



IRF/ARU Provider Alert: New AHA/ASA Guidelines on the Importance of Care Setting for Post-Acute Stroke Patients

In 2016, the American Heart Association/American Stroke Association (AHA/ASA) issued its first-ever guidelines on adult stroke rehabilitation. The guidelines provide new guidance for acute-care providers in determining the most appropriate post-acute venue for a growing population of stroke survivors.



Specifically, the AHA/ASA now strongly recommends that immediately following their acute-care stay, stroke patients should preferentially receive rehabilitation treatment in the inpatient rehabilitation setting, versus in a nursing home.

In the wake of these guidelines, it is imperative that acute-care providers facilitate access to high-quality inpatient rehabilitation services in order to enable eligible patients to achieve the highest possible level of functional mobility and independence.

The changes suggested by AHA/ASA are important given that previous guidelines focused primarily on medical issues surrounding the initial management of stroke. However, most patients survive a stroke with some level of disability, and there is increasing evidence that post-acute rehabilitation can have a significant impact on a survivor's quality of life.

Changes Included in the New Guidelines

According to the guidelines' authors, there are a few key findings – **based on accumulated research and data** – which providers should consider when evaluating stroke rehabilitation care, including:

- Stroke survivors who qualify for and have access to an inpatient rehabilitation facility (IRF) should receive treatment in an IRF, rather than a nursing home.
- Rehabilitation services should be delivered by a multidisciplinary team of experienced healthcare providers.
- Dedicated, inter-professional stroke care has been shown to not only reduce mortality rates and the likelihood of institutional care and long-term disability, but also to enhance recovery and increase independence in activities of daily living.

Stroke Recovery Settings Vary

Once a patient is discharged from their acute care setting, additional rehab treatment is warranted. To this end, the stroke guidelines review five post-acute rehab settings:

1. **Inpatient Rehab Facilities (IRFs)** – defined as entities that provide hospital-level care to stroke survivors who need intensive, interdisciplinary rehabilitation care under the direct supervision of a physician.
2. **Skilled Nursing Facilities (SNFs)** – provide rehabilitation care to stroke survivors who need limited skilled nursing or rehabilitation services.
3. **Nursing Homes** – deliver long-term residential care for individuals who are unable to live in the community.
4. **Long-Term Acute Care Hospitals (LTACs)** – provide extended medical and rehabilitative care to stroke patients with complex medical needs resulting from a combination of acute and chronic conditions (e.g., ventilator-dependent care, pain management).
5. **Home** – is an option when combined with home-health or outpatient rehabilitation. This setting is only for patients with mild or moderate stroke who do not need skilled nursing services, regular contact by a physician, or multiple therapeutic interventions.

Medicare has specific eligibility criteria for an IRF stay, and the patient's medical record must show a reasonable expectation that these standards were met at admission. Private insurers may use different criteria, but they often follow the federal government's lead. Under Medicare, the patient must:

- Require multiple types of rehabilitation services – physical, occupational or speech therapy, or prosthetics/orthotics. At least one therapy must be physical or occupational.
- Need an intensive program, generally three hours of therapy a day at least five days a week, or at least 15 hours within seven consecutive days.
- Be expected to actively participate in and benefit significantly from the intensive rehabilitation therapy program.
- Require supervision by a rehabilitation physician. Face-to-face visits must occur at least three days a week to assess the patient medically and functionally, and to modify the course of treatment as needed.
- Need an intensive, coordinated interdisciplinary team approach to the delivery of rehabilitative care. Team conferences must be held once a week.

Joel Stein, M.D., one of the guideline's authors, wants to make sure patients understand what those three-hour therapy sessions typically involve. "They imagine it's being in the gym exercising, and they get scared off." Instead, stroke recovery therapy is focused on restoring patients' ability to carry out routine activities, such as putting on clothes, speaking, getting to and from the bathroom safely, and managing daily hygiene. "It's really important to acknowledge that most people after a stroke really can participate in three hours of therapy if it's appropriately addressed to their needs," Stein said.

Treatment Settings Matter

According to the guidelines, studies comparing outcomes in hospitalized stroke patients first discharged to an IRF, an SNF, or a nursing home generally have shown that IRF patients have higher rates of return to community living and greater functional improvement, whereas patients discharged to an SNF or a nursing home have higher rehospitalization rates and substantially poorer outcomes.

These differences are the result of a number of factors. SNFs care for people with a wider range of conditions, so care teams often are more generalized. In contrast, IRFs specialize in neurorehabilitation, so they have therapists specialized in stroke recovery and more nurses with rehabilitation training, said Jason Zachariah, president of Kindred Rehabilitation Services. Inpatient rehab facilities have equipment and modalities specific to neurorecovery.

IRFs are subject to stricter requirements for physician visits than SNFs. In the acute rehab setting, a physician must see the patient at least three times every seven-day period, notes Sally Brooks, M.D., chief medical officer for Kindred Rehabilitation Services. Medicare rules require a physician to see an SNF patient at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Given the study data, the guidelines recommend that, whenever possible, initial rehabilitation should take place in an inpatient rehabilitation facility rather than a nursing home.

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The Importance of a Multidisciplinary Team

The guidelines state that, ideally, rehabilitation services should be delivered by a multidisciplinary team of healthcare providers. A diverse provider team offers each individual patient stroke-specific care from a range of important disciplines, including but not limited to neurology, rehabilitation nursing, occupational therapy, physical therapy, and speech and language therapy. This cross-functional and comprehensive team of providers is more likely to provide the care best suited for a patient's level of injury and post-rehab goals.

Medicare requires IRFs to provide interdisciplinary care and stipulates that team conferences be held once a week. "That requirement has created real teamwork among the whole multidisciplinary team, starting with the physicians engaged around bringing down every barrier to discharge for that stroke patient," Zachariah said. "The medical/clinical interventions, the therapy interventions, the psychosocial and family education components are all built around that patient to achieve the highest level of function and to get the patient home or back to the community safely."

Communication is the cornerstone of the multidisciplinary approach's success, said Stein, professor and chair of the Department of Rehabilitation and Regenerative Medicine at Columbia University College of Physicians and Surgeons. IRF care team members are skilled at troubleshooting together to solve problems as they arise, he said. For example, a nurse who notices that a stroke patient cries frequently would share that information with the rest of the team so that the physician could prescribe medication if necessary and the therapists could boost the patient's spirits by reinforcing the progress already made. "These kinds of interactions and discussions among the team members are a really important part of the process," Stein said.



Rehab Services Are Most Effective When Delivered by a Multidisciplinary Team:

- Neurology
- Rehabilitation Nursing
- Occupational, Physical, Speech and Language Therapy
- Social Work
- Psychiatry/Psychology
- Counseling

All stroke patients should undergo a formal assessment of rehabilitation needs before acute-care discharge

In addition to endorsing a multidisciplinary approach, the guidelines state that clear benefits are associated with initiating rehabilitation as quickly as possible – all stroke patients should undergo a formal assessment of rehabilitation needs before discharge from acute care. The guidelines go on to recommend that post-acute patients be transferred to inpatient rehab care as soon as they are deemed physically and mentally ready.

Implications for Acute Providers

According to the guidelines, the need for effective post-acute stroke rehabilitation is likely to remain an essential part of the continuum of stroke care for the foreseeable future. The way doctors decide the best setting for that care is little understood, Stein said. Research he is involved in suggests that often the hospital physical therapist's recommendation, conveyed by the discharge planner, plays a large role in whether the physician refers the patient to an SNF or to an IRF. Existing referral relationships and whether an IRF is nearby also are major factors.

At community hospitals, oftentimes the hospitalist or internal medicine service oversees stroke patients' care, Stein said. "Lack of information about the differences in care and the outcomes between post-acute settings is pretty pervasive."

Given the credibility of AHA/ASA and the strength of the new guidelines, acute care physicians are expected to increasingly adopt the recommendations provided in the guidelines, including a focus on the type of facility to which post-acute stroke patients are discharged. "Certain diagnoses should trigger physicians and discharge planners to think about rehab over skilled. These diagnoses are stroke, amputation, brain injury and spinal cord injury," Kindred's Brooks said.

Rehab providers that stand apart from the competition due to proven experience and documented success are likely to benefit from the AHA/ASA recommendations, with an opportunity to become "centers of excellence" in caring for stroke patients.

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Despite improved systems to recognize stroke symptoms and deliver care promptly, many patients experience ongoing functional deficits. Therefore, the need for effective stroke rehabilitation is likely to remain an essential part of the continuum of stroke care for the foreseeable future.



Sources:

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