DECISION MAKING AND DISCHARGE PLANNING IN THE ACUTE CARE SETTING

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LEARNING OBJECTIVES

• Review healthcare statistics about discharge planning
• Discuss various discharge destinations
• Explain different parts of Medicare
• Describe difference between Medicare and Medicaid coverage
• Discuss the challenges of acute care therapy and discharge planning
• Discuss a therapist's role in this setting
• Explain differences in decision making between new and seasoned therapists
• Describe all of the different factors that have an impact on decision making
• Explain the importance of all teammates involved in discharge planning and their role
HEALTHCARE STATISTICS (7)

In 2017, U.S. healthcare costs were $3.5 trillion, 17.9% of gross domestic product. That translates into an annual healthcare cost of $10,739 per person in 2017 versus just $146 per person in 1960. Healthcare costs have risen faster than the average annual income.

Statistics continued (7)

Two reasons for increase:
- Government policy
- Lifestyle changes

DEMANDS AND CHALLENGES OF ACUTE CARE (8)

- 2000
  - 65+ years: 35 million
  - 80+ years: 9.3 million

- 2030
  - 65+ years: 71 million
  - 80+ years: 19.5 million
DILEMMAS IN ACUTE CARE

• How do I know where to send my patients?
• What if I am wrong?
• How do I educate my patients on the differences in facilities?
• How do I keep track of which payor source covers what for my patient?
• What if I recommend a disposition that their insurance won’t cover?
• What if I recommend rehab and they send the patient home? Should I change my note?
• What if the doctor doesn’t agree with my recommendation?
• What if the patient or family doesn’t agree with my recommendation?
• What if my patient leaves without what they need?

HOW DO YOU PROBLEM SOLVE?

• Do you ask for help?
• Do you look up things on Google?
• Do you ask other clinicians for their opinion?
• Do you go with your gut and hope for the best?
• Do you trust what you have learned and make the decision and stick to it no matter what?
• Do you learn from your mistakes?
• Do you read what other clinicians have done and learn?

THERAPY PRIMARY FOCUS IN HOSPITAL

"For hospital-based physical therapists and occupational therapists is patients' mobility and self-care abilities to determine the need for skilled care evaluating, which drives discharge planning."

"Ensuring that patients are discharged to post acute care settings that match their health and social needs."

"Patient-centered care is a core dimension of healthcare quality and safety that prioritizes respect for patients' wishes and values in clinical decision-making."
PHYSICAL THERAPY IN ACUTE CARE (4) (5)

“...Required to have in-depth knowledge of multiple body systems across a person’s life span in order to accommodate for the variable mix of patients who are admitted to acute care.”

“Must show proficiency in reading medical charts, identifying contraindications to physical therapy and communicating with various health care professionals.”

“Must assess the benefits of physical therapy intervention against the potential risks it poses to the patient’s medical condition.”

OCCUPATIONAL THERAPY IN ACUTE CARE (17,19)

- Ensure a safe discharge home through early evaluation within 48 hours of admission, congruent education, and effective intervention in addition to discharge planning recommendations, and effective discharge planning.
- Make or facilitate changes to the home environment to make it safe and easy for the patient.
- Assist with the return home by helping the patient regain the basic skills needed for daily living, such as personal care.
- Ability to view goals as learned and discharged into the community, providing appropriate transitions to either post-acute care (PAC) setting, chemistry of long-stay (LOS), and meeting quality of care (QOC) needs.
- Ability to monitor data on the patient and report important information, in the ICU after a short hospitalization, leading to a decrease in ICU and general floor LOS by 1 day and 2.6 days, respectively.
- Collaboration early mobility decreases LOS by helping:
  - Improve function
  - Mitigate narcotic or sedative use
  - Improve respiratory status in patients who are critically ill
- Can contribute to reducing LOS and readmissions if they emphasize interventions targeting:
  - Prevention
  - Wellness
  - Patient and caregiver education
  - Safety
  - Self-management and quality of life for all patients, especially those with multiple medical comorbidities or who are critically ill

OT CONTINUED (18)

- Assessments focus on personal and domestic activities of daily living (ADL) to predict level of care and adaptive equipment requirements in order to manage safe hospital discharge
- Informal assessments—self-care (including showering, dressing, home environment, and transfers), functional abilities were the most frequent areas assessed
- The majority of the assessments were concerned with the clients’ ability to manage in their home once discharged (such as barriers in the home environment, self-care skills and meal preparation) with others being directed towards the performance components (such as cognitive and upper extremity functioning)
- Cognitive assessments were used most frequently (56%)
- Most occupational therapists believe that greater accuracy can be achieved by observing clients carrying out ADL tasks and/or by doing specific cognitive assessments
One study found that participants rarely considered using standardized measures as it was “quicker and easier to use their clinical observation skills” or to ask clients for feedback.

Other reasons for clinicians not using standardized tools for assessment include pressure of clinical workloads and therapists’ lack of familiarity within the range of assessments available for acute care practice.

While informal assessments are quick to administer, Welch and Foster in their audit of occupational therapy concluded that a lack of standardized tools resulted in difficulty communicating the outcome of assessments to the health team.

The Modified Barthel ADL Index and the Structured Anchored Approach to Functional Assessment (SAAFA) were both tools that were used and quite successful.

“The systematic triage system reduced the number of therapy evaluations that were not appropriate by 29%, resulting in an improvement in the availability of therapy services for patients whose required skilled care.”

In this article, they used a decision tree to help guide the decision-making process for the appropriateness of a consult.

“Discussion with nurse managers to define services that were within the scope of nursing practice in contrast to services that required a physical therapist or occupational therapist. Nursing staff members also were invited to in-services covering topics such as range of motion, safe transfers of patients, and mobilization techniques.”

**TRIAGING – AN ONGOING, DAILY PROCESS**

- Things to consider when triaging a consult
  - Time of consult
  - For discharge
  - Or for discharge planning?
  - Does the patient have ACUTE or NOW needs to be addressed by a therapist?
- Things to consider when triaging a treatment
  - When were they last seen?
  - What is their discharge location?
  - What is their frequency?
  - Are they making daily gains? Will they regress if not seen daily?
  - Is the nurse, nurse aide or provider asking for the patient to be seen strictly from a mobility standpoint or ADL standpoint, not a reason that requires true therapy skill? (i.e. getting to the chair or taking a bath/shower)
  - This is a difficult task that takes practice in order to do it well and efficiently
COMPREHENSIVE ASSESSMENT OF FUNCTIONAL STATUS (5)

• 35% of patients 70+ showed a decline in activities of daily living function between hospital admission and discharge
• Patients who experience this decline may not be able to return home as a result

IMPORTANCE OF THE ASSESSMENT (1) (5)

“Physical therapists and occupational therapists attempt to accurately project discharge needs using information available at hospital admission and their first visit with a patient.”

In a study by Jette et al, physical therapists appeared to use a patient’s level of functioning and disability as the core dimension in their initial decision-making process. They were guided by 4 constructs when making a discharge recommendation:
- Patients’ functioning and disability
- Patients’ assets and needs
- Patients’ ability to participate in care
- Patients’ discharge setting

BOSTON AMPAC (1)

• “The AM-PAC measures 3 functional domains: basic mobility, daily activities and applied cognition.”
• The lower the number, the lower the functional mobility level
• Advantages of these instruments:
  - completed quickly
  - provide discrete data that can be entered into an electronic medical record as part of the documentation of therapist visits
  - completed through direct observation or estimation of patients’ capabilities based on clinical judgment
  - derived from and scored on the same standardized metric as the AM-PAC instrument, which can be used in any post-acute setting.
• Limitations:
  - discharge destination likely influenced by many factors
  - doesn’t take balance into account
  - “Clinicians’ judgments of patients’ functional capabilities may be more variable than their ability to score actual performance.”
The longer version of the form might be a helpful addition if you are faced with sending the patient home as the only option — this might give you a better idea of their overall mobility level.

Here is the Self Care portion of the Boston AMPAC that can be helpful for our OTs but can also be a screening tool for PTs since you can ask these questions or observe during your session.
BOSTON AMPAC – APPLIED COGNITIVE

• How much DIFFICULTY do you (does the patient) currently have...
  • explaining how to do something involving several steps to another person
  • following/understanding a 10 to 15 minute speech or presentation (e.g., lecture or a place of worship, a guest lecture at a senior center)
  • explaining something that has happened to you so that others can understand you
  • carrying on a conversation with a small group (e.g., family or a friend)
  • telling someone that what they are doing is bothering you (e.g., interrupting or making noise that is distracting)
  • getting to know new people
  • reading a long book (over 100 pages) over a number of days
  • reading and following complex instructions (e.g., directions to operate a new appliance or for a new medication)
  • looking up a phone number or address in the phone book or in your own address book
  • filling out a long form (e.g., insurance forms or an application for services)
  • writing down a short message or note
  • planning for and keeping appointments that are not part of your weekly routine (e.g., therapy, doctor appointment, or a social gathering with friends)
  • remembering to take medications at the appropriate time
  • using a calendar, or weekly activity planner to keep track of appointments and events
  • putting together a shopping list of 10 to 15 items

WHAT OUTCOME MEASURES DO YOU USE?

• So we have outcome measures but a lot of people tend to shy away from using them – or they use the same ones over and over again! Why is that? Let’s keep going and see...

OUTCOME MEASURES (1-16)

• The reported low level of use of existing measures by clinicians may be due to:
  • their length
  • ambiguous interpretation of findings
  • ineffectiveness in facilitating the prediction of an appropriate discharge destination

• The use of standardized tests and outcome measures (STOM) has been suggested to:
  • improve patient care.
  • contribute to an evidence-based approach to clinical decision making
  • allow physical therapists to quantify observations and compare patient status between examination periods
  • facilitate communication and continuity of care for patients transitioning from one health care setting to another
  • increase efficiency of practice
  • help patients recognize improvements in a quantifiable manner
  • facilitate reimbursement under Medicare mandates for functional reporting of percentage impairment.
OUTCOME MEASURES (1, 10, 16)

- In 2009, Jette et al. cited that of the 456 physical therapists surveyed, only 218 (47.8%) indicated that they used standardized outcome measures in practice.
- Physical therapists working in the acute care setting were the LEAST likely to report use of these measures (16%). Additional studies have reported similarly low frequencies of use among rehabilitation professionals.
- Evidence also suggests that even those physical therapists who demonstrate better knowledge of evidence-based practice skills tend to rely on their clinical experience in order to inform their clinical decision making, rather than on evidence-based research. (3)

COMMON PT OUTCOME MEASURES

- Modified Berg
- Tinetti
- DGI (Dynamic Gait Index)
- FTST (Five Times Sit to Stand Test)
- Gait Speed
- TUG (Timed Up and Go)
- Short Performance Physical Battery
- RPE (Rate of Perceived Exertion)

COMMON OUTCOME NORM VALUES (20, 21, 22, 24)

- Tinetti
  - High Fall Risk - less than or equal to 18
  - Moderate Fall Risk - 19-23
  - Low Fall Risk - greater than or equal to 24

- DGI (Dynamic Gait Index)
  - A four-point ordinal scale, ranging from 0-3. "0" indicates the lowest level of function and "3" the highest level of function.
  - Total Score = 24
  - Interpretation: < 19/24 = predictive of falls in the elderly, > 22/24 = safe ambulators

- Modified Berg Norms
  - 0-28 score
  - Low Fall Risk
  - Medium Fall Risk
  - High Fall Risk

- FTST Norms, commonly abbreviated as 5XSST
  - 11.4 seconds for 60-69 years
  - 12.6 seconds for 70-79 years
  - 14.8 seconds for 80-89 years of age group
  - In the hospital setting, if you aren’t sure that they will be able to complete the test, start your stopwatch anyway so that you will have something to compare it to when you make your goal
**RPE (RATE OF PERCEIVED EXERTION)** (25)

- This is a fantastic tool to use to help your patients understand where they are during the rehab and recovery phase.
- It is also a great way to explain to nursing when those “easy” patients get exhausted going to the bathroom but require little assistance.

**SHORT PERFORMANCE PHYSICAL BATTERY**

- This is a great, short tool that combines several of the tests that we have already talked about so far.

**COMMON OT OUTCOME MEASURES**

- Boston AMPAC: Daily Activity
- Modified Barthel ADL Index
- Short Blessed
- AMPAC: Applied Cognitive
- MOCA
- Allen Cognitive Test

- There are some outcome measures that overlap between PT and OT that can be just as informative:
  - Berg Balance Scale
  - Timed Up and Go
  - Functional Reach Test
ADDITIONAL OT OUTCOME MEASURES

• Stroke Impact Scale
• Assessment of Motor and Process Skills (AMPS)
• Performance-Oriented Mobility Assessment
• Action Research Arm Test
• Arm Motor Ability Test
• Wolf Motor Function Test

• Cleveland Scales of Activities of Daily Living
• Patient-Specific Functional Scale
• Activities of Daily Living Index
• Functional Assessment Scale
• Klein-Bell Activities of Daily Living Scale
• Melville-Nelson Self-Care Assessment
• Performance Assessment of Self-Care Skills (PASS)

DISCHARGE PLANNING 101

• Home
  • Without therapy
  • HH (Home Health)
  • OP (Outpatient)

• Acute Rehab
  • Can tolerate 3 hours of therapy a day
  • Has the medical necessity for a doctor to round on them DAILY

• Subacute Rehab a.k.a SNF (Skilled Nursing Facility)
  • Cannot tolerate 3 hours of therapy a day
  • RN-driven care with MD accessible by phone but rounded on weekly

• LTAC (Long Term Acute Care) Hospital
  • Usually needs multiple medical issues handled like dialysis, wound care, ventilated, long term antibiotics
  • Inpatient Psych or Geri Psych
  • Long Term Care (No therapy)

DISCHARGE LOCATIONS (5)

• Patients were 6.9 times more likely to be readmitted when discharged to an extended care facility without physical therapy
  • These patients usually are very ill with a poor prognosis for functional gains

• Patients discharged to an acute rehab facility approached a significantly lower risk of 0.4 times as likely to be readmitted
  • With rehab patients, it is believed that they will tolerate and benefit from at least 3 hours per day of an interdisciplinary rehabilitation.
DISCHARGE PLANNING NEEDS TO BEGIN DAY 1 (1,5)

- Clinicians are usually asked to make recommendations after one evaluation
- The development of a discharge plan for follow-up services for a patient prior to leaving the hospital with the aim of containing costs and improving patient outcomes
- Complex process where many health care disciplines may contribute to the plan, including formal discharge planning coordinators, nurses, social workers, physical therapists, occupational therapists, and physicians
- Figuring out the “best” next level of care is what is the patient’s best interest

COMMON TERMS HEARD AROUND DISCHARGE (2)

- ADDO – anticipated date of discharge
- LOS – length of stay
- Patient flow

PATIENT CONSIDERATIONS (5,9)

**Functional Abilities**
- Overall physical status:
  - Transfers
  - Walking
  - Basic ADLs
  - Cognition
  - The ability to participate in basic, instrumental, and avocational ADLs

**Demographic Characteristics**
- Age
- Socioeconomic status
- Caregiver support and wishes
- Living situation
- Environmental concerns
- Access to formal and informal care
Discharge to the appropriate level of care often is a goal in acute care physical therapy and therapists routinely make recommendations regarding discharge placement and any continuing therapy services for patients.

Failure of the patient to reach optimal health and functional status, increased cost to the hospital and decreased resource availability to others due to increased length of stay and readmission, or possible adverse events or conditions causing harm to the patient.

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ACUTE CARE PHYSICAL THERAPISTS’ D/C RECOMMENDATIONS

• Medicare and the diagnosis-related groups (DRGs)
• This is challenging for many reasons:
  • Therapists often are consulted to work with the patients who are more medically and functionally compromised – patients who are more likely to have negative outcomes than their less compromised peers
  • Therapists often are advocating for additional services for patients, such as discharge to a rehabilitation facility, and the patient’s length of stay often increases as he or she waits for admission to another facility

• “Overall, patients were discharged in accordance with the physical therapist discharge recommendation 83% of the time. When the discharge recommendation was not implemented and recommended follow up services were not received, patient were 2.9 times more likely to be readmitted to our hospital within 30 days of discharge.”

SBAR

Situation

Background

Assessment

Recommendation

SSSBAR is a helpful tool for clinicians to use when they have to call those providers who are intimidating than others. It also helps you not ramble on as soon as you get a provider on the phone.
INPATIENT A.K.A ACUTE REHAB (13)

- Recovering from a serious illness, surgery, or injury and require a high level of specialized care that generally cannot be provided in another setting (such as in your home or a skilled nursing facility).
- Examples: stroke, spinal cord injury, and brain injury.
- You may not qualify for care if, as an example, you are recovering from hip or knee replacement and have no other complicating condition.
- Medicare-covered services offered by rehabilitation hospitals include:
  - Medical care and rehabilitation nursing
  - Physical, occupational, and speech therapy
  - Social worker assistance
  - Psychological services
  - Gastrostomy and prosthetic services

SKILLED NURSING FACILITY (SNF) (13)

- Post-hospital care provided
- Includes services such as administration of medications, tube feedings, and wound care.
- Can be part of nursing homes or hospitals

- During a Medicare-covered skilled nursing facility (SNF) stay, Part A covers:
  - A semi-private room and meals
  - Skilled nursing care provided by nursing staff
  - Therapy, including physical therapy, speech therapy, and occupational therapy
  - Medical social services and dietary counseling
  - Medications
  - Medical equipment and supplies
  - Ambulance transportation to the nearest provider of needed services, when other modes of transportation would endanger your health

SNF PAST 100 DAYS (13)

- Medicare covers up to 100 days of care in a SNF each benefit period.
- If you need more than 100 days of SNF care, you will pay out of pocket.
- You can become eligible again for Medicare coverage of your SNF care once you have been out of a hospital or SNF for 60 days in a row.
- You will be eligible for the new period which includes 100 days of SNF care after another 3-day qualifying inpatient stay.
- If you need medically necessary PT, OT or SLP, Medicare might still cover that but not the room and board.
- You might be better off to receive HH or OP therapy at that time.
- If you have Long term insurance this could be used when Medicare is done covering.
- Others might be able to apply for Medicaid if they have a lower income.
MEDICARE (13)

**Part A**
Inpatient/hospital coverage

**Part B**
Outpatient/medical coverage

**Part C**
Offers an alternative way to receive your Medicare benefits

**Part D**
Provides prescription drug coverage

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**MEDICARE A, B, C**

<table>
<thead>
<tr>
<th>Medicare A</th>
<th>Medicare B</th>
<th>Medicare C - commercial insurance plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 0-20: patient pays full for each benefit period</td>
<td>Other's ability to pay (OPPP)</td>
<td>Takes away everything</td>
</tr>
<tr>
<td>Days 21-100: (Inpatient hospital:00-end, outpatient:00-end, 100% of billed amount less benefits paid)</td>
<td>High-risk private insurance contracts with providers (10-0) or Medicare</td>
<td>Takes over everything</td>
</tr>
<tr>
<td>Days 101 and beyond: patient responsible for all costs</td>
<td>High-risk private insurance contracts with providers (20-0) or Medicare</td>
<td>Takes over everything</td>
</tr>
<tr>
<td>No prior authorization needed</td>
<td>High-risk private insurance contracts with providers (30-0) or Medicare</td>
<td>Takes over everything</td>
</tr>
<tr>
<td>If you are away from the SNF for less than 30 days, you do NOT need a new 3-day hospital stay to qualify</td>
<td>High-risk private insurance contracts with providers (40-0) or Medicare</td>
<td>Takes over everything</td>
</tr>
</tbody>
</table>

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**Part D**
Provides prescription drug coverage

- Medicare Part B covers outpatient PT, OT, and SLP
  - Includes a doctor's office, therapy clinic, HME, or HME
- Original Medicare covers outpatient therapy at 80% of the Medicare-approved amount.
- When you receive services from a participating provider, you pay a 20% coinsurance after you meet your Part B deductible ($198 in 2020).
- If your total therapy costs reach a certain amount, Medicare requires your provider to confirm that your therapy is medically necessary. In 2020, Original Medicare covers up to:
  - $2,080 for PT and SLP before requiring your provider to indicate that your care is medically necessary.
  - $2,080 for OT before requiring your provider to indicate that your care is medically necessary.
- If Medicare denies coverage because it finds your care is not medically necessary, you can appeal.

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MEDICARE VS. MEDICAID

- Medicare and Medicaid are two separate, government-run programs.
- They are operated and funded by different parts of the government and primarily serve different groups.
- Medicare is a federal program that provides health coverage if you are 65 or under 65 and have a disability, or no matter your income.
- Medicaid is a state and federal program that provides health coverage if you have a very low income.
- If you are eligible for both Medicare and Medicaid (dually eligible), you can have both.
- They will work together to provide you with health coverage and lower your costs.
- Also know that while Medicare and Medicaid are both health insurance programs administered by the government, there are differences in covered services and cost-sharing.

MEDICAID

- Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets.
- Each state runs different Medicaid-funded programs for different groups of people including:
  - Older adults
  - People with disabilities
  - Children
  - Pregnant women
  - Parents and/or caretakers of children
- All states also have Medicaid programs for people with limited income and assets who need nursing home care, long-term care services, and home health care services.
- Each state uses financial eligibility guidelines to determine whether you are eligible for Medicaid — your income and assets must be below a certain amount to qualify but it varies from state to state and program to program.
- It is possible to enroll in both Medicare and Medicaid if you qualify — most often this occurs when people need long-term care which Medicare does not provide.
- Medicaid can also pick up all of the out-of-pocket costs that Medicare leaves behind. Medicaid spend-down program is offered in some states — where it allows you to deduct your medical expenses from your income so that you can qualify for Medicaid.
- If you have a low monthly income and few assets, you may be eligible for coverage through Medicaid to pay for Medicare costs, for example copayments and deductibles, and for health care not covered by Medicare, such as dental care and transportation to medical appointments.

MEDICAID WITH MEDICARE

- If you are eligible for Medicare and have a sufficiently low income, you may qualify for help from certain Medicaid programs in your state.
- Qualifications:
  - Your earned and unearned income, including wages and Social Security payments.
  - Your assets, including checking accounts, stocks, and some property.
  - Your nursing care and long-term care needs.
  - You must meet your state's functional eligibility criteria (standards for assessing your need for help with activities of daily living, such as toileting, feeding, and dressing).
- Each state sets its own standards.
- Medicaid programs vary by state, but below are some Medicaid programs available to Medicare beneficiaries in all states. Medicare will pay first, then Medicaid will pay second for qualifying costs.
  - Aged, blind, and disabled (ABD) Medicaid — doctor’s visits, hospital care, medical equipment, but it may not be adequate coverage if you have long-term care needs.
  - Medicaid home and community-based waiver (HCBS) waiver program — this is to help you stay at home or in a community-based setting like an assisted living facility (ALF), can cover personal care, homemaker services, case management, adult day care, skilled nursing care, and therapy services.
  - Institutional (Institutional Medicare) — for residents in nursing homes, covers nursing home services, including room and board, nursing care, personal care, and therapy services.
MEDICAID FOR LONG TERM CARE

- Institutional Medicaid: All states have a Medicaid program for individuals who need nursing home or long-term care that provides general health coverage and coverage for nursing home services including:
  - Room and board
  - Nursing care
  - Personal care
  - Therapy services
- If you need nursing home level of care or meet nursing home functional eligibility criteria:
  - Have income and assets below certain guidelines (the program will consider you and your spouse together – you can typically set aside a certain amount of income and assets for spouse to keep – this amount will not be counted when you apply for Medicaid)
  - If you qualify, you will be able to keep a small amount of your income for a personal allowance (which the amount varies state to state)
  - You pay the remainder of your income to the nursing home

LTAC

- LTAC – acute care hospitals that provide treatment for patients who stay on average, more than 25 days and most come from an ICU:
  - Comprehensive rehab, respiratory therapy, head trauma treatment, and pain management
  - One or more serious condition
  - Okay for Medicare – does not need authorization
  - Must have three medical needs (wound care, dialysis, IV abx)
  - Some plans have LTAC benefits and others don't

SC vs. NC

- It is easier for NC patients to go to SC facilities than it is for SC patients to go to NC facilities
- If they only have Medicaid, they can only go within their state
- However, if they have Medicare (federal level) they can go anywhere
- This will vary from state to state and is becoming a much larger issue in terms of coverage and what services LTACs will provide

VETERANS ADMINISTRATION

- VA benefits: if you are a veteran and qualify for VA benefits, health care and prescription drugs that you get through the VA may be the cheapest
- The VA may also cover services that Medicare will not cover for you
- VA benefits do not work with Medicare, and if you receive care outside of a VA facility you might need Medicare
- Medicare does not pay for any care at a VA facility
NOVICE THERAPISTS (4, 18)
• Felt less confident
• More reliant on more experienced peers
• "They tend to rely on "textbook" approaches and standard workplace procedures."
• More likely to seek validation from others more often
• "The transition from novice to experienced practice lies partly in the motivation of the clinician to learn and to undertake reflective practice."
• So what can help?
  • Clearly outline expectations – job, performance, etc.
  • Mentoring program
  • Make sure newer therapists understand that the senior therapists are only there to help, not assess
  • Prepare them for making the discharge decisions by developing the skills to prognosticate around conditions and relate functional implications

EXPERIENCED THERAPISTS (4, 18)
• Made decisions with a practical certainty
• Higher levels of self-confidence about practice and decision-making ability
• More creative
• More familiar with a wide variety of problems
• Develop a network of information in long-term memory
• Better able to predict safety

DISCHARGE PLANNING (4)
• Skills required in the hospital setting:
  • In-depth knowledge of multiple body systems across a person’s life span in order to accommodate for the variable mix of patients who are admitted to acute care
  • Proficiency in reading medical charts, identifying contraindications to physical therapy, and communicating with various healthcare professionals
  • Assess the benefits of the therapy intervention against the potential risks it poses to the patient’s medical condition
**DISCHARGE BARRIERS (5)**

- Planned vs. unplanned admissions
- Patient refuses placement
- Patient refuses to go home
- Patient insists on rehab
- Family won't come in for training or answer the phone to discuss plan of care
- Insurance denies the level of care the patient needs
- Patient didn't get the therapy recommended at the next level of care
- Has no insurance
- Has no family
- Only has medical needs, no functional needs

**CLINICAL DECISION MAKING (15)**

- Four themes—
  - Collection and analysis of medical information,
  - Application of specialized physical therapy knowledge,
  - Communication to gain information,
  - Communication to provide information—

**COLLECTION AND ANALYSIS OF MEDICAL INFORMATION (15)**

- Determine medical stability
- Patient presentation
- Plan of action for therapy session or evaluation
- Test results like x-rays
- Surgical interventions
- Diagnostic reports
- Activity orders
- Weight-bearing status
- Vitals – BP, HR, O2 saturations
- Lab values
APPLICATION OF SPECIALIZED PHYSICAL THERAPY KNOWLEDGE (15)

• "We're the experts in mobility and safety from a mobility standpoint. So, we're consulted in order to give our opinion on a patient's ability to move and function"

• Participants noted that physical therapists are concerned with the quality, efficiency, and functionality of movement, not just the ability to move.

• Participants noted that their specialized knowledge about movement and function was what separated them from nurses or technicians who might walk up and down a hallway with a patient for the sake of getting the patient out of bed.

• Another participant described physical therapists' distinct role in facilitating patients' independent mobility: "I think that the nurses...tend to do more for the patient than the patient may actually need, whereas we go in with the mindset of letting the patient do as much as they can on their own."

• Participants believed that their specialized knowledge and focus on safe, effective, and independent functional mobility were what made physical therapists' role in the acute care setting unique. Put succinctly by one participant, "I don't think anyone has the training we have as far as movement dysfunction."

COMMUNICATION TO GAIN INFORMATION (15, 4)

• Perpetually acquired information about their patients from a variety of sources...with patients, families, and team members such as nurses, physicians, and case managers to collect information regarding patients' status and progress

• Speaking with nurses and physicians to gain information about a patient's status and progress since the previous session was thought to be essential to efficient and effective care. Gaining information from patients and family members regarding the living situation and the amount of assistance a patient would have at home influenced the interventions selected during the course of the patient's stay in the acute care setting

COMMUNICATION TO PROVIDE INFORMATION (15)

• Let the patient and family know how the session went
• Let the nurse know how the session went in terms of vitals, oxygen, etc.
• Let the nurse and the nurse tech know about the patient's functional abilities
• Let the MD know the final verdict – can they go home??
• Another participant said, "I'll also check in with the case manager, so that they can start planning" (PT-7).
CONTINUAL DYNAMIC ASSESSMENT (15)

Continual assessments involved a moment-to-moment process of adapting interventions, adjusting goals, and responding to an intervention.

NEEDED TO BE READY TO MAKE QUICK DECISIONS ABOUT ADAPTING IN THEIR CARE AT ANY GIVEN TIME, DEPENDING ON HOW A PATIENT WAS REACTING.

CONTINUAL DYNAMIC ASSESSMENT INVOLVED A WITHIN-SESSION, MOMENT-TO-MOMENT PROCESS OF ADAPTING INTERVENTIONS, ADJUSTING GOALS, AND ADJUSTMENTS AT EACH TREATMENT SESSION REGARDLESS OF THE SEVERITY OF THEIR CONDITIONS.

CONTINUAL DYNAMIC ASSESSMENT

PROFESSIONAL RESPONSIBILITY (15)

Having a strong sense of professional responsibility to their patients, coworkers, and institutions and to the profession.

Upheld this responsibility through maintaining standards of practice, educating others about their practice, providing education to other health care professionals to enhance their safety, and advocating for the best patient care and outcomes.

Participants viewed maintaining competence as a way in which to promote professional responsibility.

Participants also noted the obligation to use evidence in practice to uphold standards and provide the best care for their patients.

High-quality care also meant ensuring that skilled and appropriate physical therapy care was delivered. This responsibility included making decisions about which patients should receive physical therapy services and how best to provide that care.

PROFESSIONAL RESPONSIBILITY (15)

• Discrepancy between what happens and what is perceived to have happened during our session.

• "Interns and residents think our role is purely just walking, as opposed to doing true assessments of gait, of balance, of mental status, of safety" (PT 10).

• Educate those about our role as a therapist! Correct the misconceptions!

• Advocate for your patients!

• Let the team know the safest way to mobilize the patient in therapy absence.
COMPLEX ENVIRONMENT

- characterized by a fast pace, multiple interactions, ubiquitous high-tech equipment, and the precarious nature of patients' health and physiological states
- influenced all aspects of physical therapy care in the acute care setting as well as the roles and responsibilities of the physical therapist working in it
- required the understanding of medical information and the application of specialized knowledge and dictated the need for continual and rapid assessments
- Making critical decisions with a status change, worsening of mental status or potential recurrence of hemorrhaging in the brain, recognizing abnormally neurological findings that physicians had not noted, understanding the need to defer treatment when blood pressure was unstable, and knowing precautions for avoiding negative effects on surgical procedures
- Decisions have to be made quickly!
- Work quickly, efficiently and usually in a small space with a lot of stuff
- Multistep
- Participants noted that providing patient care in this complex environment required both not only effective communication skills but also the ability to think quickly and work efficiently with a large number and a wide variety of people throughout the day

DECISION MAKING – MICRO LEVEL

- Micro-level decisions included within-session decisions regarding the content of examinations, intensity of exercise, or duration of sessions and between-session decisions about frequency of treatment
- Another participant described this type of decision making as it related to considering the impact of patients' medications after cardiac surgery on her management decisions: "If they're requiring blood pressure support with pressor medications, then I'm not going to see them. I would be cautious of a patient who's requiring medication to control chest pain. These situations would indicate that they're not hemodynamically stable and they might require further medical or surgical intervention"

DECISION MAKING – MACRO LEVEL

- Major focus of participants' decision making was determining goals that supported discharge plans and moved patients toward leaving the hospital
- Based on the "big picture" and went beyond patients' stays in the acute care setting
- Participants indicated a break in their discharge planning continuum in macro-level decisions: "It depends on the diagnosis. It depends on discharge plans. It's what discharge planning is. It's what determines where you go from here. It's what discharge planning is trying to get to" (PT-16)
- Emphasized the importance of macro-level decision making, particularly in relation to patients who were transitioning from acute care to rehabilitation: "That's where we really get to make a decision whether a patient can go home or go to rehab or what their process moving" (PT-4)
The acute care setting is one in which patients who are medically unstable are treated, the physical therapists in our study needed to use knowledge about pathophysiology, symptoms and findings related to red flags, treatment precautions and contraindications, pharmaceutical benefits, adverse effects and interactions, and normal versus abnormal physiological responses to movement both before and during treatment sessions.

The physical therapists in our study also needed to know the appropriate information to collect to derive an analytically sound plan of care. The physical therapists monitored, quickly interpreted, and responded to various types of data to ensure the safety of their patients.

In the clinical reasoning process described by our participants, medical knowledge and specialized physical therapy knowledge interacted in several ways:

- considered how movement might compromise medical stability or how medical conditions or medications might affect patients’ physiological responses to movement or posed safety issues.
- The physical therapists understood, anticipated, and planned for these various possibilities. Once the medical status of a patient was understood and anticipatory preparations were made, the physical therapists in our study used their specialized knowledge and skills to evaluate safety and independence in functional mobility.
- Diagnostic reasoning... included gathering and interpreting of information to determine the type or extent of a problem.
- Most of the information used... was derived from watching patients move and assessing the quality of the movement and the physiological response to the movement.
- Similarly, Smith et al described how cardiorespiratory physical therapists used the response to an intervention to improve their understanding of a patient’s condition. Watching patients move has also been shown to be an important source of information for physical therapists’ decision making in other care settings but may focus on impairments in a specific body structure or region.
- Our participants reported focusing on total body function or broad concerns about health, safety, and mobility. This result confirms the findings of a previous quantitative study indicating that more than 80% of the patients seen by physical therapists in acute care settings had goals and interventions related to function, regardless of the type of diagnosis.

Our study attempts to articulate the clinical reasoning processes that appear to be simple and second nature to physical therapists in the acute care setting.

However, the major concerns of physical therapists in the acute care setting, like physical therapists in other settings, are patient safety and functional mobility. We believe that this information may be helpful to those who educate professional (entry-level) physical therapist students in preparing them for practice in the acute care environment.

Foundationally, these processes appear to be similar to those reported in the literature for other physical therapy practice settings. Clinical reasoning in the acute care setting, however, appears to have features that are somewhat different from those found in other settings:

- constant application of medical information
- integration of that information with specialized physical therapy knowledge
- continual dynamic assessment leading to rapid decision making
- a focus on the whole patient and the impact of all physiological systems on the patient’s physical function
- constant communication with many different people
- the application of knowledge of characteristics of various discharge settings
- complex, simple, but-paced environment.
DECISION MAKING (4)

- Short LOS makes it even harder
- Every hospital department is a different set up
- Not all have the same kinds of equipment
- Every therapists’ knowledge base can vary
- Every therapists’ personality, physical and psychological status is different
- Relationship with patient and patient’s family
- Compromises have to be made from time to time

MODEL OF DISCHARGE DECISION MAKING (9)

PATIENT’S FUNCTIONING AND DISABILITY
PATIENT’S WANTS AND NEEDS
PATIENT’S ABILITY TO PARTICIPATE
CONTEXT OF PATIENT’S LIFE
THERAPIST’S EXPERIENCE
SHARING OPINIONS
HEALTH CARE REGULATIONS

Resource availability and accessibility
Judgments about the patient’s ability to function in an environment
PTs appeared to focus on the mobility aspects of functioning and disability, whereas the Ots focused on the cognitive and ADL aspects.
How sick or hurt are they and how long will it take for them to recover?
Am I sending them to the safest place after discharge?
Further from baseline, more likely further from home
DECISION MAKING – PATIENTS' WANTS AND NEEDS (9)

“Therapists said they considered the context in which their patients lived in making decisions about discharge recommendations.”

“Therapists also shared their knowledge and opinions to influence the patient’s and family’s understanding about the setting that would best match the patient’s abilities.”

“Also included a family’s desire and willingness to either care for a patient’s needs at home or support the patient in another health care setting.”

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DECISION MAKING – PATIENTS ABILITY TO PARTICIPATE (9)

“Participation was defined as the ability to actively take part in, direct, and share responsibility for one’s care and its outcomes.”

“Occupational therapists and physical therapists considered a patient’s motivation, ability to learn and apply knowledge, confidence, and activity tolerance in terms of the patient’s ability to participate.”

DECISION MAKING – CONTEXT OF PATIENT’S LIFE (9)

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Therapists with little experience tended to rely more on their colleagues to confirm or validate their recommendations.

Physical therapists with little experience also tended to make more conservative decisions, recommending more formal supportive levels of care rather than discharge to home.

Physical therapists with little experience also reported having more difficulty than their colleagues with more experience with the time constraints imposed by regulations.

Therapists noted that their academic experience was not a major contributing factor in their learning to make discharge recommendations.

Occupational therapists and physical therapists often first looked to each other for agreement about a patient’s discharge destination before seeking opinions of others.

Therapists seemed to seek either validation of or agreement with their discharge decisions, depending on their years of experience in the acute hospital setting.

The more complex the patient’s condition, the more opinion sharing seemed to play an explicit role in making decisions.

Appeared to affect the therapists’ decision-making processes in several ways:

- Felt the need to consider their recommendations in light of the constraints placed on the patient’s options for discharge
- These constraints included insurance coverage and regulations at the private and governmental levels and institutional issues related to the acute care length of stay and criteria for various discharge settings
- Therapists did not let insurance coverage and regulations limit their initial decisions
- In cases where reimbursement was available, therapists stated that they did not consider this factor at all
- Many final recommendations, however, were influenced by insurance or the structure of the setting to which they were to be discharged
- Institutional issues affecting decision making included policies on the length of stay vs. discharge criteria
- Therapists were required to make recommendations for discharge during their initial visit with the patient
SOCIAL ASPECTS VS. MEDICAL ISSUES

- 69yo female admits to the hospital with generalized weakness stemming from dehydration and a urinary tract infection. She has also been falling but only within the last week when the infection really took her down. You receive a PT consult for her falls and weakness. However, after assessing her, you find that she moves well, doesn’t need an assistive device, has no balance deficits. She received medications and IV fluids correcting the problem that caused her to be weak and fall. She tells you she feels fine and would like to go back home to her dog. She lives alone and has family in the area who works during the day but doesn’t live with her. They would like her to go to a skilled nursing facility but she has a Medicare Humana Advantage plan. What do you do?

MEDICAL STABILITY VS. FUNCTIONAL NEEDS

- 47yo Male who presents s/p MVC with broken L leg s/p IMN. He is NWB LLE and has some bumps and bruises from the car accident. He has a couple of broken ribs and a seat belt sign but is a fortunate man to only have these injuries. He lives in a single level home with 4 steps to enter and his wife works during the day. They have three small children and two dogs at home. He is reluctant about going home because of the pain that he is in and the burden he will put on his family once home. He says that a doctor told him a short rehab stay might be a good idea after discharge. What would you do?

DIFFICULT DECISION MAKING

Environmental and contextual factors that cannot be controlled by physical therapists can alter clinical decision making, priority setting, and other aspects of PT practice in acute care settings. These factors can affect emotionally, clinically, and financially. The length of stay in the hospital was short. This affected the physiotherapists’ clinical reasoning and decision-making. Quick assessments and treatment interventions were chosen over those based on evidence. Clinical decisions made within the boundaries of the organizational structure, such as equipment provision, hospital regulations, and nature and culture of the department, funding, and in the U.S., the patient’s insurance coverage. Stress stemming from increasing number of patients, skill of support staff, and documentation demands.
REHAB IN THE HOSPITAL

This becomes an important topic when you have a patient that has no other option but home however they can’t go home because of their current physical or cognitive state.

This is our time to shine as clinicians and think outside the box in order to get these patients to a safe, functional level and back to their homes.

However, this does not mean that they will be back to the PLOF necessarily and it is important to explain that to the patient as for some recovery can take a very long time, longer than they would be in a hospital or a rehab center.

INTERDISCIPLINARY COMMUNICATION AND COLLABORATION (1)

• This has always been a part of my practice
• When I was a new clinician, I repeatedly received accolades from the case managers on the unit that I worked on for my communication about each patient that I saw
• Now for some newer therapists this can be a tricky situation as it can lend to lengthy conversations if you are on the fence about a patient’s discharge plan and the case manager has a lot of questions
• However, with time and practice with this communication with staff members, your conversations will become more succinct and helpful in planning

It can be difficult to advocate for your patient when they are medically stable and ready to discharge the hospital for that reason. Tell your fellow doctors and nurses that they are sick that they are unsafe to go home.

Don’t be afraid to speak up – call the providers, talk with the CCM and the RN – above all, make sure that they communicate to the patient.

ADVOCATING FOR YOUR PATIENTS
DIFFICULT PATIENTS

- Ask for help from fellow clinicians
  - Have someone else see the patient and then read the notes to see what they did
  - See the patient together and let them take the lead so you can observe firsthand
  - Switching it up can sometimes help you take a step back and solve the problem because you were too close

- Take CEU courses
- Google!
- Carry a note pad to keep in your pocket for quick notes to research later
- It’s ok to say you can’t treat someone because of a personality difference – sometimes people just don’t click – don’t take it personally – move on and let someone else take over

POPULATIONS MORE DIFFICULT TO MOVE TO NEXT LEVEL OF CARE (10)

- Trauma
  - “Inherent complex barriers to quality discharge that likely require a comprehensive, multimodal intervention.”
  - “20 to 50 million people surviving road traffic injuries incur permanent disability.”
  - “A large proportion of the injured live with life-altering physical, cognitive and social impairments such as loss of limbs, visual or hearing loss, and post-traumatic stress disorder. This may result in prolonged hospital stays, require multiple surgical and medical services for multi-system injuries and inability to advocate for resources.”
  - “Extensive discussions with social workers and therapists about family support needs and optimal rehabilitation centres enabled transfer preparations.”
  - “Participants perceived discharge and transfer procedures to be largely influenced by organizational pressures to move patients out, feeling rushed, shocked and scared at discharge.”
  - “Some patients attributed the unexpected speed of discharge to organizational demands to make beds available for patients who were more seriously injured than they were.”
  - “Others perceived transfer destination and timing decisions were governed by patient volume or the availability of bed in receiving facilities, not by patient stated preference.”

POPULATIONS MORE DIFFICULT TO MOVE TO NEXT LEVEL OF CARE (11, 12)

- Stroke patients
  - “In Australia and elsewhere, up to half of all patients with stroke or transient ischemic attack (TIA) are discharged directly home from an acute care hospital.”
  - “Hospital readmissions in the 12 months following stroke are common, and many survivors report having unmet needs a year or more following stroke.”
  - “Although comprehensive, individualized discharge planning has been shown to improve long-term outcomes in mixed populations, only about half of all patients with stroke or TIA who are discharged home from acute care hospitals receive comprehensive discharge care planning.”
  - “In the acute care setting, the median length of stay for people with stroke is 3 days.”
  - “Rehabilitation clinicians often see a patient only once for an acute care evaluation, and a key responsibility is to screen for sensorimotor, cognitive, and language deficits. Despite the challenges of patient, clinician, and facility-specific barriers, use of standardized assessments across the continuum of care is continuing to grow through multiple efforts.”
  - “A goal of standardized assessment is to objectively quantify deficits of impairment, activity limitations, and participation restrictions to assist rehabilitation clinicians in determining patient progress, appropriate interventions, and the need for additional services.”
READMISSIONS (1,3)

- "One recent study showed that the incidence of hospital readmission for patients discharged to settings recommended by physical therapists was lower than that for patients discharged to non-recommended settings or in concert with physical therapists."
- "Poor communication between providers in acute care and discharge settings may also contribute to readmissions."
- "The Institute of Medicine identified the failure to coordinate care at discharge from hospitals and SNFs as a cause of hospital readmissions, avoidable complications, and a decrease in functional status, especially for the chronically ill. This lack of coordination results in one in five patients being readmitted to the hospital in 30 days, one in three in 90 days, as well as $15 billion in annual hospitalization costs."
- "Up to 20% of Medicare beneficiaries discharged from hospitals will be readmitted within 1 month from discharge."
- "Older adults 80 years and older usually have more than one common chronic disease, including but not limited to diabetes, arthritis, asthma, chronic obstructive pulmonary disease (COPD), heart disease, and high blood pressure."
- "Chronic diseases such as uncontrolled diabetes and/or other neglected requirements, may also lead to readmissions."

READMISSIONS RISK FACTORS AND POOR DISCHARGE OUTCOMES (5)

- Aged 80 years and older
- Inadequate support system
- Multiple, active, chronic health problems
- History of depression
- Moderate to severe functional impairment
- Multiple hospitalizations during the prior 6 months
- Hospitalization within the past 30 days
- Fair or poor self-rating of health
- History of non-adherence to the therapeutic regimen

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