IN FOCUS

The Broken Link: Admission Criteria for Inpatient Rehabilitation and Some Common Misconceptions

Admitting a patient to a rehabilitation hospital or unit is a complex decision that involves the consideration of medical, functional, and other criteria that are almost always interrelated.[1] There are multiple factors that need to be considered by several interested parties, including the patient, admitting team and discharging team, therapists in various disciplines, in addition to the financial supporters. All of these parties must agree that admission to an inpatient rehabilitation (IPR) facility is appropriate prior to admission. There are two main factors considered during the IPR admission process. One important factor to address is whether or not the patient is suitable for this particular modality of care. Another important factor is reimbursement to the facility. This is of particular significance in health care systems where health insurance is involved. However, discussion of financial considerations is beyond the scope of this article as it varies from one health system to another.

There has been a growing demand for rehabilitation services globally, likely due to an aging population and increasing prevalence of disability.[2] An Australian study published approximately two decades ago showed that only 21% of patients who were screened as being eligible for rehabilitation actually ended up receiving it.[3] In recent years, the acceptance rate of patients referred for IPR has increased. Between 1986 and 1994, referrals and admissions to IPR facilities in the US have nearly doubled.[4] Recent reports indicate that the acceptance rate of patients who were referred for evaluation for IPR in the US ranges from 64% to 81%.[5,6]

An acute IPR program is comprised of a multidisciplinary team of health care professionals with training and experience in rehabilitation. It includes various disciplines working in coordination with each other to address the complex medical and rehabilitation needs of patients with activity limitations. The therapy services usually include a combination of the following: Physical therapy, occupational therapy, speech therapy, swallowing therapy, cognitive therapy, respiratory therapy, mental health services, dietary services, assistive technology, social worker services, prosthetic/orthotic services, and rehabilitation nursing. In many inpatient settings, physiatrists are team leaders responsible for the medical and rehabilitative care of the patients. Patients may require acute IPR after certain health-related conditions result in significant functional deficits. These conditions are secondary to medical illnesses, trauma, or developmental disorders. A wide variety of patients is admitted to IPR, including individuals with spinal cord injury, acquired brain injury, multiple sclerosis, amputations, joint replacements, major multiple trauma, debility, developmental disorders, and cancer. A patient admitted to acute rehabilitation care must be capable of fully participating in the IPR program. The goals of acute rehabilitation are to facilitate neurological recovery, minimize disability, and to achieve or regain maximum functional potential of an individual for mobility, self-care, and independent living. It is imperative to understand that complete independence may not be the ultimate goal; however, a measurable improvement in functional ability must be demonstrated.

Terms that are often used during the IPR admission process are "medical appropriateness" and "medical necessity." Medical appropriateness can be defined as the clinical judgment of a physician that a patient needs care, has the potential to benefit, and that the environment of the rehabilitation unit is the most appropriate environment for that care to be delivered.[1] Medical necessity is a term commonly used by insurers to indicate that particular health care services meet their criteria for payment under the terms of their contracts.[1] It is up to the rehabilitation physician to determine that a patient meets the criteria for both medical appropriateness and medical necessity. As referrals typically come from outside the physiatrist's purview, consultations are often requested for patients that do not meet these criteria. When it comes to these criteria, there are common misconceptions among referring providers. These misconceptions can lead to confusion, frustration, and undue consumption of resources and time. Many hospitals have developed formal admission criteria. Many insurance agencies and regulatory authorities have attempted to create similar criteria or tools as well. The lack of agreement between many of these criteria and clinical practice is striking and forms the basis of frequent disagreements that affect access to care by patients and reimbursement for care provided by IPR settings.[1] Ultimately, providers

within each specialty want the best care possible for their patients, so clarifying these misunderstandings is of the utmost importance. The goal of this report is to identify and review some of the common misconceptions often encountered during the referral process for admission to IPR.

MISCONCEPTION 1: TRANSFER TO INPATIENT REHABILITATION BECAUSE THERE IS A DISPOSITION ISSUE

One common source of frustration for both referring providers and admitting providers in regards to referrals for admission to IPR unit is the reason for the transfer. It is often observed that attempts are made to transfer chronic and inactive patients who are admitted under acute care for long durations, unable to participate in therapies and facing disposition issues. Since the acute care rehabilitation unit is an active medical service, this type of patient may not meet the criteria for IPR admission. Each patient should demonstrate the ability to participate in an intensive rehabilitation program and must meet the requirement of medical necessity. Unfortunately, some patients are appropriate to be discharged from the hospital, but because of disposition or social issues, are instead referred to IPR. In many situations, patient selection is also influenced by system factors such as rehabilitation bed availability and pressure on acute care.[7] Although physiatrists can evaluate such patients and give their expert recommendations to facilitate functional recovery and minimize disability, their consultations are generally requested for evaluation for IPR. There is a strong need to identify the role of social workers and care coordinators in these situations given their realm of expertise. Referral to IPR may not be appropriate at this stage but sometimes undertaken because of a lack of insight into the concept of IPR or, at times to avoid any anticipated medico-legal or administrative issues. In reality, physiatrists continue to receive such referrals and providers continue to make such requests with this being a long-standing “silent” muddle. Further, the necessity for nursing care alone is not enough for a patient to meet admission criteria to IPR.

MISCONCEPTION 2: PATIENT CAN BE TRANSFERRED TO INPATIENT REHABILITATION PRIOR TO ESTABLISHING DIAGNOSIS

Transferring a patient to IPR with incomplete diagnostic workup may not be appropriate and could even pose a risk to the patient. Such referrals must be carefully assessed by physiatrists. Pending investigations can range from blood work to imaging, and their results can determine the course of disease and may entirely change the patient’s management. Lack of a formal diagnosis may affect the patient’s therapy plan and may render the need for further workup. This could require services of other medical and surgical specialties, which may not be optimally provided in the rehabilitation setting. The patient may eventually have to be transferred back to acute care. In many situations, the referring team may not find it necessary to readmit the patient to acute care and would insist to continue management in IPR. Unfortunately, this is one of greatest dilemmas of IPR and is observed even in many tertiary care facilities as well.

It is extremely important to understand that a rehabilitation floor is different from an inpatient surgical or medical floor. If for medical or surgical reasons, a patient is unable to participate in the rehabilitation program for a certain period, the patient may not need to be on the rehabilitation unit any longer and would require transfer to an acute care unit. In many hospital settings, consulting physicians may be unwilling to consider transferring the patient to acute care, with the rationale that the same treatment can take place on the rehabilitation floor; however, they may not realize that the rehabilitation floors are not intended to provide exclusive medical care when patients are unable to participate in the rehabilitation program. Most IPR rehabilitation settings are not equipped with cardiac monitors, inotropic support, monitoring, and infusion of certain drugs. Further, expertise may not be available to address the special needs of patients with the left ventricular assistive device, tracheostomy, mechanical ventilation, or central lines.

MISCONCEPTION 3: UNDERSTANDING OF THE TERMS “MEDICALLY STABLE, MEDICAL APPROPRIATENESS AND MEDICAL NECESSITY”

Another source of misunderstanding, particularly between specialties, is the medical appropriateness of a patient. This lies in part due to the ambiguity of concepts such as medical stability. Stability varies greatly depending on the setting in which the patient is placed. For instance, a postoperative patient in the neurosurgical ICU who is described as “stable” may be very different from a “stable” floor patient, and both could be very different from a “stable” patient in the outpatient clinic. Stability is dependent on multiple factors, including vital signs, mental status, and disease activity. Further complicating

the issue, the literal interpretation of stability simply means the patient's status is not changing. As such, a patient with an average blood pressure of 110/70 mmHg requiring inotropes may be described as "stable." Interpreting the description of a patient as "stable" can be difficult because the meaning can change based on context, setting, and the particular provider. Therefore, transferring a patient to IPR because they are medically stable is not enough; they must be medically appropriate in that they stand to benefit from the therapy program, and they can participate actively in therapies for at least 3 h per day. To address these disagreements, an expert panel at the American Academy of Physical Medicine and Rehabilitation developed a consensus position regarding the standards that should be addressed by any decision tool or process intended to determine the correctness of the physician's judgment for admitting a patient to a comprehensive rehabilitation program.[1] Poulos and Eagar reported that there was a lack of agreement between the acute care and rehabilitation teams in determining medical stability for transfer to IPR. This study suggested utilization of a review tool to improve this process.[8]

MISCONCEPTION 4: TRANSFER TO INPATIENT REHABILITATION BASED UPON THERAPISTS' RECOMMENDATIONS AND PATIENT'S WISHES

The wants and needs of the patients should certainly always be considered when it comes to their rehabilitation plan. Their willingness and motivation to participate in IPR is a good prognostic factor; however, the decision cannot be based solely on the patient's request. Many times, when a patient is not considered to be appropriate for IPR, the referring team may argue with the rehabilitation team based upon the recommendations of the therapists working with the patient in acute care. The patient needs to be assessed first by a rehabilitation physician who will determine whether or not the patient meets the criteria for medical necessity. Even if the patient needs physical therapy, an IPR admission may not be indicated if he or she does not need other therapies. In general, a patient should require at least two out of three therapies (physical therapy, occupational therapy, and speech and language pathology) to be eligible for IPR. In addition, if the patient is not considered suitable for IPR, postdischarge rehabilitation services can be obtained through an outpatient physical therapy program or through a skilled nursing facility, assisted living, or home health therapy program. The decision is individualized to determine the most suitable setting for continued rehabilitation. A study on cancer patients admitted for IPR showed that IPR improved outcomes for a short term, but gains were difficult to maintain.[9] This was attributed to the selection of patients for admission to IPR. This study emphasized the importance of multidisciplinary intervention and improved communication to improve the appropriateness of referrals.

MISCONCEPTION 5: TRANSFER TO INPATIENT REHABILITATION BECAUSE A PREVIOUS PATIENT WITH THE SAME DIAGNOSIS WAS ACCEPTED FOR INPATIENT REHABILITATION TOO

Referring providers sometimes have misconceptions based on their prior experience with rehabilitation referrals and the previous types of patients who were successfully transferred to IPR. Such confusions among referring providers are sometimes unconsciously reinforced by the consulting physiatrist team. It is not an uncommon trend for private rehabilitation facilities to be flexible in their admission criteria when their census is low. This commonly occurs when the patient may not be medically appropriate for IPR, but may be accommodated given the availability of beds. Later, when similar patients are denied admission to IPR, the referring provider can be confused. Since they had successfully transferred a similar patient to IPR service earlier, they could obviously become uncertain as to where to draw the line when making referrals to IPR. Establishing a set of criteria for IPR admission should not be that difficult; however, standardization, uniformity, consistency, and application of these criteria are challenging. It is also important for acute care physicians to realize that two patients with a similar diagnosis may not qualify for rehabilitation, as their medical and rehabilitation needs may be different.

PINNACLE OF ALL MISCONCEPTIONS: UNDERSTANDING INPATIENT REHABILITATION AND PHYSIATRY

A physiatrist is a physician who is specialized in the field of physical medicine and rehabilitation (PMR). PMR is also called physiatry or rehabilitation medicine. Even though the US is considered to be a pioneer in the specialty of PMR, there are only 77 Accreditation Council for Graduate Medical Education accredited programs across 28 states.[10] This is reflected in diverse levels of familiarity among medical residents toward different areas of PMR.[11] Clinicians relate differently in their understanding of IPR based upon their previous

experiences, and this may affect the opportunity of patients to undergo rehabilitation. In a multicenter study performed in Australia, it was found that large numbers of stroke patients (37%) were not assessed for any type of rehabilitation.[12] Hence, the likelihood of accessing rehabilitation after a stroke was reduced markedly in the absence of a rehabilitation assessment. Many clinicians perceive "physical therapy" and "rehabilitation medicine" as synonymous and are unaware of the differences between the two. Some perceive PMR as geriatrics where others understand IPR as the rehabilitation of addicts. The domain of rehabilitation is undoubtedly vast, and there are no clear borders. Because different rehabilitation fields are not formally and effectively integrated into medical education, the role of each rehabilitation specialist may not be fully understood. The major responsibility of proactively presenting their respective specialties and their roles in the rehabilitation process lies on the shoulders of rehabilitation clinicians, especially rehabilitation physicians as they are the leaders in the field. The lack of awareness of referring providers represents an opportunity to educate them. This can be more effective if this paucity of understanding is acknowledged at administrative and academic levels.

CONCLUSION

We all operate within the same system with the mutual goal of caring for patients. On many occasions, there is a fine line between whether or not a patient should be admitted to IPR. This decision cannot be stressed enough as it typically has significant consequences on the life of that individual. Similarly, admitting a patient who technically does not qualify for an IPR program can lead to clinical and administrative complications and may consume valuable resources at the institutional and community levels. The IPR admission criteria need to be made simple, standardized, and well known to referring providers. Above all, their consistent and firm application should be encouraged. Low census or financial considerations should not influence the clinical judgment of physiatrists while evaluating patients for IPR. Admitting to or discharging from a rehabilitation unit is sometimes not a simple decision and the complexity of this decision precludes the application of firm quantified criteria. Physiatrists have a critical role in effectively utilizing their skills and medical knowledge in the selection of patients who are appropriate for IPR. Inappropriate admissions can affect the rehabilitation program, compromise bed utilization, and efficiency, impose a financial burden on the institute and possibly pose risks to the patients. Effective communication with other medical disciplines needs to be established to foster beneficial relationships for patient care as well as to minimize misunderstandings.

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