Determining the Appropriate Inpatient Rehabilitation Candidate

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Objectives

- Discuss the preadmission process limitations and/or barriers that impact IRF admission decisions
- Identify preadmission strategies and processes to better facilitate IRF admission acceptance
Can your relate?

- Has your facility ever denied a patient that another IRF accepted?
- Have a reputation for being difficult to get a patient into?
- Have you ever wondered whether your IRF is giving every referral a fair chance of being admitted?

Overview of the IRF Benefit

“The IRF benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonable be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.”

—MBPM, §110
"the decision to admit the beneficiary to the IRF is the key to determining whether the admission is reasonable and necessary"

- Preadmission Screening
- Post-Admission Physician Evaluation
- Individualized Overall Plan of Care
- Admission Orders
- IRF-PAI
- Medical Necessity Criteria
- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability to Actively Participate in Intensive Rehab Program
- Physician Supervision
- Interdisciplinary Approach to Care
- Definition of Measurable Improvement
  - Section 110 MBPM

Barriers

- What is an IRF?
- Acute care documentation
- Hurried process
- Liaison’s role
- Rehab physician’s decision to admit
Barriers: What is an IRF?

- Acute care case managers
  - High turnover = difficult to keep educated
  - Often consider SNF and IRF as the same
- Acute care therapists
  - New graduates with limited IRF experience
  - May recommend SNF on more dependent patients
- Hospitalists/specialists
  - The “3 hour rule” limits IRF consults from being made
- Insurance case managers/medical directors
  - Can the patient take steps?
- Patients and Families
  - Closest to home is best

Barriers: Acute Care Documentation

- Physician documentation
  - Does not capture conditions requiring medical management
  - Comorbidities are “stable”
- SNF recommendation throughout record
- Level of function is not accurate (prior and current)
- Therapy documentation
  - OT evaluations often not ordered or completed
  - Lack of therapy treatments/daily progress notes to support functional progress
  - High number of patient refusals
Barriers: Acute Therapy Documentation

- Patient unable to follow commands
- Patient unmotivated
- Patient with poor activity tolerance
- Patient refused
- Patient requires max encouragement to participate
- Patient with uncontrolled pain
- PLOF: “bedbound”

Barriers: Hurried Process

- Acute case managers’ focus is to manage LOS and find placement
- IRFs late getting referral - easier to place patients in SNFs
- Liaisons are focused on getting form completed with signatures
  - Unable to obtain full history on PLOF and/or PMH
Barriers: Liaison’s Role

- Often nursing background with little or no rehab nursing experience
- Difficulty assessing patients’ potential to return to a community setting
- Sometimes task oriented- focused on completing screening form
- Inability to provide on-site evaluations
- Lack of ownership of referrals, admissions, and ADC

Barriers: Rehab Physician’s Decision to Admit

- Patients too unstable for IRF level of care
- Reluctant to admit certain diagnoses
- 60% rule
- Unavailable for evening and weekend admissions
- Not getting all pertinent information to make informed admission decision
- Too low level- concern of 3 hour rule
We know the barriers, what can we do?

Possible Solutions: What is an IRF?

• Educate with case studies on previous patients

This was a NT SCI patient admitted to IRF in July; PT recommended SNF on acute eval and in daily therapy notes, “pt with very slow progress, will require SNF at dc”; family requested IPR; patient discharged home in 16 days from NCH IPR
Possible Solutions: What is an IRF?

• Educate with case studies on previous patients

Possible Solutions: What is an IRF?

• Insurance Providers
  – Know reason for past denials
    • Coach therapists on documentation needs
  – Request peer to peer
Possible Solutions: Acute Care Documentation

• Liaison to review labs, rads, PMH, med list to support medical necessity
• Liaison to contact family, PCP, HH to get accurate PLOF
• Therapy Documentation
  – Schedule onsite evaluation for better patient assessment (ADLs, cognition, motivation)
  – Speak with therapists/participate in therapy sessions
  – Emphasize importance of acute therapy treatments to case mgr. with certain dx and insurance providers
Possible Solutions: Hurried Process

• The earlier the better
  – Add pre-checked IP rehab consult to admission order sets
  – Add IP rehab screen to acute therapy assessments

Possible Solutions: Hurried Process

• Prioritize liaison’s completion of preadmission evaluation for faster admission decision
  – Provide tentative admission acceptance when able
**§110.1.1 Required Pre-Admission Screening**

- Pre-admission screening documentation must indicate the following:
  1. The patient’s prior level of function (prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy)
  2. The expected level of improvement
  3. The expected length of time necessary to achieve that level of improvement
  4. An evaluation of the patient’s risk for clinical complications
  5. The conditions that caused the need for rehabilitation

- Pre-admission screening documentation must indicate the following:
  6. The treatments needed (i.e., physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics)
  7. The expected frequency and duration of treatment in the IRF
  8. The anticipated discharge destination
  9. Any anticipated post-discharge treatments
  10. Other information relevant to the care needs of the patient
Possible Solutions: Liaison’s Role

• Develop liaison
  – Observe current process
  – Establish new process to improve efficiency
    • Track hours for admission decisions to be made from time referral is made (internal and external); set goals

<table>
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<tr>
<th>CRITERIA</th>
<th>TOTAL RECOMMENDATIONS</th>
<th>SAME DAY?</th>
<th>GREATER THAN 24 HRS</th>
<th>THRESHOLD</th>
<th>AVG RESPONSE TIME</th>
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<tr>
<td>ADMISSION DECISION FOR RECOMMENDATIONS</td>
<td>Int.- 18 Ext.- 80</td>
<td>Int.- 90% Ext.- 93%</td>
<td>Int.- 4% Ext.- 9%</td>
<td>90%</td>
<td>Int.- 2.5 hrs. Ext.- 5 hrs.</td>
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SUMMARY
The Rehab Unit values efficient patient care and avoids delay in services. The Rehab Unit assists to provide recommendations to that patients can transition to the most appropriate setting. Both targets were met this quarter. Continue to monitor.

Possible Solutions: Liaison’s Role

• Liaison should form opinion of admission decision prior to review with physician
  – Opinion must be based on medical record findings and interviews

• Orientation/Education
  – Participate in therapy sessions
  – Participate in family conferences
  – Participate in team conferences

• Contact family, friends, PCP, previous HH agency to get accurate PLOF

• On-site evaluations if denying patients due to inability to follow commands and/or ability to tolerate the program
Possible Solutions: Liaison’s Role

- Track and trend all denials

- Review all potential denials with program director when based on:
  - Too high level
  - Too low level
  - Not medically stable

Possible Solutions: Rehab Physician’s Decision to Admit

- Program Director and Medical Director establish admission criteria (confusion, sitters, restraints, SCI level, trach mgt, weight, infections, TPN)
- Medical consult on medically complex patients
- Seek physician input on screening form
  - Trend labs and vitals
  - Home and current medication list
Establish comfort level on medically complex patients

• Examples:
  – COPD, pulmonary fibrosis, respiratory…
    • Sats > 88% with activity on max. of 6L
  – Acute stroke (hemiparesis only)
    • If > 70% carotid stenosis, need repair prior to rehab?
  – Acute coronary syndrome (MI, unstable angina)
    • Stress test, cath prior to rehab?

Possible Solutions: Rehab Physician’s Decision to Admit

• Modified therapy programs
• Establish evening and weekend coverage
• Seek physician input on screening form
  – Trend labs and vitals
  – Home and current medication list
Case Study #1

- Patient presents with acute CVA; flaccid RUE and RLE; impaired trunk control; expressive and receptive aphasia and difficulty following simple commands. Patient has been receiving limited OT/PT/ST on acute and requires total assistance (2 persons) with bed mobility and has yet to transfer out of bed. Lives with spouse in two story home with 5 steps to enter. Patient was independent with all ADLs, mobility, and IADLs prior to CVA.
  - Inpatient Rehab
  - SNF
  - Home with home health
  - Not sure
Case Study #2

- Patient presents with hip fracture, s/p ORIF and TTWB; patient has history of dementia and has difficulty following WB restrictions; confused and has been refusing acute care therapies at times. Patient has developed multiple comorbidities since surgery including blood loss anemia (HGB of 7.9), PNA requiring IV antibiotics, stage II PU, and UTI. Patient was living alone prior to fracture; children live close by. Currently requires max to total assistance with transfers due to WB restrictions. Lives in one story home with 2 steps to enter and was mod. Independent with ADLs and mobility prior to fracture.
  - Inpatient Rehab
  - SNF
  - Home with home health
  - Not sure

Case Study #3

- Patient presents with PNA and has also developed DVT in LE and pressure ulcers since in hospital; also with old SCI resulting in paraplegia. Prior to admission patient was modified independent with transfers/WC mobility and min to mod assist with ADLs. Patient living with spouse who works during the day. Due to prolonged hospital stay, patient now requiring total assistance with bed mobility and transfers (2-3 persons) and having difficulty sitting EOB.
  - Inpatient Rehab
  - SNF
  - Home with home health
  - Not sure
Case Study #4

- Patient presents with syncope and history of multiple falls at home; patient has been to ED and admitted to OBS several times in past few months due to falls at home. Patient did spend 21 days in SNF two months ago after fall and home that resulted in rib fractures. Acute care work up revealed orthostatic hypotension and COPD exacerbation; patient also with complicated PMH including CAD, COPD oxygen dependent (2L), and DM. Patient lives alone and was mod independence to independent with ADLs and mobility prior to hospital admission. Currently patient requires mod assist with bed mobility, min assist with transfers and is symptomatic with hypotension; able to ambulate 60 feet with CGA and RW; min assist with ADLs. Oxygen saturation with activity and ambulation 86-88% on 3L.
  - Inpatient Rehab
  - SNF
  - Home with home health
  - Not sure

QUESTIONS?