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Standardization of Inpatient Rehabilitation Consults

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Background/Introduction

- The Center for Medicaid and Medicare Services (CMS) tracks and monitors the inpatient rehabilitation facility (IRF) return to acute (RTA) rate as quality improvement metric.
- Our academic IRF experienced a significant rise in the number of RTA patients over the past academic year 2021-2022 well above the national average.
- The reason for this increase is multifactorial in nature. These potential factors include but are not limited to: physician dependent, increased medical acuity of patients, premature admission into IPR before medical optimization etc…
- As an academic IRF, patient selection was determined by a teaching model where a resident physician would present new IRF consults to a larger multidisciplinary admissions team.
- Our academic IRF sought to reduce the RTA rate by implementing a standardized template for this presentation. Our IRF proposed that standardizing the presentation format template would lead to admitting only the most medically and functionally optimized patients to the IRF, thereby reducing the RTA rate.

Collaborative Team Members

- Michael A. Snover II, DO. PM&R Resident Physician & Presenting Author
- Abigail Morales, MD. PM&R Attending Physician. Medical Director of Inpatient Rehabilitation Consults.
- Evan Zeldin, MD. PM&R Attending Physician
- Kimberly Brookbank, OT. Rehab Admissions Coordinator.
- Katie Henderson, RN. Rehab Admissions Coordinator.
- Janet Andrews, RN. Rehab Admissions Coordinator.
- Kandyce Klugh, RN. Rehab Admissions Coordinator.
- Cass Wigent, RN. Rehab Admissions Coordinator.
- Paul Heath. Rehab Data Analyst.

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Aim Statement

The goal of this project is to refine and standardize the quality of resident physician's new consult presentations as to facilitate a more efficient meeting as well as to improve understanding of the relevant aspects of each patient to make a more appropriate decision on ultimate level of therapy recommendations as well as decrease the IPR RTA rate.

Methods

- A new template was enacted to evaluate each new consult patient that was to be reviewed the by the admissions team.
- The categories were as follows: 1) name/age/gender, 2) room number, 3) brief medical history, 4) level of functioning with therapies, 5) therapy discharge recommendation, 6) level of caregiver support after hospital discharge, 7) barriers to rehab admission and finally 8) patient's insurance.
- Over a 60 day period, the resident physician presented each patient in the same fashion by following the aforementioned 8 step template.
- At the end of 60 days, data was collected on the number of RTA's, number of reconsults and a subjective questionnaire was given to each member of the consult team including the attending and other team members.
- The Resident Physician as primary author of the study did not complete the questionnaire given reasons of likely bias. The data analyzed compared the dates of (experimental group for which the new consult meeting format was enacted to the previous consult meeting (format control group).
- **Outcome Measures:**
- 10 Question Questionnaire Provided to Each Member of the Admission Team Evaluating the Efficacy of the New Consult Presentation Format
- Comparison of the Return to Acute Rate between 2 separate 10-week time periods

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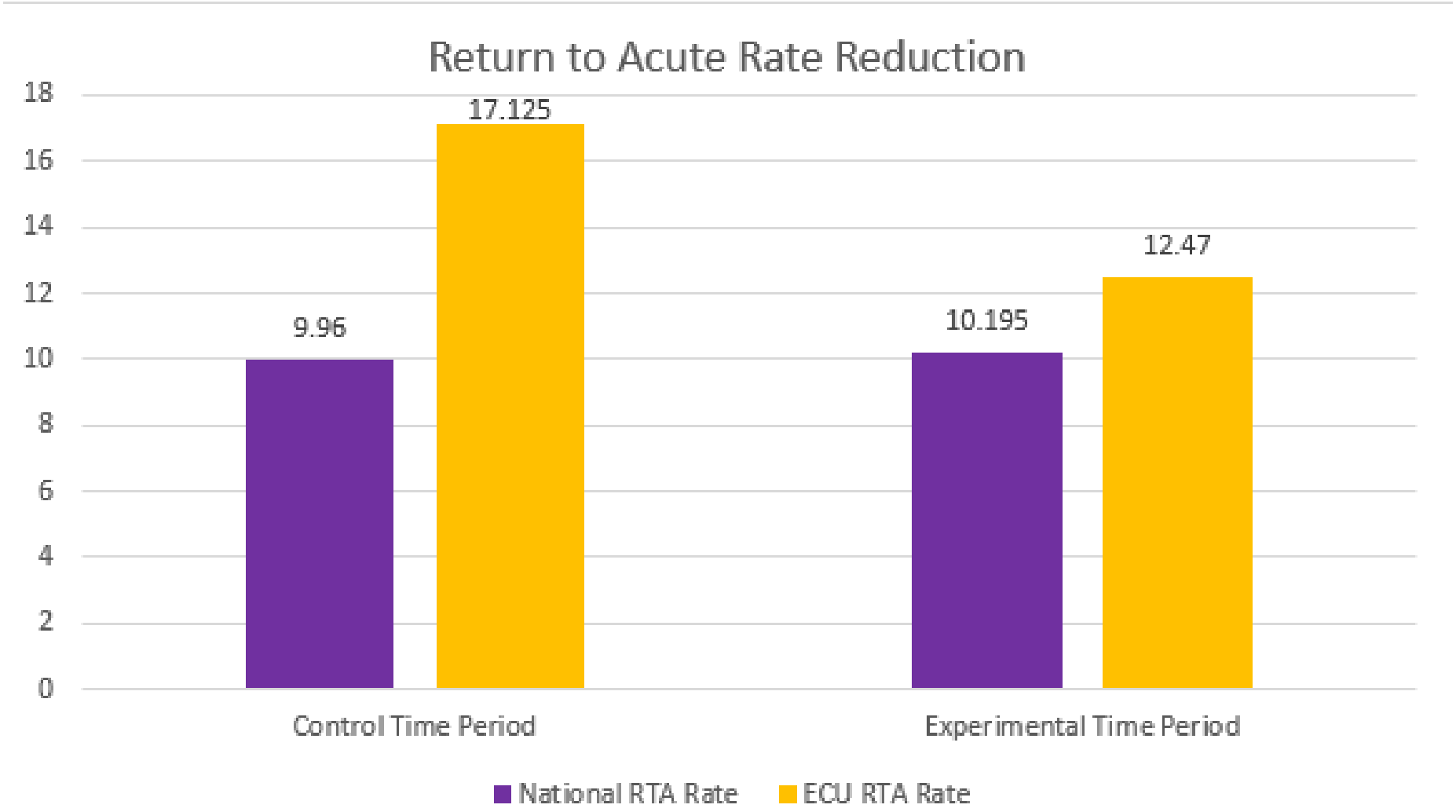
Baseline Data

- Our average IRF RTA rate in the control group was 17.125% compared to the national average of 9.96%.
- Our average IRF RTA through the dates of the experimental group using the new template was 12.47% compared to the national average of 10.195%.
- Utilizing the new consult template, the RTA rate decreased by 4.7% **(P-Value of 0.87),** meanwhile the national RTA rate increased by 0.24%.
- On the satisfaction survey, 83% of participants agreed the experimental format was more efficient and 100% of team members felt the new format optimally identified a patient's barriers to IRF admission compared to prior.

Pictographic Illustration of Data



Important Admission Team Questionnaire Data

Do you feel the consult meeting is more efficient with the new presentation format?	Yes: 67%, No: 0%, Neutral: 33%
Are you more fully informed about the patient's medical history?	Yes: 83%, No: 0%, Neutral: 17%
Does the new formatted structure add unnecessary time to presentations?	Yes: 0%, No: 100%, Neutral 0%
Is the new format a good standard to be adopted for future consults?	Yes: 100%, No: 0%, Neutral: 0%
Does the new format decrease required time to review follow up patient's charts after initial consult?	Yes: 67%, No: 0%, Neutral 33%

Challenges Encountered in QI Process

1. Hospital bed shortage crisis termed “Red Capacity” by our hospital could have potentially caused more medically complex patients to come down to rehab prior to medical optimization aimed to assist the hospitalist teams. This in term could have theoretically increased the rate of patients returning to acute from inpatient rehab.
2. A constant changing census can skew our data point and make it difficult to objectively compare the data from two different 60 day periods in this study. Prior to starting the study, our rehab total census would fluctuate between 55-57 patients (between the dates of 5/1/22-6/30/22). Towards the end of the trial period with the new consult presentation experimental group, there were approximately 2-3 weeks of hospital “internal disaster” open bed status whereby our rehab census went up to an 60 beds in order to help the hospital by admitting more patients from our parent institution/hospital. This is something our rehab hospital has not accommodated for in over a decade.
3. Another challenge to the subjective review of the formatting changes is that the resident physician who conducted the study was the one to distribute the questionnaire forms which may induce bias to those completing the surveys. All in all, the project was single blinded in that sense as the surveys did not include the names of the participating member of the survey.

Next Steps

- Employing the template increases efficiency and team satisfaction which correlated with an improved RTA rate.
- Next steps include maintaining this new model with an increased look forward and lookback period to assess the effectiveness of the new model.
- The new standardized template has been accepted as a standard model since initial rollout.
- The analysis of the RTA rate is continued to be analyzed this year but the results look promising.
- The P Value showed us that our data was not necessarily statistically significant however it was very close.
- We believe that with a longer period following the data, it will likely become statistically significant.

Questions?

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