



# Long Term Acute Care Liaison: An Innovative Approach to Reducing Length of Stay in an Acute Care Setting

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## Abstract

Long term acute care hospitals (LTACH) offer the opportunity to provide care to stabilized, critically ill patients. The availability of this transitional care setting, and the need to increase efficiency and reduce costs led to creating the Long Term Acute Care (LTACH) Liaison role. This innovative position optimized throughput and decreased length of stay (LOS) by having a registered nurse analyze potential patients appropriate for LTACH level of care. This evaluation includes assessing patients' transition needs and coordinating and collaborating with members of the healthcare team to develop a comprehensive plan of care. Additionally, the LTACH Liaison communicates with insurance providers to facilitate approval and authorization for LTACH level of care. The LTACH liaison proactively assesses and monitors a patient's progression of care. As a result, complex patients are effectively transitioned to the next level of care. This process has improved capacity management by decreasing LOS without compromising the quality of patient care.

## Objectives

1. Review LTACH level of care and criteria for admission
2. Describe the role and justification for creating the LTACH Liaison in the acute care setting
3. Identify LTACH Liaison responsibilities for patient coordination and collaboration with members of the healthcare team, and development of a comprehensive plan of care for transition.

## What is an LTACH?

- Provides post acute care to medically complex patients who require intensive and/or special medical care and rehabilitation for an extended period of time. This care includes but is not limited to ventilator weaning, cardiac monitoring, hemodialysis, and complex wound management.
- Employs a multidisciplinary team of specialists to address the medical issues and focus on rehabilitation therapies for functional improvement. The end result of this collaboration is implementation of a cost effective, individualized care plan that is patient and family focused.
- Licensed according to state hospital regulations; Certified by Medicare and Accredited by The Joint Commission.

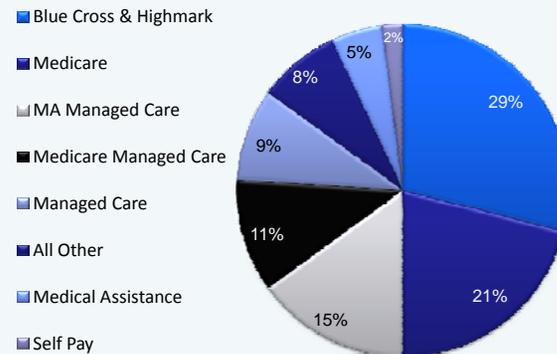
## Rationale for Use of LTACH

Prolonged and extensive ICU stays account for 40% of the critical care dollars spent by acute hospitals directly impacting the availability of ICU beds. The average LOS for an LTACH patient is 25 days compared to a four to five day average hospital stay. Therefore, LTACH is a cost effective and appropriate setting for the sickest patients as a bridge to acute rehabilitation or alternative care setting. Thirty-three to 40% of patients admitted to an ICU are elderly, require mechanical ventilator support to treat respiratory failure, and account for 18 million ICU days annually.

## Other data also show

- 23% of patients with five or more chronic conditions account for 68% of Medicare spending.
  - 31% of this population is hospitalized annually
  - Cost related to hospitalization increases dramatically with each additional chronic condition.
- Nosocomial infection rates are five to ten times higher in ICU patients leading to the potential for an increase in length of stay.
- ICU bed availability is related to better utilization of appropriate level of care beds for critically ill patients.
- MedPac found LTACH care to be cost-effective for targeted patients; patients treated in LTACH have had fewer acute care hospital readmissions.
- LTACH level of care saves Medicare dollars in the acute hospital setting.

## 2010 PSHMC Payor Mix



## LTACH Liaison Role and Responsibilities

The primary role of the LTACH Liaison is to identify, assess, and recommend patients for LTACH level of care in conjunction with the interdisciplinary team. The Liaison also has the responsibility to develop plans to overcome barriers related to care transitions.

- Promotes Patient-and Family-Centered Care by:
  - Communicating with patients and families to provide knowledge and information regarding L-TACH;
  - Educating patients and families about this level of care;
  - Supporting families related to complex critical illness and transitions of care;
  - Communicating frequently and early with patients and families.
- Facilitates and ensures appropriate handoff communication:
  - Reviews data, identifies opportunities to increase referrals, meets with physicians to discuss appropriate referrals to LTACH level of care, and develops plans to overcome obstacles;
  - Provides education and written materials designed to enhance the understanding of LTACH capabilities;
  - Coordinates and collaborates with Medical Center personnel and LTACH liaisons to facilitate transfer of information and expedite transfer;
  - Communicates with insurance companies and obtain approval and authorization for admission and transfer.

## Outcomes Data

### Penn State Hershey: Patients Discharged/transferred to (LTACH)\*

Year	Cases	LOS Outliers	Mean LOS (Observed)	SD LOS (Observed)	Mean LOS (Expected)	LOS Index	LOS Variance (Days)	% ICU Cases	Mean ICU Days	% With Complications
2008	206	8	20.42	15.54	15.15	1.35	1,086	81.55	16.18	21.36
2009	346	12	17.68	11.58	14.58	1.21	1,074	74.57	12.59	16.76
2010	307	10	19.03	16.67	15.40	1.24	1,113	79.15	14.88	20.11

\* University HealthSystem Consortium data

## Considerations for Future Direction

An understanding of Payor Mix and case mix index in today's medical environment is essential, including:

- State Considerations: Does State recognize LTACH level of care?
- Governmental Considerations: Medicare is predominant payer for LTACH and payment is based primarily on patients' principal diagnoses.
- Commercial Payor Considerations: Authorization is typically provided for seven days and based on acuity of illness.
- Organizational capacity management constraints need identified.
- Physician and Advance Practice Clinician concerns regarding oversight and management of patients during care transitions and follow-up care need to be addressed.