

# Strategies to Overcome the Loss of Graduated Therapy

AMRPA  
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Jim Haulihan



- Develop strategies to engage the treatment team in looking for ways to meet, not defeat, the challenging patient
- Track and trend outcome data for low level patients as part of the PI process
- Provide 8 Strategies to Overcome the Loss of Graduated Therapy

- Term used by some in the industry to describe the 3-10 day Medicare evaluation/trial period.
- As part of the 2010 IRF Final Rule, the 3-10 day Medicare evaluation/trial period was removed.
- “....we believe that it is no longer appropriate to allow up to 10 days in an IRF merely to assess the patient. At that point, the average IRF patient would already be preparing to be discharged. In addition, we believe that, in today’s clinical environment, licensed physicians with training and experience in rehabilitation are able to assess a patient prior to admission to an IRF and determine whether there is a reasonable expectation that the patient can participate in and benefit from treatment in an IRF.....”

- Tracking and trending our non-admissions, which are broken down into 13 categories or reasons why the patient was not admitted.
  - Focus: Patients not admitted to our IRFs for being:
    - “Too Impaired Functionally”
    - “Too Impaired Medically”
- Our fear was that we would see an increase of non-admissions in these 2 categories since CMS would no longer allow for the 3-10 day evaluation/trial period.
- Q1 and Q2 impact nationwide uncertain but the number of IRF admissions was down approx 5% throughout the industry



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**How Do You Get There?**

# Development of Strategies to Limit Non-Admissions

- Establish buy-in from Unit Leadership
- Communicate Clear Expectations to Staff
- Early engagement of Family/caregiver
- Daily Team Stand-Up Meeting
- Improved Therapy and Nursing Relations
- Working Closely with your MD
- Individualized Scheduling
- Collaboration with Other Post-Acute Providers

- Often, the biggest barriers to admission of low functioning, high acuity patients resides in Unit Leadership
  - Medical Director/rehabilitation physician
  - Director of the IRF
  - Nurse Manager
  - Case Manager/SW
- All members of Unit Leadership must be on the same page regarding patient selection, as their respective staffs will look to them for guidance
- May bring to light perceived areas of weakness

# Communicate Clear Expectations to Staff

- Verbally review case with MD prior to presenting the pre-admission screen
- Get Staff to buy-in to taking low functioning, high acuity patients
  - Challenge them to provide the best inpatient rehabilitation care in your area
  - Use national benchmarks as targets for what you want the IRF to achieve
    - FIM Gain
    - Discharge to Community
    - Case Mix Index
  - Share Success stories with staff about low-functioning patients who have met or exceeded LTGs to help motivate staff
    - Case Studies

# Communicate Clear Expectations to Staff

- Increase Staff Awareness
  - Notify staff of low functioning patients prior to admission
    - Gives them time to formulate a plan
- Work with team to recognize “success” in treating low functioning patients
  - Celebrate those successes
    - Open Houses
    - Patient Satisfaction data
- Work with team to set appropriate STG and LTG
  - Can be the most difficult for the rehab team to accept
  - May want to give up on the patient after a week because not progressing as quickly as other patients

- Discuss rehab potential with patient/caregiver early in process
- Increases the likelihood of preparing the patient/family to get the patient home after their rehab stay
- Established “buy-in” from the family into the goals of the rehab program
- Begin family training from the start of the rehab program versus waiting until the end

- Daily interdisciplinary 15-minute meeting including therapy, nursing, SW/CM, and the MD.
  - Builds bridge between therapy and nursing
  - Inclusion of MD can assist in rectifying any patient participation issues
- Focus: Discussion of any changes in patient status overnight and to discuss plan for the day

- Daily Team Stand up will assist in building the foundation
- Therapy and Nursing will need to work together to schedule based on each patient's Nursing Care Needs
  - Don't schedule low functioning/high acuity patients for the first session of the day in the PT/OT gym during the first week of their IRF stay
- Close working relationship between therapy techs and nursing aides is optimal
  - Patient transportation must be considered when moving to 30-minute therapy increments

- Allows team to assist MD in identifying and overcoming any current or potential barriers to therapy participation
- Have MD visit patient 1:1 if refusing therapy for that day
- MD can then be proactive in ordering psychology/psychiatry consult or starting meds in attempts to improve participation with therapy

- Patients must be scheduled based on their individual needs not the therapists needs
- Therapy schedule broken down into 30-minute increments
  - High acuity patients will have difficulty tolerating 60-minutes of therapy in the beginning of their IRF programs.
- Spread 3 hours out throughout the day
  - Remember that SLP counts towards the 3 hour rule

# Individualized Scheduling

Room	8-830	830-9	9-930	930-10	10-1030	1030-11	Lunch
210	PT1	PT1				OT1	
211	OT1	OT1				PT1	SLP
212			OT1	OT1	PT1		
213		PT1	OT1		OT1		
214			PT1	PT1		OT1	

- PT and OT work in teams
  - Incorporate nursing into the teams too
- Make use of specialty equipment (BWSS)
- Consider co-treatments between PT and OT in the beginning of stay

- Options for Collaboration with other post-acute providers to allow for optimization of this patient population:
  - LTACH
  - SNF
  - Home Health
- Establish partnerships or agreements with these post-acute providers in your area
- Both parties must be flexible to do what's best for the patient

- HPI: 62 year old right hand dominant female who on 2/8/2010 experienced acute onset of right-sided weakness and subsequently diagnosed with ischemic Left CVA with Right Hemiparesis and slurred speech. Admitted to IRF 7 days post CVA.
- Comorbid Conditions:
  - Morbid Obesity
  - Acute on Chronic kidney disease
  - Prior CVA
  - Type 1 Diabetes Mellitus
  - Hypertension
  - CAD
  - Hyperlipidemia
  - Chronic Anemia

- Lives with husband in single story home
- PLOF: Modified independence with cane and rolling walker in community due to impaired LE strength secondary to multiple back surgeries, which were complicated by infections and neurogenic claudication
- Patient currently on disability
- 1-step threshold into her home
- Husband works long hours (6am to 4pm, 5 days/wk)
- No money for hired caregiver, no close family or friends able to assist post-discharge
- Patient Goals
  - Return home with husband
  - “I want to be able to walk better”

- OT Eval
  - Eating – Supervision using Left hand
  - Grooming – Min Assist due to strength and coordination
  - Bathing – Not safe for patient on admission and patient declined
  - UB/LB dressing – Dependent
  - Toileting – Dependent (used lift)
  - Toilet Transfer – Max Assist x 2
  - Tub/Shower Transfer – Not tested due to safety
  - Impaired coordination and proprioception

- PT Eval
  - Bed Mobility – Max Assist
  - Transfers Bed/Chair/Wheelchair – Mod Assist x 2
  - Walk/WC – not tested due to safety
  - Fair static sitting balance
  - Poor static standing balance
    - Dynamic standing balance not tested
  - Weakness in trunk for upright posture, anterior pelvic tilt with thoracic extension
- Speech Language Pathology evaluated patient and worked briefly on higher level cognitive tasks, but discharged patient in first week as patient was at baseline level of cognition

- Low Back Pain (4/10)
- Morbid Obesity
- Max Assist to Dependent for most functional tasks
- Fall Risk

- OT
  - Mod Assist of one for UB dressing at edge of bed
  - Supervised set up for grooming/hygiene tasks in sitting
  - Max Assist of one for toileting
  - Mod Assist x 2 for reach pivot transfer to bedside commode
- PT
  - Bed Mobility Mod Assist of one and Min Assist of second person
  - Bent pivot vs. slide board transfer Mod Assist of one and Min Assist of second person
  - Sit to stand with Mod Assist of one and Min Assist of second person

- PT and OT co-treatments (only used as necessary)
- Focus on sitting in midline for UE dressing
- Low squat in sitting to retrieve clothes in seated position
- Sit to Stand with table/mat raised on the left
- Transfers – broken into components (bed, WC, mat)
- WC to mat with slide board
- Sitting edge of mat with WB into B/L UE's on stools
- Work in sitting with forward reach in preparation for standing
- Pre-gait activities: focusing on weight shift to left

- Bed Mobility - Mod Assist of one
- Bent Pivot Transfer – Mod Assist of one and Min Assist of second person
- Sit-to-Stand Transfer – Mod Assist of one
- Sitting Balance – Good with tactile cues for lateral flexion to get into midline
- Ambulation – beginning from raised mat
- Standing Balance – Min Assist x 2 for clothing management
- Grooming – Min Assist of one seated at sink

- 22 day LOS
- Met and surpassed all LTGs
- Grooming – Independent in sitting
- Bathing – Mod Assist seated
- Toileting – Min Assist
- Transfers – Min Assist
- Ambulation – Min Assist 50 feet with RW
- Husband trained to assist at home
- Discharged home with husband

- Co-treatments as needed, progress to use of aide and individual treatments as able
- Use of specialty equipment for transfers
- Proper positioning devices for treatment
  - Stools, hi-lo mats, bedside tables, phone books, ace wraps, etc
- Prepare the environment for success