SUBJECT: Trauma Rehab & Discharge Planning Guideline **PAGE:** 1 of 1
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PURPOSE:

To create a process for providing multidisciplinary assessments of patients to determine services that will be required during the acute phase of care. This also serves as a pathway for determining the level of care and specific rehabilitation care services patients will require after discharge.

DEFINITIONS:

Activities of Daily Living (ADL): performing basic physical needs such as hygiene, dressing, eating, toileting, and mobilizing

Instrumental Activities of Daily Living (IADL): performing complex skills to live independently such as communication, transportation, shopping, food preparation, housekeeping, health management, and finances

Discharge Planning: The process of assessing the patient's needs of care after discharge from a healthcare facility and ensuring that the necessary services are in place before discharge. This process ensures a patient's timely, appropriate, and safe discharge to the next level of care or setting including appropriate use of resources necessary for ongoing care.

Subacute/Skilled Nursing Facility (SNF) is a level of care for a patient who does not require hospital acute care, but who requires more intensive skilled nursing care, therapy and physician services than is provided to most patients in a skilled nursing facility. SNF's offer 24-hour skilled nursing and personal care. They also have rehabilitation services. Patients must be medically stable to qualify for SNF level of care. They must also have a need that must be performed by a skilled, licensed professional daily. Examples are complex wound care and rehabilitation when a patient cannot tolerate 3 hours of therapy a day.

Nursing Home/Long Term Care is a facility that can provide 24-hour supervision as well as assistance with ADLs and IADLs. It is a residential care facility for older adults and/or the disabled.

Long-Term Acute Care Hospitals (LTACHs) are certified as acute care hospitals, but LTACHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTACHs are transferred there from an intensive or critical care unit. LTACHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. Services provided in LTACHs typically include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Inpatient Rehabilitation Hospitals provide intense, multidisciplinary therapy to patients with functional loss. To qualify for this level of care, patients must be able to tolerate at least 3 hours of therapy per day, 5 to 7 days a week.

Home health care provides intermittent skilled care to patients in their home. Skilled nursing, physical therapy, occupational therapy, speech therapy and medical social worker visits are services that home health agencies provide. For a patient to qualify for home health, they must be deemed homebound. To qualify as homebound, the patient must be unable to leave their home, or it would require great effort to leave.

GUIDELINE:

Evaluation:

1. Patients with multisystem trauma or with injuries that affect one's ability to perform ADLs and IADLs will require multidisciplinary evaluations after admission to determine acute care needs and to begin discharge planning process. Consults for these evaluations will be placed within the first 24 hours of admission or when the patient is surgically/medially stable for evaluations. Consultations will be placed by trauma team based on preexisting functioning, injury burden, social support, social barriers, and psychosocial functioning.
2. Case Management/Social Work perform assessment within 24 hours of admission to determine social support, preexisting functional status, barriers, and/resources for time of discharge.

Inpatient Consultations/Referrals:

1. **Physical Therapy:** evaluate and treat patients after injury to assess limitations in mobility that may require specialized equipment or rehabilitation post discharge
2. **Occupational Therapy:** evaluate and treat patients after injury to assess limitations in ability to perform ADLs that require fine motor skills
3. **Speech Therapy:** evaluate and treat patients after injury to assess limitations in IADLs in relation to cognitive deficits.
4. **Physical Medicine and Rehabilitation:** specialized group of providers whose goal is to improve function and quality of life in those who have suffered an injury or significant medical event
5. **Social Work/Case Management:** assess the physical and psychosocial needs of patients and families to coordinate care, advocate, and arrange needs throughout hospitalization and discharge
6. **Neuropsychology:** specialized provider who evaluates, supports, and treats patients and families through how brain injury, cognitive deficits, and illness can affect daily life

Discharge Planning:

1. Daily updates from Trauma Team in EMR for estimated discharge date
2. Daily multidisciplinary meeting to include Trauma Team, Case Management, Social Work, Rehabilitation Services, Neuropsychology and Nursing to discuss medical status, rehabilitation needs, Rehabilitation Services recommendations, barriers to discharge, and post-discharge level of care.
3. Discussion with patients/families/caregivers on daily rounds that includes information about discharge needs.

Follow-up:

1. Appropriate orders placed upon discharge for follow-up from consultants
2. Trauma Clinic follow-up as indicated by injuries
3. Post-discharge phone call from outpatient nurses
4. Arkansas Trauma Rehab Program for Traumatic Brain Injury and Spinal Cord Injury

References:

American Academy of Physical Medicine and Rehabilitation. AAPM&R Post-Acute Care (PAC) Toolkit (2023) https://www.aapmr.org/quality-practice/aapm-r-post-acute-care-(pac)-toolkit/patient-eligibility#IRF

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