Bridging the Gap in Healthcare: Long Term Acute Care Hospital

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Bringing the Gap: Objectives

• Evolution of Long-Term Acute Care Hospital (LTACH)

• Medicare created LTACH services for the Medically Complex

• STACH and LTACH Financial Partnership Opportunities designed by Medicare

• Select Specialty Hospital- Quad Cities Overview
Bridging the Gap: What Is An LTACH?

- Extended acute care for Medically Complex, Critically Ill, or Traumatically Injured patients with multiple co-morbidities not ready for Acute Rehab, Skilled Nursing Facility, or Home.

- Licensed as an Acute Care Hospital

- Certified by Medicare & Accredited by The Joint Commission

- Fully Credentialed Medical Staff

Bridging the Gap: Evolution of LTACH

In the early 1980’s, Medicare conducted national research within Short-term Acute Care Hospitals and Nursing homes analyzing patient quality outcomes in the United States.
Quality Research Discoveries:

- Medically Complex Patients requiring a longer hospital stay statistically showed decline in physical condition. Additionally, patients demonstrated a higher risk of hospital acquired infections the longer these patients stayed at the Short-Term Acute Care level.

- Medically Complex Patients were being discharged to nursing homes. There, a high number of patients acquired nursing home infections, wounds, and readmissions back to the Short-Term Hospitals.
Bridging the Gap: 
The Evolution of LTACH

In 1982, Medicare developed the LTACH program into the Continuum of Care System

Continuum of Care System
- Short-term Acute Care Hospital (<6 days on average)
- Long-term Acute Care Hospital (25-30 days on average)
- Acute Rehab Hospital
- Skilled Nursing Facility
- Home

Bridging the Gap: Medicare Design

- Medicare designed the healthcare system to meet a patient's clinical needs based on the highest level of successful statistical outcomes
- Specialized care will get patients back home sooner
- Utilizing LTACH services has the potential of returning patients to the lower level of care without numerous readmissions to the STACH
- Financially cost-effective for the patient and the STACH
Bridging the Gap: LTACH Core Programs

- Pulmonary/ Vent
- Cardiac/ Heart Failure
- Wound Care
- Trauma
- Medically Complex
- Renal
- Infectious Disease

Bridging the Gap: What's the Difference?

STACH
- Establishes Diagnosis
- Manages Acute Onset
- Surgery
- Implement Treatment Plan
- Average LOS <6 days

LTACH
- Manages Long-term acute needs
- Continues Plan of Care
- Average LOS 25-30 days
Bridging the Gap: Common Goals

• Avoid Hospital Readmissions by providing High Quality Care
• Improves Patient Outcomes
• Reduce LOS
• Return Patients to their Community
• Financial Benefit to the patient and Health Care System

Bridging the Gap: Select Specialty Hospital-Quad Cities

• 50 Bed Free Standing Hospital in Davenport, IA
• All Private Rooms, 6-Bed ICU
• Full Hospital Services
• Credentialed Medical Doctors
• Patients seen daily by Critical Care/ Internal Medicine MD
• ACLS Certified RNs and RTs
• Wound Care Nurse Team
• In house Dialysis
• Full Time PT, OT, ST
Thank You!
Any Questions?

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selectmedical.com/hospitals