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Long Term Acute Care: A Good Fit for New Jersey

BY KERRY McKEAN KELLY

Long term acute care facilities would fill a small but critical niche in New Jersey's healthcare continuum.

Take a look at the healthcare continuum in New Jersey and you see an array of services in a variety of settings. But study it closer and you're likely to see one small gap in the spectrum of services — an appropriate level of care for patients who have an acute condition for an extended period of time.

In industry parlance, that level of care is called long term acute care, or LTAC. And while it's been available in other states for many years, LTAC is only now beginning to emerge in New Jersey. For New Jersey hospitals and their patients, it's a long overdue development that could reap benefits on a number of levels, including increased revenues, better outcomes and reduced lengths of stay.

LTAC's niche on the healthcare continuum lies between traditional inpatient acute care and extended care services such as subacute and skilled nursing. LTAC patients typically have an unstable acute illness or injury, often combined with a complicating condition. Many times, they require technology such as ventilators. And their course of treatment is an extended one, usually defined as at least 25 days.

They're the types of patient Stan Alliker has seen countless times since 1974, when he served as deputy director of Baltimore city hospitals and began operating his first LTAC facility. Now the CEO at Camden County Health Services, Alliker previously served as president and CEO of Levindale Hebrew

Geriatric Center and Hospital, a freestanding LTAC hospital in Baltimore.

"LTAC is designed to provide a level of care that is really hospital level, but a level that is past the initial acute phase and is not going to resolve quickly," said Alliker. "(LTAC patients represent) a small group of people... but they're real and they're out there."

According to Theresa Edelstein, NJHA's assistant vice president of health policy and planning, these individuals have an unmet need in New Jersey.

"Right now, patients who need this kind of care can't be appropriately placed in any of the levels of care that we have," Edelstein said.

Small in Numbers, Profound in Impact

While the pool of potential LTAC patients is quite small, they can have a profound impact on the system as a whole. That's because LTAC patients are the ones who elevate hospital lengths of stay and became outliers in the DRG reimbursement system.

That's a key point in New Jersey, where the average Medicare length of stay is 7.5 days, one-and-a-half days higher than the national average. In addition,

New Jersey's average treatment cost for a Medicare patient is \$6,824, compared with a national average of \$5,804.

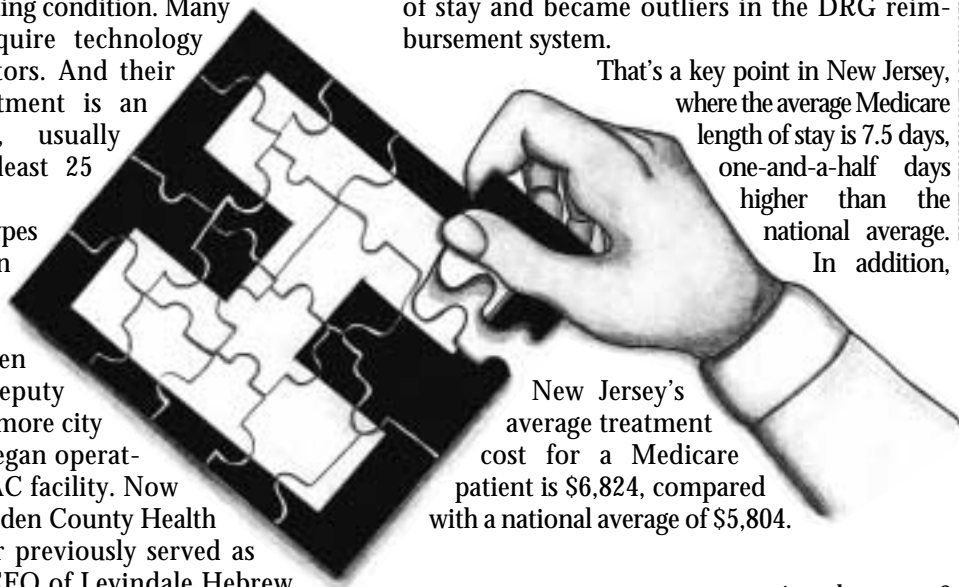


ILLUSTRATION BY PAMELA BROWN-VILLARUZ

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Acute Care ... continued from page 1

An NJHA white paper, released in June with the help of an NJHA LTAC work group, noted that the LTAC population represents just 2 to 3 percent of total discharges from acute care, but can represent as much as 40 percent of the critical care dollars spent by acute care hospitals.

“Right now, patients who need this kind of care can’t be appropriately placed.”

— NJHA’s Theresa Edelstein

Acute care hospitals that treat these long-term patients often don’t receive full reimbursement for the costs of that care. That’s because the Medicare system uses a scale of DRGs, or diagnosis-related groupings, to pay hospitals a single, predetermined rate based on diagnosis. Those rates simply aren’t enough to cover the costs associated with an LTAC patient’s extended stay in a traditional acute care hospital.

LTAC facilities, on the other hand, receive cost-based reimbursement from a separate pool of Medicare dollars.

Acute care hospitals aren’t the only providers who meet with reimbursement woes in caring for LTAC patients. Nursing homes, for example, now operate under a prospective payment system in which Medicare payments are based on national averages. According to Alliker, those new PPS rates are not enough to cover the expenses of these highly complex patients.

Finding the right staffing mix for these patients and making efficient use of supplies are other challenges.

In a traditional acute care hospital, hands-on care is provided by a combination of RNs assisted by healthcare technicians. However, these professionals are accustomed to a quick turnover of patients, and the pace of the unit responds accordingly, said Alliker. Skilled nursing facilities, on the other hand, often rely on certified nursing assistants to augment the

care provided by nurses, yet those CNAs are not trained to deal with the complex issues and high-tech equipment prevalent in long term acute care.

Edelstein agrees.

“The driving force in acute care today is to get the patient out,” says Edelstein. “When someone needs a long course of treatment, the team isn’t focused on that. In LTAC, that is the focus. Because all of their patients have that level of need, the resources, the equipment, the staff are all geared toward that.”

Alliker stresses that LTAC is also important on another critical level — the human level. Traditional acute care hospitals, especially intensive care units where LTAC patients often are treated, simply are not designed to meet the privacy, comfort and other needs of long-term patients and their families. He recalls an incident from his years as an LTAC administrator in Maryland in which a ventilator patient was transferred to an LTAC facility after

two weeks in an intensive care unit. The patient was in tears – tears of relief, it turns out – because he was finally able to get a decent night’s sleep. It seems the patient had spent many sleepless nights in the high-intensity bustle of the ICU.

The lesson learned? “You have to meet their needs in all ways,” says Alliker.

A Need in New Jersey

Both Alliker and other members of NJHA’s work group see a logical place for LTAC in New Jersey. The work group used 1998 Uniform Bill data to determine the benefits LTAC could bring to the Garden State. Those identified benefits included as much as \$50 million in additional federal revenue and a reduction in Medicare length of stay by as much as 10 percent. Other advantages of LTAC include better patient outcomes and a clinically appropriate and financially viable use for underused hospital facilities.

Perspective

GARY S. CARTER, FACHE – President

New Jersey hospitals are bombarded with signals from the Medicare program — reduce length of stay, cut Medicare discharge costs, improve outcomes and quality of care.

And now, sitting before us, is a care option that could help us do all three — long term acute care.

This specialty level of care, long available in other states but only now emerging in the Garden State, would provide the much-needed buffer that long-term seriously ill people need between a traditional acute care hospital stay and post-acute care such as rehab or skilled nursing. Planned strategically and carried out correctly, long term acute care would fill a need without making a dent in the patient base and revenues of the providers who fall alongside it on the healthcare continuum.

Of course, getting there will require serious discussion and strategic plan-

ning between providers and state regulators. It’s a process that’s going on now, and NJHA is pleased to be a part of it.

My hope for those discussions is a well thought-out approach to serve both patients and providers. Other states have reaped the benefits of a successful LTAC strategy for years, and now nearly 280 LTAC facilities are in operation nationwide. It’s time New Jersey enters the LTAC landscape. Taking its cue from common practice already used across the country, I believe New Jersey can arrive at its own approach using general acute care licensing standards.

Adopting a sound LTAC strategy for New Jersey simply makes sense — and it would send the right signal back to those Medicare officials in Washington.



Work Group Offers Criteria To Gauge LTAC Readiness

By KERRY MCKEAN KELLY

For now, LTAC is only available to New Jersey hospitals that already hold an acute care license — in essence, by shutting down an underused hospital. That's the current situation in Dover, where St. Clare's Health Services is awaiting the state health commissioner's final OK on its LTAC plan. (See Page 4 interview.)

NJHA would like to see those opportunities expanded to allow other hospitals to consider an LTAC startup.

LTAC patients represent as much as 40 percent of the critical care dollars spent.

"We're not looking for widespread proliferation of LTACs," explains Edelstein. "But having said that, everyone should have an equal opportunity to consider whether this is right for them."

NJHA is currently engaged in an ongoing discussion with state Department of Health officials to find an appropriate way to expand the state's LTAC options. Among the issues being addressed in those talks are certificate of need requirements, licensing standards and how LTACs could be adequately staffed in the midst of a nursing shortage.

"There certainly remain a number of important issues to be addressed," says Edelstein. "The important thing is that we've started the conversation and are working together to find the right fit for LTACs in New Jersey."

"I don't think anyone believes LTAC will take away the state's length-of-stay problem, but it is another piece in solving the puzzle. If we can all get together and think creatively, I think there's great potential for a new level of care that meets with financial success while better serving patients."

While long term acute care may make good sense for New Jersey, the niche it fills is a small one. An NJHA white paper on the issue suggests that just 1,400 to 1,700 LTAC beds are needed in the Garden State.

That level of need — great in intensity, but small in number — makes it especially important that hospitals and health systems undergo a thorough analysis before jumping into an LTAC proposal.

"The growth in this area should be somewhat limited, because these are resource intensive to open and operate," says Theresa Edelstein, NJHA's assistant vice president of health policy and planning.

With that in mind, NJHA's LTAC work group compiled the following trigger points to assess what makes a successful LTAC facility:

■ **VOLUME/REFERRAL BASES** — To succeed, it's critical that the LTAC facility is located in an area where it can draw referrals from more than its host hospital. That's key to ensuring that the facility's success is not dependent on the census of a single hospital.

■ **PHYSICIAN COMMITMENT** — Physician leaders and clinical specialists must be educated early in the process so they can champion the effort once the LTAC facility is up and running.

Bed capacity — There are unused hospital beds across the state that could be converted to LTAC use. However, these need to be evaluated in terms of their compliance with regulations before being put into operation.

■ **Financial commitment** — A hospital planning to establish an LTAC facility must be prepared for the initial outlay required, but more importantly, must be able to manage the operational outlay for at least six months under a DRG reimbursement system. That's because

a new LTAC facility must be in operation six months under DRGs — and prove it meets the LTAC criteria for length of stay — before receiving Medicare certification as a PPS-exempt facility.

■ **CLINICAL EXPERTISE/COMMITMENT** — Hospitals must ensure that they either have or can attract the physician and nursing leaders and other clinicians required to provide this highly specialized, intensive care.

■ **MANAGEMENT EXPERTISE/COMMITMENT** —

It's especially important that hospitals and health systems undergo a thorough analysis before jumping into an LTAC proposal.

Providers must be prepared to develop the management expertise in this area. And if they're planning to lease space to a proprietary company that will operate the LTAC facility, they must do exhaustive due diligence to ensure that they enter a relationship with a reputable, experienced provider of LTAC services.

■ **GEOGRAPHIC ACCESSIBILITY** — Regardless of whether the LTAC facility is a freestanding one or housed within a larger hospital structure, geographic access for patients, families, physicians and other sources of referrals is critical and must be carefully examined in terms of bed count and number of LTAC facilities.

Interview

Kevin Slavin

BY RON CZAJKOWSKI

Kevin Slavin, a 20-year veteran of hospital and health planning, has been instrumental in developing one of the first LTAC proposals to receive State Health Planning Board approval. The proposal, which would create a 45-bed LTAC at Saint Clare's Dover campus, is awaiting a final sign-off from state regulators. Here, Slavin shares his thoughts on starting up a long term acute care facility.

Q Describe Saint Clare's LTAC proposal.

The Saint Clare's LTAC plan calls for the initiation of a 45-bed long term acute care unit to be located on our newly reconfigured Dover Campus. The program will be located in space that will be made available once all acute care inpatient services are relocated to the nearby Denville campus. We feel that we have all of the necessary expertise in place to develop and implement the LTAC program in the next several months. We are currently focusing on the development of an implementation plan, including medical staff composition and responsibilities, facility plans, support services and operational policies and procedures.

Q How does this fit with Saint Clare's services overall?

The LTAC program is an excellent fit with the proposed reconfiguration of services under way at our campuses. Saint Clare's Hospital is currently comprised of four acute campuses — Dover, Denville, Boonton and Sussex. Due to financial pressures, a reorganization plan of the Saint Clare's acute care facilities was developed calling for the consolidation of all behavioral health services at the Boonton campus; acute, inpatient services at the Denville campus; and the reconfiguration of the Dover campus to focus on ambulatory care, long term care and long term acute care services.

Q How will an LTAC serving Morris and surrounding counties meet community needs?

The initiation of LTAC services at the Dover campus will result in a needed new service being brought to the community and will strengthen the financial viability of that campus. A detailed feasibility analysis determined that there was more than sufficient volume of potential LTAC patients from within the

entire Saint Clare's hospital system. We also expect a large number of regional referrals from throughout Morris, Sussex and Warren counties.

Q What one piece of advice would you offer other hospitals considering the creation of an LTAC?

Carefully evaluate the demand for the service, looking first at internal demand within your existing system or hospital. But most importantly, don't overstate that demand.

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