ACUTE REHABILITATION UNIT
OR
INPATIENT REHAB FACILITY

John R. Carbon, DO, MS

Physiatrist - Physical Medicine & Rehabilitation

What Do ARUs Do?

1. Acute Inpatient Rehabilitation Units use a combinations of med-clinical management, therapists & nursing, with a goal of returning the patient to his pre-admit functional status.
2. This includes: mobility (P.T.)

   Functional ADLs (O.T.)

   Cognitive Function/ Speech, Swallow (S.T.)

   Wounds, skin, B/B, medical, (RNs)

Also…

Mental function & communication, with the help of - ***Neuropsychology.***

Discharge planning to appropriate level of care/needs, family training- ***Social Work***.

Adaptive equipment, DME, training, home evals; home→ out-pt therapies & follow-ups

WHICH PATIENTS ARE APPROPRIATE FOR CONSIDERATION TO THE ARU???

1. The patient must have a documented need for multiple therapies, one of which must be O.T. or P.T.
2. Other therapies may include: S.T., Orthotist or Prosthetist.
3. In addition, medical management which requires physician supervision. Eg: DM, PAIN CONTROL, WOUNDS; IV-MEDS, ETC.

ARU ADMIT CRITERIA

From CMS

- ~ The patient must be able to ***actively participate*** in the Rehab services.
- ~ And ***significantly benefit*** from the program.
- ~ The patient needs to make ***measurable improvement*** of ***practical value***.
- ~ The patient must be able to actively partake in Rehab ***3 H/day or 15H/week***.
- ~ Ongoing improvement & needs must be ***documented.***

Disposition From The ARU

~ In general, the goal of an ARU stay is to D/C the patient to ***home or community*** level.

~ The discharge planning ***begins*** with the patient's admission to the ARU.

~ Improvement must be of practical functional value & ***sustainable***.

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The full course of medical treatment , from the referring hospital, must be completed prior to admission to the ARU. {';'}

~ Cardiac stable, angiograms, echos ***done***

EKGs, Holters, Labs are OK.

~ ID-consult, cultures, Imaging, ABx ***done***

Cont. IV-ABx, CXR, F/Us are OK.

~ Anemia, HemOnc, GI, Endoscopy ***done***

Labs, Guiac, F/Us & out-pt are OK.

MEASURE OF FUNCTION

~ 1983 AAPMR & SUNY-Buffalo developed ***FIM***

~ FUNCTIONAL INDEPENCE MEASURE

~ **18** fnx-s, **13** motor & **5** cognitive tested

~ score **0** = dependent **7** = independent

~ FULLY INDEPENDENT = **126**

FIM SCORES ACTIVITIES

1. EATING
2. GROOMING
3. BATHING
4. U. BODY DRESSING
5. L .BODY DRESSING
6. TOILETING
7. BLADDER CONT.
8. BOWEL CONTROL
9. BED → CHAIR TF
10. TOILET TF
11. SHOWER TF
12. LOCO (WALK/W-CHAIR)
13. STAIRS
14. COG. & COMP.
15. EXPRESSION
16. SOC. INTERACT
17. PROBLEM SOLVE
18. MEMORY

FIM SCORE DESCRIPTORS

- 0 = DEPENDENT CAN NOT PERFORM
- 1 = TOTAL ASSIST PT DOES < 25%
- 2 = MAXIMUM ASSIST PT DOES 25 -49%
- 3 = MODERATE ASSIST PT DOES 50-74%
- 4 = MINIMAL ASSIST PT DOES 75%
- 5 = SUPERVISION – SETUP
- 6 = MODIFIED INDEPENDENCE PT /C A.D.
- 7 = COMPLETE INDEPENDENCE… 100%

HOW IS THE KENT ARU DOING ON AVERAGE?

- ADMIT FIM AVERAGE FOR ALL PATIENTS 59

- DISCHARGE FIM AVERAGE PER PATIENT 87
- FIM IMPROVEMENT AVERAGE/PT 28.25

- FIM INCREASE/DAY ON ARU 2.71
- AVE PT IMPROVEMENT IN FNX 48%

KENT ARU DATA 2013

From Kindred/RehabCare

1) Total Admits & Discharges **413**
2) AVE. AGE 69.4
3) Case Mix Index 1.34
4) Community D/Cs 77%
5) SNF D/Cs 12%
6) MED-SURG D/Cs 12%
7) AVE. LOS 12.5 DAYS

HOW DOES A PATIENT GET ADMITTED TO THE ARU?

- 1) Case Mgrs, RNs, ask the attending for an order for P.T. & O.T. S.T. if needed. ARU Consult Order should also be placed. The patient should be assessed within 24 hrs .

- 2) Plan & do this early, a day or 2 post the admission. The therapist should assess & forward this info → to Kent's ARU admissions team for processing.

PATIENT → ARU

3) The info from the therapists will be eval'ed & the criteria described above will be used to determine if the ARU is an appropriate clinical goal & setting for the patient.

4) If #3 is questionable have a back-up plan for the proper level of further clinical care.

The Clinical Work

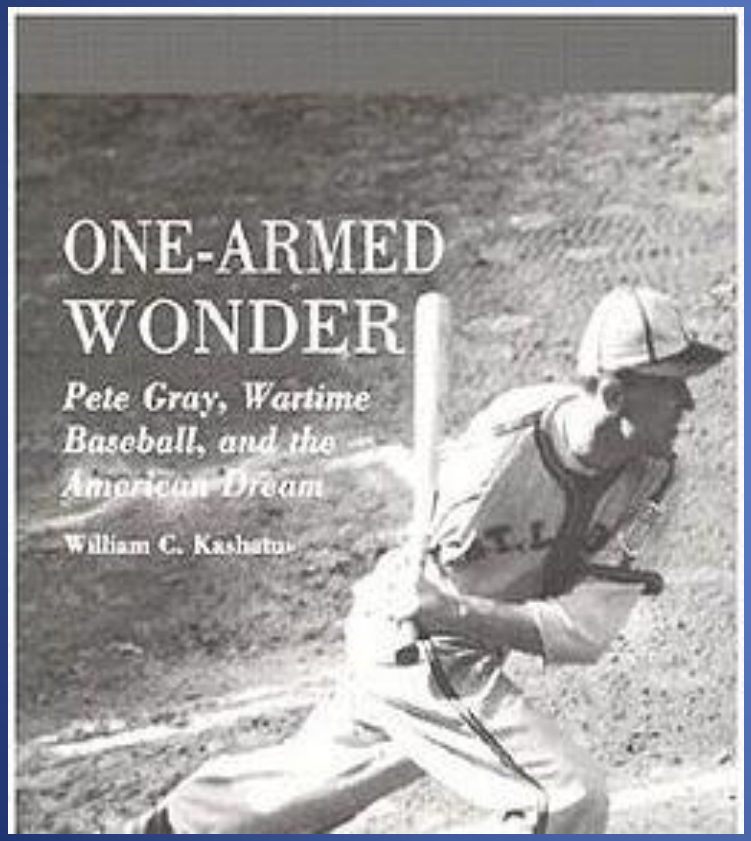
~ It is more laborious to get a patient admitted to the ARU than a SNF, but for the patients who fit the criteria it is a service!

~ The ARU is not the proper setting for patients who have difficult discharge planning.

~ Don't wait until the last moment (Friday @ 1400) to start planning a D/C to the ARU.

~ The ARU staff is here to help you serve your patients… ask questions, let us work together. Medicine is service, not an industry!

THANK YOU


ONE-ARMED
WONDER
Pete Gray, Wartime
Baseball, and the
American Dream
William C. Kashatus