Optimizing the System of CARE With a Long-term Acute Care Hospital

Challenge/Opportunity

Long-term acute care hospitals (LTACHs) serve a niche population of complex critical patients who require extended hospital stays. LTACHs are an efficient alternative to short-term acute care hospitals and can be an essential post-acute care offering within an organization’s System of CARE. Although a CMS moratorium prohibits new LTACHs through at least 2012, partnering with existing LTACHs remains an option for health systems interested in offering their patients this integral component of the care continuum.

Bethesda Hospital in St Paul, MN, is a freestanding, nonprofit LTACH that is part of the HealthEast Care System. It provides a safety net for step-down ICU patients throughout Minnesota, ensuring appropriate levels of care for complex critical cases. National trends underscore how essential this option will continue to be for many hospitals.

- Studies project that by 2020, ICU beds will make up nearly 20% of all hospital beds.
- Costs of ICU care can average more than $3,000 per day. LTACHs, in contrast, curtail costs through decreased reliance on expensive technologies and drugs as well as development of specialized programs and competencies.

The Solution

With careful planning, Bethesda successfully converted from an acute care facility by:

- Educating key stakeholders—including leaders of short-term acute care hospitals, payers and legislators—early in the process about the value provided through LTACHs
- Implementing a hospitalist program for daily physician coverage and rounds
- Empowering subspecialty physician leaders to advise the executive team on advances in their fields and to guide decisions on quality initiatives
- Initiating aggressive educational programs for physicians and nurses to ensure they had the necessary skills to handle complex patients and to improve the organization’s performance in ventilation weaning, hospital-acquired conditions, infection control, tissue integrity, etc
- Disbanding inpatient rehab to limit confusion on the role of the LTACH vs an inpatient rehabilitation facility
- Establishing partnerships to ensure timely transfers for acute conditions and to improve post-acute care transitions

Key Metrics

<table>
<thead>
<tr>
<th>Key Metrics</th>
<th>CY 2010 Target</th>
<th>CY 2010 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator Weaning Rate</td>
<td>60%</td>
<td>76%</td>
</tr>
<tr>
<td>Ventilator-Associated Pneumonia</td>
<td>1.59/1,000 vent days</td>
<td>0.33/1,000 vent days</td>
</tr>
<tr>
<td>Catheter-Associated UTI</td>
<td>3.24/1,000 Foley days</td>
<td>1.89/1,000 Foley days</td>
</tr>
<tr>
<td>Central Line Bloodstream Infections</td>
<td>1.81/1,000 central line days</td>
<td>0.75/1,000 central line days</td>
</tr>
</tbody>
</table>

The Organization

- 140-bed stand-alone LTACH
- Converted from acute care IP facility in 2005
- Core competencies: respiratory care, neurovascular care, brain injury, cognitive dysfunction and complex medical cases

CARE = Clinical Alignment and Resource Effectiveness; CMS = Centers for Medicare & Medicaid Services; IP = inpatient; UTI = urinary tract infection; ICU = intensive care unit.
Lessons Learned

- Organization-wide engagement from the executive level to the caregiver is needed to improve and sustain quality.
  - Quality must be routinely monitored. Bethesda posts robust dashboards in every unit and compares performance against national benchmarks.
  - Quality updates should come directly from the physician leaders for their respective service lines.
- Health care organizations across the region must clearly understand the role of the LTACH. For example, short-term acute care hospitals need to recognize that the LTACH can help them address their own length of stay issues and create a win-win for both types of providers, as well as for patients.
- Initiatives to increase patient compliance and engagement are vital to patient and family satisfaction.
  - Bethesda holds an “early update meeting” with the patient, key family members and all of the staff involved in the patient’s care (eg, case manager, nurse leader, RN, hospitalist, respiratory therapist) to discuss the patient’s current status, estimated length of stay and prognosis. After the meeting, the family writes down what they heard to ensure everyone is on the same page and to maintain ongoing engagement in the care plan.
  - Familiarizing staff with current patients helps them to customize care. At Bethesda, “Get to Know Me” boards posted throughout the units include such facts as patients’ hobbies and nicknames.

Resource Requirements

- Hospitalist/intensivist physicians on-site for 24-hour coverage
- Extensive educational resources for entire staff on complex medical treatment
- Education for social workers/discharge planners at short-term acute hospitals on appropriate LTACH admission criteria
- Dedicated data and performance management systems to report key metrics
  - Bethesda uses the growing database of the National Association of Long Term Hospitals (NALTH) for benchmarking data.
- Extensive monitoring equipment, including telemetry and ventilators, as well as radiology equipment, including computed tomography and magnetic resonance imaging
- Partnerships with short-term acute care hospitals for any patients necessitating transfer for surgery, cardiac interventions, etc
- Partnerships with home health providers and skilled nursing facilities
  - Following LTACH discharge, most patients will need to be followed by nurses either at home or in a transitional care unit/skilled nursing facility.