Eli's Rehab Report

Acute Rehab: Inappropriate Referrals Throwing Other POCs for a Loop?

Get tips on more efficient patient screenings for therapy

If you work in an acute rehab setting, you're probably familiar with a growing trend of inappropriate therapy referrals that are chewing up a good portion of your time -- and taking away from your other plans of care.

Experts have noted it too. "The demand for therapy evaluations has probably increased four-fold in the last four years," says **Fran Fowler, FAAHC,** president of Fowler Healthcare Affiliates Inc. in Atlanta. Perhaps it's due to the nursing shortage, but hospital staff has less and less time to get patients out of bed. And when physicians take note, they may order therapy evaluations in hopes that patients may qualify and get out of bed.

"But many referrals don't qualify for therapy, and the therapists spend a lot of their time doing evaluations -- which leaves the patients who really could use rehab in a lurch," Fowler says. So therapists in acute care must create screening methods that quickly evaluate whether the patient doesn't qualify for skilled therapy or he actually does need a full eval.

Start With Good Staff Education

The best way to keep inappropriate therapy referrals at a minimum is to educate others at your hospital. See what your peers are doing along these lines to ensure appropriate therapy referrals.

Physicians: "We have a hospitalist program, and one of the acute PTs attends the rounds every morning, which is about 30 minutes," says **Cindy Sayce, OTR/L,** director of acute care and inpatient rehab programs for FirstHealth of the Carolinas in Pinehurst, N.C. "The PT takes a laptop with access to therapy documentation so she can answer questions on whether patients are already being seen, etc., and she can also educate the hospitalist on appropriate referrals through the rounding."

If you have residents at your facility, you'll also want to reach out to them so they're informed about appropriate therapy referrals wherever they take their career. "We educate residents at our hospital on what would be an inappropriate referral," says **Susan Davis, PT, MBA,** director of acute rehab at Moses Cone Health System in Greensboro, N.C. "We also give a typical spiel on what PT, OT and SLP consist of and these therapists' roles in the acute care setting."

Nursing staff: Make sure your nursing staff is educated too. You don't want a nurse suggesting to the physician that a patient needs rehab when the nurse may simply need to walk or transfer the patient. "We [therapy staff] often work with nursing staff to make sure they feel comfortable on an individual basis with moving patients, and we may even take them through a transfer," Davis says. The key is to make sure nursing staff is doing everything they can that's within their scope of practice before calling on rehab.

You can also take the approach of, "if you [nursing] help us [therapy] by assisting the easy patients, then we will have more time to get the more involved patients out of bed," Sayce says.

Hospital administration: Putting a bug in a bigwig's ear isn't a bad idea either. For example, administration should know that it's much cheaper for a well-trained CNA to assist patients out of bed, compared to the cost of a PT, Sayce says. "Most physicians, as well, are getting more involved in controlling their cost per case, so you can use that angle with the doctors as well."

Modify Your Eval Process

Another way to ensure you have ample time to treat patients who really need therapy is to make your evaluation process as efficient as possible. Most therapists look at preadmission status for starters, but if you do have an

inappropriate referral, try using a screening form to weed out patients right away who don't need or wouldn't benefit from therapy. "Within acute care, we have a shorter form that just hits the highlights and has all the information we need from a regulatory standpoint to ensure the patient doesn't have any subtle therapy needs," Davis says. "But we would use a much more in-depth form for a stroke patient, for example."

Another way: "We might decide to do a screen if we can tell from a chart review and a quick discussion with the nurse that the patient may not need skilled therapy," Sayce says. As for billing, FirstHealth has a charge setup that does not have a dollar value but does assist in calculating the man-hours of the staff that completed the screen, she adds.

Smart: Good use of technicians can also make your evals more efficient. For example, "if a therapist has three or four evaluations to do in the morning, he may take a technician with him to set up the patient room and to explain to the patient what's about to happen," Davis says. "Then after the eval, the technician can help wrap up the room while the therapist is doing the documentation."

Location, Location, Location

If all else fails, or if staff education and eval modification seems like a tall order at the moment, the simplest of changes can help speed the eval process and give therapists more time to work with patients. Moses Cone, for example, focuses heavily on ensuring that everything the therapist needs is in a convenient location. "We have carts that our therapists use that have things they would likely use to treat or evaluate patients," Davis says. A cart might have things like oxygen tubing, a cane, pulse oximeters, and sanitary booties for walking, among other things.

"We also have some storage space now at three different locations in the hospital, so if the patient needs something, such as a wheelchair, the therapist doesn't have to go to the other end of the hospital to get it," Davis says. In addition, the hospital places specialty equipment (e.g., a bariatric walker) in a centralized location.

Good idea: It also helps to think "location" with staff, as well. "We've gone to floor assignments so that our therapists are assigned to a couple of floors, and they're on those floors pretty much all day," Davis says. This helps them establish relationships with nursing staff, which leads to better information about the patients and who may really need therapy.

So in the end, whether you decide to do a complete overhaul of processes to avoid inappropriate referrals, or you decide to take baby steps, every little thing counts. The key is to keep open communication with every person involved with the patient.