



## Why Care Settings Matter: Advantages of Inpatient Rehabilitation for COVID-19 Recovery and Beyond

Ensuring patients receive the right level of care at the right time in their care journey is especially critical in today's environment. Post-acute care has played an important role during the pandemic and will continue to be a part of the solution as more patients recover and work to regain a high quality of life. All post-acute settings are not created equal, as recently acknowledged by the American Hospital Association.<sup>1</sup> Each setting has value, but are designed for specific and different patient types. **This guide breaks down the key differences between the levels of post-acute care, the unique benefits of inpatient rehabilitation in treating COVID-19 patients, and the opportunity to optimize your rehab program or start a new program.**

The impact of COVID-19 has challenged all healthcare providers and will continue to do so for years to come.<sup>2</sup> By quickly adapting and incorporating new techniques to successfully treat the entire patient population – especially those recovering from COVID-19 – hospitals can ensure the highest quality outcomes across the care continuum.

### The Unique Benefits of Inpatient Rehab

**“The pandemic has highlighted the uneven patient care abilities across the four PAC settings, with regard to physician leadership and oversight, the contributions of other specialists and clinicians, infection control reliability, and patient outcomes,”** according to the AHA. Since each setting is designed for a unique patient population, it is important to understand the key differences and the impact on patient recovery. This delta has the greatest consequence for medically-complex patients and those recovering from COVID-19.<sup>1</sup>

“Early rehabilitation of COVID-19 patients can enhance pulmonary, respiratory function, reduce complications, improve function, cognitive impairments and quality of life,”<sup>3</sup> according to a recent *Journal of Rehabilitative Management* study.

**Inpatient rehabilitation offers a variety of resources and programs that help hospitals deliver quality care, reduce readmissions and improve overall facility operations. These include:**



Employing specially-trained Registered Nurses (RNs) who are fully equipped to treat patients with various care needs.



Hospital-level infection control measures.



Daily physician oversight and a multidisciplinary therapy team providing daily therapy tailored to each patient.

**By increasing patient access to inpatient rehabilitation, hospitals are better able to deliver high-quality outcomes in a safe environment.**

This focus on quality is evident in that inpatient rehabilitation units treat sicker patients yet produce better outcomes than other post-acute care settings.<sup>4</sup> Recent studies found that while treating a more complex patient population, inpatient rehabilitation operations maintain a higher discharge to the community rate of 70%, which is 37% higher than SNFs on average. The care provided in the inpatient rehabilitation setting continues to benefit patients even after discharge as they experience a lower rate of potentially-avoidable hospital readmissions of 4.3% compared to 22% of SNF patients who were re-hospitalized after admission.<sup>4</sup>

# Key Benefits of Inpatient Rehabilitation

Below is a care graph that further breaks down the key benefits inpatient rehabilitation provides for patients and what sets it apart from other care settings.

	Inpatient Rehabilitation Facility or Acute Rehabilitation Units	Skilled Nursing Facilities/ Transitional Care Units	Home Health Care
<b>License/ Certification</b>	Certified as acute care hospitals and licensed as freestanding inpatient rehabilitation hospitals or distinct rehabilitation units within a host hospital.	Licensed as a skilled nursing facility.	Certified to provide skilled nursing and skilled therapy services for home-bound patients.
<b>Physician Involvement</b>	Daily physician visits including a medical director of rehabilitation who provides services in the facility on a full-time basis.	Required physician visit during first 30 days; one visit every following 60 days. May be more frequent based on patient need.	Patient's physician certifies need and oversees care; face-to-face encounter with physician required.
<b>Nursing</b>	Receive specialized training in rehab nursing; Provide 24-hour nursing care; intervention, assessment, monitoring of: VS, IVFs/ antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment.	Must have at least one RN for at least eight straight hours a day, seven days a week, and either an RN or LPN/LVN on duty 24 hours per day; intervention, assessment, monitoring of: VS, IVFs/antibiotics, ostomy, catheter, trach, NG care; routine labs and diagnostics and respiratory equipment.	Nursing supervision of acute and chronic medical conditions. Teach/train/observe/assess and provide care plan management; instruct on medication administration, including oral, injections, infusions or tube feeding; wound, catheter and ostomy care; NG/trach aspiration and care.
<b>Rehab Therapy</b>	PT/OT/ST available. Patient able to participate in therapy three hrs/day, five days a week or 15 hours over seven days. Requires the services of at least two therapy disciplines. Level of rehab services provided in an IRF is more intense than other levels of post-acute care.	PT/OT/ST available. Participation varies based on medical needs and functional potential. Type and amount of therapy based on patient condition and medical needs. Patient prognosis varies. When possible, goal is to return patient to prior living setting but expectation that patient will return home or to community setting not required for admission.	PT/OT/SLP available. Participation varies based on medical needs and functional potential. Type and amount of therapy depends on patient condition and medical needs. Therapy goals are to restore function and improve patient independence and safety in the home environment. As patient function improves and patient is no longer homebound, therapy may be transferred to outpatient setting.
<b>Team Treatment</b>	Interdisciplinary approach between physician, therapy team, and nursing to facilitate recovery.  Physician-led weekly team conferences required.	Interdisciplinary approach between therapy and nursing to facilitate recovery.	Multidisciplinary team with nursing, therapy, social worker and home health aide. Visits are intermittent based on patient need and physician orders. Private duty (usually paid for by patient) may be available.
<b>Ancillary Services</b>	Services on site: pharmacy, lab, radiology.	Services readily available, but not on site: pharmacy consultant, lab, radiology.	Not available.
<b>Patient Characteristics</b>	<p>Patient's functional prognosis is good with the goal that they will return to home or a community-based setting.</p> <p>Patient demonstrates sufficient endurance and potential to participate in a rehab program and make significant gains in functional capabilities.</p> <p>Common admission patient description:</p> <ul style="list-style-type: none"> <li>Stroke or other neurologic disorder</li> <li>Multiple major trauma to brain, spinal cord, or amputation</li> <li>Burns</li> <li>Arthritic and pain syndromes</li> <li>Orthopedic fracture or bilateral joint replacement</li> <li>Medically complex patients such as those with CHF, COPD, post-COVID-19 or other cardiac conditions that have good endurance and potential for significant functional gains</li> </ul>	<p>Common admission patient description:</p> <ul style="list-style-type: none"> <li>Medically complex patients such as those with CHF, COPD and diabetes exacerbation requiring monitoring, management</li> <li>Wound care &gt; stage 2</li> <li>Orthopedic surgery, surgery with complications or stroke requiring mobility and activity of daily living recovery (tolerates less than three hrs therapy/day)</li> <li>Infections requiring ongoing IV antibiotics</li> <li>Neurological illnesses</li> </ul>	<p>The patient must be considered "confined to the home," defined as:</p> <ol style="list-style-type: none"> <li>Due to illness or injury the aid of a supportive device, the use of special transportation, or the assistance of another person is required in order to leave home, or they have a condition that makes leaving home contraindicated.</li> <li>If either of the above are true then there must also exist a normal inability to leave home and leaving home must require a considerable and taxing effort.</li> </ol> <p>Common patient needs:</p> <ul style="list-style-type: none"> <li>Wound, ostomy, catheter, NG, tube feeding or tracheostomy care</li> <li>Medication reconciliation and management</li> <li>Treatment of gait disturbances and balance disorders</li> <li>Infusion therapy</li> <li>Management of chronic, complex medical diagnoses (CHF, COPD, diabetes, arthritis)</li> <li>Teaching patients self-management techniques</li> <li>In-home rehabilitation</li> <li>Post-op therapy visits for orthopedic conditions (e.g., hip/knee replacement).</li> </ul>

# Importance of Partnerships in Post-Acute Recovery

Strong coordination between an acute episode and the next level of care is more important than ever because of the unique and positive role rehabilitation units play in pandemics, and specifically treating patients recovering from COVID-19.<sup>3</sup>

Many hospitals are partnering with Kindred Hospital Rehabilitation Services (KHRS), as their rehabilitation expert, to help them optimize their rehabilitation unit and relieve the burden of self-management. KHRS' decades of experience and national footprint has enabled hospital partner facilities to experience a faster rebound with greater agility compared to self-operating, while improving quality outcomes and delivering greater patient access.

To learn how KHRS can help your hospital provide the best possible care for patients recovering from COVID-19 and beyond, visit [www.kindredrehab.com](http://www.kindredrehab.com).

## References

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