

After critical illness, long-term acute care hospitalization common, increasing

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From 1997 to 2006, the number of long-term acute care hospitals doubled, the number of Medicare patients who were transferred to a long-term acute care hospital after a critical illness tripled, and the 1 year survival for these patients was poor, according to a study in the June 9 issue of *JAMA*.

"Approximately 10 percent to 20 percent of patients recovering from [critical illness](#) experience persistent organ failures necessitating complex care for a prolonged period of time. Traditionally these patients spent their entire acute care episode in a general medical-surgical hospital. However, in recent years long-term acute care hospitals have emerged as a novel care model for patients recovering from severe acute illness," according to background information in the article. The extent and increases in activity at these hospitals at the national level has not been known.

As defined by the Centers for [Medicare](#) & Medicaid Services, long-term acute care hospitals have average patient length of stay of 25 days or greater and typically provide care for patients who do not require all of the services of a short-stay hospital but still have significant ongoing care needs. "In the post-intensive care unit (ICU) setting, these hospitals act as specialized hospitals for patients requiring prolonged mechanical ventilation and those with other types of chronic critical illness," the authors write. They add that with an aging population, the need and utilization of these hospitals may increase.

Jeremy M. Kahn, M.D., M.Sc., of the University of Pennsylvania, Philadelphia, and colleagues examined long-term acute care hospital utilization following hospitalization in an ICU for critical illness among fee-for-service Medicare beneficiaries aged 65 years or older. The researchers analyzed data from the Medicare Provider Analysis and Review files from 1997 to 2006.

The authors found that the absolute number of long-term acute care transfers, as well as transfers as a proportion of all ICU discharges, steadily increased, with critical care hospitalizations ending in transfer to a long-term acute care hospital increasing from 13,732 (0.7 percent) in 1997 to 40,353 (2.5 percent) in 2006. The number of long-term acute care hospitals increased at an average rate of 8.8 percent per year, from 192 in 1997 to 408 in 2006. Transfers after critical illness increased from 38.1 per 100,000 capita in 1997 to 99.7 per 100,000 capita in 2006, with the incidence of transfers higher for male individuals and black individuals in all periods. Also, the total associated costs increased from \$484 million in 1997 to \$1.325 billion in 2006 (average rate of increase, 12.1 percent).

"Over time, transferred patients had higher numbers of [co-existing illnesses] (5.0 in 1997-2000 vs. 5.8 in 2004-2006) and were more likely to receive mechanical ventilation at the long-term acute care hospital (16.4 percent in 1997-2000 vs. 29.8 percent in 2004-2006). One-year mortality after long-term acute care hospital admission was high throughout the study period: 50.7 percent in 1997-2000 and 52.2 percent in 2004-2006," the authors write.

"The clinical and economic burden of patients with chronic critical illness is significant and likely to expand with the aging of the population and advances in critical care that increase patient survival. Long-term outcomes of the chronically critically ill are poor, with substantial need for new approaches to their care. We demonstrate that long-term acute

care hospitals play an increasingly important role in patients with chronic critical illness, despite scant data to guide decision making about transfer or inform policy decisions about whether to support or restrict this rapidly growing cost center."

"Our results underscore the capability of the medical system to adopt new organizational innovations and highlight the need for a diverse program of comparative effectiveness research to determine the optimal organization of care for patients recovering from critical illness, including the best way to maximize survival and control costs for this high-risk patient group," the authors conclude.

More information: JAMA. 2010;303[22]:2253-2259.

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