Defining Post-Acute Care and Elements to Successful Patient Transitions

Changes to Medicare, which include substantial fees associated with unnecessary rehospitalizations, are driving the need for hospitals to partner with trusted post-acute care providers and closely manage patient transitions. It is beneficial for case managers, discharge planners, social workers, and even nurses to have a working understanding of the varying levels and choices of post-acute care as they are being asked to help make value judgments regarding when and where a patient is transitioned. When discharge teams understand how care is provided at post-acute institutions, "they are better able to ensure a smoother transition of care between settings [which] will ultimately prevent unnecessary readmissions," according to Tochi Iroku-Malize, MD, MPH, MBA, FAAFP, SFHM.[i]

DEFINING LEVELS OF POST-ACUTE CARE:

Long-Term Acute Care Hospital (LTACH)

LTACHs provide care for hospital-level medical conditions through comprehensive diagnostics and having the capacity for surgery. The average length of stay must be 25 days or greater and there must be a need for intensive medical care. Patients receive extended periods of care in the LTACH before they are well enough to return home or go to rehab.

Types of patients typically seen in LTACHs include those requiring:

- Prolonged ventilator use or weaning
- Ongoing dialysis for chronic renal failure
- Intensive respiratory care
- Multiple IV medications or transfusions
- Complex wound care/care for burns

Skilled Nursing Facility (SNF)

Patients discharged to a SNF require ongoing long-term nursing care or need short-term concentrated rehabilitation while recovering from surgery or an illness. Sometimes referred to as sub-acute facilities, nursing homes, or convalescent homes, SNFs provide low intensity skilled care in the form of nursing services or rehabilitation to chronically ill patients.

When to use SNF:

- Patient requires 24-hour licensed nursing services, eight hours of which are RN coverage
- Patient may be dependent and require total assistance with activities of daily living
- Patient receives medications by a nurse according to a licensed practitioners order
- Patient requires rehabilitation services

Intermediate Care Facility (ICF)

ICFs serve individuals who do not require the degree of care or treatment given in a hospital or skilled nursing facility, but who (because of their mental or physical condition) require care and services that are greater than custodial care and can only be provided in an institutional setting. ICF services are designed to facilitate transition from medical dependence to functional independence, where the objectives of care are not primarily medical, and a clinical outcome of recovery is desired, or to help terminally ill people be as comfortable as possible at the end of life.

When to use ICF:

- Patient needs licensed nursing supervision and supportive care, but does not require continuous nursing care
- Patient may be semi-independent or dependent
- Patient may need full assistance with activities of daily living
- Patient may need full assistance with transfers
- Patient requires medications from a nurse following a doctor's order
- Patient may need outpatient rehab services
- Resident receives periodic assessments by a licensed practitioner

Long-Term Care (LTC)

The main difference between LTC and SNF is care at a SNF is provided by a medical specialist as opposed to LTC services provided by aides, volunteers, family or friends, and caregivers. LTC services often involve assistance with personal hygiene, using the toilet, getting into and out of bed and chairs, and bathing. Caregivers may also help clients manage finances, communications, and may provide companionship and social interaction. LTC can be for clients in relatively good health but in need of extra assistance. For these people, LTC services in a setting such as an assisted living community may be an adequate solution.

When to use LTC:

- Patient may require full assistance with activities of daily living
- Patient may be semi-independent and may require the assistance of one person for transfers or to evacuate the facility
- Patient may receive assistance with medication or have medications administered by a nurse
- Patient requires general nursing care
- Patient must be free of communicable diseases that could be transmitted to others through the normal course of activities

Home Health Care

Medicare considers home health care to be skilled, in-home nursing care or outpatient therapy services to treat an illness or injury. This type of care helps older adults recover at home from a serious health issue. It is usually less expensive, more convenient, and as effective as care from a SNF, although acuity is typically lower than SNF in a home health setting.

When to use home health care:

- Services must be ordered by a doctor
- Patient requires care from nurse, home health aide, therapies (OT, Speech, PT)
- Patient needs assistance with all or some of activities of daily living
- Patient may be dependent, semi-independent, and have acute or chronic health status
- Patient services are on an intermittent basis, not 24 hours a day
- Patient participates in a plan-of-care developed by a registered nurse

Hospice

Hospice is a special kind of medical and supportive care that focuses on symptom management and emotional support when a patient is expected to live six months or less. Most Hospice care involves active participation in daily care-giving by a family member, friend, or volunteer supported by an interdisciplinary team of hospice professionals.

Hospice misconceptions:

- Hospice is not only for the last three days of life.
- Hospice is not a physical place where patients go to die.
- Hospice is not only for cancer patients.
- Hospice does not deal only with pain management.
- Hospice does not discriminate based on age, gender, race, or religion

HELPING PATIENTS TRANSITION BETWEEN CARE SETTINGS

1. **Patient-centered care** meaning the patient or appropriate representative is involved in the decision making, transfers are consistent with patient goals of care, and appropriate education is provided.
2. **Clear communication** amongst all parties involved from relevant professionals to patient family members, all medication and care plans are collected and available in advance of any transition, and sending and receiving professionals should have reliable contact information for each other.
3. **Safety** that encompasses appropriate assessment of the patient prior to transfer, which includes:
   - Patient's functional and cognitive status
   - Plan of care and advance care directives
   - Current treatment regimen, including all necessary equipment needed
   - Allergies
   - Meal consistencies and preferences
   - Recent labs, consultations, and diagnostic testing results

Although these three elements to successful patient transitions are not exhaustive, they supply a framework for hospital discharge teams and downstream partners to work within. It is important for the discharge team – including case managers, discharge planners, social workers, and nurses – to establish preferred post-acute provider relationships and understand the level of services they provide. Making an informed decision on where to send a patient can help prevent unnecessary hospital readmissions, reduce the cost of care, and ensure the patient progresses toward their health care goals.

[i] https://www.the-hospitalist.org/hospitalist/article/128764/transitions-care/ready-post-acute-care