Creative Discharge Planning: Tools and Tips

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CHI Health
Good Samaritan

May 2, 2024

Learning Objectives

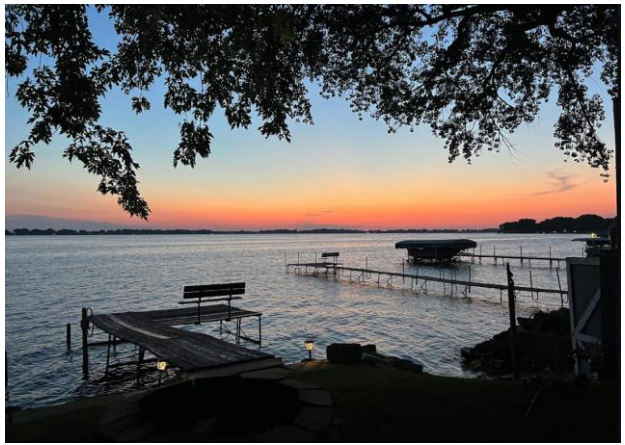
1. Identify tools & resources to assist with post stroke discharge planning.
2. Compare and contrast various post-acute stroke rehabilitation settings based on characteristics and patient criteria.
3. Review “Top 10” discharge list to assist with discharge planning.
4. Apply a case study to identify recommendations for post stroke rehabilitation & recommended resources.

CHI Health Good Samaritan, Kearney, NE

SERVICES:

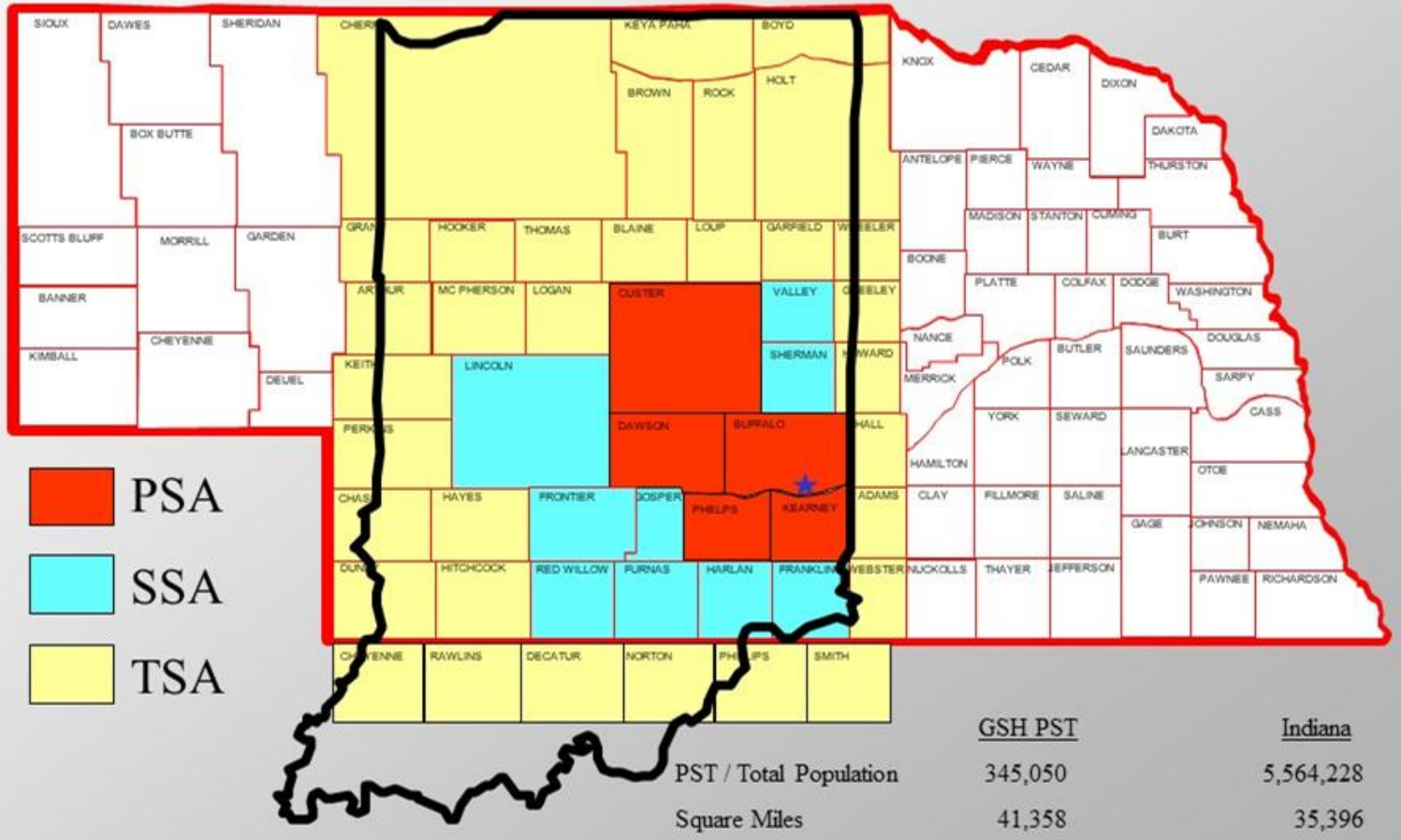
- Primary Stroke Center
- Comprehensive acute care
- Level 2 Trauma Center
- Level 2 NICU
- Inpatient Rehab Unit
- Richard Young Behavioral Health
- Air transport for adult and neonatal patients


Huskers
Huskers Football
Est. 1890



GSH PST Service Area

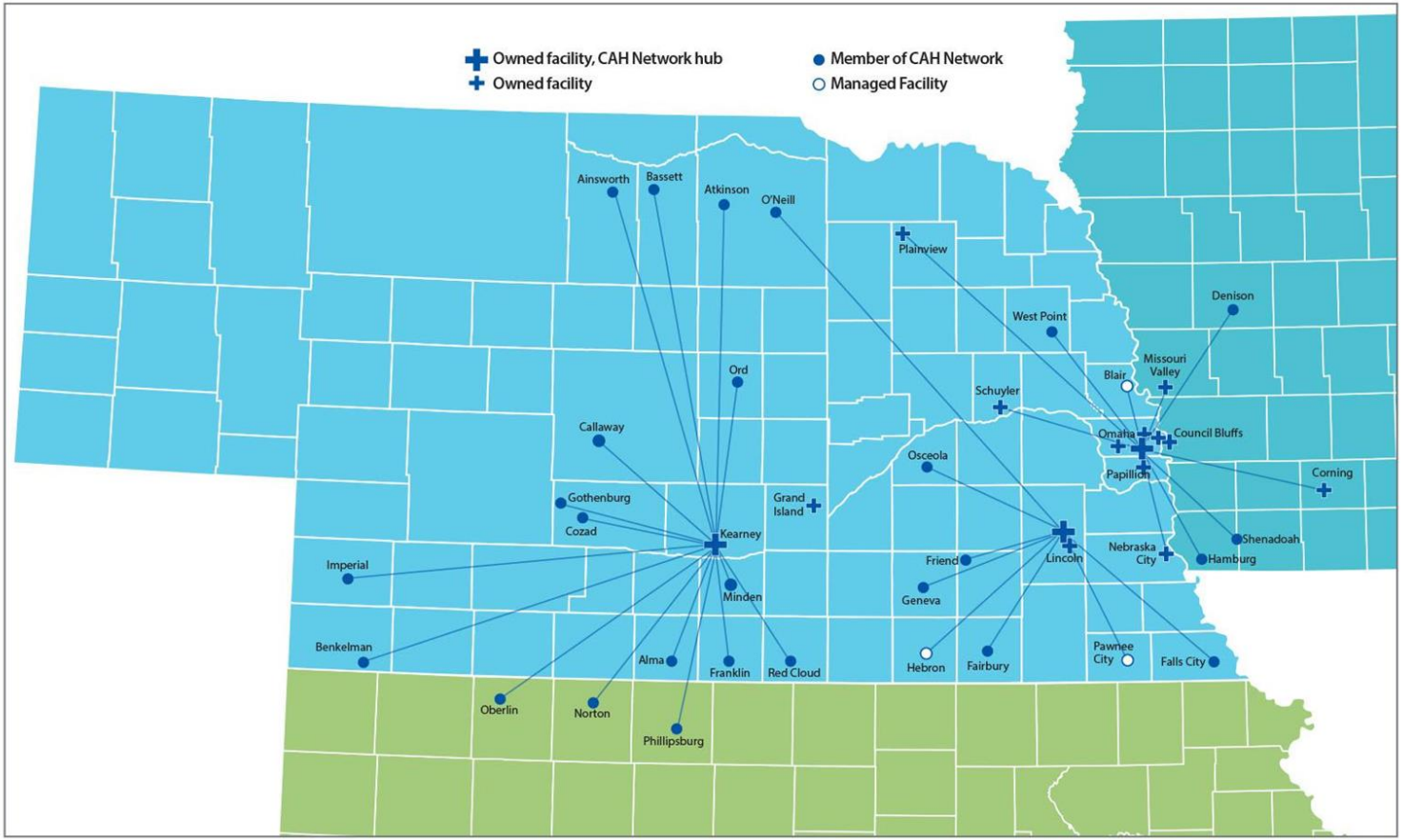
Inpatients: 59% outside Buffalo County
Outpatients: 36% Outside of Buffalo County



	GSH PST	Indiana
PST / Total Population	345,050	5,564,228
Square Miles	41,358	35,396

Critical Access Hospital Network

- 16 CAH's in our system
- 25 CAH's we routinely work with



Montana & Nebraska Services per Medicare.gov

	Montana	Nebraska
Population	1.123 million	1.968 million
Size of State	147,040 sq miles	77,348 sq miles
Hospitals	63	92
Critical Access Hosp	49	63
Inpatient Rehab Programs	4 Billings, Missoula, Kalispell, Great Falls	10
SNF	60	184
HHC	24	66
Long Term Care Hospital	1 Billings	3

- Montana Stroke Initiative
- AHA: Mission Lifeline Stroke
- Brain Injury Alliance

Why is Discharge Planning with Stroke Patients so Challenging?

1. Ongoing rehab needs
2. Social, psychological and emotional impact
3. Prior functional status
4. Support system
5. Financial needs-insurance and/or income
6. Medical needs
7. Community resources
8. Transition planning.
9. Transportation
10. Returning to prior lifestyle

Ref. Exploring Stroke Patients' Needs after Discharge Centres: Meta Ethnography

Where do we start?

- Every patient is different medically, socially and resource available
- Level of care
  - Home with Home Health Care
  - Home with Outpatient Therapy
  - SNF
  - Swing Bed
  - Long Term Acute Care Hospital
  - Inpatient Rehab Preferred level of care post stroke

1 Stroke Recovery & Rehab Needs

1. Post Acute Care Options & Resources
    a. Providers criteria has changed with who they will admit; funding, discharge plans

1. Location & access with the vast amount of miles & many Tourists

1. Rehab Guide Review
    a. Know your resources

COMPARE AND CONTRAST VARIOUS POST-ACUTE STROKE REHABILITATION SETTINGS BASED ON CHARACTERISTICS AND PATIENT CRITERIA.

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Beth Malina, RN, BSN, CNRN, American Heart Association

Stacie Christensen, PT, DPT, NCS, University of Nebraska Medical Center

Kristy Weissling, SLP.D., CCC-SLP, University of Nebraska Lincoln

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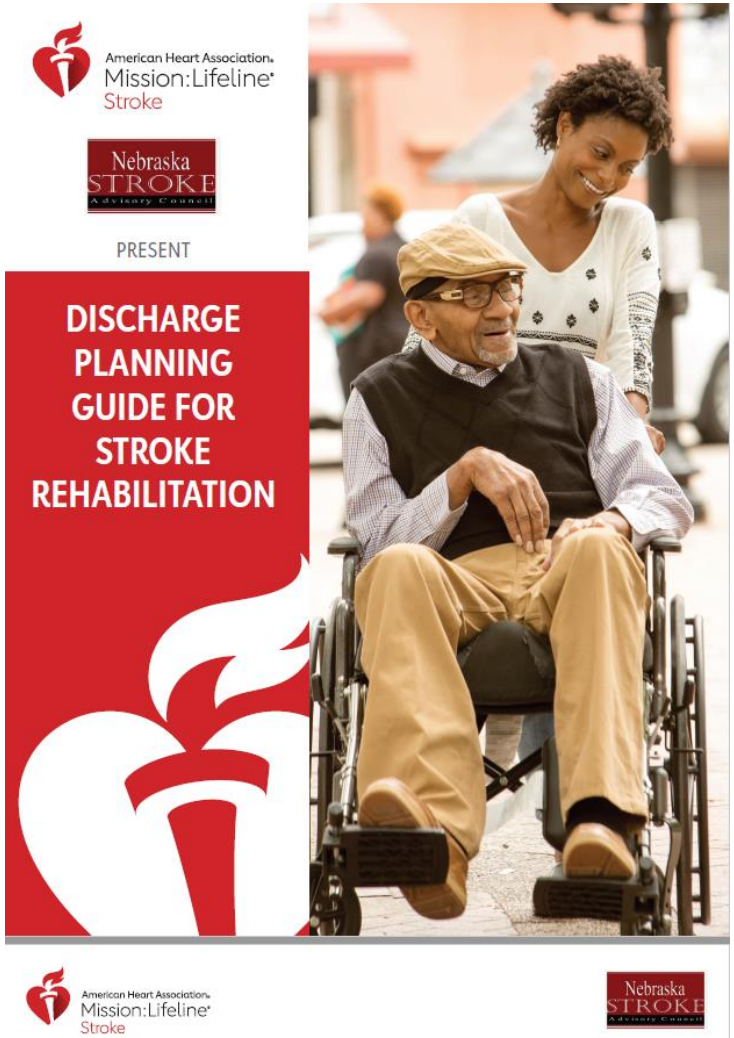


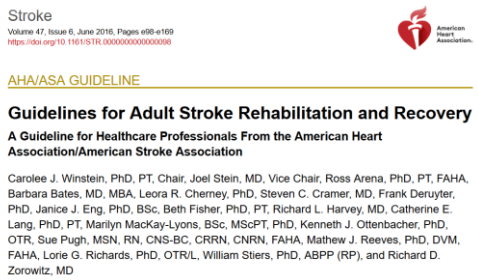
PURPOSE OF THE GUIDE:

To assist healthcare professionals in determining the appropriate level of stroke rehabilitation care by comparing various types and setting in an easy-to-read format.

THE GUIDE:

- Is designed to assist health care professionals who plan discharge, including social workers, case managers, nurses, physicians, and therapists.
- Describes the various options for post-acute stroke rehabilitation with the inpatient rehabilitation facility offering the most intense, comprehensive care.
- Aligns with recommendations from the *Guidelines for Adult Stroke Rehabilitation and Recovery: A Guideline for Healthcare Professionals from the AHA/ASA* (Winstein et al., 2016).

DEVELOPMENT OF THE GUIDE


Stroke
Volume 47, Issue 6, June 2016, Pages e98-e169
https://doi.org/10.1161/STR.0000000000000098

AHA/ASA GUIDELINE

Guidelines for Adult Stroke Rehabilitation and Recovery

A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

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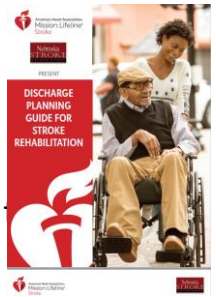
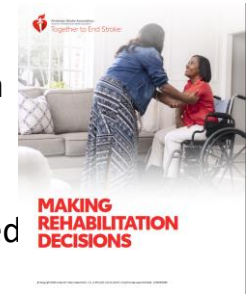
- **2016:**
  - *Guidelines for Adult Stroke Rehab and Recovery* published
- **2017:**
  - *Making Rehabilitation Decisions* published
- **2017-2018:**
  - NSAC Rehab Taskforce reviewed literature for decision-making
- **2018:**
  - Helmsley Charitable Trust awarded Mission: Lifeline Stroke grant to Nebraska
  - Further support to Rehab Taskforce to develop a tool
- **2018-2021:**
  - *Discharge Planning Guide for Stroke Rehabilitation* was developed & published





American Heart Association.
Mission:Lifeline®

Table. Stroke Rehabilitation Performance Measures by Category and Setting

No.	Performance measure	Category	Applicable settings
1	People with stroke who cannot safely swallow should have enteral feeding initiated within 7 d after stroke	Preventive Treatment	Acute hospital
2	People with stroke and urinary symptoms should have an assessment of urinary retention through bladder scanning or intermittent catheterizations after voiding while recording volumes	Preventive Treatment	Acute hospital, postacute facility*
3	People with stroke who qualify for, would benefit from, and have geographic access to IRF care should receive acute inpatient rehabilitation in an IRF	Treatment Standards/ Disposition Process	Acute hospital, postacute facility*
4	People with stroke should receive ADL and mobility training tailored to individual needs and eventual discharge setting	Active Treatment Process	Acute hospital, postacute facility,* home care, outpatient
5	People with stroke with residual aphasia should receive SLT	Active Treatment Process	Acute hospital, postacute facility,* home care, outpatient
6	People with stroke should be provided education about stroke, including information on secondary prevention, rehabilitation, and the opportunity to talk about the impact on their lives	Educative Treatment Process	Acute hospital, postacute facility,* home care, outpatient
7	People with stroke who have impaired balance, low balance confidence, or fear of falls should be provided a fall prevention training program	Active and Preventive Treatment Process	Acute hospital, postacute facility,* home care, outpatient
8	People with stroke should be screened for depression with a structured depression inventory	Assessment	Acute hospital, postacute facility,* home care, outpatient
9	People with stroke diagnosed with poststroke depression should receive appropriate evidence-based treatment	Treatment	Acute hospital, postacute facility,* home care, outpatient
10	People with stroke who have impaired mobility should receive DVT prophylaxis during postacute inpatient rehabilitation	Preventive Treatment	Postacute facility*
11	People with stroke receiving postacute rehabilitation in an inpatient setting should receive organized, coordinated, interprofessional care	Treatment Standards/ Disposition Process	Postacute facility*
12	Follow-up is recommended to ensure that people with stroke and their families receive the necessary rehabilitation services after discharge	Assessment Process	Home care, outpatient
13	People with stroke should be provided an individually tailored exercise and fitness program	Active Treatment Process	Outpatient

ADL indicates activity of daily living; DVT, deep vein thrombosis; IRF, inpatient rehabilitation facility; SLT, speech and language therapy; and SNF, skilled nursing facility.

* Postacute facility includes IRFs, SNFs, and long-term acute care hospitals.

THE GUIDE CONSISTS OF TWO PARTS

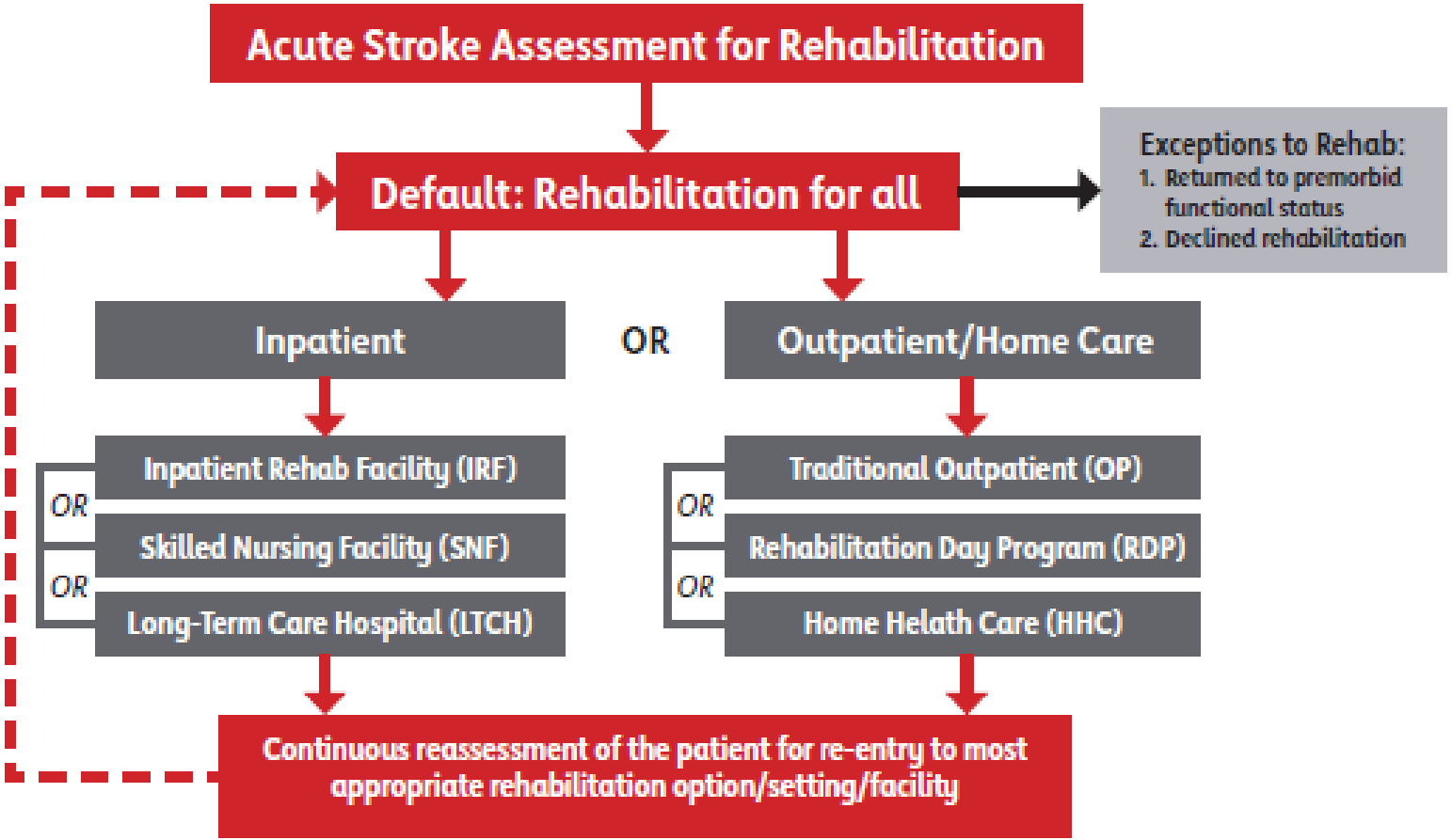
Discharge Planning Pathway

Post-Acute Stroke Rehabilitation Comparison Tables

https://www.heart.org/-/media/Files/Affiliates/MWA/Nebraska-ML-Stroke/2021NEMLStrokeDischargeplanning-Guide-for-Providers.pdf

American Heart Association. Mission:Lifeline®

Discharge Planning Guide for Stroke Rehabilitation Pathway



Discharge Planning Guide for Stroke Rehabilitation: Post-Acute Stroke Rehabilitation Comparison Tables

Inpatient Program Settings	Inpatient Rehabilitation Facility (IRF, Acute Rehab) Recommended setting for stroke rehabilitation[1]	Skilled Nursing Facility (SNF Sub-Acute Rehab)	Long-Term Care Hospital (LTCH)
Purpose of program/facility	For patients with complex medical, rehab, and nursing needs	For patients with daily skilled nursing and/or rehab needs who cannot tolerate intensity of IRF and who do not require a daily physician visit	For patients with complex medical needs requiring a hospital level of care (e.g. ventilator weaning, wound care)
Medical services	Daily physician visit required, often a physiatrist	Daily physician visit not required	Daily physician visit, often an internist
Nursing services	24/7 nursing; may be certified rehab nurse	Nursing onsite based on patient population needs	24/7 nursing
Rehabilitation services	Comprehensive, intensive rehab program with a coordinated team approach (PT, OT, SLP, Psych, Recreation Therapy)	Rehab program with PT, OT, SLP	Multiple therapy disciplines (PT, OT, SLP, Respiratory Therapy) are available
Coordinated, team approach	Yes, with regular coordinated, interdisciplinary team meetings	Not required	Not required
Therapy intensity	3 hours/day, 5 days/week minimum	No minimum therapy requirement; typically, lower intensity than IRF	No minimum therapy requirement
Type of patient needs	Able to tolerate intensive rehab (3 hours/day, 5 days/week minimum)	Daily skilled nursing and/or rehab needs for patients who cannot tolerate intensity of IRF; minimal medical complexity	Complex medical needs with multiple co-morbidities
Expectation for discharge	Expect measurable improvement in functional status by discharge; goal is return to community	Expect measurable improvement in functional status within 100 day stay	Dependent on progress and medical stability
Type of facility	Separate unit of a hospital or a free standing rehab hospital	Stand-alone facility, or separate licensed unit of a hospital or nursing home	Stand-alone facility, or separate licensed unit of a hospital

Discharge Planning Guide for Stroke Rehabilitation: Post-Acute Stroke Rehabilitation Comparison Tables

Home/Outpatient Settings	Traditional Outpatient (OP)	Rehabilitation Day Program (RDP)	Home Health Care (HHC)
Purpose of program	For patients who benefit from 1-2 skilled therapies	For patients who no longer require hospitalization and would benefit from at least 2 skilled therapies and a more intense OP program	For patients who live at home but are unable to travel to obtain treatment
Medical services	Medical services provided by primary care provider and/or specialist	Medical services provided by primary care provider and/or specialist	Medical services provided by primary care provider and/or specialist
Nursing services	No nurse on-site	Available	Available
Rehabilitation services	PT, OT, and/or SLP	PT, OT, SLP, Recreation Therapy, Psychology	PT, OT, and/or SLP
Coordinated, team approach	Not required	Yes, with weekly interdisciplinary team meetings	Not required
Therapy intensity	1-3 therapies per day, 2-3 days per week	2-3 therapies, 4-6 hours/day, 2-3 days per week	1-3 therapies per day, 2-3 days per week
Type of patient needs	**Able to travel**, medical problems are well controlled, continue to have rehab needs	Living at home, able to travel and would benefit from high-intensity rehab services but do not require 24-hour nursing care in a hospital setting	**Homebound**, with rehab and/or nursing needs
Expectation for discharge	Maximal rehab potential	Maximal rehab potential	No longer home bound or achieves maximal rehab potential
Type of facility	Outpatient clinic, outpatient clinic of a hospital, other outpatient centers	Outpatient clinic of a hospital	In the home

DISCHARGE PLANNING GUIDE – FOR PATIENTS

American Heart Association. Mission:Lifeline® Stroke

Nebraska STROKE Advisory Council

I just had a stroke... now what?

Choosing the right place for you!

The patient *and* family both need to choose the facility/provider that will best meet their needs and goals for recovery.

Start with these questions:

QUESTIONS BEFORE DISCHARGE

- What areas of my brain have been affected?
- How does this affect my life?
- What is the prognosis and expected course for my recovery?
- Will I continue to make progress after I go home?
- What medication and activities are needed to help prevent a future stroke?

QUESTIONS ABOUT REHABILITATION

- How do I find accredited Rehab facilities?
- What types of rehab care will my insurance cover?
- How do you individualize the therapy program?
- What do you do to make it a safe environment?
- How often will I see a doctor?
- How long will I be in rehab?
- How will I know when I am ready to go home from rehab?
- What percentage of patients are able to go home from rehab ?
- Will I continue to improve after I discharge from rehab?
- How do you involve my family member/caregiver?

TIPS FOR CHOOSING A REHABILITATION FACILITY

Not all types of facilities are available everywhere. Depending on where you live you may have lots of choices, few choices, or no choice without traveling some distance.

Insurance may limit what facilities are available (e.g. a specific facility may not be "in-network on your health plan). If there are multiple options in your area, ask the health care team for a recommendation.

For further information on Stroke Accredited Rehabilitation Programs check this website:
Find a Provider (carf.org)

Programs	What Patients Get	Setting	Frequency of Rehabilitation	Likely Candidates
Inpatient Rehabilitation facilities (IRF)	Hospital level of care that is physician directed with 24-hour specialized nursing care. An interdisciplinary team of specialty trained staff who develop an individualized plan of care. Daily physician visits are required	Separate unit of a hospital or a free standing rehab hospital	3 hours/day, 5 days/ week minimum	Survivors who have medical issues and may develop problems without continued medical treatment. Able to tolerate 3 hours of some therapy each day
Skilled Nursing facilities (SNF)	Skilled nursing and/or therapy services with no minimum therapy requirement. Services are commonly performed by or under the supervision of a registered nurse. Periodic physician visits but no minimum number of physician visits is required.	Stand-alone facility or separate licensed unit of a hospital or nursing home	Less demanding program, but continues for longer periods	Survivors with minimal medical issues, but often fairly serious disabilities who are unable to tolerate the intensity of an inpatient rehab program
Long-term acute care facilities (LTCH)	Hospital level of care with highly specialized medical care and rehabilitative services; daily physician visit required	Stand-alone facility or separate licensed unit of a hospital	2-3 days per week	Survivors who have complex medical needs, often with multiple medical conditions, requiring 24- hour nursing care
Outpatient clinics	Care transitioned to primary care provider; physical, occupational, and/ or speech therapy, and possibly other services	Outpatient clinic, outpatient clinic of a hospital, other outpatient centers	As needed	Survivors who have medical problems under control enough to live in their homes and are able travel to receive treatment
Home Health Care	Care transitioned to primary care provider, skilled nursing; speech, physical and occupational therapy; health aide; and social services as needed	In the home	As needed	Survivors who live at home but are unable to travel to get their treatment

Members who may be a part of your Rehabilitation Team	
Physiatrist	A doctor who specializes in rehabilitation following injures, accidents or illness
Neurologist	A doctor who specializes in preventing, diagnosing, and treating stroke and other disease of the brain and spinal cord
Rehabilitation Nurse	Specializes in helping people with disabilities; helps survivors manage health problems that affect stroke (e.g. diabetes, high blood pressure) and adjust to life after stroke
Physical Therapist (PT)	Helps stroke survivors with problems in moving and balance; suggests exercises to strengthen muscles for walking, standing and other activities
Occupational Therapist (OT)	Helps stroke survivors learn strategies to manage daily activities such as eating, bathing, dressing, writing, or cooking
Speech-Language Pathologist (SLP)	Helps stroke survivors re-learn speech, language, and cognitive skills (talking, reading, writing, memory, and problem solving); treats swallowing problems
Dietitian	Teaches survivors about special diets and diet consistency (e.g. thickened liquids) and health eating (e.g. low salt, low fat, low calorie)
Social Worker	Helps survivors make decision about rehabilitation programs, living arrangements, insurance, and support services in the home
Neuropsychologist	Diagnoses and treats survivors facing changes in thinking, memory, behavior, or depression
Case Manager	Helps survivors facilitate follow-up, coordinate care from multiple providers and link to local services
Recreation Therapist	Helps stroke survivors learn strategies to improve thinking and movement skills by using recreational activities

Many other resources for stroke survivors can be found at Recovery Resources for Patients | American Stroke Association

https://www.heart.org/-/media/Files/Affiliates/MWA/Nebraska-ML-Stroke/2021NEMLStrokePatientGuide.pdf

American Stroke Association.
A division of the
American Heart Association.

2 Funding

- Insurance for health care needs
- Funding
  - Prior authorization
    - NO auth needed for traditional Medicare AB
    - Medicare Advantage plans, Medicaid, Commercial Insurances
    - 60% rule is a must for advantage plans (Inpatient Rehab)
    - Average 48-72 hrs turnaround time for most auths
    - TIP: Submit good therapy notes, use standardized test results
    - TIP: Patient initiated appeals – good chance of getting approval, but does delay discharge
    - In or out of network: single case agreements
- What is the financial situation? Still working? Difficult Conversation!
- Long term financial planning, planning beyond the next step
- Additional expenses: medications, equipment, home modifications,

3 Support: Patient and Family

- Involve the patient and support person
  - What are the patient and family preferences?
  - What is their understanding of medical situation?
  - Are their expectations realistic?
  - Know level of commitment and ability to assist, what is the tipping point?
  - Tip: Care partner program
  - AHA Resource

4 Intentional Conversation

- Plan two steps ahead with discharge needs and recovery
- Communicate discharge goals and level of care anticipated, be transparent
- Tip: Have three plans
  - Hope for the best, return to baseline
  - Plan for the worst, no change from current status
  - Middle of the road plan, progress with more progress to make, rehab recovery is a journey!
- Who in your facility is having this conversation with the patient and family?
  - Provider
  - Therapy Team
  - Discharge Planner

GREY Box = NOT CANDIDATE

Example of Referral Tool-Consults

Date: 10/17/20

(Care Management: Jordan

Physiatrist on call: WS

Program Coordinator: Shelly

CURRENT CONSULTS

Priority	Status	Room #	Name		60 %	PM&R	Hosp Dr	Tx Goal	Tol Therapy	Funding	Med Rdy	D/C Plan	Pt Agrees/ Other
	Wants to avoid too much therapy. **Wants to go home.**	3200		GB Plasmapheresis QOD for 10 days		DS	Y	Y	N	Mcr + supp		Home alone, Kearney	
Wed	Approved	6201		s/p CABG	N	WS	Y	Y	Y	Healthy Blue		Wel Cov ALF	
Thur	72 y/o female	1115		CVA	Y	DS	Y	Y	Y	Mcr + supp		Loperland, spouse avail 24/7 2 steps	
Priority	**Status**	**Room #**	**Name**	**Dx**	**60 %**	**PM&R**	**Hosp Dr**	**Tx Goal**	**Tol Therapy**	**Funding**	**Med Rdy**	**D/C Plan**	**Pt Agrees/ Other**
	Not wanting to come or participate in therapy overnight ativan x3 for CIWA	6301		Acute Encephalopathy		WS	Y	N	N	Pending medicaid		Huskerville, alone	
	Follow for goals… Fell on Monday **TEE Tues**	6322		CVA, multifocal cause? Poly drug use Cardiology and Echo	Y	DS	Y	Y	?	UHC Medicaid	N	Alone, Lots of family support	
denied	Auth Denied	6323		Polytrauma, cow		DS	N	Y	?Y	UHC Mcr		Wife / family. MO	

#5 Competing Priorities

- Length of Stay
- Readmissions
- Financial Needs of the Organization
- Tip & Tool: Complex case team meeting, involve your entire team and leadership

Pt Name	Room Location	Care Manager	Attending	Admit Date	Admitting Diagnosis	GMLOS	LOS	Avoidable days assigned	READMIT RISK	Current Charges (those over $100K)	Last Covered day of acute stay

Primary Payer	Clinical barriers	Barriers to dc/placement	Proposed solutions	CM updates	Conifer/EES update	Action Task Assigned	Outcome	CAH denials

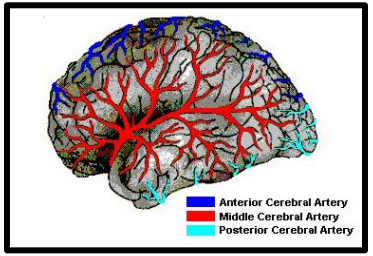
6 Social Determinants of Health

The social determinants of health (SDH) are the non-medical factors that influence health outcomes.

1. Income and social protection
2. Education
3. Unemployment and job insecurity
4. Working life conditions
5. Food insecurity
6. Housing, basic amenities and the environment
7. Early childhood development
8. Social inclusion and non-discrimination
9. Structural conflict
10. Access to affordable health services of decent quality.

Reference: World Health Organization

7 Medical Complexities



- Medical complexities & co-morbidities
  - **HTN** - monitor BP and treat with antihypertensive regimen.
  - **Diabetes** - Monitor blood sugars. Diabetic diet. Insulin management. Resume home meds as indicated. Outpatient follow-up for continued care with PCP
  - **Atrial fibrillation** - anticoagulation management when appropriate (avoid excess risk of hemorrhagic conversion). Rate control.
  - **Tobacco use** - cessation counseling. Nicotine substitute. Outpatient follow up PCP for ongoing cessation. Behavior / psychological.
  - **Secondary stroke prevention** - statin. HTN control. Diabetes control. Afib control. Tob cessation. Physical activity. Lifestyle counselling as indicated.
  - **DVT prophylaxis** - SCDs. Mobilize. Pharmacological prophylaxis when appropriate.
- Prolonged wait times for procedures and tests
- Multiple specialists
- Patient readiness & medical stability for transition to the next level of care
- Connection with Primary Care Physician, PCP

8 Transition Planning & Resources

Ideal Discharge - return to previous home at prior functional level

- TIP: Home Safety Evaluation or Home Video Assessment
- Equipment ordering - wheelchairs, walkers, canes, etc.
- Car Transfer Training or RV
- Family/care partner training
- Up independent in the room privileges
- Community Integration Program
- Blood Pressure Monitor at discharge

Alternate Discharges & Community Resources - swing bed, skilled nursing facility, family member’s home, hotels, homeless shelter

8 Transition Planning & Resources

Can the patient or family state the plan and who is going to be doing what?

- Continue therapy
  - HHC, Clinic, home exercise program (outpatient therapy) TeleHealth, Home Exercise Program
- Hired Caregivers, chore services, grocery, food prep plans
- Medication Plans, med packs, pill organizers
- Lifeline/Alert Systems
  - Twice daily check in system, iamfine.com $120 per year
- Transportation or return to driving
- Outpatient Medical follow ups
  - PCP, Neurology, PM&R, other specialties (diabetes education, tobacco cessation)
- Reminders
  - Phone reminders and alarms
  - Reverse home mortgages as a resource to obtain resources
  - Technology with Alexa

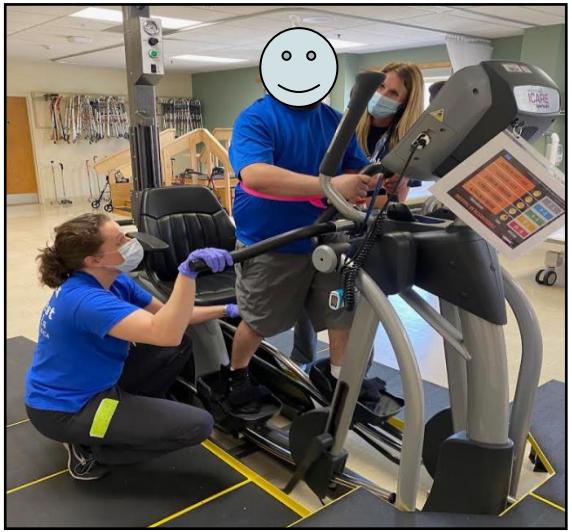
9 Bring Inpatient Rehab to the Patient

- Limited Inpatient Rehab Options; Bring Inpatient Rehab Program to the Patient
  - 3+ hours of focused therapy per day between Physical Therapy, Speech Therapy and Occupational Therapy, Medical Management, Nursing Interventions
  - Up & dressed by 8 a.m., Wellness Focus & Structured Therapy Day with a Schedule
  - Follow patient for medical and rehabilitation management.
    - Initial evaluation on admission.
    - Daily rounding and management.
    - Individualized care conference.
    - Discharge planning.

TIP & TOOL: Daily Huddle Sheet- Current Patients

Rm	Current Patients Name	Admit	PM &R	PCP	Spec need	Mob	Current Issues	D/C Plan	D/C Goal	Fund	D/C Needs dressing, IV's, therapy	Equip Needs	D/C Date	CLOS	ELOS	IRF-skin, cont, diet, falls,dx
0																
1																
2	Taylor Smith 76 yo F	10/13	WS	Y	Stroke	1A	Vision and speech	Home with husband SD	SBA	Mcr + supp	TBD	TBD	10/27	4	14 14d	
3	72 y/o F	11/15	DS	Y		1A		Home with husband	Mod I	Mcr + supp	TBD	TBD	10/27	4	14 14d	
4	Alan Jackson 60 y/o male	10/12	WS	Y	Stroke	1A	McGowan to see??	Kearney, sig other	Mod I	Mcr & Supp			10/23	5	10 11d	
11	Dolly Parton 79 yo F	10/16	DS	Y	C Spine surg	2A	ENT consult	Hastings, NE alone Patient wants DC on 10/20	Mod I	BC NRD 11/23		Has a 4WW and w/c	10/30	1	14	10-16 fall, no injury
12																

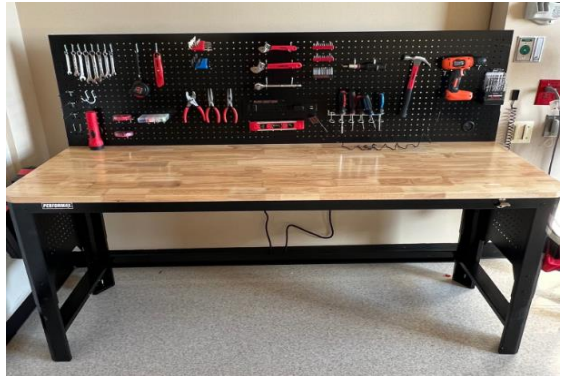
Equipment



- Reachers
- Sock Aides
- Long Handled Shoe Horns

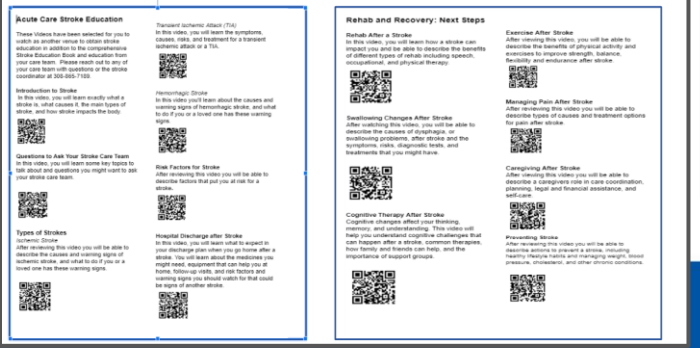
- Communication Boards/Augmentative Devices
- Slide boards/beasy boards
- Sit to stand lifts/Sara Stedy

Inpatient Rehab & Stroke Support Group



New patient education handout that will be in the white acute and rehab stroke education books to enhance education options for patients & families!

Please help encourage the patient and family to view the videos!



CHI Health

Kearney Physical Therapy Experience Mobility

Third Thursday of the Month

Stroke Support & Wellness Group

Providing Support & Education

This group is designed to promote health and healing following a stroke for both the caregiver and survivor. Participants will be provided with education, support and networking opportunities.

- **Join us the third Thursday of the month**
  - **4:30 to 5:30 p.m.**

Location: Kearney Physical Therapy
2707 2nd Ave Suite B, Kearney, NE

For questions: 308-865-7189 or 308-865-7183

To receive reminder updates and to be added to our email distribution list please send an email to: shelly.jorges@commonspirit.org

A zoom link can also be shared upon request!

Hello humankindness

CHI Health

LET'S USE THE GUIDE!

Case 1 Jennifer

- 75 y/o woman with left cerebral stroke resulting in paralysis of right arm, weakness of right leg, and difficulty speaking.
- Requires moderate to maximal assistance for most ADLs and walking with a device. Needs supervision for feeding so that she doesn't over fill her mouth and is on a mechanical soft diet.
- Client has fluent speech output with no hesitation. However, the output of what is said is empty and contains made up words. She produced the following when looking at a picture of her grandchildren playing in the park. "this one is is words and sentences that one is a pollysterman that is so wild no-one knows what he is doing so they just start at his being toad."
- Social History: Lives in rural town in Montana with spouse who is somewhat frail. Active in civic affairs. Has family living within 60 miles. Funding Medicare and a supplement.
- PLOF: Independent with ADL & IADLs. Still driving; drove most of the time for spouse, though spouse can still drive.

Case 2 Jack

- 57 y/o man with right hemorrhagic stroke resulting in weakness of left arm and leg, difficulty seeing and attending to things on the left side, and cognitive difficulties (impulsive behavior, short-term memory impairment, difficulty with decision-making).
- Requires supervision to minimal assistance for walking, though collides with objects on the left.
- Performs ADLs with minimal assistance – supervision (verbal cues). IADLs with cognitive components require moderate to maximal verbal cueing.
- Social History: Lives in Florida with spouse who works as a schoolteacher who is on a 9-month contract. Works full time as a truck driver. They are camping for an extended period of time near Livingston,MT. They have extended family that live in Billings Mt. Funding Medicare Advantage Plan.

Use Pathway and Comparison Tables to discuss recommended post-acute rehab setting; and any barriers, conflicts or challenges to recommended setting.

Program Considerations

- Collect & know your data
- Don’t forget about patient experience
- Establish outcomes metrics
- Complete follow up phone calls
- Learn from the patients & families
- Establish a Steering Committee
- Continual Process Improvement
- Involve all the team and the facility

Review Top 10 Discharge Considerations

1. # 1 Stroke Recovery & Rehab Needs
2. # 2 Funding
3. # 3 Support: Patient and Family
4. # 4 Intentional Conversation
5. # 5 Competing Priorities
6. # 6 Social Determinants of Health
7. # 7 Medical Complexities
8. # 8 Transition Planning & Resources
9. # 9 Bring Inpatient Rehab to the Patient

AND

1. # 10 Support, Integration & Meaning

#10 Support, Integration & Meaning

- Continued recovery to improve quality of life, regain function, adaptation,
  - Beyond ADLs, Return to recreational and leisure activities
  - What brings meaning to the patient?
  - What is on his or her bucket list?

- Return to work
  - Temporary and permanent restrictions
  - Vocational rehabilitation

- Celebrate recovery!!

Celebrate!! Code Rainbow

Sources & Resources

- Guidelines for Adult Stroke Rehabilitation and Recovery, A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association, Stroke AHA Journal, June 2016
- Which Road to Recovery? Factors Influencing Postacute Stroke Discharge Destinations: A Delphi Study, Stroke AHA, Feb 22
- Use of a Standardized Assessment to Predict Rehabilitation Care After Acute Stroke, PM & R 2015
- Clinical Performance Measures for Stroke Rehabilitation, Stroke 2021
- Information on Standardized Assessment Tools Used in Stroke Rehabilitation, Nebraska State Rehab Taskforce, 2023
- Discharge Planning Guide for Stroke Rehabilitation & Patient Guide, 2021Making Rehabilitation Decisions: https://www.stroke.org/-/media/stroke-files/stroke-resource-center/recovery/patient-focused/rehab/ds16058-asa-rehab-decisions_digital_2020.pdf?la=en
- Post-Acute Stroke Program Standards, AHA 2022

Questions

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