# Eli's Rehab Report

## Acute Rehab: Are Inappropriate Referrals Bogging You Down?

**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 patients.

The demand for therapy evaluations has probably increased significantly in the last few years. Perhaps it's due to the nursing shortage, but hospital staff have less and less time to get patients out of bed. And when physicians take note, they may order therapy evaluations in the hope 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. 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. Ensure appropriate therapy referrals by taking these steps.

**For physicians:** Put in place a hospitalist program, and ensure that one of the acute PTs attends the rounds every morning, which is about 30 minutes. The PT can take 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 rounds.

If you have resident doctors at your facility, you'll also want to reach out to them so they're informed about appropriate therapy referrals which will stand them in good stead even if they move elsewhere. Educate them on what would be an inappropriate referral. Also you need to clarify during that training 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. Therapy staff often works with nursing staff to make sure they feel comfortable on an individual basis with moving patients, and they might even take them through a transfer.

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.

**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. Most physicians 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 who don't need or wouldn't benefit from therapy right away. Within acute care, a shorter form that just hits the highlights and has all the information you need from a

regulatory standpoint to ensure the patient doesn't have any subtle therapy needs will do the job. But you'll need a much more in-depth form for a stroke patient.

**Another way:** You could decide to do a screen if you can tell from a chart review and a quick discussion with the nurse that the patient may not need skilled therapy. As for billing, you might initiate 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.

**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. 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. You could focus heavily on ensuring that everything the therapist needs is in a convenient location. Ensure there are carts that your therapists use which have things they would likely use to treat or evaluate patients. A cart might have things like oxygen tubing, a cane, pulse oximeters, and sanitary booties for walking, among other things.

You could also have some storage space at three or more 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. In addition, the hospital might place specialty equipment (e.g., a bariatric walker) in a centralized location.

**Good idea:** It also helps to think "location" with staff as well. Try initiating floor assignments so that your therapists are assigned to a couple of floors, and they're on those floors pretty much all day. 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.