



Why IRFs and ARUs Are a Better Choice for Many Trauma Patients

Trauma patients usually have two primary options upon discharge for continued facility-based rehabilitation: an inpatient rehabilitation facility (IRF/ARU) or a skilled nursing facility (SNF).

Recently released research published by the American College of Surgeons compared treatment in both settings and provides guidance to patients, clinicians and families of patients who have experienced traumatic incidents. The research shows trauma patients who went to an IRF following acute care significantly increased their functional independence, improved their chances of going home and had a lower risk of death than patients who did not receive IRF care.¹

Despite the empirical evidence, the number of trauma patients going to a SNF is rising, while the number discharged to inpatient rehabilitation locations appears to be declining. Dr. Saman Arbabi, who was the lead investigator in the longitudinal research studying IRF care for trauma patients, says that trend is concerning.²

"Advances in hospital care have benefited the most severely injured patients who now survive to discharge," Arbabi shared with the American College of Surgeons in advance of the study's publication.³

The authors explain, "These injured patients are typically motivated and productive members of society who regain their

functional independence and return to community living and work. Helping them regain their functional independence has the potential to improve their quality of life considerably, and also decrease the socioeconomic impact of their injuries."⁴

According to the Centers for Disease Control, losses in productivity total \$150 billion annually for injured patients who are discharged from the hospital. "Trauma is the most common cause of significant functional impairment, disability and mortality worldwide," the authors write in their article, *Acute Rehabilitation After Trauma: Does It Really Matter?*

Why IRFs Are the Better Choice

The study published in *Journal of American College of Surgeons* looked at the impact of post-discharge rehabilitation care for 933 trauma patients in Washington over two years. It is believed to be the first longitudinal research study to address the impact of IRFs in comparison to their alternatives.

The research reveals patients discharged from an acute care facility to an inpatient acute rehabilitation facility:

- Improved their functional independence by almost 50 percent,
- Were nine times more likely to go home after their post-hospital care than patients who did not receive IRF care, and
- Had a 40 percent lower risk of death a year later than patients who did not receive IRF care.

This chart from their research shows the difference between IRFs and SNFs in several categories:

Clinical Outcomes ⁵		
Issue	IRF Patients	SNF Residents
Average length of stay in post-acute care for all clinical categories	12.4 days	26.4 days
Risk of mortality in two years for all clinical categories	24.3%	32.3%
Additional days of life for all clinical categories	621.0 days (20.7 months)	569.1 days (18.9 months)
Ability to remain home without facility-based care for all clinical categories	582.3 days	530.8 days
Emergency room visits for all clinical categories	642.7 ER visits/1,000 patients/year	688.2 ER visits/1,000 patients/year
Hospital readmissions for all conditions	957.7 readmissions/1,000 patients/year	1,008.1 readmissions/1,000 patients/year

Source: Dobson DaVanzo & Associates, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, pages 28-38, Exhibits 4:1-4:10.

“Acute trauma patients should be recognized as an underserved population that would benefit considerably from inpatient rehabilitation services after discharge from the hospital,” the researchers conclude.⁶

An earlier study by MedPAC comparing patients with similar profiles also found those who went to IRFs had higher functional status on discharge, walked independently with more frequency, and were transferred independently at discharge more often than their counterparts who went to SNF.⁷

More Specifically, the MedPAC Study Found:

- **76 percent of IRF patients** (vs. 31 percent of SNF residents) were walking independently at discharge at 14 days after admission, and
- **79 percent of IRF patients** (vs. 30 percent of SNF residents) were transferring independently 14 days after admission.

Why Do IRFs Provide Better Outcomes?

IRFs are licensed as rehabilitation hospitals and have the same Medicare certifications as acute care hospitals, allowing these facilities to appropriately care for higher acuity and

more complex patients. Acute rehabilitation units are similar to IRFs but are embedded within the acute care hospital. As such, IRFs and ARUs must comply with Medicare mandates, including providing hospital-level care through physician-led interdisciplinary medical teams, which are not present in SNFs.

Nursing care in IRFs is often provided by specially-trained Registered Nurses. These nurses are less likely to be employed at most SNFs. IRFs are also required to provide patients with at least three hours of therapy a day, five days a week, which is a higher standard than all other post-acute care options.⁸

The goal of IRF services is to get the patient to perform independent daily living activities through physical, occupational, cognitive and social therapy. At SNFs, therapy services vary widely and are generally less than IRFs, Dr. Arbabi says.⁹

As he concludes, “Post-hospital care is as important, if not more important, than hospital care for trauma patients, and in that post-hospital care there should be a plan for physical therapy, cognitive therapy and educational activities of daily living.”

How We Can Help

Kindred Hospital Rehabilitation Services (KQRS) works with more than 150 hospital-based programs nationwide to help them bring greater success and better patient outcomes to their acute rehabilitation settings. We also operate 19 free-standing IRFs in partnerships with health systems, with an additional six such facilities opening in next 12 months. We see over 45,000 patients per year and we are the largest contract manager of hospital-based acute rehabilitation programs in the country.

KQRS has over 100 medical directors with a national acute rehabilitation medical advisory board; over 180 clinical intake personnel nationwide, over 120 social workers/ discharge planners and over 50,000 therapists – all backed by a national support team.

We provide management services including corporate and field/regional management, billing and coding oversight, 60/40 management, analysis and projects of admission trends, staffing, market analysis, financials, reimbursement expertise, denials management, chart documentation, education and training, and IT solutions.

KQRS is committed to providing a valuable partnership and collaboration that assures regulatory compliance, is committed to clinical quality, optimizes financial performance and is solidly rooted in physician engagement.

References

1, 2, 3 and 9

<https://www.facs.org/media/press-releases/jacs/acuterehab110116>

4. [http://www.journalacs.org/article/S1072-7515\(16\)31399-0/fulltext](http://www.journalacs.org/article/S1072-7515(16)31399-0/fulltext)

5. [http://www.journalacs.org/article/S1072-7515\(16\)31399-0/fulltext](http://www.journalacs.org/article/S1072-7515(16)31399-0/fulltext)

6. [http://www.journalacs.org/article/S1072-7515\(16\)31399-0/fulltext](http://www.journalacs.org/article/S1072-7515(16)31399-0/fulltext)

7. http://www.medicareadvocacy.org/old-site/News-Archives/RehabHosp_RehabOptions.htm

8. <http://www.aha.org/content/12/12factsheet-irf.pdf>

Marty Mann
Vice President, Strategic Partnerships
Kindred Hospital Rehabilitation Services
630.904.8400 • martin.mann@kindred.com



www.kindredrehab.com

Kindred  Hospital
Rehabilitation
Services