure critically ill patients receive the most appropriate level of care while reducing LOS and readmissions.

Each year, the Centers for Medicare & Medicaid Services (CMS) penalizes hospitals for excessive 30-day readmission rate. In 2018, over 2,500 hospitals were penalized, amounting to more than$564 million.[6] Strategic partnership can help your hospital reduce readmissions, improve outcomes and increase patient throughput.

As an industry leader with a history of successful partnerships, Kindred Hospitals offers hospital-in-hospital, contract management and joint-venture opportunities. Expand access to needed acute care services by integrating an LTACH into your health system's care continuum today.

Discover how your hospital can benefit f om an LTACH partnership by visiting **KindredLTACHPartner.com**.

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