Title

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Journal

Journal of the American Geriatrics Society, 68(3)

ISSN

0002-8614

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Publication Date

2020-03-01

DOI

10.1111/jgs.16317

Peer reviewed

Reply to Comment on: The Clinical Course after Long-Term Acute Care Hospital Admission among Older Medicare Beneficiaries

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Word Count: 367

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We appreciate Dr. Dawson's and Dr. Grigonis' interest in our study.[1] We agree that the field needs further comparative effectiveness studies to evaluate how LTACH care compares to other post-acute care alternatives, which will require sophisticated analytic methods to address selection bias. However, this is beyond the scope of our current paper, which is intended as a foundational descriptive study to better characterize the clinical trajectory of older adults after LTACH transfer. We benchmarked mortality and recovery to hospitalized older adults who were not transferred to an LTACH for context. Given the unadjusted nature of these analyses, we deliberately avoided making any causal inferences about whether the observed outcomes were "resultant from care at an LTACH".

With regard to our "high acuity subgroup," we retrospectively applied the federal CMS site-neutral payment criteria to more closely approximate the contemporary LTACH population. An updated prognostic assessment of LTACH patients in the site-neutral policy era will require waiting several more years, as the federal policy will not be fully implemented until the end of 2020. As the authors suggest, there likely is variation in outcomes among this high acuity subgroup by individual LTACHs, potentially mediated by a volume-outcome relationship for chronically critically ill patients, but this will require further study.

Through our descriptive analysis of national Medicare data, we discovered that after LTACH transfer, older adults face an uphill and often insurmountable struggle with a significant burden of inpatient utilization and high mortality rates, yet have incredibly limited access to specialty palliative care and very low use of hospice at the end-of-life.[2,3] We are encouraged that Dawson and Grigonis, members of one of the largest LTACH providers nationwide, acknowledge the need for LTACHs to better incorporate geriatric and palliative care into their facilities. In addition to the ethical considerations raised by Dawson and Grigonis, we would like to reiterate that palliative care improves clinical outcomes,[4] and is considered the standard of care among patients with similarly poor prognoses due to cancer or other advanced illnesses. Future research is needed to identify the burden of unmet palliative care needs in this population, and to design and test new models of how LTACHs and other post-acute care settings can meet these needs.

ACKNOWLEDGEMENTS

Conflict of Interest: The authors have no conflicts of interest to disclose, financial or otherwise.
Author Contributions: Manuscript preparation: ANM; Critical revision of manuscript and final approval: all authors
Sponsor's Role: The study sponsors had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript.

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