



EAGLE TELEMEDICINE SOLUTIONS

The Value of Telemedicine for the Long-Term Acute Care Hospital



Eagle Long-Term Acute Care Hospital

EXECUTIVE SUMMARY

With the increasing physician shortage, particularly in specialty areas such as critical care, cardiology and nephrology, telemedicine is delivering valuable support to the clinical care programs at many U.S. hospitals. And now, with the growth of long-term acute care hospitals, telemedicine offers an effective model for bringing periodic specialized physician care to their patients, while solving night coverage challenges.

LTACHS NUMBERS INCREASE

Research shows that an estimated 10 to 20 percent of hospital patients with critical illnesses require prolonged medical care after acute care hospitalization. They might be on a ventilator, or have other needs that require more specialized physician care than a skilled nursing facility (SNF) provides. Centers for Medicare & Medicaid Services (CMS) created a category of facilities called long-term acute care hospitals (LTACHs) to offer this higher level of care. The number of LTACHs has increased significantly over the last 25 years in response to a growing patient population.

Many LTACHs are free-standing facilities. Others occupy a wing or section of an existing acute care hospital. Medicare administration data shows there were 192 LTACHs in 1997; 436 LTACHs were recognized by Medicare in 2011,

with annual admissions increasing from 13,732 to more than 40,000 over those years.¹ Recent figures show 474 LTACHs in the United States.

To qualify as an LTACH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals, and treat patients with medically complex conditions who have an average inpatient length of stay greater than 25 days. Research shows that most LTACH patients don't stay much longer than that. Their average actual length of stay is 30 days.

TYPES OF PATIENTS

Originally, LTACHs were intended for patients in need of prolonged weaning off mechanical ventilator use. (Medicare rules require that patients on ventilators cannot be admitted to an SNF.) However,

present admissions encompass a wide range of diseases. A review of the most frequent DRGs for LTACH patients today shows such illnesses as pulmonary edema and respiratory failure, septicemia, renal failure, skin ulcers and bone infections as well as post-operative and post-traumatic infections. LTACH patients typically require:

- **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**



In our recent experience with LTACH facilities, we have seen brain-injured patients recovering from auto accidents; stroke patients who have had hospital care and rehab care but might be incontinent or have other issues that require long-term attention; and patients who, due to a long-term illness, are too weak to go into a nursing home and need periodic treatment from a physician.

TIGHTER MEDICARE CRITERIA POSE CHALLENGES

In 2015, Medicare began tightening its criteria for LTACH admission. Under the new policy, long-term acute care facilities will be paid at the full Medicare prospective rate only for patients who spend at least three days in an ICU and four days on a ventilator. LTACH care for other patients will be reimbursed on a per diem site neutral rate that amounts to less than the Prospective Payment Systems (PPS) rates on average.

At least one facility, the Partners' Spaulding Rehabilitation Network's 160-bed North Shore hospital in Salem, Mass., announced it would close its doors in the face of steep business challenges with federal reimbursement changes.² On tap for 2017 is a new stipulation that LTACHs receiving more than 25 percent of their patients from a single referring hospital will receive payment reductions.

90% NURSING CARE, 10% PHYSICIAN CARE

Although LTACHs meet a clearly defined need in communities today, it's apparent that the federal government is looking for ways to tighten their Medicare reimbursement. All the more reason, then, for LTACHs to consider more efficient ways to deliver care. Many of them are already struggling with finding the specialists that are typically required for LTACH patients.

LTACH patients don't usually require any higher level of nursing care than patients in SNFs. In addition, the level of care they need from a primary care physician is not intensive. Often, rounding once per day by a primary care physician is sufficient. The average LTACH patient requires roughly 90 percent nursing care and 10 percent physician care each day. It would seem, then, that staffing a LTACH would be easy. But the unique conditions of LTACH patients pose challenges.

With the low-intensity level of nursing and primary physician care comes a higher level of specialized physician care for LTACH patients—requiring more visits by specialists than most hospital patients typically need. Because of the high percentage of patients on ventilators, LTACHs typically contract with pulmonary intensivists who keep a close watch on them to evaluate when the patient can come off the ventilator, be discharged to an SNF, or sent home.

LTACH patients may also need regular access to rehab and select hospital diagnostics such as lab work, X-rays, ultrasound, etc. Unlike many SNF patients whose plan of care might only involve maintenance at existing functional levels or keeping them comfortable in their last days, LTACH patients typically do have hope of recovery. They require a plan of care and physician attention to help them improve during their extended stay. This is the key element that makes LTACHs unique entities in the healthcare system, with requirements for periodic but focused involvement by specialists for extended periods.

HOW TELEMEDICINE CAN WORK FOR LTACHS

Because of their unique profile, LTACHs are an ideal environment for telemedicine coverage. Here are a few examples of how telemedicine can work to help LTACHs ease physician staffing challenges and lower costs while providing consistent, quality care.

Economies of Scale

One telemedicine primary care physician or hospitalist can typically cover rounding requirements for five LTACHs with a total of 100 beds among them—and do it much faster than on-call physicians because they don't have to spend time traveling to facilities where they have patients.

Specialists When Needed

Depending on patient mix at an LTACH on any given day, telemedicine specialists in cardiology, nephrology, neurology and pulmonary care can



be immediately available for remote diagnosis, as well as treatment and counseling to patients and direction to the on-site staff. Telemedicine physicians can do everything an onsite physician can do except perform procedures—so most of the time, they can do what is needed for LTACH patients remotely. In the cases when a specific procedure is called for, a local specialist can be brought in and provided with the diagnosis and recommended treatment plan already established by the telemedicine specialists.

Night Coverage

LTACHs often struggle to find nocturnists to work on site. If they cannot recruit a provider to cover nights, the burden typically falls to the daytime doctors. With a telemedicine team providing comprehensive coverage of night calls, code management and admission, an LTACH can let its physicians recharge and revitalize, knowing their patients are in good hands at night. The telemedicine physicians provide valuable support to nighttime nursing staff and can respond quickly—usually within two minutes of receiving a call or text message for help.

Pre-Emptive Rounding

Other than routine daily rounds, physicians are also needed to do pre-emptive rounding—that is, rounding to spot any declines by patients to prevent a crash or a code blue. LTACH patients are typically stable, but quick declines do occur, especially among patients who have been recently admitted to the facility. This is another task that telemedicine physicians can regularly perform.

Rapid Response

Telemedicine physician response is fast. Most hospital bylaws require on-call physicians to respond to calls within 30 minutes by phone. And then it can take another half hour or longer for the physician to travel to the hospital. All that is avoided with telemedicine. As stated earlier, telemedicine physicians can generally be interacting with a patient in less than two minutes after receiving a call or text message for assistance. This is especially important in cases of stroke or other neurological emergency.

Provide Discharge Planning and Physician-to-Physician Transfer

Regulations require a physician-to-physician transfer whenever a patient is discharged to another facility. LTACH telemedicine physicians can perform this process, as well. Because they are readily available, the discharge can happen more quickly and more efficiently once the patient is ready to be released.

AN IDEA WHOSE TIME HAS COME

According to the American Telemedicine Association (ATA), over half of all U.S. hospitals use some form of telemedicine today. Acceptance of this new model of care is widespread. Not long ago, telemedicine was a great concept that worked in certain specific situations, but wasn't quite ready for prime time. Because the computers and videoconferencing networks involved in early telemedicine took time to "boot up," telemedicine units were often used as coat racks in Emergency Departments

and nursing stations. They just weren't advanced enough for the fast-on-your-feet requirements of everyday hospital care.

All that has changed, however. The latest telemedicine videoconferencing and diagnostic stations are always on and able to respond instantly when they are needed—even in the most intense ED scenarios when seconds can mean life or death for a patient suffering a stroke or other emergency. No longer coat racks, the telemedicine stations have become an integral part of the clinical team—day and night.

TELEMED READY TO GO TO WORK FOR LTACHS

Patients requiring prolonged mechanical ventilation are rapidly increasing in number. Because of improved ICU care, many patients survive acute respiratory failure and require prolonged mechanical ventilation during convalescence. In addition, the rapidly increasing rate of chronic kidney disease in older patients has been described as a "pandemic." These are just two of the reasons why LTACHs are growing in the United States, why the industry is searching for new models of care to meet the unique requirements of their patients, and why telemedicine and the variety of specialties it offers—telehospitalist care, telecardiology, telenephrology, and telepulmonary care—stand ready to help.

References

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