A POST-ACUTE CARE GUIDE FOR PROVIDERS AND CLINICIANS

What You Need to Know About Post-Acute Care (PAC) Services to Support the Needs and Goals of Your Patients and Their Families

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Section 1. Introduction

The Massachusetts Health & Hospital Association (MHA) prepared this guide to assist providers and clinicians in making the best recommendations to their patients about the care that they may need following a health event.

Many people need care after a health event to recover from an injury, illness, surgery, and/or hospitalization. Some people may need comfort care or end-of-life care. It is very important that your patients receive care that will meet their individual needs. We hope this guide helps you to make the best recommendations for your patients.

This guide provides the following information:

- The essential elements of a successful process
- The range of post-acute care (PAC) services
- Three provider checklists to support your patient's care transition process
- A list of key terms and concepts to build into your understanding of PAC

Post-Acute Care

Post-acute care services play an important role in our healthcare delivery system. Health insurers often refer to these services as "PAC" services.

Many people may require continued post-acute care to support recovery and improve functional status following an illness, injury, surgery, or hospitalization, and to meet their hospice and palliative care needs.

Massachusetts has many options for post-acute care. Services range in focus from recuperation, rehabilitation, chronic disease management, skilled nursing, and end-of-life care.

Services may be provided at home, in an outpatient clinic, or in a facility such as a skilled nursing facility (SNF). Services may be provided via telehealth. Services should be consistent with the needs and goals of the patient and recognize their social determinants of health.

Section 2. The Essential Elements of a Successful Process

In this section, we have outlined a handful of key goals and some of the essential elements for providers and clinicians to consider in making the best recommendations for their patients.

Key Goals for Providers and Clinicians

- Support patients on their path to optimizing quality of life
- Understand patient and family goals and needs
- Engage with patients consistently; be available and committed
- Evaluate decisions though the lens of health equity
- Practice effective communication, ask questions, and listen carefully
- Provide education to patients and families, with clear explanations
- Ensure the right services and supports are in place for patients going home
- Address underlying concerns and help patients/families feel confident about care transitions

Essential Elements

Element 1. Find out about the patient's goals and life context. Providers should seek information from patients and families about the context for care, such as personal goals; social and cultural backgrounds; health beliefs and attitudes; advanced care directives, such as a Medical Orders for Life Sustaining Treatment (*MOLST*) form; living environment; lifestyle; socioeconomic status; insurance coverage; degree of family and social supports; and other relevant factors. Providers should understand what matters most to the patient. This process should involve the patient's care partner or designated caregiver, if one is available. This approach will help to ensure that providers make the best recommendations for additional treatment and/or support, based on the patient's needs, preferences, values, and expectations. Consider The Joint Commission's (TJC) Health-Related Social Needs when completing this assessment, which explores patients' access to transportation, difficulty paying for prescriptions or medical bills, education and literacy, food insecurity, housing insecurity, and access to high-speed broadband services in their residence.

Note: the state is transitioning the MOLST system to the digitally-based POLST (Portable Medical Orders for Life-Sustaining Treatment) in summer of 2024, with rollout continuing into 2025. For more information on transition from MOLST to POLST, click here.

Element 2. Inform your patients about post-acute care services. The post-acute care (PAC) landscape can be fragmented and confusing for patients and family members, and for providers. Communicating specific information about the range of PAC services will help patients make the most informed choices possible. For each PAC service, it's important to understand clinical indicators and qualifying criteria, intensity, duration, level of care provided, and associated costs and insurance coverage. PAC plays a vital role in the healthcare continuum; it is positioned between acute care and long-term services and supports. Explore the services available for your patient if they are enrolled in managed, integrated, or accountable care programs. These programs may offer benefits of care coordination as well as more options for home-based support.

Element 3. Work together as a team and speak with one voice. Working collaboratively as an integrated team will help healthcare and social service professionals arrive at a consensus about post-acute care (PAC) planning. In relatively straightforward cases, one team member, such as a case manager or care coordinator, may recommend a choice of PAC to patients and family members as a matter of course. Sometimes, there is disagreement. When there are different perspectives on PAC planning between patients and families, it is important for providers to bring a clear and simple explanation to patients and families to help them understand the differences between services.

Element 4. Make the care transition process a smooth one. The transition from hospital to post-acute care (PAC) often begins right after a patient is admitted to the hospital or healthcare facility. PAC providers are essential but often untapped partners within the healthcare system. The ideal process includes tight communication and effective collaboration between hospitals and PAC providers working together and in partnership with community organizations. The goal is to deliver the greatest value to patients and minimize care disruptions and readmissions. The ideal process should bring together patients and their family members and healthcare providers across the continuum of care to set the patient up for the best possible outcome.

Providers May Want to Present PAC Options to Patients

Once patients and family members have a basic understanding of the condition and PAC options, providers may want to begin framing the goals early in the discharge planning process. Consider presenting a range of possibilities with contingencies and the best option to the patient. Patients may only qualify for certain levels of PAC based on their needs.

"Given our clinical experience and your home situation and preferences, we think the best PAC option may be _____."

In clinically complex patients or those with complicated living situations, it may be ideal to schedule a family meeting to discuss options as a large group. The role of team members in such a meeting is to present their clinical observations and rationales for recommendations. (For a more detailed discussion about running a family meeting, please see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3681449/.)

Providers don't necessarily have to agree with the PAC choice a patient makes. They should respect them, however, and provide the information and resources and support to maximize the chances of their success.

Section 3. The Range of Post-Acute Care Services

Post-acute care services refer to a range of healthcare services to support a patient's recovery and maximize their functioning, often following a hospitalization. PAC services can offer comfort care or end-of-life care to a patient.

Key Facts to Consider

- Post-acute care is often referred to as "PAC"
- PAC services can address many different clinical scenarios
- PAC services can either be provided at home, in an outpatient clinic, or in a facility
- Patients' individual goals, needs, and preferences are critical to understand
- Most patients receive home health services at home to support their recovery
- Some patients live in an assisted living community where they can receive PAC services
- Health insurers vary in how they cover PAC and what they will cover
- Treatment options and services differ from patient to patient
- Factors to consider include length of stay, hours of therapy, diagnosis, treatment plan
- Community social services and supports are critical to supporting the patient and family
- Long-term services and supports (LTSS) overlap with PAC services to support patients

Post-Acute Care

- Post-acute care services include home health services; medical services; therapy services, including occupational therapy, physical therapy, and speech therapy; nursing care; hospice and palliative care services; telehealth; behavioral health therapy; and recovery supports.
- PAC services can be provided at home, in an assisted living residence, in an outpatient setting, skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term acute care hospital (LTACH).
- The chart on the following page presents examples of the most common types of facility-based care (the chart does not present examples of PAC services for behavioral health conditions, including mental health and/or substance use disorder treatment services).

Setting	Services
Outpatient Rehabilitation	
Clinical indications	Sports medicine injuries, loss of physical function, loss of balance, cognition, speech impairments, pain, loss of function
Types of care	Orthopedic injuries, amputee care, post-concussion treatment, stroke recovery, task management, speech
Skilled Nursing Facility (SNF)	
Clinical indications	Nursing therapy and medical needs, after a hospital stay
Types of care	Stroke care, cancer care, orthopedic recovery, wound care, cardiac and pulmonary recovery
Inpatient Rehabilitation Facility (IRF)	
Clinical indications	Intensive therapy (3 hours/day), nursing and medical needs for significant injury or illness after hospital stay
Types of care	Aggressive rehabilitation for spinal cord injuries, brain injuries, trauma injuries, stroke, amputee
Long-Term Acute Care Hospital (LTACH)	
Clinical indications	Intensive medical, nursing needs, and therapy care.
Types of care	Recovery for ventilator weaning, wound care, organ transplant, cardiopulmonary disease, cancer

Other Services and Supports for Patients

Community-Based Social Services and Supports

- Social services and supports, including meals, food, housing supports, transportation, broadband access, and non-medical transportation

Long-Term Care Services and Supports

- Long-term care services and supports (LTSS), including home and community-based services (HCBS) and facility-based services for those with long-term needs
- LTSS services include unskilled home care, personal care attendant services, transportation, durable medical equipment, and many other services

Section 4. Provider Checklists to Support Care Transitions

The purpose of this checklist is to give providers and clinicians a simple way to confirm that you have considered the key issues affecting patient success during care transitions, prior to discharging patients from the hospital to home or hospital to facility-based care.

The Care Transition Process

Care transitions are the most important part of the process, yet often the most difficult part of the process for patients. When patients move from one environment to another environment, they are exposed to new risks. The checklist is intended to mitigate these risks.

#	Questions to Consider When Patient is Going from Hospital to Home	Check
1	Is discharge from the hospital premature?	☐
2	What are the patient's individuals needs and goals?	☐
3	Who is in charge during the care transition process?	☐
4	Does your patient understand your instructions for discharge?	☐
5	Does your patient have a loved one who will be there on the day of transfer? Who is going to be your patient's "eyes and ears" on Day 1 of your patient's transfer? Is this person available for the entire day?	☐
6	Are services in place for discharge?	☐
7	Does your patient have what they need at home to be successful? Does the patient have enough help at home? Does the patient have enough food at home?	☐
8	Does your patient have enough money to fill prescribed medications? Does your patient have someone who will fill their medications? Does your patient understand your medication instructions?	☐
9	Does your patient have transportation to follow up appointments? Does your patient need to have a follow-up appointment scheduled before discharge?	☐
10	Does your patient need medical equipment or remote patient monitoring technology at home?	☐
11	Does the patient have access to broadband services and devices at home?	☐

#	Questions: When Patient is Going from the Hospital to a Facility	Check
1	Is discharge from the hospital premature?	☐
2	What are the patient's individuals needs and goals?	☐
3	Does the patient have a signed Health Care Proxy and/or POLST form? Have the documents been shared with the facility? Is it in their electronic medical record?	☐
4	Are facility staff ready to care for the patient? Has transportation been arranged?	☐
5	Do facility staff have complete clinical information on the patient? Do facility staff understand functional status and cognitive needs of the patient?	☐
6	Does your patient meet the qualifying hospital stay requirements for a facility?	☐
7	Have you spoken to admissions staff at the facility to ensure that the facility has received all necessary information and paperwork? Have you provided the information? Is a call warranted? Has a nurse-to-nurse report been completed?	☐
8	Will your patient need post-acute care upon discharge from the facility?	☐

PAC Planning Process

The purpose of this checklist is to provide providers with a simple checklist to support the best post-acute care planning process.

#	Questions to Consider During the Planning Process	Check
1	Has the team established a person-centered care planning process?	☐
2	What are the patient's needs and goals? Does the team understand the patient's goals, needs, values, and social needs and family context? Does the patient have an advanced care directive (POLST form), and is it up to date?	☐
3	Has the team discussed the options for PAC services?	☐
4	Does the patient understand the full range of PAC options?	☐
5	Has the team reached internal consensus about the PAC recommendation?	☐
6	Has the patient been engaged throughout the process?	☐
7	Has the team discussed time frames, duration of care, and potential obstacles with the patient and family?	☐
8	What will the patient's insurance cover in terms of services and costs?	☐
9	Is the family caregiver aware of and in agreement with the plan for PAC?	☐
10	Does the patient know who to contact for follow up questions or concerns?	☐

Section 5. Key Terms and Concepts

Providers and clinicians will want to be familiar with these concepts and build them into their decision-making relationships with patients. Follow the links to learn more about each concept.

- **Ableism**.
  http://cdrnys.org/blog/uncategorized/ableism/
- **"Dignity of risk."**
  https://www.resourcesforintegratedcare.com/physical_disability/dcc/webinars/dignity1
- **Disability**.
  https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html
- **Health equity.**
  https://www.cdc.gov/chronicdisease/healthequity/index.htm
- **Health-Related Social Needs (HRSNs)**
  https://www.cdc.gov/health-equity-chronic-disease/social-determinants-of-health-and-chronic-disease/index.html
- **Independent living philosophy.**
  https://ncil.org/about/aboutil/
- **Integrated care.**
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5354214/
- **Long-term services and supports.**
  https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
- **Lived experience of disability.**
  https://www.resourcesforintegratedcare.com/physical_disabilities/disability_competent_care/webinar/webinar2/lived_experience/2013
- **Patient-centered care.**
  https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559
- **Person-centered care**.
  https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care#:~:text=Person%2DCentered%20Care%3A%20Integrated%20health,make%20effective%20care%20plans%20together.
- **Recovery model.**
  https://namitm.org/mhr/10fcr/
- **Social determinants of health.**
  https://health.gov/healthypeople/priority-areas/social-determinants-health
- **Social services and supports.**
  https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.0170
- **Supported Decision Making.**
  http://www.supporteddecisionmaking.org/
  http://www.supporteddecisionmaking.org/state-review/massachusetts

MASSACHUSETTS Health & Hospital ASSOCIATION

Care After the Hospital: Guide to Post-Acute Care

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