Long-term acute care in an accountable care network

For clinical partners considering how an accountable care organization (ACO) coordinates complex hospital care, rehabilitation and follow-up. The case and financial figures in this brief describe an earlier network.

Why an ACO might include LTACH care

An accountable care organization coordinates care across providers with attention to quality, outcomes and spending. A small group of patients may still need hospital-level treatment after the first acute stay. The 2021 source cited 2017 Medicare inpatient data estimating that 0.3% to 3.3% required an LTACH transition in the groups compared. Their care can account for substantial clinical effort even when they represent a small share of admissions.

These patients may have several chronic conditions, prolonged ventilation or another need for physician-directed hospital treatment. A skilled nursing facility, inpatient rehabilitation hospital and LTACH offer different levels of support. Identify which care is still required and which receiving team can deliver it. Remaining in the original hospital, or moving before the next setting is ready, both carry consequences.

Selecting a partner

Document medical coverage, respiratory capacity, rehabilitation disciplines, response to deterioration, exchange of clinical information and the plan for the next transition. Ask how the provider shares outcomes, defines readmissions, identifies patients at higher risk and works with payers. Confirm the scope and dates of any certification offered as evidence.

The source described a former network's focus on respiratory failure and sepsis certification and a historical 2018 readmission figure of 8.6% based on internal data. That number came from a specific provider and period. Request current local measures and their definitions before using an outcome in a network agreement.

Following a person after discharge

The earlier network used an RN call within 24–48 hours of discharge to home, with a primary-care visit targeted within 7–14 days. It described further calls at one week, two weeks and 30 days. Staff checked medicine use, durable medical equipment, appointments, new symptoms and unmet service needs.

For a local care plan, agree on who will make each contact, who receives a report when a concern arises and how a patient can reach help between scheduled contacts. Verify that the patient or caregiver can explain the medicine and equipment plan and knows the next appointment. Record the actual follow-up arrangement for that person.

What the earlier ACO example reported

The historical case described a network with more than 400 physician partners serving approximately 55,000 people. The participating provider reported managing network and care-management functions during the early years of the partnership. The source described the ACO as being in the top fifth nationally on its reported comparison.

The case reported shared savings of $6.3 million in 2015, $15 million in 2016, $15 million in 2017 and $34 million in 2018. These are ACO-wide historical results, and multiple participants contributed. The archived paper does not isolate the savings attributable to one hospital or establish a savings target for Lakeview.

Evidence to request before comparing arrangements

Ask for the assigned population, period, financial benchmark, reconciliation method, risk adjustment, quality measures and whether figures refer to total savings or the amount distributed. For care measures, clarify the denominator, follow-up window and handling of transfers. The original sources were the 2017 Medicare Provider Analysis and Review file, former-network internal readmission data and 2018 CMS ACO data.

Network questions for a case review

If a patient is being considered for skilled nursing, ask whether the next provider can safely manage the current airway, monitoring, treatments and therapy needs. If the patient is staying in acute care, ask which treatments require the present level and what would allow a safe transfer. Include what the patient and family prefer and what the payer has confirmed.

The historical case also discussed risk-bearing agreements and closer coordination of network and care management. Before comparing those arrangements, ask which entity controlled the network, which party carried financial risk, which services were included in the benchmark and how patient choice was preserved. A network's shared savings and a hospital's readmission rate are different measures.

Talk with Lakeview

Call Lakeview Admissions at (262) 534-8509 to discuss a referral. For clinical records, use the referral fax at (262) 534-8507.

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