Why LTAC Hospitals Are Often the **Right Choice for Critically Ill Patients**

Choosing the right care path for critically ill patients is essential to achieving optimal outcomes for both patients and providers. Without the right clinical capabilities and surrounding environment in which to recover, patients may suffer medical setbacks that impede recovery. For providers, such as hospitals, major penalties (including extensive fines) can be incurred due to patients readmitting after discharge.

All of these considerations make knowing when and to where to discharge high acuity patients a challenging and unique case-by-case process.

In this whitepaper, we outline the clinical capabilities that distinguish two post-acute care (PAC) settings and assess the most appropriate patient types for each to help deliver better results for chronically, critically ill patients and providers alike.

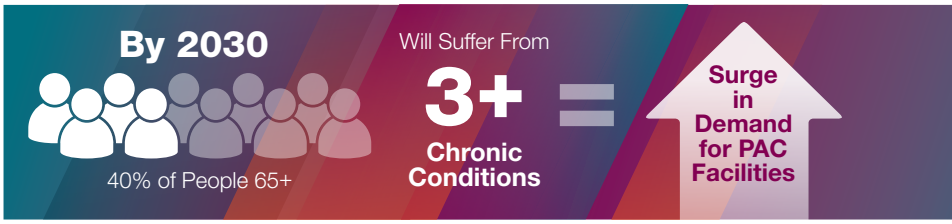
Benefits of Long-Term Acute Care (LTAC) Hospitals: Complex, Intensive Care

Long-term acute care hospitals are in a unique position to effectively treat critically ill patients. Unlike other post-acute settings, long-term acute care hospitals can help patients who need to see a physician or several specialty physicians every day. These specialists coordinate care with an interdisciplinary team made up of nurses, therapists, dietitians, pharmacists and other specialists.

These experts work together to determine the best treatment options and care plan for each and every patient. Most treatment plans involve many clinical disciplines, are complex, intensive, and evolving, and may require a length of stay measured in weeks.

Long-term acute care hospitals have three key benefits:

- They have the same licensing, accreditation, and certification standards as traditional hospitals, yet offer the personalized focus of a smaller hospital.
- Government data shows that this type of care can reduce hospital readmissions by 26-44%.
- As an acute care hospital, LTAC hospitals costs per patient day are generally 25-44% lower than traditional hospitals.



A Growing Need for LTAC Hospitals

America's aging population is now suffering from far more chronic and critical illnesses, and the trend is only worsening. By 2030, about 40% of people aged 65 and older will suffer from three or more chronic conditions.[3] This is creating a surge in demand for PAC facilities that are able to successfully treat these seriously ill patients.

Compounding this need is the recent pressure from the Centers for Medicare and Medicaid Services to decrease rehospitalizations. CMS is bolstering their

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value-based purchasing program, which reduces payments to providers with overly high readmission rates.[4] These shifts in legislation and the associated penalties are pushing providers to strive for the best possible patient outcomes and to choose post-acute care treatment settings that are the most clinically effective.

While LTAC hospitals provide care for a very high-acuity, niche patient population, they play a vital role in achieving more efficient recovery of patients who have a high risk of readmission due to their clinical complexity. By transitioning these challenging patients to a LTAC hospital, when it is the most appropriate site of care for their needs, a significant portion of financial losses for short-term providers can be avoided.

Benefits of Skilled Nursing Facilities (SNFs): Nursing and Rehabilitation

Skilled nursing facilities are often an appropriate setting for patients who have extended medical needs that cannot be cared for in a lower level of care, such as at home. These facilities are most suitable for patients who are not in a critical stage of illness as they offer physician or physician–extended visits on a weekly or as-needed basis.

SNFs are most appropriate for patients who require 24-hour nursing care and an interdisciplinary approach to care delivered by therapy and nursing staff, rather than a team of physicians. These patients are often medically stable so the team can focus on helping patients regain their functional independence and mobility.

With more and more of the older population interested in aging at home, many SNFs are attempting to grow beyond their conventional offerings. SNFs around the country are exploring options like palliative care, expanded residential accommodations and addiction recovery services to better connect with a larger patient demographic.

AS MANY AS **25%** of SNF Patients **Require Rehospitalization**

INDICATING THAT When SNF Patients Are in Need of Acute Level Care, **a Short- or Long-Term Hospital Is a More Appropriate Setting**[1]

What About Super SNFs?

Super SNFs are nursing centers with expanded capabilities, able to accommodate more clinically-complex patients.[2] These facilities are equipped with specialists and advanced medical technologies not generally available in a standard SNF. Nevertheless, they remain focused on providing therapies to patients who are no longer critical and are ready to begin a rehab program, so the same key clinical elements of comprehensive acute-level care offered in LTAC hospitals are not as readily available.

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Comparing Levels of Care

To better understand the levels of care offered by different types of post-acute facilities, refer to this comparison chart:

	Long-Term Acute Care Hospitals	Inpatient Rehabilitation Facility or Acute Rehabilitation Units	Skilled Nursing Facilities/ Transitional Care Units
License/ Certification	Comparable to and licensed, accredited and certified as an acute care hospital (med/surg floors, telemetry and ICU)	Licensed as inpatient hospitals or distinct rehabilitation units within a hospital	Licensed as a skilled nursing facility
Physician Involvement	Daily physician visits	Daily physician visits	Physician or a non-physician professional (NP, PA, clinical nurse specialist) visits frequently, not daily
Nursing	24-hour nursing care; assessment, planning, implementing, evaluating of: VS, IVFs/antibiotics/drips, critical labs and diagnostics, respiratory and cardiac equipment, catheter, trach, NG care	Receive specialized training in rehab nursing; 24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/ antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment	24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/ antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment
Rehab Therapy	PT/OT/ST available. Participation in therapy varies due to stability of medical condition. No minimal level of therapy participation required for admission. Therapy intensity often ramped up during course of care as patient condition improves.	PT/OT/ST available. All patients able to participate in therapy three hrs/day, five days a week or 15 hours over seven days. Requires the services of a minimum of two therapy disciplines (PT & OT, PT & ST). Level of rehab services provided in an IRF is more intense than other levels of post-acute care.	PT/OT/ST available. Participation varies based on medical needs and functional potential. Type and amount of therapy based on patient condition and medical needs. Patient prognosis varies. When possible, goal is to return patient to prior living setting but expectation that patient will return home or to community setting not required for admission.
Team Treatment	Interdisciplinary care approach between physician, nursing, therapy, respiratory, pharmacy and nutrition services to facilitate healing and recovery	Interdisciplinary approach between physician, therapy team, and nursing to facilitate recovery; physician-led weekly team conferences required	Interdisciplinary approach between therapy and nursing to facilitate recovery
Ancillary Services	Services on site: pharmacy, lab, radiology, procedure rooms	Services on site: pharmacy, lab, radiology	Services readily available as send outs, but not on site: pharmacy consultant, lab, radiology
Patient Characteristics	Specializes in patients not meeting acute med/surg hospital clinical milestones quickly. Patients most often transition from the intensive or critical care unit of a short-term hospital for continued, acute-level care. Common admission patient description: • Prolonged mechanical ventilation requiring weaning and pulmonary care • Complex wound care • Multiple resistant infections • Complex medical issues requiring daily physician management • Major post-surgical complications • Multiple concurrent acute and/or unstable illnesses	Patient's functional prognosis is good with the goal that they will return to home or a community-based setting. Patient demonstrates sufficient endurance and potential to participate in a rehab program and make significant gains in functional capabilities. Common admission patient description: • Stroke or other neurologic disorder • Multiple major trauma to brain, spinal cord, or amputation • Burns • Arthritic and pain syndromes • Orthopedic fracture or bilateral joint replacement • Medically complex patients such as those with CHF, COPD, or other cardiac conditions that have good endurance and potential for significant functional gains	Common admission patient description: • Medically complex patients such as those with CHF, COPD and diabetes exacerbation requiring monitoring, management • Wound care > stage 2 • Orthopedic surgery, surgery with minor complications or stroke requiring mobility and activity of daily living recovery (tolerates less than three hrs therapy/day) • Infections requiring ongoing IV antibiotics • Neurological illnesses **Note:** *Some of Kindred's Transitional Care Hospitals contain Subacute Skilled Units that provide a skilled level of therapy for patients with higher acuity needs*

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	Home Health Care	Outpatient Therapy	Hospice Care
License/ Certification	Certified to provide skilled nursing and skilled therapy services for patients for whom leaving home takes considerable effort or is otherwise unsafe	Licensed/certified for patients whose rehabilitation and medical needs can be met in an outpatient setting	Certified services that provide care for those with a terminal illness in a setting that the patient considers home
Physician Involvement	Patient's physician certifies need and oversees care	Physician or non-physician practitioner (NPP) review/ certifies outpatient therapy plan of care	Hospice physician certifies terminal illness and, in coordination with attending, directs medical management of the hospice plan of care, with visits as indicated
Nursing	Nursing supervision of acute and chronic medical conditions. Teach/train/observe/assess and provide care plan management; instruct on medication administration, including oral, injections, infusions or tube feeding; wound, catheter and ostomy care; may include NG/trach aspiration and care.	Patients do not have skilled nursing needs	Nursing services are intermittent and individualized to meet the needs of the patient, typically increasing in frequency with patient decline
Rehab Therapy	PT/OT/SLP available. Participation varies based on medical needs and functional potential. Type and amount of therapy depends on patient condition and medical needs. Therapy goals are to restore function and improve patient independence and safety in the home environment. As patient function improves and patient is no longer homebound, therapy may be transferred to outpatient setting.	Participation in therapy varies based on medical needs and functional potential. PT/OT/ST available. Type and amount of therapy depends on the patient's condition and rehab prognosis. Frequency can range from one to five days per week.	PT/OT/ST services are available when their provision meets the patient's palliative goals of care, usually meaning providing relief from distressing symptoms
Team Treatment	Multidisciplinary team with nursing, therapy, social worker, home health aide. Visits are intermittent based on patient need and physician orders. Private Duty (usually paid for by patient) may be available.	PT/OT/ST provided	The core hospice team includes physician, nursing, social work, and counselor services. Counseling can be provided by spiritual care counselors, bereavement counselors, or nutritional counselors; volunteers, hospice aides, and others may also be included on the interdisciplinary team.
Patient Characteristics	The patient must be considered "confined to the home," defined as: 1. Due to illness or injury the aid of a supportive device, the use of special transportation, or the assistance of another person is required in order to leave home, or they have a condition that makes leaving home unsafe or impractical. 2. If either of the above are true then there must also exist a normal inability to leave home and leaving home must require a considerable and taxing effort. Common patient needs: • Wound, ostomy, catheter, NG, tube feeding or tracheostomy care • Medication reconciliation and management • Treatment of gait disturbances and balance disorders • Infusion therapy • Management of chronic, complex medical diagnoses (CHF, COPD, diabetes, arthritis) • Teaching patients self-management techniques • In-home rehabilitation • Post-op therapy visits for routine orthopedic conditions (e.g., hip/knee replacement)	Stable medical condition that does not require frequent adjustments. Patient has functional limitations as compared to prior level of function. Potential for function to improve with therapy intervention exist.	Focus is on management of pain and other distressing symptoms to improve quality of life. Typical patients have a likely life expectancy of six months or less, if the illness runs its normal course. Common patient diagnoses: • Cancer • End-stage heart, lung or kidney disease • Alzheimer's, Parkinson's, other neurologic illnesses • Failure to thrive

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How Kindred Can Help

We specialize in the treatment and rehabilitation of the post-intensive care and complex medical patient requiring continued intensive care, including specialized rehabilitation, in an acute hospital setting.

Our team of skilled and caring clinicians in our long-term acute care hospitals can be the right partner for you for your patients who have been in an ICU or critical care unit or who are chronically ill and readmit to the hospital frequently.

With daily physician oversight, ICU/CCU-level staffing and specially trained interdisciplinary teams, we work to improve outcomes, reduce costly readmissions and help patients transition to a lower level of care.

If you have a critically ill patient in need of care after a hospital stay, call a Kindred Clinical Liaison for a patient assessment. Our experts will help you determine the most appropriate care setting for your patient's next stage of treatment. If you are unsure of who your Kindred representative is, please visit us online at **www.kindredhospitals.com** for information on how to contact us.

Sources

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