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.
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 INDEPENDENCE 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%
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>1</td>
<td>Total Admits &amp; Discharges</td>
<td>413</td>
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<tr>
<td>2</td>
<td>AVE. AGE</td>
<td>69.4</td>
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<tr>
<td>3</td>
<td>Case Mix Index</td>
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<tr>
<td>4</td>
<td>Community D/Cs</td>
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<tr>
<td>5</td>
<td>SNF D/Cs</td>
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<tr>
<td>6</td>
<td>MED-SURG D/Cs</td>
<td>12%</td>
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<tr>
<td>7</td>
<td>AVE. LOS</td>
<td>12.5 DAYS</td>
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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.
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