Homeward Bound

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Objectives

• Identify and differentiate the levels of stroke rehabilitation care.
• Identify barriers to discharge planning.
• Recognize availability of community resources for stroke patients.
• Understand the roles and responsibilities of the discharge planning team.
Social Work

Amanda Melvin, MSW
Role of the Social Worker

- Stroke Order Set- SW consult included
- Consulted by physician, case manager, nurse, chart reviews.
- Assessment of support system
- Decision Maker / Next of kin
- Check funding source
- Make referrals:
  - Ex: EAS- Eligibility Assistance Services
Role of Social Work

- Collaborate with the interdisciplinary team for discharge needs.
- Physical, Occupational, Speech Therapy recommendations
- Family Meetings to discuss discharge plan
- Offer choice
- Review /Referrals to rehab facilities
- Assist during discharge process
- Advance Directives
Levels of Stroke Rehabilitation

- Inpatient Rehab
- Skilled Nursing Facility
- Swing Bed
- Home Health Rehab
- Outpatient Rehab
- Long term acute care
Barriers to Skilled Nursing Facility Discharge (SNF)

- Self Pay - no funding
- Medicaid – does not fund SNF.
- Insurance Delays for Authorizations
  - United Medicare
  - Humana Medicare
  - CCC – Medicare & Medicaid plans
  - Private insurance
- Medicare - 3 day stay
Additional Barriers to SNF discharge

- Temporary Feeding Tubes
- Physical Restraints
- Chemical restraints
- Negative Behaviors
  - Wandering, combative, verbally abusive, or non-compliance with treatment.
- Sex Offenders
- Morbidly obese
Additional Barriers to SNF discharge cont.

- Bed availability
- Family cooperation
- Guardianship Cases
- West VA PAS
- Transportation to out of state SNF.
Role of the Case Manager

- Complete needs assessment upon admission
  - Home support
  - Services prior to admission
  - Funding
Role of the Case Manager

• Promote interdisciplinary collaboration and teamwork to progress plan of care and discharge planning.
  • Unit huddles
  • Communicating with other disciplines
  • Appropriate referrals
  • Identify discharge needs

[Image]
Role of the Case Manager

- Promote appropriate length of stay and facilitate transition to the next level of care.
  - Collaborate with utilization review
  - Discussions with patient and family on discharge planning needs
  - Referrals to SW, IPR and Home Health
Discharge Planning to Home

- Home Health and Outpatient Therapy
  - Ensure home support and safety
  - Provide adequate DME
  - Private Care Aides
  - Follow up appointments for high risk patients

- Medication Authorizations/Co-Pays
  - Examples: Lovenox and Xarelto
  - Anticoagulation Clinic – PT/INR lab draws
Discharge Planning to Home

- Hospice
  - Referrals to discuss goals of care
  - Discussion with family
  - Options available at home
Discharge Planning to Home

- Community Referrals
  - League of Older Americans (LOA)
  - Center for healthy aging
  - 2-1-1 Resource Guide
  - Follow-up appointments
Barriers

- No funding source
  - EAS
  - Free Clinics
  - Medication Assistance
  - Community Resources
- Patient with needs living out of state
- Out of network insurance providers
Acute Inpatient Rehabilitation

Tiffany Curtis, BSN, CRRN
Overview

1) Acute Inpatient Rehabilitation (IPR)
2) Physical Medicine and Rehabilitation (PM&R)
3) Inpatient Rehabilitation Liaison Role
4) Admission Criteria for Acute IPR
5) Mission of Carilion Acute IPR
Acute Inpatient Rehabilitation

Inpatient Rehabilitation (IPR) also called Inpatient Rehabilitation Facility (IRF)

Intensive rehabilitation program provided in a hospital setting
The PM&R Consult Team evaluates patients to determine eligibility for admission to acute IPR based on specific criteria.
IPR Liaison Role

- Part of PM&R Consult Team
- Collaborates with Medical Team
- Provides Education to patients/family members/support system
IPR Liaison Role

- Completes Pre-Admission Screening (PAS)
- Coordinates IPR admission plan
Admission Criteria

- Medically stable
- Able to tolerate 3 hours of therapy per day, 5-6 days a week
- Needs in at least 2 therapy disciplines (PT, OT, and/or SLP)
Admission Criteria

- Ability to learn, follow directions, and retain learned information
- Viable discharge disposition to community setting
- Confirmed support system
Mission of Carilion Acute IPR

Our mission is to provide rehabilitation services to our patients so they can return to their community and live as independently as possible.
Home Health Care for the Stroke Patient

A Vital Link in the Health Care Continuum

Cindy Regan, MSN, RN - BC
Criteria for Home Health Care

Patient must be under the care of a physician

The physician must indicate a need for:
- Intermittent skilled nursing care
- Physical Therapy
- Occupational Therapy
- Speech Language Pathology
Additional Home Health Services

Home Health Aide:
- Bathing, personal care, assist with home exercise program

Medical Social Worker:
- Evaluate for community resources
- Emotional needs, counseling
Homebound Status-What Does it Mean?

- Not advisable to leave the home
- Leaving home is a difficult taxing effort
- Help of another person or use of an assistive device is needed
Home Health Goals for Stroke Patients:

- Improved functional abilities
- Greater independence
- Achieving optimal well-being
- Remaining in home
- Avoiding additional hospitalization or long-term care
Challenges for Home Health

- Increased chronic, complex conditions
- Shorter hospital stays, more intensive care
- Advanced medical technology in home
- Cultural diversity
- Lack of financial resources
- Medical illiteracy
Skilled Nursing Services

- Assessment, evaluation, and education
- Disease management
- Medication management
- Pain management
- Injections, IV infusions, lab work
- Wound care, tube feeding management
- Telehealth Monitoring
Physical Therapy

- Gait/stair training
- Strengthening
- Range of motion
- Balance Training
- Transfers/bed mobility
- Patient and family education
- Wheelchair mobility
- Muscle toning and coordination
- Home safety evaluation
- Pain management
Occupational Therapy

- Activities of daily living
- Home management and modifications
- Cognitive/ problem solving
- Vision perception

- Upper extremity strengthening
- Joint mobility
- Energy Conservation
- Adaptive equipment
Speech Language-Pathology Services

- Speaking-language training
- Comprehension and reading
- Writing
- Cognition
- Swallowing
- Feeding-diet modification
Hospice Consideration

Stroke: Major cause of death and disability

- Coma or persistent vegetative state
- Poor functional status
- Inability to maintain food or fluid intake
- Less than 6 month life expectancy
- Comfort care/symptom management
Questions???