

Shorter acute care hospital stay, longer stay in post-acute care facilities

In recent years, a reduction in the duration of acute-phase hospital stays, per episode of care, has inevitably resulted in longer stays in post-acute care facilities (Barnett et al., 2017).

This reduction may be linked to the inpatient prospective payment system, applied by Medicare in the past 30 years in the US, and also in other countries (Guterman et al., 1986; Coulam et al., 1992), which has had profound implications, in particular, for the costs and efficacy of post-acute rehabilitation facilities, which are rarely properly recognized and adequately supported by national public health systems.

Discharging patients “quicker and sicker” has a significant impact on the scope for applying more aggressive rehabilitation in patients with functional limitations, because of the general medical conditions and complications of “sicker” patients. In fact, although shorter hospital stays do not seem to have had a negative effect on mortality, it would be more meaningful to measure their impact on disability (Barnett et al., 2017). Aspects to consider with regard lower-resource settings, such as post-acute care facilities, are their lower risk of iatrogenic harm, and also their safety, but it is also necessary to evaluate how safe it is to transfer patients with unstable vital functions to such settings, and how likely it is that the iatrogenic risk will be spread to post-acute care facilities. This has already been seen with nosocomial infections and colonizations in rehabilitation care settings (Bilavsky et al., 2012). Indeed, patients with more severe and complicated clinical pictures, discharged from intensive care units, often require increasing rates of emergency department visits, aggressive antibiotic therapies and even longer stays in post-acute care facilities; in addition, recurrent medical complications can make it difficult to apply more intensive rehabilitation in these patients (Formisano et al., 2017).

Furthermore, in the measurement of home-to-home time for patients with complex conditions, the rate of hospital readmissions and the final outcomes should also be taken into account (Morrisey et al., 1988).

These concerns and the question of the efficacy of early rehabilitation are well illustrated by the population of patients with severe brain injury (Formisano et al., 2017).

Indeed, the interval from brain injury to admission to rehabilitation facilities seems to increase with age, brain injury severity, the presence of tracheal tube, and the percentage of transfers back to acute care wards from rehabilitation settings, because of medical, surgical or neurosurgical complications (Formisano et al., 2017).

Thus, the final question is: “Is there actually any benefit from early rehabilitation?”

In fact, the better recovery and more positive outcomes reported after early rehabilitation might be due more to lower severity of brain injury and lower rates of complications in the acute and post-acute phase than to the time of starting rehabilitation.

International recommendations on the inclusion criteria for admission of patients with severe acquired brain injury to post-acute rehabilitation settings should be mandatory (Taricco et al., 2006), and only more global and complete evaluations of hospitalization episodes would actually measure the real efficiency of patient care.

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