Rehabilitation’s Role in Decreasing Returns to Acute Care

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Objectives

- Participants will verbalize three primary reasons for skilled nursing facility patient’s return to acute care hospitals.

- Participants will demonstrate understanding of the role of each therapy discipline in the treatment of patients with cardiac, pulmonary and other medical diagnoses.

- Participants will communicate a minimum of two strategies for engaging their rehabilitation staff in the care of their medically complex patient population.

- Participants will demonstrate knowledge of key Medicare guidelines for rehabilitation services for the care of patients with medically complex conditions.
Rehospitalization Rates Within 30 Days of Discharge

Tremendous Opportunities Exist to Better Manage Patient Care After Discharge From Acute Care Hospitals

>35% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

Medicare Patients’ Use of PAC Services Throughout an “Episode of Care” (1)

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<tr>
<td>Intensity of Service</td>
<td>10% RR</td>
<td>2% RR</td>
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<td>7% RR</td>
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<td>21% RR</td>
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Patients’ first site of discharge after acute care hospital stay:

- Short-term acute care hospitals: 2%
- Long-term acute care hospitals: 10%
- Inpatient rehab: 41%
- Skilled nursing facilities: 9%
- Home health care: 37%

Patients’ use of site during a 90-day episode:

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<th>2%</th>
<th>11%</th>
<th>52%</th>
<th>21%</th>
<th>61%</th>
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(1) Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System
* Source: Kaiser Family Foundation, 2012 statehealthfacts.org, and AARP 2011 projections
News by the Numbers

- 39.5 million hospital discharges per year = $329.2 billion
- 20% of all hospitalizations are rehospitalizations within 30 days
- 23% of patients older than 65 are discharged from the hospital to another institution
- 20% of Medicare patients readmitted within 30 days – only half had a visit to a physician in the 30 days after discharge

Agency for Healthcare Research and Quality, Project RED The Re-Engineered Discharge, JCR’s AHRQfunded Project, Webinar, April 2010
Readmission Penalty - CMS’s Top Conditions Will Expand to Four in FY 2015

- Pneumonia
- Heart attack
- Heart failure
- COPD (FY 2015)
- Elective lower extremity total joint replacement (Proposed rule for CY 2015)

- Coronary artery bypass graft
- Percutaneous transluminal coronary angioplasty
- Renal failure
- Urinary tract infection
- Sepsis
- Cerebral vascular accidents

These three conditions made up 10% of hospital discharges in 2009.
Readmission - STACHs D/C 40% AMI, HF, Pneumonia Patients to Post-Acute Care

Advantage Care Positioning System
2009 Medicare, 100% Standard Analytic File claims data from CMS.
Other = different acute hospital from original incident of care episode
SNFs Are Part of the Answer

- Treatment and stabilization of acute problem
- Medication management
- Management of secondary diagnosis or co-morbidity
- SNF and hospital need to be together on:
  - Rehab
  - Patient education
  - Eventual patient D/C to home
PPACA Report

- Medicare Payment Advisory Commission (MedPAC) 2005
  - 17.6% of hospital admissions resulted in readmissions within 30 days of discharge
  - 11.3% within 15 days
  - 6.2% within 7 days

  - 9.6% of Medicare beneficiaries were readmitted to the hospital within 30 days
  - 34.0% within 90 days
  - 56.1% within one year of discharge

- MedPAC - readmissions within 30 days accounted for $15 billion of Medicare spending.
Quality Concerns with Readmissions

- Unplanned readmissions are stressful to patients and their families
- Unplanned readmissions are costly and resource intensive
- Potential adverse effects of rehospitalizations can include:
  - Delirium
  - Deconditioning
  - Development of pressure ulcers
  - Hospital acquired infections
  - Unintentional weight loss/poor nutrition
  - Use of restraints
  - Urinary catheters
Fears and Anxieties Emerge:

- Nursing centers and hospitals viewed as prelude to death
- Failing health
- Institutionalization
- Loss of decision making
- Increased dependence
- Financial uncertainty
- Separation from loved ones
- Feelings of rejection
Facilities – Key Areas to Assess

Does Your Facility...

- Receive complete and accurate admission information from all disciplines from referral sources/sites?
- Have a process for referral to interdisciplinary team members?
- Communicate assessment results within interdisciplinary team with identification problem list or “red flags”?
- Utilize a patient discharge checklist outlining expectations and goals for safe discharge?
- Implement assessments to identify signs/symptoms, complications and possible resolutions prior to readmission to the hospital?
- Utilize a process to refer to hospital if a rehospitalization is required?
Interventions That Led to a (Significant) Reduction in Readmissions Within One Month of Discharge Included:

- In-hospital daily visits by care coordinators and pharmacists, combined with post-discharge phone calls (proportion readmitted: 10 percent vs. 38 percent in usual care; p<0.05) (USA)61

- Comprehensive geriatric assessment and *multidisciplinary intervention* (DEED II Study) (proportion readmitted: 61 percent vs. 82 percent in usual care; p<0.05) (Australia)62

- Care transitions intervention with in-hospital visits, home visits and telephone follow-up by a transition coach (proportion readmitted: 8.3 percent vs. 11.9 percent in usual care; p<0.05) (USA)63
Why Are Patients Readmitted to the Hospital?

- Faulty care transitions
- Medication mismanagement
  - Not taking prescribed dosage
  - Polypharmacy
  - Cost issues
- Communication between facility caregivers and physicians
- Exacerbation of primary disease
- Cognitive/physical dysfunction
TARGET Assessment Tool - The 9Ps - The BOOST Program

Tool for Addressing Risk: a Geriatric Evaluation for Transitions

- Prior hospitalization
- Problem medications
- Psychological
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Palliative care
- Physical function

www.hospitalmedicine.org/boost
What Does the Research Say About Therapy?

• One unexpected finding was that a high level of usual physical activity was associated with a 46% reduction in the risk of admission.

• Identification of risk factors that were potentially amenable to modification showed that lack of rehabilitation and poor inhaler technique were the most frequent associations.

Key Elements of Rehab Roles

- Be familiar with sign/symptoms of disease process (decline)

- Proactive communication with nursing staff at all times
  - Identifying appropriate admission
  - Alerting nursing staff to issues
  - Communicating with interdisciplinary team (IDT) members related to concerns ongoing D/C planning
  - Ongoing patient education to prepare for D/C
Coverage for Therapy Services in SNF

• Not diagnosis specific

• The determining issue is whether the skilled services of a health care professional are needed, not whether the beneficiary “will improve.”

• These services are provided by or under the supervision of skilled personnel and are covered by Medicare if the services are needed to maintain the individual’s condition or prevent or slow his/her decline.
Fundamentals of Therapy Intervention

- Standardized testing tools
- Ensure “best practice”/evidence-based care for each individual patient
- Individualized care/treatment
- Use of objective tests and measures – baseline and outcome measures
- Ensure patient engagement
Therapy Partnership with Facility Team to Develop Diagnosis-Specific Protocols

- Medication management (cognitive assessment)
- Energy conservation/work simplification
- Specific protocols/standards of care
- Utilization of discharge checklists (ensure safety and knowledge transfer)
- Ensure patient engagement
- Structured and complete hand-off of care to other providers
- Include thorough and complete patient/family education throughout the episode of care and ensure understanding at and before D/C
Setting Expectations for Your Therapists

At Evaluation

- Ensure knowledge of facility/site’s initiatives and process
- Assess patient’s readiness for change
- Assess patient’s current knowledge and education needs (a patient education resource)
  - Condition/disease
  - Medication management
  - Benefits of exercise/therapy and risks of non-compliance
  - Safety
- Use objective tests and measures
- Establish patient’s baseline and safe range for vitals and lab values
- Assess family involvement, knowledge, and support of patient
Setting Expectations for Your Therapists

Developing the Plan of Care

• Frequency, intensity, duration matches patient medical status
• Includes formal patient education plan with handouts
• Condition/disease
• Medication management
• Benefits of exercise/therapy, risks of non-compliance
• Safety and when to contact the provider
  - Measures to encourage patient/family engagement
  - Designed to ensure thorough and continuous patient and family engagement and education
  - Uses established protocols/evidence-based practice
Throughout Episode of Care and Before Discharge:

- Monitor vital signs before, during and after treatment
- Be alert for S&S of possible worsening or exacerbation of condition
- Try multiple interventions
- Ensure patient engagement
- Consider a home evaluation
- Ensure patient/family competence with education provided
- Assess executive functioning of the patient/family
At Discharge...

**Prepare Formal Hand-Off**

- Education/exercise handouts
- When to contact provider
- Date of your follow-up with patient/receiving facility
- Formal communication strategy with physician and next level caregivers on concerns and risks
Physical Therapy Scope of Practice

- Gait, locomotion, balance
- Mobility and transfers
- Pain management
- Aerobic capacity/endurance
- Ventilation – pulmonary
- Wound care – including debridement
- Wheelchair seating and mobility
- Central nervous system assessment
- Environmental modification
- Orthotic, prosthetic and supportive devices
- Work integration/reintegration
- Postural stability
- Electromodalities
- Assistive and adaptive equipment
• Cognitive assessment and treatment
• Self-care/activities of daily living and home management
• Motor and neurological assessment
• Work integration/reintegration
• Functional mobility

• Assistive/adaptive equipment
• Environmental modification
• Postural assessment
• Wheelchair seating and mobility
• Sensory integration
• Therapeutic exercise
• Orthotic/prosthetic devices
• Electromodalities
• Oral dysphagia
Speech-Language Pathology
Scope of Practice

- Comprehension – Auditory and reading
- Communication – Expressive and receptive skills (Aphasia), voice quality, fluency
- Cognition
- Dysphagia – Pulmonary, oral, pharyngeal and esophageal phase, postural control
- Oral Motor – assessment and treatment
Steps for Success

Take inventory of rehab department materials and equipment to ensure appropriate tools and assessments are available.

- Vital signs: O2 saturation, blood pressure, heart rate, respiratory rate
- 6-minute walk test
- BORG rating of perceived exertion
- Edema measurement
- Manual muscle test
- Respiratory: posture, breathing pattern, cervical auscultation
- Activities of daily living assessment
- Cognition – brief cognitive assessment tool
- Medication management forms and tools
- Energy conservation tools
Ensure the Relationships Are Strong - Early Identification

- Therapists spend 45-60 minutes with each patient
- Therapists may be the first to notice changes in the patient’s physical or cognitive function
- Open dialog must be encouraged and rewarded:
  - Small changes are addressed when observed
  - Standard 24-hour communication process
  - Clear feedback loops
  - No-blame culture
Identify Strategic Opportunities

- Establish Who Partner for Key Clinical Focus Areas (Nursing and Therapy):
  - Pulmonary
  - Cardiac
  - Wound care
  - Medically complex
Identify Strategic Opportunities

- Partner With Key Physicians:
  - Develop standardized protocols
  - Promote standard feedback loops for physicians
  - Identify key physician relationships to enhance patient outcomes
Therapists’ Value to Your Program

Your Therapy Team Has Received Education On:

- Pharmacology
- Gross anatomy
- Pathophysiology of disease
- Functional implications of disease processes
- Central nervous system assessment and intervention
- Functional capacity and task segmentation
- Assessment of cognitive function

Most therapists are able to synthesize information from multiple sources and develop an appropriate plan for the patient, and assist with risk assessment and mitigation.
Strengthen Your Strategy

Integrating your therapy team into the rehospitalization strategy could be the missing link in many facilities.
Current vs. Future...and the Roadblocks
Audience Questions and Participation

We’d like to open the floor to any questions you may have.

Thank you for your time!