Acute Inpatient Rehab

Transitions from Acute and Discharges to Home

Wisconsin Stroke Statistics
(Coverdell)

- That year, there were over 11,000 hospitalizations for stroke
- 94% survived their stroke at the point of discharge from the hospital.
- Only 44% of stroke survivors discharged to their own home.
- Majority of stroke patients are discharged to a skilled care or rehabilitation facilities.
- Over 2,500 Wisconsinites died of stroke in 2017, making it the fifth leading cause of death in the state. (Ranked 38th)

Who are we?

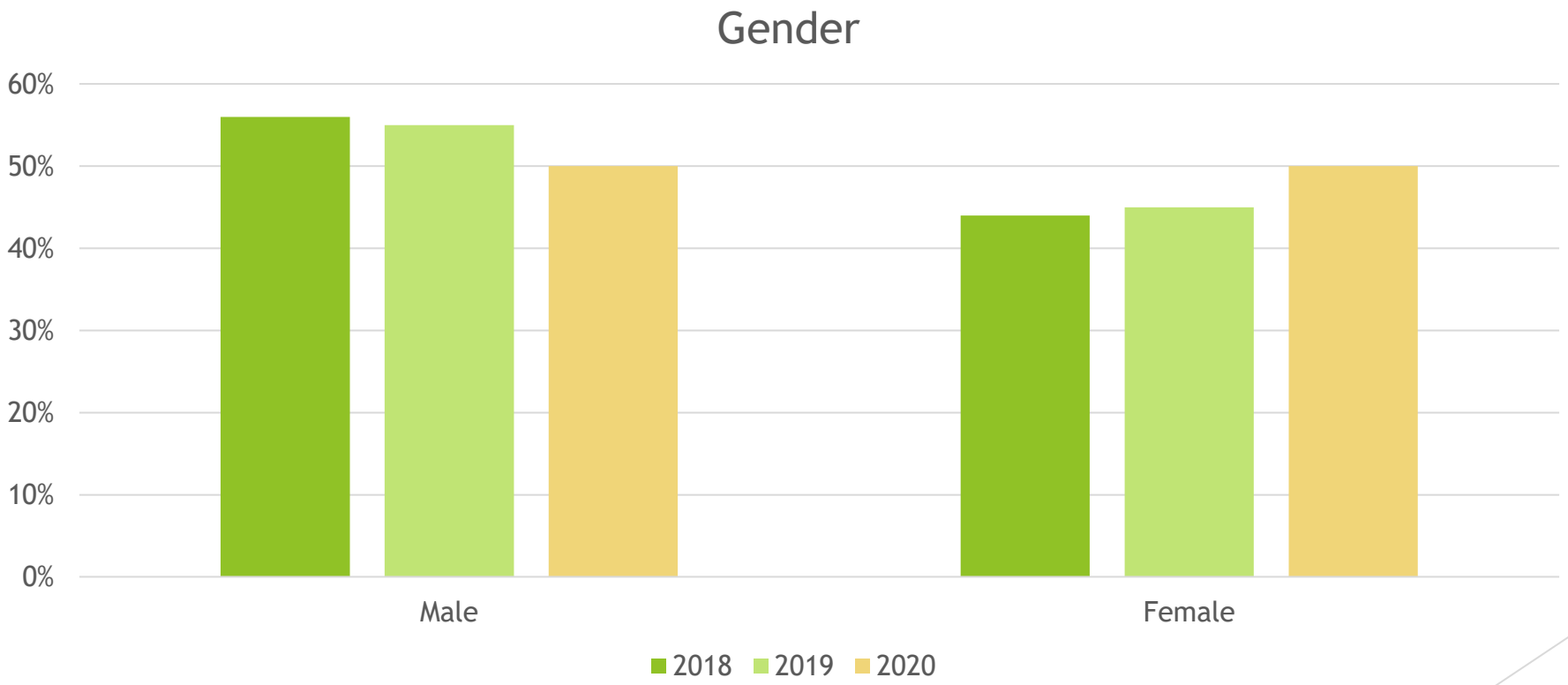
Rehabilitation Unit
Swing Bed
Skilled Nursing Facilities

ThedaCare Regional Medical Center-Neenah

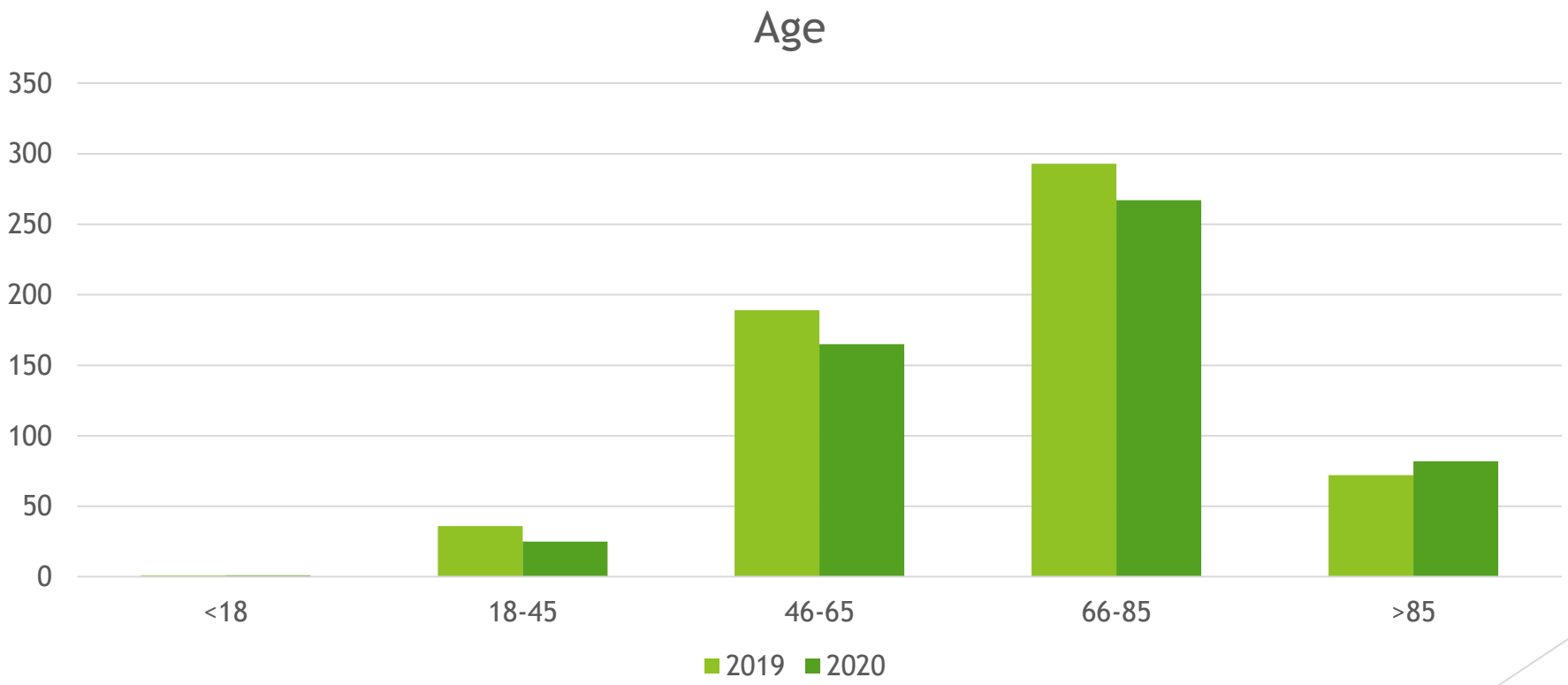
- Comprehensive Stroke Center
  - DNV – 2019
  - Average 500-600 patients/year
- Stroke Unit
  - 16 Bed Unit
  - Neurology is Attending
- Rehabilitation Unit
  - 12 Bed Unit

Demographic of our Stroke Patients

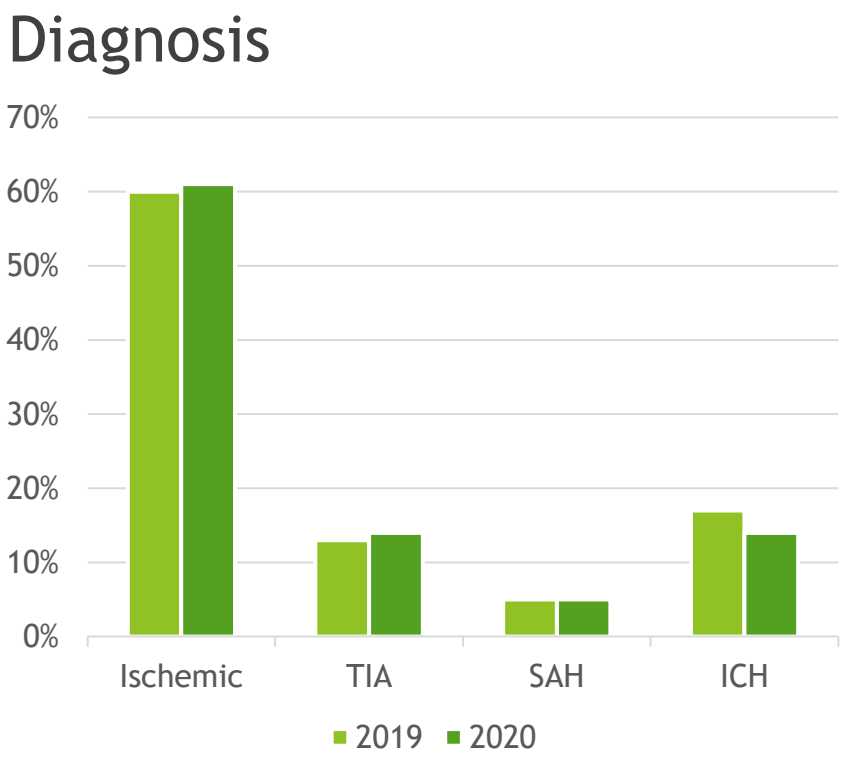
Demographics: Male vs Female

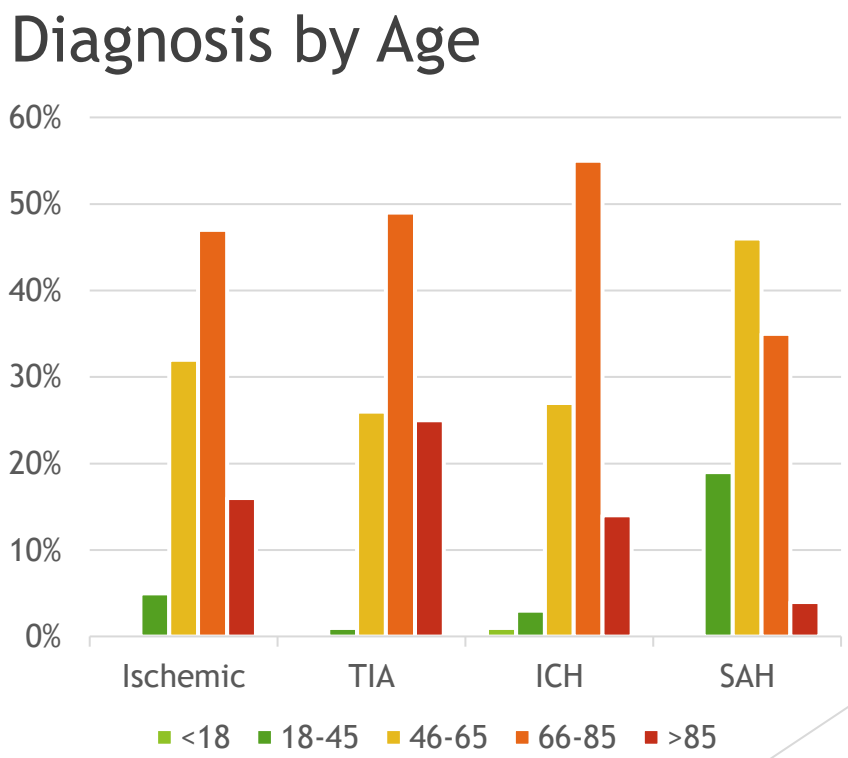


Demographics: Age

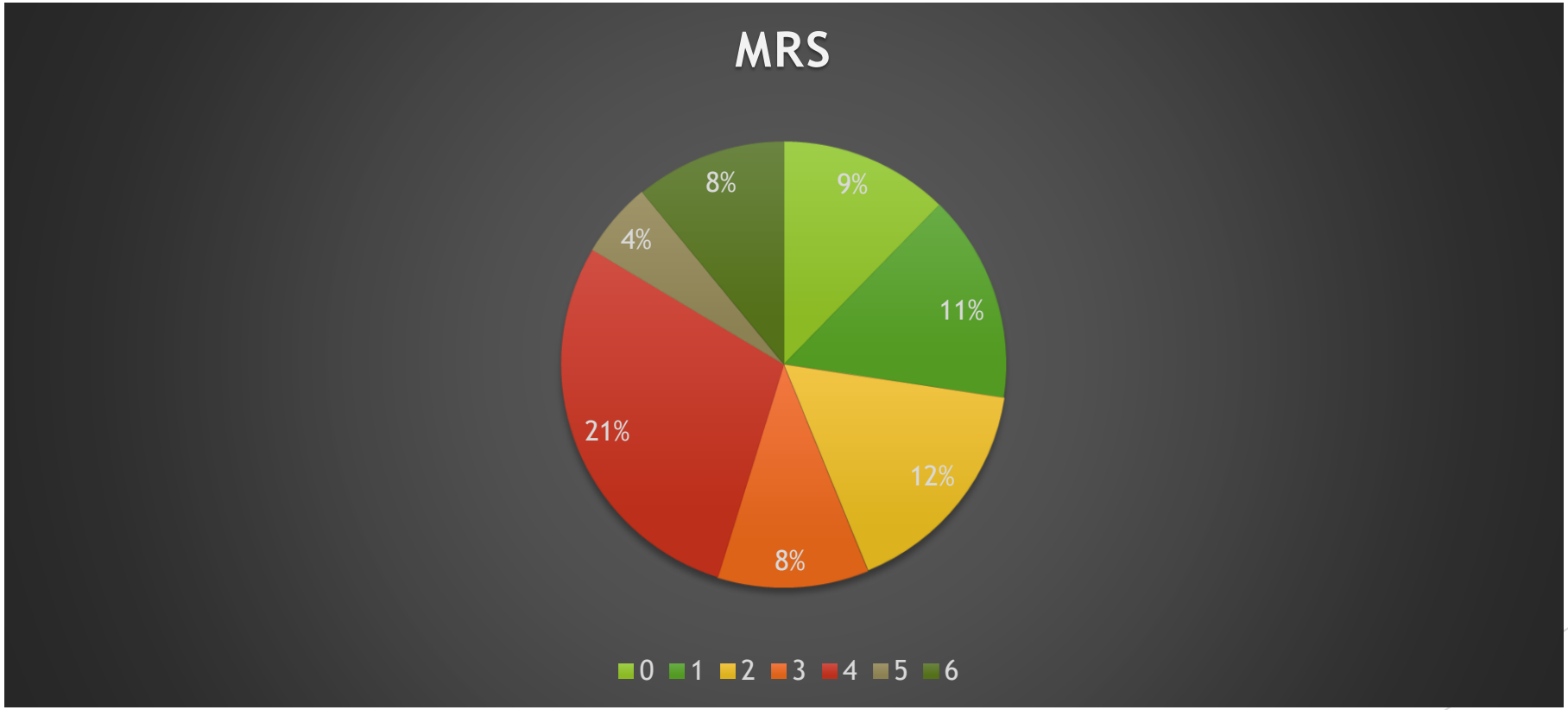


Diagnosis


Diagnosis
70%
60%
50%
40%
30%
20%
10%
0%
Ischemic
TIA
SAH
ICH
2019
2020

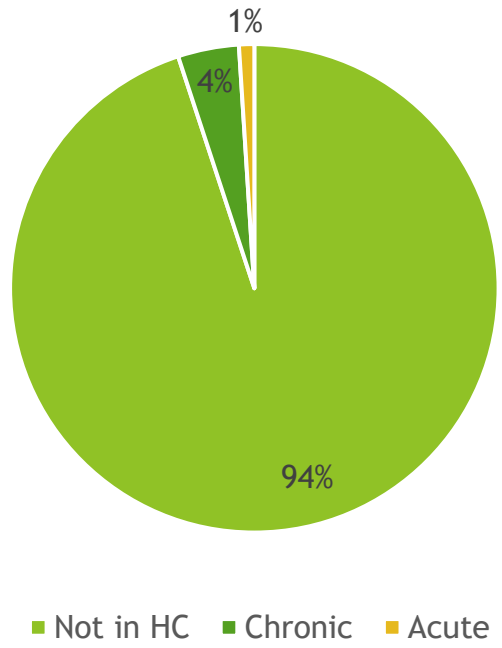

Diagnosis by Age
60%
50%
40%
30%
20%
10%
0%
Ischemic
TIA
ICH
SAH
<18
18-45
46-65
66-85
>85

Discharge Modified Rankin Scores

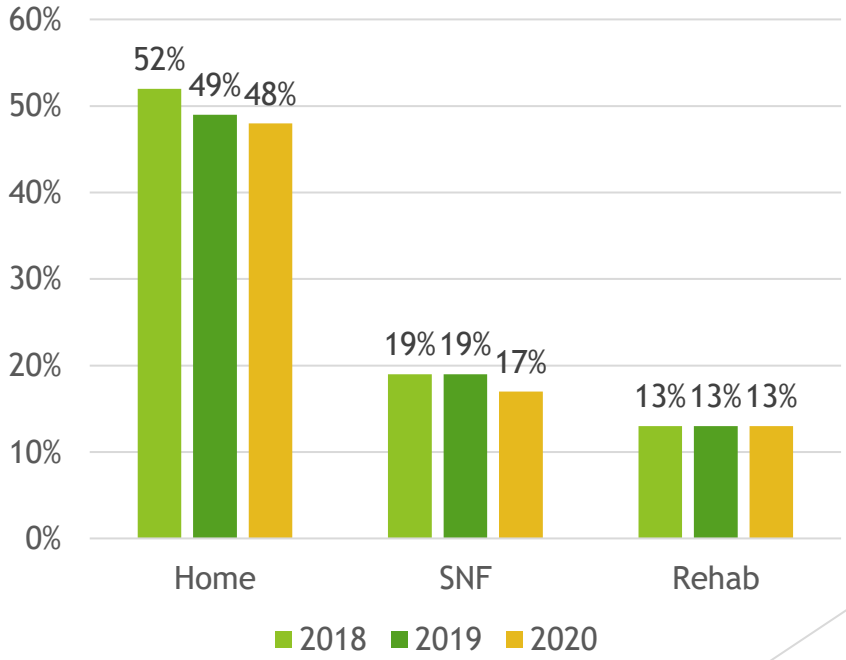


Discharge Diagnosis

Prehospital



Discharge



Discharge Planning

Interdisciplinary Rounds

- Tuesdays and Fridays
  - 30 minutes in the morning
  - Phone or in-person

- Team:
  - Provider
  - Stroke Coordinator
  - Patient RN and Lead RN
  - Therapy
  - Dietician
  - Pharmacy
  - Care Management/Social Worker
  - Rehab Manager

Goal of the Huddle

- Determine patient's current medical condition
- Determine patient's therapy needs and/or barriers
- Is the patient appropriate for a Physiatry Consult?
  - Inpatient versus Outpatient
- Are there any dietary needs?
- Discharge disposition, barriers, and current status

It starts with the consult!

Physiatry Consult

- The earlier we identify the need for a Physiatry Consult the better.
  - Outpatient Physiatry follow up vs Inpatient Rehab Admission
  - Inpatient: Allows time to obtain insurance authorization paired with medical readiness
- Physiatrist sees the patient in person at our Regional locations otherwise chart reviews are done to complete the Consult
  - Addresses expectations on rehab and answers questions
- Rehab admission is determined through a provider chart review & information obtained from the patient, family or Care Manager

Importance of a Seamless transfer from acute hospital to rehab

- Adequate acute care therapy documentation
  - Participation, number of minutes & tolerance to meet the 3 hours of therapy requirement per CMS and/or modified therapy schedule program
- Referral & Care Manager Handover
  - Patient's premorbid function, family support, discharge options
  - Answer patient/family questions related to rehab services
- Seek Insurance Authorization
  - H&P, Diagnosis, Therapy Participation, Discharge plan/support, Rehab Goals, PM&R Consult Note
- Without supportive documentation admission can be denied!

What information does a Rehab facility want to receive from the hospital?

- Face Sheet (Demographics, Payer information, Name/DOB)
- H&P on admit
- Recent provider notes from all consulted services (last 3 days or more)
- Recent labs in last 3 days or other pertinent values
- Recent imaging
- POA forms
- Recent nursing notes
- 1st day and last 3 days of therapy notes to show progression
- Discharge support for the patient (24/7 or intermittent support & by who)

All of this helps a rehab facility establish appropriate goals for discharge and know who will be receiving education/training alongside the patient throughout their stay to set the patient up for success and prevent readmission.

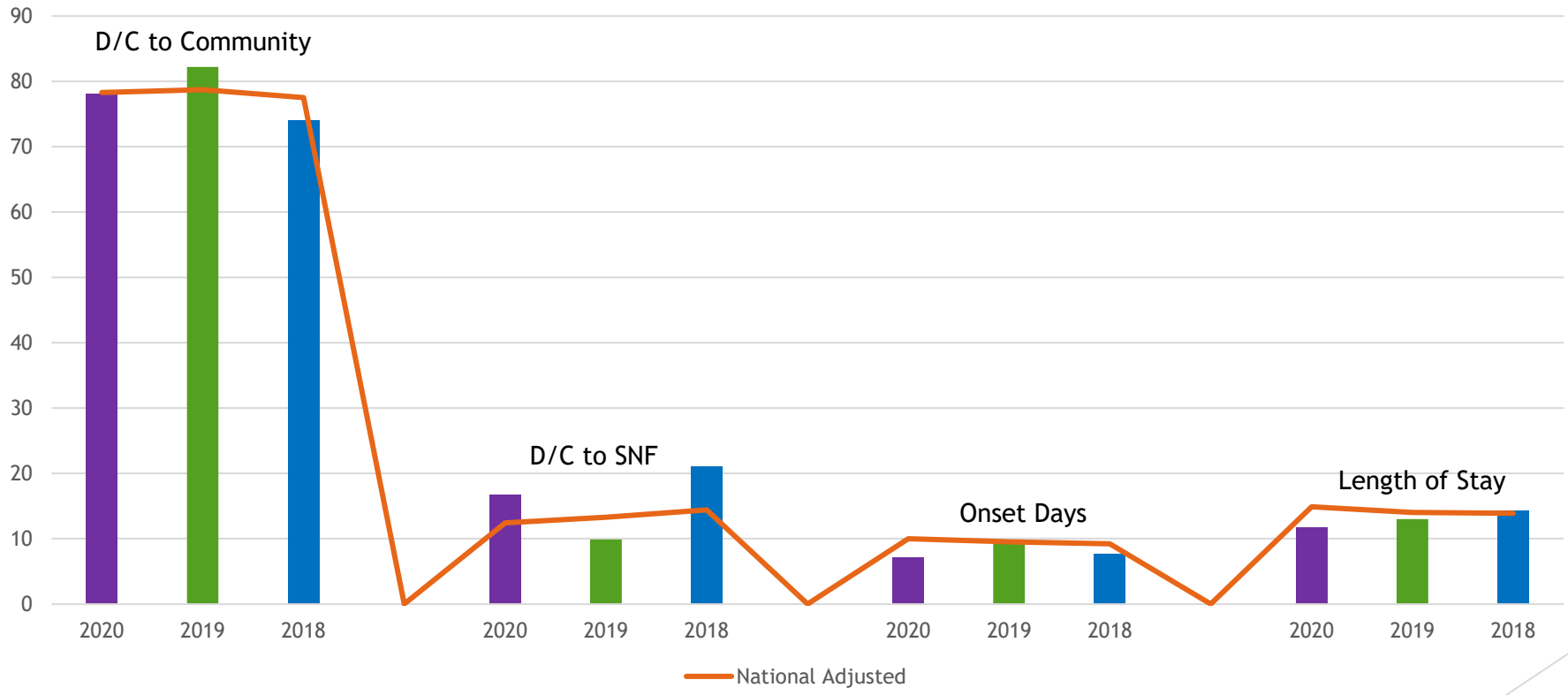
How can hospital staff make the transition to rehab seamless for the patient/family?

- A thorough RN to RN handover is so important from a medical and personal standpoint. This can include patient likes/dislikes/routines so we can make the transition as comforting as possible.
- Ensure staff understand the services of a rehab facility and the goal of patient progression.
  - Operates 24/7 with provider oversight
  - 3 hours of therapy 5 days per week and/or a modified therapy schedule for medical reasons (ie. Chemo/radiation/dialysis)
  - PT, OT, SLP and Recreational Therapy services are offered along with psychology/counselor support
  - Patient/Family training is consistent throughout the patient's stay
  - Speech services cannot stand alone
  - Average length of stay is approximately 2 weeks

Discharge Process from Rehab to Home

- Interdisciplinary Weekly Team Conferences
  - MD, APC, RN, PT, OT, SLP, Care Management, Social Work, Counselor as applicable
- Education Day(s) Arranged (6-8 hours)
- Post Rehab Continuation of Therapy (In home or Outpatient) as well as Nursing/Care Management if needed
- Durable Medical Equipment Ordered/Delivered
- All discharge Follow-Ups are Scheduled for the patient and included in their Rehab Discharge Letter

Rehab Stroke Data for 2018-2020



Community Resources Post Stroke from Rehab

- Local Stroke Support Group: SAAS (Survivors Active After Stroke)
- Online Resources
- Aging and Disability Resource Center (ADRC)
- Lions Club Loan Closet

Questions?

- Thank you!
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